Reimbursement Policy:

No Cost/Reduced Cost Drugs, Implants & Devices

(Commercial and Medicare)

POLICY NUMBER	EFFECTIVE DATE:	APPROVED BY
RPC20210006	1/01/2022	**RPC (Reimbursement Policy Committee)**

Reimbursement Guideline Disclaimer: We have policies in place that reflect billing or claims payment processes unique to our health plans. Current billing and claims payment policies apply to all our products, unless otherwise noted. We will inform you of new policies or changes in policies through postings to the applicable Reimbursement Policies webpages on emblemhealth.com and connecticare.com. Further, we may announce additions and changes in our provider manual and/or provider newsletters which are available online and emailed to those with a current and accurate email address on file. The information presented in this policy is accurate and current as of the date of this publication.

The information provided in our policies is intended to serve only as a general reference resource for services described and is not intended to address every aspect of a reimbursement situation. Other factors affecting reimbursement may supplement, modify or, in some cases, supersede this policy. These factors may include, but are not limited to, legislative mandates, physician or other provider contracts, the member's benefit coverage documents and/or other reimbursement, and medical or drug policies. Finally, this policy may not be implemented the same way on the different electronic claims processing systems in use due to programming or other constraints; however, we strive to minimize these variations.

We follow coding edits that are based on industry sources, including, but not limited to, CPT® guidelines from the American Medical Association, specialty organizations, and CMS including NCCI and MUE. In coding scenarios where there appears to be conflicts between sources, we will apply the edits we determine are appropriate. We use industry-standard claims editing software products when making decisions about appropriate claim editing practices. Upon request, we will provide an explanation of how we handle specific coding issues. If appropriate coding/billing guidelines or current reimbursement policies are not followed, we may deny the claim and/or recoup claim payment.

Overview:

This reimbursement policy applies to services reported using the UB04 claim form or HCFA/CMS-1500 or electronic equivalent. This policy applies to all products, all network and non-network physicians and other qualified health care professionals, including, but not limited to, non-network authorized and percent of charge contract physicians and other qualified health care professionals.

Policy Statement:

For inpatient and outpatient hospital services; this policy provides coding guidelines associated with reporting drugs, devices and/or implants with their associated procedures as well as the coding guidelines for reporting drugs, devices or implants obtained by the provider at no cost or at a reduced cost.

Reimbursement Guidelines:

Device or Implant Dependent Procedures:

EmblemHealth/ConnectiCare have aligned with CMS on the following guidelines for outpatient hospital services for devices and implants. When the use of a device or implant is necessary in the performance of certain procedures, the device or implant must be submitted with the same date of service and on the same claim as the procedure.

- A device or implant dependent procedure will be denied if reported without an applicable device or implant on the same claim and date of service.
- A submission of the procedure code without a device or implant would only be considered for reimbursement when the service was discontinued prior to the placement of the device or implant and appended with an appropriate modifier indicating it was a discontinued procedure.
- Devices, implants, or brachytherapy sources with CMS Outpatient Clams Editor (OCE) Status Indicator H (pass-through device) or U (brachytherapy sources) will be denied if reported without a procedure

Reimbursement Policy:

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(Commercial and Medicare)

with OCE Status J1, S, or T on the same date of service and same claim.

Devices, implants, or brachytherapy sources with CMS OCE Status Indicator H (pass-through device) or U (brachytherapy sources) will be denied if reported without a procedure with OCE Status J1, S, or T on the same date of service and same claim.

Definitions:

Status Indicator	Definition
H	Pass-through Device Categories
J1	Hospital Part B Services Paid through a Comprehensive APC
S	Procedure or Service, Not Discounted when multiple
T	Procedure or Service, Multiple Procedure Reduction Applies
U	Brachytherapy Sources

No Cost/Credit for Drugs, Devices and/or Implants:

When a drug, device or implant was obtained by the provider at no cost or a reduced cost it must be submitted with the appropriate condition code, value code, and modifier.

UB-04 Claims:

Condition Codes applicable to device or implant credit:	
Condition Code **49**	Product Replacement within Product Lifecycle--Replacement of a product earlier than the anticipated lifecycle.
Condition Code **50**	Product Replacement for Known Recall of a Product--Manufacturer or FDA has identified the product for recall and therefore replacement.
Condition Code **53**	Initial placement of a medical device provided as part of a clinical trial or free sample

Value Code applicable to device or implant credit:	
Value Code **FD**	Credit Received from the Manufacturer for a Medical Device
Line must be billed with $0.01	

Reimbursement Policy:

No Cost/Reduced Cost Drugs, Implants & Devices (Commercial and Medicare)

HCFA/CMS-1500 Claims:

Charges billed with a token amount of $0.01-$1.01 and no modifier will deny

Modifiers applicable to device or implant credit:	
FB	Items without cost to provider, supplier, or practitioner, or full credit received for replaced device (examples, but not limited to, covered under warranty, replaced due to defect, free examples).
FC	Partial credit for replaced device.

For outpatient hospital claims, when a drug is provided at no cost, claims processing edits prevent drug administration charges from being billed when the claim does not contain a covered/billable drug charge. Therefore, for drugs provided at no cost in the hospital outpatient department, providers must report the applicable drug HCPCS code and appropriate units with a token charge of less than $1.01 for the item in the covered charge field and mirror this less than $1.01 amount reported in the non-covered charge field.

Claim Form Instructions:

Facility Claims (UB-04)

- Loop 2400 Segment SV202-7 or Box 80
  - Enter "Drug Donated" or another appropriate message
  - Enter code description, strength, and dosage - if billing a Not Otherwise Classified (NOC) HCPCS code
- Loop 2400 Segment SV202-2 or Box 44
  - Enter drug (HCPCS) code
- Loop 2300 Segment CLM02 or Box 47 and 48
  - Enter $0.01 for the billed amount

CMS-1500

- Loop 2400 Segment SV101-7 for the 5010A1 837P or Item 19
  - Enter "Drug Donated" or another appropriate message
  - Enter code description, strength, and dosage - if billing a Not Otherwise Classified (NOC) HCPCS code
- Loop 2400 Segment SV101-2 or Item 24D
  - Enter drug (HCPCS) code
- Loop 2300 CLM02 or Item 28
  - Enter $0.01 for the billed amount

Examples:

Example 1: The hospital receives a device credit of $16,500 for an ICD replacement procedure (APC 107). The device offset amount for APC 107 is $20,244. The hospital's APC payment is reduced by $16,500.

Example 2: The hospital receives a device credit of $22,000 for an ICD replacement procedure (APC 107). The device offset amount for APC 107 is $20,244. The hospital's APC payment is reduced by $20,244.

References:

1. Center for Medicare and Medicaid Services (CMS), Manual System and other CMS publications and services
2. Center for Medicare and Medicaid Services (CMS) Integrated Outpatient Code Edit (IOCE)
3. Center for Medicare and Medicaid Services (CMS) Hospital Outpatient Prospective Payment System (OPPS) Code of Federal Register U.S Food and Drug Administration

Revision History

Company(ies)	DATE	REVISION
EmblemHealth ConnectiCare	8/2021	• Updated to include Commercial effective 1/01/2022; Medicare effective 1/01/2020 • Reformatted and reorganized policy, transferred content to new template with new Reimbursement Policy Number