# Program Memorandum Intermediaries/Carriers

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

**Transmittal AB-01-37** **Date: FEBRUARY 26, 2001**

**CHANGE REQUEST 1549**

**SUBJECT: Verteporfin**

The purpose of this Program Memorandum (PM) is to instruct carriers and intermediaries on the processing of claims for services related to the drug **verteporfin** when it is furnished intravenously incident to a physician's service. Verteporfin is approved by the Food and Drug Administration (FDA) for ocular photodynamic therapy (OPT), which is a treatment for age-related macular degeneration ( AMD). Medicare covers verteporfin, subject to the instructions contained in this PM.

## Background

OPT combines a light-sensitive medication and laser to destroy diseased tissue and abnormal blood vessels in the eye. A photosensitive drug is introduced into the body. The drug selectively identifies and adheres to diseased tissue, but it remains inactive until it is exposed by means of a laser to a specific wavelength of light. Activation of the drug results in a photochemical reaction which treats the diseased tissue without affecting surrounding normal tissue.

Verteporfin, a benzoporphyrin derivative, is an intravenous lipophilic photosensitive drug with an absorption peak of 690 nm. This drug was first approved by the FDA on April 12, 2000. On July 18, 2000, it was approved for inclusion in the United States Pharmacopoeia, thereby meeting the definition of a drug set forth under §1861(t)(1) of the Social Security Act.

## Medicare Coverage Policy

**CPT code 67221**, Destruction of localized lesion of choroid (eg, choroidal neovascularization); photodynamic therapy (includes intravenous infusion), and **HCPCS code Q3013**, Verteporfin (per 15 mg) are covered services when billed with diagnosis code **ICD-9-CM 362.52**, Exudative senile macular degeneration. This policy is effective for services furnished on or after July 1, 2001.

## Carrier Claims Processing Instructions:

- Allow payment for CPT code 67221 and HCPCS code Q3013 when billed with diagnosis code ICD-9-CM 362.52.
- Install edits to deny claims for CPT code 67221 and HCPCS code Q3013 when billed with either ICD-9-CM 362.51 or 362.50.
- Do not make separate payment for intravenous infusion services. Payment for infusion is packaged into CPT code 67221.
- CPT code 67221 is priced under the physician fee schedule and is listed in the Medicare Physician Fee Schedule Database (MFSDB) with an “A” indicator. HCPCS code Q3013 will be included in the July quarterly update of the MFSDB with an “E” indicator. Price this code using the standard payment methodology for drugs that are furnished incident to a physician’s service.

**Intermediary Claims Processing Instructions for Hospital Outpatient Services:**

- For hospital outpatient services, allow payment for CPT code 67221 and **HCPCS code C1203** when billed with diagnosis code ICD-9-CM 362.52. NOTE THAT IN ORDER TO RECEIVE A TRANSITIONAL PASS-THROUGH PAYMENT UNDER THE OUTPATIENT PPS, HOSPITALS MUST USE HCPCS CODE C1203 TO BILL FOR VERTEPORFIN.

- Deny claims for CPT code 67221 and HCPCS code C1203 when billed with either ICD-9-CM 362.51 or 362.50.

- Do not make separate payment for intravenous infusion services. Payment for infusion is packaged into CPT code 67221.

**Intermediary Claims Processing Instructions for Hospital Inpatient Services:**

For inpatient services, report diagnosis code 362.52, and procedure codes 14.24 (Destruction of chorioretinal lesion by laser photocoagulation) and 99.29 (Injection or infusion of other therapeutic or prophylactic substance).

**Instructions for Both Carriers and Intermediaries:**

- You may require the fluorescein angiogram (FA) to be maintained in the patient's file for audit purposes. However, do not require an FA to be submitted with each claim.

- Publish this information in your next regularly scheduled provider bulletin and website update.

**Medicare Summary Notice (MSN), and Remittance Advice Messages (RA)**

The following messages can be used to notify beneficiaries and providers of denial situations that may occur.

**MSN 14.9**

Medicare cannot pay for this service for the diagnosis shown on the claim.

Medicare no puede pagar por este servicio debido al diagnostico indicado en la reclamacion.

**Remittance Message RA B22**

This claim/service is denied/reduced based on the diagnosis

**The *effective date* for this Program Memorandum (PM) is for items and services furnished on or after July 1, 2001.**

**The *implementation date* for this PM is July 1, 2001.**

**These instructions should be implemented within your current operating budget.**

**If you have any questions, contact your regional office.**

**This PM may be discarded after July 1, 2002.**