PAYMENT POLICY ID NUMBER: 24-085

Original Effective Date: 11/15/2024

Revised: N/A

Outpatient "Token Charges" Reimbursement and Billing - Medicare Advantage

THIS PAYMENT POLICY IS NOT AN AUTHORIZATION, CERTIFICATION, EXPLANATION OF BENEFITS, OR A GUARANTEE OF PAYMENT, NOR DOES IT SUBSTITUTE FOR OR CONSTITUTE MEDICAL ADVICE. ALL MEDICAL DECISIONS ARE SOLELY THE RESPONSIBILITY OF THE PATIENT AND PHYSICIAN. BENEFITS ARE DETERMINED BY THE GROUP CONTRACT, MEMBER BENEFIT BOOKLET, AND/OR INDIVIDUAL SUBSCRIBER CERTIFICATE IN EFFECT AT THE TIME SERVICES WERE RENDERED. THIS PAYMENT POLICY APPLIES TO ALL LINES OF BUSINESS AND PROVIDERS OF SERVICE. IT DOES NOT ADDRESS ALL POTENTIAL ISSUES RELATED TO PAYMENT FOR SERVICES PROVIDED TO BCBSF MEMBERS AS LEGISLATIVE MANDATES, PROVIDER CONTRACT DOCUMENTS OR THE MEMBER'S BENEFIT COVERAGE MAY SUPERSEDE THIS POLICY.

DESCRIPTION:

This policy applies to Medicare Advantage business and short-term acute care hospitals. It is applicable to outpatient claims, providing billing and reimbursement guidelines for services reported with "token charges". The need for this validation of correct billing came from internal processes and is a reinforcement of correct billing impacting Original Medicare reimbursement.

The Centers for Medicare and Medicaid Services (CMS) documents the instances for appropriate billing of services with no cost to the hospital via a "token charge". A "token charge" is a billed amount of less than $1.01 for a claim line service. CMS references three scenarios where a "token charge" may be billed by a hospital for a drug, device or radiopharmaceutical. OPPS editing can deny claims where associated services for a procedure are not included on the claim. CMS implemented a "token charge" amount to help providers with the denial edits applied by the Outpatient Prospective Payment System (OPPS).

REIMBURSEMENT INFORMATION:

To apply proper reimbursement to outpatient hospital claims containing "token charges" for a device, drug or radiopharmaceutical, Florida Blue will deny the claim line with a "token charge" as the billed amount.

CMS instructs their third-party claims administrators and the hospitals to use the "non-covered charge field" to ensure appropriate pricing of the claim for no cost drugs. FB does not use the "non-covered charge field" from institutional claims. This limits the ability to ensure overpayments do not occur on claims submitted with a "token charge". The OPPS program does not use lesser of logic when applying pricing to most outpatient services. Only those services that use external fee schedules for determination

of the allowed amount apply lesser of allowed or charge logic. If the service was billed with an amount of $0.00, the claim line will still be considered during pricing of the claim. To ensure overpayments are not made, Florida Blue will deny outpatient claims billed with a “token charge” for a device, drug or radiopharmaceutical.

BILLING AND CODING:

Outpatient claims with a detail claim line billed amount less than $1.01 will be denied ensuring overpayments are not made for no cost devices, drugs, or radiopharmaceuticals.

A “token charge” service should always be billed on a separate detail claim line.

CMS has instructed hospitals to use HCPCS code C9898 (Radiolabeled product provided during a hospital inpatient stay) with a token charge (of less than $1.01) when radiolabeled product does not need to be administered again due to being administered during a recent admission.

The table below identifies the revenue code(s) or range of codes, HCPCS for radiopharmaceuticals only, and their description included in the denial logic when billed with a “token charge” amount.

Revenue Code	Description	HCPCS if applicable
250 – 259	Pharmacy	Any code when submitted
254 or 255	Drugs incident to other diagnostic services or to radiology services	C9898 for radiopharmaceuticals only
636	Drugs requiring detail coding.	All
274	Prosthetic devices	All
275	Pacemakers	All
276	Intraocular lens	All
278	Other devices/implants	All

REFERENCES:

1. CMS IOM Publication 100-04, Medicare Claims Processing Manual,
   a. Chapter 4 - Part B Hospital, Section 61.3 - Billing for Devices Furnished Without Cost to an OPPS Hospital or Beneficiary, 61.3.5 - Reporting and Charging Requirements When a Device is Furnished Without Cost to the Hospital or When the Hospital Receives a Full or Partial Credit for the Replacement Device Beginning January 1, 2014
   b. Chapter 17 - Drugs and Biologicals, Section 90 - Claims Processing Rules for Hospital Outpatient Billing and Payment, 90.2 - Drugs, Biologicals, and Radiopharmaceuticals
   c. Chapter 32 – Billing Requirements for Special Services, Section 67 – No Cost Items, 67.2 – Institutional Billing for No Cost Items
2. MLN Matters Number: MM10521 – Institutional Billing for No Cost Items
3. National Uniform Billing Committee Official UB-04 Data Specifications Manual – only available via a subscription.

GUIDELINE UPDATE INFORMATION:

11/15/2024	New Policy – effective 11/15/2024