

Outpatient Facility Coding Alert

Coding: Replacing Medical Devices at No Cost? Report 'FD' Plus Condition Code 40 or 50

Failing to correctly report value and condition codes led to overpayments of \$2.7 million in 2016.

Providers: When Medicare issues a reminder, it's time to listen. And that's just what they did in October's issue of MLN Connects, CMS' weekly newsletter from the Medicare Learning Network.

Around this time last year, the OIG published audit results regarding a review of outpatient claims for replaced cochlear devices.

Of the 149 claims reviewed, 116 were found to contain coding errors that resulted in overpayments of \$2,685,588. On those claims, which listed no-cost cochlear device replacements, coders failed to append the appropriate value and condition codes to the procedure codes.

Those modifiers - value code FD (Credit received from the manufacturer for a replaced medical device) and condition codes 40 (Product replacement within product life cycle) and 50 (Product replacement for known recall of a product) - are used to indicate device credits. They alert Medicare contractors of the need for a reduction to the OPPS payment amount relative to the discount that providers receive from device manufacturers. Because the modifiers were missing, providers received the full payment amount, even though the devices were obtained at no cost or at a discount.

"Medicare does not cover items or services for which neither the beneficiary nor anyone on his or her behalf has an obligation to pay," the report states. This includes medical devices replaced under warranty at no cost to the patient or facility, or when the replacement device was purchased but a credit from the manufacturer was received. Essentially, providers received payment for a non-covered item.

If a provider receives a device at no cost, only partial OPPS payment is warranted.

According to federal regulations, providers are not entitled to full reimbursement for the replacement of an implanted device in the following situations:

- The device is furnished at no cost to the patient or the provider.
- The provider receives a full credit for the device's replacement cost.
- The provider receives a partial credit of 50 percent or more of the cost of the replacement device.

Value and condition codes help identify situations that warrant a Medicare payment reduction.

When coding a no-cost or reduced cost device replacement, do the following:

- Append value code FD to the procedure code.
- Report the amount of the device credit in the amount portion corresponding to value code FD. The OPPS payment amount will be reduced by the amount of the credit.
- Depending on the situation, report **ONE** of the following condition codes along with value code FD:

o 49 o 50.

Good-to-know: The OIG's review initially focused on cardiac devices, but was later expanded to include cochlear devices. However, the same rules apply to medical devices in general.



The OIG found that back-office processes often contributed to the erroneous claims.

Facilities submitting claims that did not comply with Medicare billing requirements tended to:

- Lack coordination between departments (clinical and billing, for example) to ensure that information regarding no-cost replacements was correctly documented and reported
- Lack communication with device manufacturers regarding no-cost replacements
- Lack understanding or awareness of billing requirements for no-cost replacements
- Lack a system for flagging claims listing no-cost replacement procedures for review before submission to the Medicare contractor.

One more tip: If you're not signed up for MLN Connects newsletter, you should be. "When CMS issues reminders like this, it's a clue as to what they're looking for during audits," says **Sarah L. Goodman, MBA, CHCAF, COC, CCP, FCS**, president and CEO of SLG, Inc. Consulting in Raleigh, North Carolina. You can sign up by visiting cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Provider-Partnership-Email-Archive.html.