Medicare Hospital Manual

Department of Health and Human Services (DHHS)
HEALTH CARE FINANCING ADMINISTRATION (HCFA)

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HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
Table of Contents – Chapter IV	4-3 - 4-4 (2 pp.)	4-3 - 4-4 (2 pp.)
440.1 (Cont.) – 440.2 (Cont.)	4-291 - 4-293 (3 pp.)	4-291 (1 p.)

NEW/REVISED MATERIAL--*EFFECTIVE DATE: January 1, 2001*
IMPLEMENTATION DATE: January 1, 2001

Section 440.2, Extracorporeal Immunoadsorption (ECI) Using Protein A Columns, adds a new section providing coverage, billing, and payment instructions for ECI using Protein A columns. For claims with dates of service on or after May 6, 1991 through December 31, 2000, the use of Protein A columns is covered by Medicare only for the treatment of patients with idiopathic thrombocytopenia purpura (ITP) failing other treatments. For claims with dates of service on or after January 1, 2001, Medicare covers the use of Protein A columns for the treatment of ITP and, under limited conditions, for the treatment of rheumatoid arthritis (RA).

This section of the Medicare Hospital Manual is based on a national coverage decision made under §1862(a)(1) of the Social Security Act (the Act). National coverage determinations (NCDs) are binding on all Medicare carriers, fiscal intermediaries, Peer Review Organizations, and other contractors. Under 42 CFR 422.256(b) an NCD that expands coverage is also binding on a Medicare+Choice Organization. In addition, an administrative law judge may not disregard, set aside, or otherwise review a national coverage decision issued under §1862(a)(1) of the Act. (42 CFR 405.732, 405.860.)

DISCLAIMER: The revision date and transmittal number only apply to the redlined material. All other material was previously published in the manual and is only being reprinted.

CHAPTER IV
BILLING PROCEDURES

Section

Billing for Medical and Other Health Services

DME

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BILLING PROCEDURES

In both instances, the indicated diagnosis or the procedure conflicts with the sex of the patient. Therefore, either the patient's diagnosis, the procedure or the sex is incorrect. The intermediary returns the bill and requests a corrected bill with the proper sex, diagnosis, and procedure.

Addendum E, pages E-18-31 and E-35-36 contain listings of female and male related ICD-9-CM diagnosis codes and the corresponding descriptions. For listings of female and male related HCPCS procedure codes see Addendum F. Review the medical record and/or face sheet and enter the proper diagnosis/procedure before returning the bill.

6. Questionable Covered Procedures.--These are procedures that may be covered, depending upon the medical circumstances. For example, HCPCS code 19360 "Breast reconstruction with muscle or myocutaneous flap" is a condition that is not covered when performed for cosmetic purposes. However, if this procedure is performed as a follow up to a radical mastectomy, it is covered.

Addendum F contain listings of questionable covered procedure codes. Your intermediary performs medical review prior to a payment.

7. Noncovered Procedures.--These are procedures that are not payable. Your intermediary denies the bill.

Addendum F contain listings of noncovered procedure codes.

8. Medicare as Secondary Payer - MSP Alert.--Addendum E, pages E-61-68 identify situations that may involve automobile medical, no-fault or liability insurance. Develop other insurance coverage as provided in §262, before billing Medicare.

9. Invalid Age.--If the age reported is not between 0 years and 124 years, the OCE assumes the age is in error.

If you report an age over 124, your intermediary requests you to determine if you made a bill preparation error. If the beneficiary's age is established at over 124, enter with 123.

10. Invalid Sex.--The sex code reported must be either 1 (male) or 2 (female). Usually, your intermediary can resolve the issue.

11. Date Range.--This edit is used in internal intermediary operations.

12. Valid Date.--The OCE checks the month, day, and year from FL 6 (from date). If the date is impossible, your intermediary returns the bill.

13. Unlisted Procedures.--These are codes for surgical procedures (i.e., codes generally ending in 99). For listings of these codes and development instructions, see §424.

14. PRO Review.--The OCE identifies all hospital outpatient bills which contain ASC procedure codes. These are subject to medical review by the State's PRO.

440.2 Extracorporeal Immunoadsorption (ECI) Using Protein A Columns.--Extracorporeal immunoadsorption using Protein A columns has been developed for the purpose of selectively removing circulating immune complexes (CIC) and immunoglobulins (IgG) from patients in whom these substances are associated with their diseases. The technique involves pumping the patient's anticoagulated venous blood through a cell separator from which 1-3 liters of plasma are collected and perfused over adsorbent columns, after which the plasma rejoins the separated, unprocessed cells and is retransfused to the patient.

For claims with dates of service on or after May 6, 1991 through December 31, 2000, the use of Protein A columns is covered by Medicare only for the treatment of patients with idiopathic thrombocytopenia purpura (ITP) failing other treatments.

For claims with dates of service on or after January 1, 2001, Medicare covers the use of Protein A columns for the treatment of ITP. In addition, Medicare will cover Protein A columns for the treatment of rheumatoid arthritis (RA) under the following conditions:

1. Patient has severe RA. Patient disease is active, having > 5 swollen joints, > 20 tender joints, and morning stiffness > 60 minutes.

2. Patient has failed an adequate course of a minimum of 3 Disease Modifying Anti-Rheumatic Drugs (DMARDs). Failure does not include intolerance.

Other uses of these columns are currently considered to be investigational and/or experimental and, therefore, not reasonable and necessary under the Medicare law. (See §1862(a)(1)(A) of the Act.)

Payment is made under Part B on a reasonable cost basis for claims with dates of service prior to August 1, 2000. Payment for claims with dates of service on or after August 1, 2000 is made under the outpatient prospective payment system. Payment is made on a reasonable cost basis in critical access hospitals (CAHs). Deductible and coinsurance apply.

Bill on Form HCFA-1450 or electronic equivalent.

A. Applicable Bill Types.--The appropriate bill types are 12X, 13X, 83X, and 85X.

When utilizing the UB-92 flat file, use record type 40 to report bill type. Record type (Field No. 1), sequence number (Field No. 2), patient control number (Field No. 3), and type of bill (Field No. 4) are required.

When utilizing the hard copy UB-92 (Form HCFA-1450), report the applicable bill type in Form Locator (FL) 4 “Type of Bill”.

When utilizing the Medicare A 837 Health Care Claim version 3051 implementations 3A.01 and 1A.C1, report the applicable bill type in 2-130-CLM01, CLM05-01, and CLM05-03.

B. Revenue Code Reporting--Report revenue code 940. When utilizing the UB-92 flat file, use record type 61, Revenue Code (Field No. 5). When utilizing the hard copy UB-92, report the revenue code in FL 42 “Revenue Code.” When utilizing the Medicare A 837 Health Care Claim version 3051 implementations 3A.01 and 1A.C1, report the applicable revenue code in 2-395-SV201.

C. HCPCS Code Reporting--For claims with dates of service on or after May 6, 1991, report HCPCS code Q0068 (Extracorporeal plasmapheresis, immunoadsorption with staphylococcal protein A columns). For claims with dates of service on or after January 1, 2000, report CPT code 36521, (Therapeutic apheresis; plasma and/or cell exchange with extracorporeal affinity column adsorption and plasma reinfusion). When utilizing the UB-92 flat file, use record type 61, HCPCS code (Field No. 6) report HCPCS/CPT code. When utilizing the hard copy UB-92, report the HCPCS/CPT code in FL 44 “HCPCS/Rates.” When utilizing the Medicare A 837 Health CareClaim version 3051 implementations 3A.01 and 1A.C1, report the HCPCS/CPT in 2-395-SV202-02.

D. ICD-9-CM Reporting.--For claims with dates of service on or after May 6, 1991, report ICD-9 code 287.3 (Primary thrombocytopenia). For claims with dates of service on or after January 1, 2001, report 287.3 (Primary thrombocytopenia), 714.0 (Rheumatoid arthritis), 714.1 (Felty's syndrome), 714.2 (Other rheumatoid arthritis with visceral or systemic involvement), 714.30, 714.31, 714.32, or 714.33 (Types of juvenile rheumatoid arthritis). When utilizing the UB-92 flat file, use record type 70, Principal Diagnosis Code/Other Diagnoses Code (Field No. 4-12) to report the ICD-9 code. When utilizing the hard copy UB-92, report the ICD-9 code in FLs 67 –75 (Principal Diagnosis Code/Other Diagnoses Codes). When utilizing the Medicare A 837 Health Care Claim version 3051 implementations 3A.01 and 1A.C1, report the ICD-9 in 2-225.A-HI02-02 through HI10-02.

E. MSN/EOMB.--If the claim for the use of the protein A column is denied, your intermediary states on the MSN/EOMB the following message:

21.22/16.58 Medicare does not pay for this service because it is considered investigational and/or experimental in these circumstances.

F. Remittance Advice Message.--If the claim is denied, your intermediary uses exiting American National Standard Institute (ANSI) X-12-835 claim adjustment reason code/message B22, "This claim/service is denied/reduced based on the diagnosis."