Medicare
Carriers Manual
Part 3 - Claims Process

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

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REFER TO CHANGE REQUESTS 2123, 1514 & 1553

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MANUALIZATION--*EFFECTIVE/IMPLEMENATION DATE: Not Applicable*

Section 5202, Payment Limit for Certain Drugs and Biologicals, manualizes Program Memorandum (PM) AB-02-075, Change Request 2123, dated May 22, 2002. The effective date of the policy reflected in this PM is January 1, 1998.

Section 5202.1, Procedures for Determining Payment Limit, manualizes PM AB-02-075, Change Request 2123, dated May 22, 2002. The effective date of the policy reflected in this PM is January 1, 1998.

Section 5202.2, Injection Services, manualizes PM AB-02-075, Change Request 2123, dated May 22, 2002. The effective date of the policy reflected in this PM is January 1, 1998.

Section 5247, Mandatory Assignment for Drugs and Biologicals**,** manualizes PMs AB-01-16, Change Request 1514, dated January 29, 2001, effective January 1, 2001, and B-01-10, Change Request 1553, dated February 9, 2001, effective February 1, 2001.

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These instructions should be implemented within your current operating budget.

Section

information and advice in this connection. Determine the reasonableness of a specific additional charge for a long distance call on the basis of the customary and prevailing charge criteria. Since the expense of the long distance call is subject to a standard fee of the telephone company, this standard fee may be considered to be a part of the reasonable charge.

5202. PAYMENT LIMIT FOR CERTAIN DRUGS AND BIOLOGICALS

Drugs and biologicals not paid on a cost or prospective payment basis are paid based on the lower of the billed charge or 95 percent of the AWP as reflected in published sources (e.g., Red Book, Price Alert, etc.). Examples of drugs that are paid on this basis include but are not limited to drugs furnished incident to a physician's service, immunosuppressive drugs furnished by pharmacies, drugs furnished by pharmacies under the durable medical equipment benefit, covered oral anti-cancer drugs, and blood clotting factors.

5202.1 Procedures for Determining Payment Limit.--The procedure for determining the AWP is described below. In general, local carriers and intermediaries do not use this procedure because the payment allowance limits for most drugs covered by Medicare are provided on the Single Drug Pricer (SDP) file issued by CMS. Local carriers apply the following procedure for any covered drug that is not included on the SDP file. On a quarterly basis and upon request, within 7 days of any such request, carriers must furnish to FIs within their jurisdiction, free of charge, the subset of files that includes the drug payment allowance limits that the carrier has determined locally. Generally, products that are obsolete may not be used for determining these payment limits. The one exception is where every product described by a particular HCPCS code is obsolete. In that case, the last payment allowance limit is carried forward for a reasonable amount of time to allow existing inventories to be exhausted.

1. For a single-source drug or biological, the AWP equals the AWP of the single product.

2. For a multi-source drug or biological, the AWP is equal to the lesser of the median AWP of all of the generic forms of the drug or biological or the lowest brand name product AWP. A "brand name" product is defined as a product that is marketed under a labeled name that is other than the generic chemical name for the drug or biological.

3. After determining the AWP, multiply it by 0.95. This is the drug payment allowance limit. Round in accordance with standard rounding procedure. Part B coinsurance and deductible requirements apply.

In applying this procedure, use the package sizes that are most commonly used for the most frequently administered dosage of the drug.

5202.2 Injection Services.--Where the sole purpose of an office visit was for the patient to receive an injection, payment may be made only for the injection service (if it is covered). Conversely, injection services (codes 90782, 90783, 90784, 90788, and 90799) included in the Medicare Physician Fee Schedule (MPFS) are not paid for separately, if the physician is paid for any other physician fee schedule service furnished at the same time. Pay separately for those injection services only if no other physician fee schedule service is being paid. However, pay separately for cancer chemotherapy injections (CPT codes 96400-96549) in addition to the visit furnished on the same day. In either case, the drug is separately payable. All injection claims must include the specific name of the drug and dosage. Identification of the drug enables you to pay for the services.

5202.3 Injections Furnished to ESRD Beneficiaries.--When an ESRD beneficiary is given a renal-related injection outside the ESRD facility or provider-setting, it should be administered by the beneficiary's monthly capitation payment (MCP) physician or his/her staff as "incident to" such physician's services. There is no additional allowance for the physician or his staff, e.g., an office nurse. This is because payment for the administration of a renal-related injection to a dialysis patient is included in the physicians' monthly capitation payment (MCP). The regulations governing Medicare payment for physicians' ESRD services (42 CFR 405.542) require that all physicians' outpatient ESRD-related services except declotting shunts be paid under the MCP. If a physician, other than the patient's MCP physician, administers a renal-related injection, the other physician must look to the MCP physician for compensation for the services. Although an additional allowance for the administration of a renal-related injection to a dialysis patient may not be made, the patient's MCP physician or a physician other than the MCP physician may submit claims and be paid for the drug itself as well as supplies, e.g., needles and syringes, used to administer the drug.

EXAMPLE: Dr. Jones is Mr. White's MCP physician. Dr. Jones is unable to furnish the regular EPO injections his patient needs three times a week. It is Dr. Jones' responsibility to compensate the physician who administers the injections. The administering physician submits claims for the injectables and necessary supplies. In this case, make a reasonable monthly allowance, e.g., $3 for the cost of supplies (i.e., syringes and needles).

5247. MANDATORY ASSIGNMENT FOR DRUGS AND BIOLOGICALS

Effective for claims with dates of service on or after February 1, 2001, payment for any drug or biological covered under Part B of Medicare may be made only on an assignment-related basis. Therefore, no charge or bill may be rendered to anyone for these drugs and biologicals for any amount except for any applicable unmet Medicare Part B deductible and coinsurance amounts. All entities (including physicians, non-physician practitioners, pharmacies and suppliers) that bill Medicare for drugs or biologicals must take assignment on all claims for drugs and biologicals furnished to any beneficiary enrolled in Medicare Part B. Apply this policy to all items paid based on the lower of the actual charge on the claim or 95 percent of the average wholesale price (AWP). See §5202 for a description of the AWP.