Medicare
Intermediary Manual
Part 3 - Claims Process

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

Transmittal 1815 **Date: NOVEMBER 17, 2000**

CHANGE REQUEST 1333

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
3610.18 (Cont.) – 3610.18 (Cont.)	6-113 – 6-116 (4 pp.)	6-113 – 6-116 (4 pp.)

CLARIFICATION/MANUALIZATION--*EFFECTIVE DATE: Not Applicable*
IMPLEMENTATION DATE: Not Applicable

Section 3610.18, Payment For Blood Clotting Factor Administered to Hemophilia Inpatients, is revised to correct a typographical error in Transmittal 1792 issued April 2000. The examples given stated the incorrect Form Locator to be used when reporting units.

These instructions should be implemented within your current operating budget.

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

For discharges occurring on or after October 1, 1991, and through September 30, 1992, the codes and charges are:

J7190	Factor VIII	- $ .72 per IU
J7194	Factor IX, complex,	- .26 per IU
J7196	Other Hemophilia blood factors (e.g., anti-clotting inhibitors.)	- 1.11 per IU

The prices per unit for discharges October 1, 1992, through September 30, 1993, are:

J7190	Factor VIII	- $ .76 per IU
J7194	Factor IX	- .30 per IU
J7196	Other Hemophilia blooding clotting factors	- l.02 per IU

The prices per unit for discharges October 1, 1993, through September 30, 1994, are:

J7190	Factor VII	- $ .76 per IU
J7194	Factor IX	- .33 per IU
J7196	Other Hemophilia blooding clotting factors	- 1.02 per IU

Effective January 1, 1994, there is an additional covered clotting factor:

J7192 Factor VIII, Anti-Hemophilic, recombinant - $ .76 per IU

For discharges occurring on or after October 1, 1997 through September 30, 1998.

J7190	Factor VIII	- $ .76 per IU
J7192	Factor VIII	- 1.00 per IU
J7194	Factor IX	- .32 per IU
J7196	Other Hemophilia clotting factors (e.g., anti-inhibitors)	- 1.10 per IU

Effective for services on or after April 1, 1998, two new HCPCS billing codes are established for purified and recombinant Factor IX.

Q0160	Factor IX (Anti-Hemophilic factor, purified, non-recombinant)	- $ .93 per IU
Q0161	Factor IX, (Anti-Hemophilic Factor, purified, Recombinant)	- $1.00 per IU

For discharges occurring on or after October 1, 1998 through September 30, 1999, the prices are as follows:

J7190	Factor VIII (Anti-Hemophilic Factor, Human)	- $ .78 per IU
J7192	Factor VIII (Anti-Hemophilic Factor, Recombinant)	- 1.00 per IU
J7194	Factor IX, (Complex)	- .38 per IU
J7196	Other Hemophilia clotting Factor, (anti-inhibitors)	- 1.10 per IU
Q0160	Factor IX (Anti-Hemophilic Factor, purified, nonrecombinant)	- .93 per IU
Q0161	Factor IX (Anti-Hemophilic Factor, purified, recombinant)	- 1.00 per IU

For discharges October 1, 1999 through September 30, 2000, the following prices apply to add-on payments for blood clotting factor administered to inpatients with hemophilia:

J7190	Factor VIII (Antihemophilic Factor, Human)	$0.79 per IU
J7191	Factor VIII (Antihemophilic Factor, Porcine)	$1.87 per IU
J7192	Factor VIII (Antihemophilic Factor, Recombinant)	$1.03 per IU
J7194	Factor IX (Complex)	$0.45 per IU
J7196	Other Hemophilia clotting Factors (e.g., anti-inhibitors)	$1.43 per IU
Q0160	Factor IX (antihemophilic Factor, purified, nonrecombinant)	$0.97 per IU
Q0161	Factor IX (Antihemophilic Factor, recombinant)	$1.00 per IU
Q0187	Factor VIIa (Coagulation Factor, Recombinant)	$1.19 per MCG

PRICER does not calculate the payment amount. Calculate the payment amount and subtract the charge from those submitted to PRICER so it is not included in cost outlier computations.

One hundred IUs of any of the clotting factors are reported as one unit. (100 IUs = one billing unit.) Therefore, payment for one billed unit of hemophilia clotting Factor VIII furnished December 1, 1993, is $76.00. One billed unit of Factor IX is $33.00. One billed unit of other hemophilia clotting factors is $102.00. If the number of units provided is between even hundreds, hospitals round to the nearest hundred. Thus, units of 1 to 49 are rounded down to the prior 100 and units of 50 to 99 are rounded up to the next 100 (i.e., 1,249 units are entered on the bill as 12; 1,250 units are entered as 13).

In reporting the number of IUs administered, hospitals divide the number of IUs administered by 100 and round the answer to the nearest whole number to determine the billing unit. (An answer which includes fractions of .50 to .99 = 1 additional billing unit. An answer which includes fractions of .01 to .49 = no additional billing units). The following examples illustrate the correct billing for the different types of clotting factors:

EXAMPLE 1: A patient receives 1,200 IUs of Factor VIII (J7190) on December 1, 1993. The hospital divides the number of IUs administered by 100 to obtain the number of billing units. (1,200 divided by 100 = 12 billing units.) The hospital enters 12 in FL 46 of the HCFA-1450. The payment amount is $912 (12 billing units x $76 (100 IUs x $.76)).

EXAMPLE 2: A patient receives 3,449 IUs of Factor IX (J7194) on January 4, 1994. The hospital divides this number by 100 to obtain the number of billing units. (3,449 divided by 100 = 34.49 billing units.) The hospital rounds down to the nearest whole number to obtain the billing units and enters 34 in FL 46. The payment amount is $1,122 (34 billing units x $33 (100 IUs x $.33)).

EXAMPLE 3: A patient receives 5,250 IUs of anti-inhibitors (J7196) (which are a type of other hemophilia clotting factor) on July 6, 1994. The hospital divides the number of IUs administered by 100 to obtain the number of billing units. (5,250 divided by 100 = 52.50 billing units.) The hospital rounds up to the nearest whole number to obtain the billing units and enters 53 in FL 46. The payment amount is $5,406 (53 billing units x $102 (100 IUs x $1.02).

EXAMPLE 4: A patient receives 4,850 MCGs of Factor VIIa (Q0187) on November 1, 1999. The hospital divides the number of MCGs administered by 100 to obtain the number of billing units (4850 divided by 100 = 48.50 billing units). The hospital rounds up to the nearest whole number to obtain the billing units and enters 49 in FL 46. The payment amount is $5,831 (49 billing units x $119 (100 MCGs x $1.19).

When the number of units of blood clotting factor administered to hemophiliac inpatients exceeds 999,999,949 (reported as 9,999,999), the hospital reports the excess as a second line for revenue code 636 and repeats the HCPCS code. One billion fifty million (1,050,000,000) units are reported on one line as 9,999,999, and another line shows 500,001.

Revenue Code 636 is used. It requires HCPCS. Other inpatient drugs continue to be billed without HCPCS codes under pharmacy. Electronic billers must enter the HCPCS code in field 5 of Record Type 60. (See Addendum A.)

No changes in beneficiary notices are required. Coverage is applicable to hospital Part A claims only. Coverage is not applicable to inpatient Part B or SNF claims.

B. Intermediary Action.--Make the following changes to your systems:

o Accept HCPCS codes for inpatient services;

o Edit to require HCPCS codes with Revenue Code 636. Multiple iterations of the revenue code are possible with the same or different HCPCS codes. Units provided generally range from about 600 IUs (reported as 6) to over 10,000 (reported as 100 on the bill). Do not edit units except to ensure a numeric value;

o Develop inpatient fee tables based on HCPCS codes and revenue code 636. Pay the fee amount regardless of the charges;

o Reduce charges forwarded to PRICER by the charges for revenue code 636. Retain the charges and revenue and HCPCS codes for CWF, and for PS&R;

o Determine what changes you need in your remittance record to hospitals;

o Modify your data entry screens to accept HCPCS codes for hospital inpatient claims (bill types 110, 111, 112, 113, 114, 115, 117, & 118);

o Include the HCPCS code and payment amount in the following records for each HCPCS code billed under revenue code 636:

RECORD	HCPCS CODE	PAYMENT AMOUNT
PS&R UNIBILL	Financial Data Corresponding to CWF	Field 79
CWF (HUIP)	Field 90	Field 99

o Treat the bill as a single bill for MSP, and for charging deductible and coinsurance. Use total charges for deductible and coinsurance calculations.

Changes are not planned for MSP pay. Where MSP recovery is made, the PS&R system allocates MSP primary payer payments between revenue code 636 and the remainder of the charges. It will delete the primary payment applicable to the final revenue code 636 payment from the primary payment amount carried forward to the PS&R detail record. PS&R will do this allocation based on charges for revenue code 636 and total covered Medicare charges.

The PS&R provides a separate revenue code report for charges under revenue code 636 for your use at cost report review.

The September 1, 1993 PPS final rule (58 FR 46304) states that payment will be made for the blood clotting factor only if an ICD-9-CM diagnosis code for hemophilia is included on the bill. Since blood clotting factors are only covered for beneficiaries with hemophilia, ensure that one of the following hemophilia diagnosis codes is listed on the bill before payment is made:

286.0 Congenital factor VIII disorder
286.1 Congenital factor IX disorder
286.2 Congenital factor IX disorder
286.3 Congenital deficiency of other clotting factor
286.4 von Willebrands' disease

C. Part A Remittance Advice.--

1. **X12.835 Ver. 003030M**.--

a. For remittances reporting PIP and/or non-PIP payments, the Hemophilia Add on will be reported in a claims level 2-090-CAS segment exhibiting an >OA' Group Code and adjustment reason code "97' (payment is included in the allowance for the basic service/ procedure) followed by the associated dollar amount (POSITIVE) and units of service. For this version of the 835, >OA' group coded line level CAS segments are informational and are not included in the balancing routine. The Hemophilia Add On amount will always be included in the 2-010-CLP04 Claim Payment Amount.

b. For remittances reporting PIP payments, the Hemophilia Add On will also be reported in the provider level adjustment PLB segment with the provider level adjustment reason code >CA' (Manual claims adjustment) followed by the associated dollar amount (NEGATIVE).

NOTE: A data maintenance request will be submitted to ANSI ASC X12 for a new PLB adjustment reason code specifically for PIP payment Hemophilia Add On situations for future use. However, continue to use adjustment reason code >CA' until further notice.

c. Enter MA103 (Hemophilia Add On) in an open MIA remark code data element. This will alert the provider that the reason code 97 and PLB code >CA' adjustments are related to the Hemophilia Add On.

2. **X12.835 Ver. 003051**.--

a. For remittances reporting PIP and/or non-PIP payments, Hemophilia Add On information will be reported in the claim level 2-062-AMT and 2-064-QTY segments. The 2-062-AMTO1 element will carry a >ZK' (Federal Medicare claim MANDATE - Category 1) qualifier code followed by the total claim level Hemophilia Add On amount (POSITIVE). The 2-064QTY01 element will carry a >FL' (Units) qualifier code followed by the number of units approved for the Hemophilia Add On for the claim. The Hemophilia Add On amount will always be included in the 2-010-CLP04 Claim Payment Amount.

NOTE: A data maintenance request will be submitted to ANSI ASC X12 for a new AMT qualifier code specifically for the Hemophilia Add On for future use. However, continue to use adjustment reason code >ZK' until further notice.