Payment Policy | Device Intensive Procedure Edit

EFFECTIVE DATE: 08|15|2026
POLICY LAST UPDATED: 06|02|2026

OVERVIEW
The purpose of this policy is to ensure appropriate billing and reimbursement for device intensive procedures performed in the outpatient facility setting. Device intensive procedures generally require the implantation, insertion, replacement, or utilization of a costly medical device integral to the performance of the procedure.

This policy establishes an edit that recommends denial of a device intensive procedure when a corresponding device procedure code is not billed on the same claim for the same date of service, by the same provider, unless an applicable modifier indicates a reduced, discontinued, or terminated procedure.

MEDICAL CRITERIA
Not applicable

PRIOR AUTHORIZATION
Not applicable

POLICY STATEMENT
Medicare Advantage Plans & Commercial Products
Blue Cross & Blue Shield of Rhode Island may deny the device intensive procedure line when a qualifying device intensive procedure code is billed without an associated device procedure code on the same claim, for the same date of service, by the same provider.

This policy applies to:
Facility claims only, Outpatient institutional claims, Claims billed on a UB-04 or electronic equivalent, Providers submitting bill types 13X or 76X

This policy does not apply to:
Professional claims, Physician office claims, Inpatient facility claims, Claims outside the identified bill types

COVERAGE
Benefits may vary between groups/contracts. Please refer to the appropriate Benefit Booklet, Evidence of Coverage, or Subscriber Agreement for applicable contract exclusions and limitations of benefits/coverage when services are not medically necessary.

BACKGROUND
This edit is based on guidance established by the Centers for Medicare & Medicaid Services (CMS) under the Outpatient Prospective Payment System (OPPS) for device-intensive procedures. CMS identifies certain procedures as device intensive when a significant portion of the procedure cost is attributable to an implanted or utilized medical device and expects appropriate device coding to accompany these services for accurate reimbursement and claims processing.

The Device Intensive Procedure Edit Policy was developed to promote billing accuracy and alignment with CMS outpatient reimbursement methodologies by identifying device intensive procedure claims submitted without an associated device procedure code.

Definitions

Device Intensive Procedure
A procedure designated as device intensive under applicable reimbursement methodologies in which the cost of an implantable or medical device represents a significant portion of the total procedure cost.

Device Procedure Code
A HCPCS or CPT code that identifies the insertion, implantation, replacement, supply, or use of a qualifying medical device associated with a device intensive procedure.

CODING

A device intensive procedure code must be billed with an associated device procedure code when required under applicable coding and reimbursement guidelines. When a device intensive procedure code is submitted without a corresponding device procedure code on the same date of service, the same claim, and by the same provider, the device intensive procedure line may be denied. The presence of a device code does not guarantee reimbursement.

Applicable device intensive procedures and corresponding device procedure codes are identified based on current industry-standard reimbursement methodologies, including but not limited to CMS outpatient prospective payment system (OPPS) guidance.

Code lists may be updated periodically in accordance with annual coding and reimbursement updates.
The link below is the CMS device intensive procedure list of codes that require a device.

Device Intensive Procedure Code List

This edit applies to outpatient facility claims submitted with bill types:
13X – Hospital Outpatient
76X – Community Mental Health Center (when applicable)

RELATED POLICIES

Coding and Payment Guidelines- Modifiers

PUBLISHED

Provider Update June 2026

REFERENCES

1.Centers for Medicare & Medicaid Services (CMS) OPPS
(https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient)
2.National Correct Coding Initiative (NCCI) Policy Manual
(https://www.cms.gov/medicare/coding-billing/national-correct-coding-initiative-ncci-edits)
3.American Medical Association CPT® Professional Edition
(https://www.ama-assn.org/practice-management/cpt)

CLICK THE ENVELOPE ICON BELOW TO SUBMIT COMMENTS

This medical policy is made available to you for informational purposes only. It is not a guarantee of payment or a substitute for your medical judgment in the treatment of your patients. Benefits and eligibility are determined by the member's subscriber agreement or member certificate and/or the employer agreement, and those documents will supersede the provisions of this medical policy. For information on member-specific benefits, call the provider call center. If you provide services to a member which are determined to not be medically necessary (or in some cases medically necessary services which are non-covered benefits), you may not charge the member for the services unless you have informed the member and they have agreed in writing in advance to continue with the treatment at their own expense. Please refer to your participation agreement(s) for the applicable provisions. This policy is current at the time of publication; however, medical practices, technology, and knowledge are constantly changing. BCBSRI reserves the right to review and revise this policy for any reason and at any time, with or without notice. Blue Cross & Blue Shield of Rhode Island is an independent licensee of the Blue Cross and Blue Shield Association.