

2009 MEDICARE UPDATE

REINSTATEMENT OF PASS-THROUGH CODES (C codes)

On January 1, 2004, Medicare reinstated the 95 pass-through codes that were retired on 1/1/03. These C codes, which only apply to Medicare hospital outpatient claims, will not trigger additional payment to the outpatient hospital facility. They have been reinstated to assist Medicare in establishing future APC rates. It is important for hospitals to continue using C codes in 2009 and beyond to ensure that cost data for Medicare outpatient procedures is accurate.

QUESTIONS & ANSWERS

Does C code reinstatement mean that hospitals will once again use pass-through codes to obtain separate payment for devices?

No. As of 1/1/04, Medicare reinstated all pass-through C codes that existed as of December 31, 2002. However, the C codes were reinstated to improve collection of device cost data, not for payment of previously eligible medical devices. Hospitals will continue to be paid for outpatient care using ambulatory payment classification (APC) rates based on procedures performed, and not on pass-through codes (C codes).

How soon would the claims data be used to update APC rates?

Specifically, 2008 hospital outpatient claims will be used as the basis for setting Medicare's 2010 hospital outpatient APC payments. If medical devices are used but not billed, claims will not record these device costs, the median cost of claims using devices would fall, and future rates could be adjusted downward.

How will I know if a medical device used in a procedure should be billed with a C code?

If a medical device meets the criteria established by Medicare and is described by one of the 95 pass-through categories that existed as of December 31, 2002, a C code should be billed and charged for on the claim recording the procedure(s) performed.

Why is it important to charge for devices if they do not directly impact the Medicare outpatient payment for that service?

It is important to charge appropriately for device-related procedures because hospital's charging practices will determine adequacy of future Medicare outpatient rates. Medicare sets new rates using hospital claims data from prior years. When hospitals fail to include appropriate device charges on the claim, this reduces future payment rates because the device-related costs are not captured for that service. As a result, it is important for hospitals to accurately reflect all procedure costs in insurance claims charges, including device cost, using the appropriate C code or revenue center code.

What is the impact when hospitals inaccurately code for device-related procedures.

Boston Scientific and others analyzed Medicare outpatient claims data for calendar year 2001 and found there were large numbers of inaccurately coded hospital claims for device-related procedures. In particular, many hospitals failed to bill and charge appropriately, either using the appropriate C codes or revenue center codes, for medical devices. Missing device and revenue center charges on these claims led directly to large underpayments to hospitals for Medicare outpatient services during 2001. To address this, CMS accepted Boston Scientific's recommendation to calculate payment rates for 40 outpatient procedure groups only on claims that appropriately included charges for high cost devices known to be associated with those procedures.