Medicare
Intermediary Manual
Part 3 - Claims Process

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

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CHANGE REQUEST 2341

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
3660.8 Cont. – 3660.9	6-342.1 – 6-342.2 (2 pp.)	6-342.1 – 6-342.2 (2 pp.)

NEW/REVISED MATERIAL--*EFFECTIVE DATE: April 1, 2002*
IMPLEMENTATION DATE: April 1, 2003

Section 3660.8 Immunosuppressive Drugs Furnished to Transplant Patients, is revised to permit payment to a Renal Dialysis Facility (TOB 72X) in the State of Washington. This change is being made because the State contributes to the cost of the beneficiary's coinsurance if the beneficiary receives his/her immunosuppressives from a particular dialysis facility.

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.

These instructions should be implemented within your current operating budget.

Coverage of immunosuppressive drugs received as a result of a transplant is contingent upon the transplant being covered by Medicare. (See §3613.)

Pay for immunosuppressive drugs which are provided outside the approved benefit period if they are covered under some other provision of the law (e.g., when the drugs are covered as inpatient hospital services or are furnished incident to a physician's service).

During a covered stay, include payment for these drugs in your payment to the provider. If the same patient receives a subsequent transplant operation the immunosuppressive coverage period begins anew (even if the patient is mid-way through the coverage period when the subsequent transplant operation was performed).

The FDA has identified and approved for marketing only the specifically labeled immunosuppressive drugs. (See §3112.4 for a list of covered drugs and discussion of coverage of other drugs.)

Prescription drugs used in conjunction with immunosuppressive drugs as part of a therapeutic regimen reflected in FDA-approved labeling for immunosuppressive drugs are also covered. You are expected to keep informed of FDA additions to the list of the immunosuppressive drugs. Prescriptions generally should be non-refillable and limited to a 30-day supply. The 30-day guideline is necessary because dosage frequently diminishes over a period of time, and further, it is not uncommon for the physician to change the prescription. Also, these drugs are expensive and the coinsurance liability on unused drugs could be a financial burden to the beneficiary. Unless there are special circumstances, do not consider a supply of drugs in excess of 30 days to be reasonable and necessary. Deny payment accordingly.

A. Billing Requirements.--The provider bills on Form CMS-1450, or electronic equivalent, with bill type 12X, 13X, 22X, 72X in the State of Washington, 83X, or 85X, as appropriate. For claims with dates of service prior to April 1, 2000, providers report the following entries:

- o Occurrence code 36 and date in FLs 32-35;
- o Revenue code 250 in FL 42; and
- o Narrative description in FL 43

For claims with dates of service on or after April 1, 2000, providers report:

- o Occurrence code 36 and date in FLs 32-35;
- o Revenue code 636 in FL 42;
- o HCPCS code of the immunosuppressive drug in FL 44;
- o Number of units in FL 46 (the number of units billed must accurately reflect the definition of one unit of service in each code narrative. For example, if fifty 10 mg. Prednisone tablets are dispensed, bill J7506, 100 units (l unit of J7506 = 5 mg).

The provider completes the remaining items in accordance with regular billing instructions.

B. MSN Messages.--If the claim for an immunosuppressive drug is denied because the benefit period has expired, state on the MSN the following message;

4.2 "This service is covered up to (insert appropriate number) months after transplant and release from the hospital."

If the claim for an immunosuppressive drug is partially denied because of the 30 day limitation, use the following message;

4.3 "Prescriptions for immunosuppressive drugs are limited to a 30-day supply."

If the claim for an immunosuppressive drug is denied because a transplant was not covered, use the following message;

6.1 "This drug is covered only when Medicare pays for the transplant."

If the claim for an immunosuppressive drug is denied because it was not approved by the FDA, use the following message :

6.2 "Drugs not specifically classified as effective by the Food and Drug Administration are not covered."

C. Remittance Advice Messages.--If the claim is denied because the immunosuppressive drug is not approved by the FDA, you use existing American National Standard Institute (ANSI) X-12-835 claim adjustment reason code/message 114, Procedure/product not approved by the Food and Drug Administration.

If the claim is denied because the benefit period has expired or because of the 30 day limitation, you use existing ANSI X-12-835 claim adjustment reason code/message 35, Benefit maximum has been reached.

If the claim is denied for the immunsuppressive drug because a transplant was not covered, you use existing ANSI X-12-835 claim adjustment reason code/message 107, Claim/service denied because the related or qualifying claim/service was not paid or identified on the claim.

3660.9 Payment for CRNA or AA Services.--Anesthesia services furnished on or after January 1, 1990, at a qualified rural hospital by a hospital employed or contracted CRNA or AA can be paid on a reasonable cost basis. Determine the hospital's qualification using the following criteria.

The hospital must be located in a rural area (as defined for PPS purposes) to be considered. A rural hospital that qualified and was paid on a reasonable cost basis for CRNA or AA services during calendar year 1989 can continue to be paid on a reasonable cost basis for these services furnished during calendar year 1990 if it can establish before January 1, 1990, that it did not provide more than 500 surgical procedures, both inpatient and outpatient, requiring anesthesia services during 1989.

A rural hospital that was not paid on a reasonable cost basis for CRNA or AA services during calendar year 1989 can be paid on a reasonable cost basis for these services furnished during calendar year 1990 if it establishes before January 1, 1990, that:

- As of January 1, 1988, it employed or contracted with a CRNA or AA (but not more than one full-time equivalent CRNA or AA); and

- In both 1987 and 1989, it had a volume of 500 or fewer surgical procedures, including inpatient and outpatient procedures, requiring anesthesia services.

Each CRNA or AA employed by, or under contract with the hospital, must agree in writing not to bill on a fee schedule basis for services furnished at the hospital. A rural hospital can qualify and continue to be paid on a reasonable cost basis for qualified CRNA or AA services for a calendar year beyond 1990 if it can establish before January 1 of that year that it did not provide more than 500 surgical procedures, both inpatient and outpatient, requiring anesthesia services during the preceding year. For a calendar year beyond 1990, it must make its election after September 30, but