CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1597	**Date: September 12, 2008**
	Change Request 6050

SUBJECT: Payment for Implanted Prosthetic Devices for Part B Inpatients in Hospitals that are Paid Under the Medicare Hospital Outpatient Prospective Payment System (OPPS)

I. SUMMARY OF CHANGES: The purpose of this Change Request is to revise the Medicare Claims Processing Manual, Pub.100-04, Chapter 4, §240 to provide instructions regarding how contractors are to establish the payment to be made for implanted prosthetic devices that are furnished to Medicare beneficiaries who are inpatients of hospitals that are paid under the OPPS when the beneficiary does not have Part A coverage of services on the date that the device is implanted. These instructions do not apply to hospitals that are not paid under the OPPS for outpatient hospital services.

New / Revised Material
Effective Date: January 1, 2009
Implementation Date: January 5, 2009

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	4/240/Inpatient Part B Hospital Services

III. FUNDING:
SECTION A: For Fiscal Intermediaries and Carriers:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

SECTION B: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:
Business Requirements
Manual Instruction
**Unless otherwise specified, the effective date is the date of service.*

Attachment - Business Requirements

Pub. 100-04	Transmittal: 1597	Date: September 12, 2008	Change Request: 6050

SUBJECT: Payment for Implanted Prosthetic Devices for Part B Inpatients in Hospitals that are Paid Under the Medicare Hospital Outpatient Prospective Payment System (OPPS)

Effective Date: **January 1, 2009**

Implementation Date: January 5, 2009

I. GENERAL INFORMATION

A. Background: Section 1833(t)(2)(A) of the Act permits the Secretary to designate medical and other health services that are payable under the Medicare OPPS for beneficiaries who are hospital inpatients, and who have Part B benefits but do not have Part A coverage of the inpatient hospital services they received. Implanted prosthetic devices are included in the list of designated services for which payment may be made under the OPPS for Medicare beneficiaries in this circumstance. See the Medicare Benefits Policy Manual, Pub. 100-02, Chapter 6, §10 for the definition of an implanted prosthetic device for which payment may be made under this benefit and for the circumstances under which the beneficiary qualifies for coverage. The processing of claims for these services is discussed in the Medicare Claims Processing Manual, Pub.100-04, Chapter 4, §240. Payment for implanted prosthetic devices is packaged into the OPPS payment for the procedure in which they are implanted when they are implanted in a hospital outpatient department.

B. Policy: The purpose of this Change Request is to revise the Medicare Claims Processing Manual, Pub.100-04, Chapter 4, §240 to provide instructions regarding how contractors are to establish the payment to be made for implanted prosthetic devices that are furnished to Medicare beneficiaries who are inpatients of hospitals that are paid under the OPPS when the beneficiary does not have Part A coverage of services on the date that the device is implanted. These instructions do not apply to hospitals that are not paid under the OPPS for outpatient hospital services.

Specifically, the manual is revised to specify that providers must report a new C- code that will be effective for services furnished on and after January 1, 2009, when they furnish an implanted prosthetic device to a Medicare beneficiary who is a hospital inpatient, but who does not have coverage of inpatient services on the date that the implanted prosthetic device is furnished. The new C-code is necessary to report that the device is an implanted prosthetic device that meets the criteria for payment when furnished to inpatients who do not have Part A coverage on the date that the device is furnished. Currently existing HCPCS codes for specific implanted prosthetic devices do not exist for all implanted prosthetic devices that may be furnished to inpatients and therefore they are not sufficient for this purpose. The manual is also revised to specify that the contractor will determine if the device meets the definition for an implanted prosthetic device and if so, will establish the payment to be made for the device. If the device has pass through status under the OPPS, payment would be made at charges reduced to cost by the hospital specific overall cost to charge ratio in the same manner as they currently pay for pass through devices under the OPPS.

The fiscal intermediary standard system (FISS) is revised to establish the beneficiary coinsurance for services billed on a 12X type of bill and which are contractor-priced at the lower of 20 percent of the payment rate or the amount of the inpatient deductible applicable to the year in which the device is furnished. The common working file (CWF) is revised to establish an edit that permits payment of the new C-code only on a 12X type of bill (TOB) and only if the line item date of service for the device is a date on which the beneficiary does not have Medicare Part A coverage of inpatient hospital services.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6050.1	Medicare Contractors shall accept the new C-code as a valid code effective for services furnished on and after January 1, 2009.	X		X			X			X	I/OCE
6050.2	Medicare contractors shall suspend all claims from hospitals paid under the OPPS that contain the new C-code for manual review and pricing of the item reported under the new C-code.	X		X			X				
6050.3	Medicare contractors shall determine via claim review if the item furnished to the patient meets the definition of a prosthetic device as defined in the Medicare Benefit Policy Manual, Pub. 100-02, Chapter 6, Section 10, and if so, whether it is implanted in the body at least temporarily.	X		X							
6050.4	Medicare contractors shall make a payment for the item reported by the new C-code only if they have determined that it is an implanted prosthetic device that is implanted in the body at least temporarily.	X		X							
6050.5	Medicare contractors shall deny payment for the item reported by the new C-code if they have determined that it does not meet the definition of an implanted prosthetic device that is implanted in the body at least temporarily.	X		X							
6050.5.1	Medicare contractors shall use the following Remittance Advice (RA) Remark Code when denying non-covered charges: N180 – This item or service does not meet the criteria for the category under which it was billed.	X		X							
6050.5.2	Medicare contractors shall use the following Group Code when denying non-covered charges: PR – Patient Responsibility	X		X							
6050.5.3	Medicare contractors shall use the following Claim Adjustment Reason Code when denying noncovered charges: 96 – Non-covered Charges	X		X							
6050.6	Medicare contractors shall determine if the specific device reported by the new C-code has pass through	X		X							

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	status under the OPPS. If so, contractors shall set the payment at charges reduced to cost by the application of the hospital specific cost to charge ratio.										
6050.7	If the specific device reported by the C-code does not have pass through status under the OPPS, contractors shall determine if there is a payment amount for the device under the DMEPOS fee schedule. If so, contractors shall set payment at the lower of the actual charge for the item or the amount on the DMEPOS fee schedule for the device.	X		X							
6050.8	If the specific device identified by the new C-code is not on the DMEPOS fee schedule and does not have pass through status under the OPPS, contractors shall establish a payment amount for the device. The contractor shall pay the lesser of the actual charge or the contractor established amount for the specific device.	X		X							
6050.9	FISS shall calculate the coinsurance on a contractor-priced item on a 12X TOB to be equal to the lesser of 20 percent of: a) the pass through amount, the DMEPOS fee schedule amount, or the contractor-established rate, whichever is applicable, or b) the amount of the inpatient deductible for the year in which the service was furnished.						X				
6050.10	Medicare contractors shall pay the new C-code only when submitted on 12X TOB.	X		X							
6050.11	FISS shall create an edit that will return to provider claims containing the new C-code if it is not billed on a 12X TOB by a provider that is paid under the OPPS.						X				
6050.12	CWF shall allow payment of the new C-code only if the beneficiary does not have coverage of Part A inpatient hospital services on the date that the item is furnished.									X	
6050.13	Medicare contractors shall deny payment if they or CWF determine that the beneficiary was in a Part A covered stay on the date of service of the item reported by the new C-code.	X		X							
6050.13.1	Medicare contractors shall use the following Remittance Advice (RA) Remark Code when denying non-covered charges: M2 – Not paid separately when the patient is an inpatient. Start: January 1, 1997	X		X							

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6050.13.2	Medicare contractors shall use the following Group Code when denying non-covered charges: CO – Contractor Obligation	X		X							
6050.13.3	Medicare contractors shall use the following Claim Adjustment Reason Code when denying noncovered charges: 96 – Non-covered Charges	X		X							

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6050.13	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X		X							

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below: N/A
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
6050.14	Hospitals that are paid under the OPPS and which are claiming payment for implanted prosthetic devices furnished to inpatients on a date on which the beneficiary does not have Part A coverage may wish to further identify the implanted prosthetic device for which payment is claimed under the new C-code in the "remarks" section of the claim, either by narrative description or by the HCPCS device code if there is one, to facilitate prompt payment and to avoid the submission of medical records.
6050.15	Medicare contractors may pay the OPPS full credit offset amount for the APC in which the device is used if they believe that amount to be a reasonable payment for the implanted prosthetic device. See www.cms.hhs.gov/HospitalOutpatientPPS/ for the list of devices, the list of applicable APCs and the APC offset percentages that could be used to calculate the estimated device cost in the APC. From the OPPS webpage, select "Device, Radiolabeled Product, and Procedure Edits". Open the most recent file "Procedure to Device Edits" to determine the APC that is most applicable to the specific device reported by the new C-code. Then select "FB/FC Modifier Procedures and Devices". Select the applicable file of APCs subject to full and partial credit reduction policy (e.g. "CY 2008 APCs Subject to Full and Partial Credit Reduction Policy"). Select the "Full offset reduction amount" that pertains to the APC that is most applicable to the specific device reported by the new C-code. It would be reasonable to set this amount as the payment for a device furnished to a Part B inpatient. For example, if the new C-code is reporting insertion of a single chamber pacemaker (C1786 or equivalent narrative description) the file of procedure to device edits shows that a single chamber pacemaker is the dominant device for APC 0090 (APC 0089 is for insertion of both pacemaker and electrodes). The table of offset reduction amounts for CY 2008 shows that the estimated cost of a single chamber pacemaker for APC 0090 is $4881.77. It would therefore be reasonable for the contractor/MAC to set the payment rate for a single chamber pacemaker furnished to a Part B inpatient to $4881.77.

Section B: For all other recommendations and supporting information, use this space: N/A

V. CONTACTS

Pre-Implementation Contact(s):

Anita Heygster at 410-786-4486 or anita.heygster@cms.hhs.gov for payment policy questions.

Maria Durham at 410-786-6978 or maria.durham@cms.hhs.gov for claims processing questions

Post-Implementation Contact(s): Regional Office

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Carriers, and Regional Home Health Carriers (RHHIs)* use only one of the following statements:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: *For Medicare Administrative Contractors (MACs)*, use the following statement:

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

240 - Inpatient Part B Hospital Services

(Rev.1597, Issued: 09-12-08, Effective: 01-01-09, Implementation: 01-05-09)

Inpatient Part B services which are paid under OPPS include:

- Diagnostic x-ray tests, and other diagnostic tests (excluding clinical diagnostic laboratory tests);
- X-ray, radium, and radioactive isotope therapy, including materials and services of technicians;
- Surgical dressings applied during an encounter at the hospital and splints, casts, and other devices used for reduction of fractures and dislocations (splints and casts, etc., include dental splints);
- Implantable prosthetic devices;
- Hepatitis B vaccine and its administration, and certain preventive screening services (pelvic exams, screening sigmoidoscopies, screening colonoscopies, bone mass measurements, and prostate screening.)
- Bone Mass measurements;
- Prostate screening;
- Immunosuppressive drugs;
- Oral anti-cancer drugs;
- Oral drug prescribed for use as an acute anti-emetic used as part of an anti-cancer chemotherapeutic regimen; and
- Epoetin Alfa (EPO)

When a hospital that is not paid under the OPPS furnishes an implantable prosthetic device that meets the criteria for coverage in Medicare Benefit Policy Manual, Pub.100-02, Chapter 6, §10 to an inpatient who has coverage under Part B, payment for the implantable prosthetic device is made under the payment mechanism that applies to other hospital outpatient services (e.g., reasonable cost, all inclusive rate, waiver).

When a hospital that is paid under the OPPS furnishes an implantable prosthetic device to an inpatient who has coverage under Part B, but who does not have coverage of inpatient services on the date that the implanted prosthetic device is furnished, the hospital should report the new C-code that will be effective for services furnished on or after January 1, 2009. This code may be reported only on claims with TOB 12X when the prosthetic device is implanted on a day on which the beneficiary does not have coverage of the hospital inpatient services he or she is receiving. The line containing this new code will be rejected if it is reported on a claim that is not a TOB 12X or if it is reported with a line item date of service on which the beneficiary has coverage of inpatient hospital services. By reporting the new C-code, the hospital is reporting that all of the criteria for payment under Part B are met as specified in the Medicare Benefit Policy Manual, Pub.100-02, Chapter 6, §10, and that the item meets all Medicare criteria for coverage as an implantable prosthetic device as defined in that section.

Medicare contractors shall first determine that the item furnished meets the Medicare criteria for coverage as an implantable prosthetic device as specified in the Medicare Benefit Policy Manual, Pub. 100-02, Chapter 6, §10. If the item does not meet the criteria for coverage as an implantable prosthetic device, the contractor shall deny payment on the basis that the item is outside the scope of the benefits for which there is coverage for Part B inpatients. The beneficiary is liable for the charges for the noncovered item when the item does not meet the criteria for coverage as an implanted prosthetic device as specified in the Medicare Benefit Policy Manual, Pub.100-02, Chapter 6, §10.

If the contractor determines that the device is covered, the contractor shall determine if the device has pass through status under the OPPS. If so, the contractor shall establish the payment amount for the device at the product of the charge for the device and the hospital specific cost to charge ratio. Where the device does not have pass through status under the OPPS, the contractor shall establish the payment amount for the device at the amount for a comparable device in the DMEPOS fee schedule where there is such an amount. Payment under the DMEPOS fee schedule is made at the lesser of charges or the fee schedule amount and therefore, if there is a fee for the specific item on the DMEPOS fee schedule, the payment amount for the item will be set at the lesser of the actual charges or the DMEPOS fee schedule amount. Where the item does not have pass through payment status and where there is no amount for a comparable device in the DMEPOS fee schedule, the contractor shall establish a payment amount that is specific to the particular implanted prosthetic device for the applicable calendar year. This amount (less applicable unpaid deductible and coinsurance) will be paid for that specific device for services furnished in the applicable calendar year unless the actual charge for the item is less than the established amount). Where the actual charge is less than the established amount, the contractor will pay the actual charge for the item (less applicable unpaid deductible and coinsurance).

In setting a contractor established payment rate for the specific device, the contractor takes into account the cost information available at the time the payment rate is established. This information may include, but is not limited to, the amount of device cost that would be removed from an applicable APC payment for implantation of the device if the provider received a device without cost or a full credit for the cost of the device.

If the contractor chooses to use this amount, see www.cms.hhs.gov/HospitalOutpatientPPS/ for the amount of reduction to the APC payment that would apply in these cases. From the OPPS webpage, select "Device, Radiolabeled Product, and Procedure Edits" from the list on the left side of the page. Open the file "Procedure to Device edits" to determine the HCPCS code that best describes the procedure in which the device would be used. Then identify the APC to which that procedure code maps from the most recent Addenda B on the OPPS webpage and open the file "FB/FC Modifier Procedures and Devices". Select the applicable year's file of APCs subject to full and partial credit reductions (for example: CY 2008 APCs Subject to Full and Partial Credit Reduction Policy"). Select the "Full offset reduction amount" that pertains to the APC that is most applicable to the device described by the new C-code. It would be reasonable to set this amount as a payment for a device furnished to a Part B inpatient.

For example, if the new C-code is reporting insertion of a single chamber pacemaker (C1786 or equivalent narrative description on the claim in "remarks") the file of procedure to device edits shows that a single chamber pacemaker is the dominant device for APC 0090 (APC 0089 is for insertion of both pacemaker and electrodes and therefore would not apply if electrodes are not also billed). The table of offset reduction amounts for CY 2008 shows that the estimated cost of a single chamber pacemaker for APC 0090 is $4881.77. It would therefore be reasonable for the contractor/MAC to set the payment rate for a single chamber pacemaker furnished to a Part B inpatient to $4881.77. In this case the coinsurance would be $936.75 (20 percent of $4881.77, which is less than the inpatient deductible).

The beneficiary coinsurance is 20 percent of the payment amount for the device (i.e. the pass through payment amount, the DMEPOS fee schedule amount, the contractor established amount, or the actual charge if less than the DMEPOS fee schedule amount or the contractor established amount for the specific device), not to exceed the Medicare inpatient deductible that is applicable to the year in which the implanted prosthetic device is furnished.

Inpatient Part B services paid under other payment methods include:

- Clinical diagnostic laboratory tests, prosthetic devices other than implantable ones and other than dental which replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices;
- Leg, arm, back and neck braces; trusses and artificial legs; arms and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition; take home surgical dressings; outpatient physical therapy; outpatient occupational therapy; and outpatient speech-language pathology services;
- Ambulance services;
- Screening pap smears, screening colorectal tests, and screening mammography;
- Influenza virus vaccine and its administration, pneumococcal vaccine and its administration;
- Diabetes self-management *training*;
- Hemophilia clotting factors for hemophilia patients competent to use these factors without supervision).

See Chapter 6 of the Medicare Benefit Policy Manual for a discussion of the circumstances under which the above services may be covered as Part B Inpatient services.

240 - Inpatient Part B Hospital Services

(Rev.1597, Issued: 09-12-08, Effective: 01-01-09, Implementation: 01-05-09)

Inpatient Part B services which are paid under OPPS include:

- Diagnostic x-ray tests, and other diagnostic tests (excluding clinical diagnostic laboratory tests);
- X-ray, radium, and radioactive isotope therapy, including materials and services of technicians;
- Surgical dressings applied during an encounter at the hospital and splints, casts, and other devices used for reduction of fractures and dislocations (splints and casts, etc., include dental splints);
- Implantable prosthetic devices;
- Hepatitis B vaccine and its administration, and certain preventive screening services (pelvic exams, screening sigmoidoscopies, screening colonoscopies, bone mass measurements, and prostate screening.)
- Bone Mass measurements;
- Prostate screening;
- Immunosuppressive drugs;
- Oral anti-cancer drugs;
- Oral drug prescribed for use as an acute anti-emetic used as part of an anti-cancer chemotherapeutic regimen; and
- Epoetin Alfa (EPO)

When a hospital that is not paid under the OPPS furnishes an implantable prosthetic device that meets the criteria for coverage in Medicare Benefit Policy Manual, Pub.100-02, Chapter 6, §10 to an inpatient who has coverage under Part B, payment for the implantable prosthetic device is made under the payment mechanism that applies to other hospital outpatient services (e.g., reasonable cost, all inclusive rate, waiver).

When a hospital that is paid under the OPPS furnishes an implantable prosthetic device to an inpatient who has coverage under Part B, but who does not have coverage of inpatient services on the date that the implanted prosthetic device is furnished, the hospital should report the new C-code that will be effective for services furnished on or after January 1, 2009. This code may be reported only on claims with TOB 12X when the prosthetic device is implanted on a day on which the beneficiary does not have coverage of the hospital inpatient services he or she is receiving. The line containing this new code will be rejected if it is reported on a claim that is not a TOB 12X or if it is reported with a line item date of service on which the beneficiary has coverage of inpatient hospital services. By reporting the new C-code, the hospital is reporting that all of the criteria for payment under Part B are met as specified in the Medicare Benefit Policy Manual, Pub.100-02, Chapter 6, §10, and that the item meets all Medicare criteria for coverage as an implantable prosthetic device as defined in that section.

Medicare contractors shall first determine that the item furnished meets the Medicare criteria for coverage as an implantable prosthetic device as specified in the Medicare Benefit Policy Manual, Pub. 100-02, Chapter 6, §10. If the item does not meet the criteria for coverage as an implantable prosthetic device, the contractor shall deny payment on the basis that the item is outside the scope of the benefits for which there is coverage for Part B inpatients. The beneficiary is liable for the charges for the noncovered item when the item does not meet the criteria for coverage as an implanted prosthetic device as specified in the Medicare Benefit Policy Manual, Pub.100-02, Chapter 6, §10.

If the contractor determines that the device is covered, the contractor shall determine if the device has pass through status under the OPPS. If so, the contractor shall establish the payment amount for the device at the product of the charge for the device and the hospital specific cost to charge ratio. Where the device does not have pass through status under the OPPS, the contractor shall establish the payment amount for the device at the amount for a comparable device in the DMEPOS fee schedule where there is such an amount. Payment under the DMEPOS fee schedule is made at the lesser of charges or the fee schedule amount and therefore, if there is a fee for the specific item on the DMEPOS fee schedule, the payment amount for the item will be set at the lesser of the actual charges or the DMEPOS fee schedule amount. Where the item does not have pass through payment status and where there is no amount for a comparable device in the DMEPOS fee schedule, the contractor shall establish a payment amount that is specific to the particular implanted prosthetic device for the applicable calendar year. This amount (less applicable unpaid deductible and coinsurance) will be paid for that specific device for services furnished in the applicable calendar year unless the actual charge for the item is less than the established amount). Where the actual charge is less than the established amount, the contractor will pay the actual charge for the item (less applicable unpaid deductible and coinsurance).

In setting a contractor established payment rate for the specific device, the contractor takes into account the cost information available at the time the payment rate is established. This information may include, but is not limited to, the amount of device cost that would be removed from an applicable APC payment for implantation of the device if the provider received a device without cost or a full credit for the cost of the device.

If the contractor chooses to use this amount, see www.cms.hhs.gov/HospitalOutpatientPPS/ for the amount of reduction to the APC payment that would apply in these cases. From the OPPS webpage, select "Device, Radiolabeled Product, and Procedure Edits" from the list on the left side of the page. Open the file "Procedure to Device edits" to determine the HCPCS code that best describes the procedure in which the device would be used. Then identify the APC to which that procedure code maps from the most recent Addenda B on the OPPS webpage and open the file "FB/FC Modifier Procedures and Devices". Select the applicable year's file of APCs subject to full and partial credit reductions (for example: CY 2008 APCs Subject to Full and Partial Credit Reduction Policy"). Select the "Full offset reduction amount" that pertains to the APC that is most applicable to the device described by the new C-code. It would be reasonable to set this amount as a payment for a device furnished to a Part B inpatient.

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The beneficiary coinsurance is 20 percent of the payment amount for the device (i.e. the pass through payment amount, the DMEPOS fee schedule amount, the contractor established amount, or the actual charge if less than the DMEPOS fee schedule amount or the contractor established amount for the specific device), not to exceed the Medicare inpatient deductible that is applicable to the year in which the implanted prosthetic device is furnished.

Inpatient Part B services paid under other payment methods include:

- Clinical diagnostic laboratory tests, prosthetic devices other than implantable ones and other than dental which replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices;
- Leg, arm, back and neck braces; trusses and artificial legs; arms and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition; take home surgical dressings; outpatient physical therapy; outpatient occupational therapy; and outpatient speech-language pathology services;
- Ambulance services;
- Screening pap smears, screening colorectal tests, and screening mammography;
- Influenza virus vaccine and its administration, pneumococcal vaccine and its administration;
- Diabetes self-management *training*;
- Hemophilia clotting factors for hemophilia patients competent to use these factors without supervision).

See Chapter 6 of the Medicare Benefit Policy Manual for a discussion of the circumstances under which the above services may be covered as Part B Inpatient services.