

2007

MEDICARE C-CODES (PASS-THROUGH 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, do NOT trigger additional payment to the outpatient hospital facility. They are tracking codes to assist Medicare in establishing future APC rates. It is essential for hospitals to report C-codes to ensure that cost data for Medicare outpatient procedures is accurate and APC rates are set appropriately.

QUESTIONS & ANSWERS

- **Do hospitals use C-codes (pass-through codes) to obtain separate payment for devices?**

No. As of 1/1/04, C-codes were reinstated to improve collection of device cost data. Hospitals will continue to be paid for outpatient care using APC rates based on procedures performed but will not receive additional payment based on C-code reporting.

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

2007 hospital outpatient claims will be used to establish 2009 Medicare hospital outpatient APC payments. If medical devices are used in 2007 but not reported, claims will not capture these device costs and future APC rates could decline.

- **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. **See the Endoscopy C-code Summary and C-code Cross Reference Guide for information on Endoscopy products to which C-codes apply.**

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

In 2005, CMS mandated that certain C-codes must be billed with CPT[®] codes mapping to device-dependent APCs, otherwise the claim will not be paid. For the remainder of non-required C-codes, it is still important to charge appropriately for device-related procedures because hospitals' 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?**

Failing to bill and charge appropriately, either using the appropriate C-codes or revenue center codes, can lead to reduced payments to hospitals for Medicare outpatient services.

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