Medicare Hospital Manual

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

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CHANGE REQUEST 1841

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
460.1 – 460.1 (Cont.)	4-552.13 – 4-552.16 (4 pp.)	4-552.13–4-552.16 (4 pp.)

NEW/REVISED MATERIAL--*EFFECTIVE DATE: Various dates as described in the instruction*
IMPLEMENTATION DATE*: *April 1, 2002

Section 460.1, Payment for Blood Clotting Factor Administered to Hemophilia Inpatients, reflect the following changes:

- Changes the average wholesale price from 85% to 95% beginning FY 2001.
- Discontinues the use of HCPCS code J7196 effective December 31, 1999.
- Adds HCPCS codes J7198 and J7199 effective January 1, 2000 and Q2022 effective July 1, 2000.
- Corrects the payment calculation for HCPCS Code Q0187.
- Changes the reporting of HCPCS code Q0187, for discharges after September 30, 2000 to 1 billing unit per 1.2 mg.
- Adds diagnosis codes 286.5 and 286.7 effective for discharges on or after August 1, 2001.

Other Bills
Not Required.

FL 84. Remarks
Required. For DME billings show the rental rate, cost, and anticipated months of usage so that your intermediary may determine whether to approve the rental or purchase of the equipment. Where Medicare is not the primary payer because WC, automobile medical, no-fault, liability insurer or an EGHP is primary, enter special annotations. (See §§469, 470, 47l, and 472 for appropriate annotations.) In addition, enter any remarks needed to provide information that is not shown elsewhere on the bill but which is necessary for proper payment.

FL 85. Provider Representative Signature and Date
Not Required. A hospital representative makes sure that the required physician's certification and recertifications are in the records before signing the form. A stamped signature is acceptable. (See §§273ff.)

FL 86. Date
Not Required. This is the date of the provider representative's signature.

460.1 Payment for Blood Clotting Factor Administered to Hemophilia Inpatients.--Section 6011 of Public Law (P.L.) 101-239 amended §1886(a)(4) of the Act to provide that prospective payment hospitals receive an additional payment for the costs of administering blood clotting factor to Medicare hemophiliacs who are hospital inpatients. Section 6011(b) of P.L. 101-239 specified that the payment is to be based on a predetermined price per unit of clotting factor multiplied by the number of units provided. This add-on payment originally was effective for blood clotting factor furnished on or after June 19, 1990 and before December 19, 1991. Section 13505 of P.L. 103-66 amended §60ll (d) of P.L. 101-239 to extend the period covered by the add-on payment for blood clotting factors administered to Medicare inpatients with hemophilia through September 30, 1994. Section 4452 of P.L. 105-33 amended §6011(d) of P.L. 101-239 to reinstate the add-on payment for the costs of administering blood clotting factor to Medicare beneficiaries who have hemophilia and who are hospital inpatients for discharges occurring on or after October 1, 1998.

The add-on payment for FY 1999 was calculated using the same methodology used in the past. The price per unit of clotting factor is established based on 85 percent of the current price listing available from the 1998 Drug Topics Red Book, the publication of pharmaceutical average wholesale prices (AWP). Beginning FY2001 the payment for blood clotting factor administered to hemophilia inpatients will be equal to 95 percent of the AWP.

A. Billing.--Three separate add-on amounts have been set, one for each of the three basic types of clotting factor--Factor VIII, Factor IX and other factors which are given to the patients with inhibitors to Factors VIII and IX.

The HCPCS codes which identify the three types of clotting factor along with the price per unit for discharges occurring on or after June 19, 1990, and before October 1, 1991 are:

J7190	Factor VIII, viral inactivated	- $ .64 per IU
J7194	Factor IX, complex, heat treated	- .26 per IU
J7196	Other Hemophilia clotting factors (e.g., anti-clotting inhibitors.)	- 1.00 per IU

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

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

For discharges October 1, 1992, through September 30, 1993, the following prices per unit are in effect:

J7190	Factor VIII	- $ .76 per IU
J7194	Factor IX	- .30 per IU
J7196	Other Hemophilia blood clotting factors	- 1.02 per IU

For discharges occurring on or after October 1, 1993, through September 30, 1994, the prices are as follows:

J7190, J7192	Factor VIII	- $ .76 per IU
J7194	Factor IX	- .33 per IU
J7196	Other Hemophilia blood clotting factors	- 1.02 per IU

Effective January 1, 1994, a new Factor VIII code was introduced, J7192 (Antihemophilic recombinant) paid at the same rate as other Factor VIII products ($.76 per unit).

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

For discharges occurring on or after October 1, 1997 through September 30, 1998, the prices are as follows:

J7190	Factor VIII (Anti-Hemophilic Factor, Human)	- $ .76 per IU
J7192	Factor VIII	- 1.00 per IU
J7194	Factor IX Complex	- .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-combinant)	- $ 0.93 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, non-recombinant)	- .93 per IU
Q0161	Factor IX (Anti-Hemophilic Factor, purified, recombinant)	- 1.00 per IU

These prices will be effective for add-on payments for blood clotting factor administered to inpatients who have hemophilia for discharges beginning on or after October 1, 1999 through September 30, 2000.

J7190	Factor VIII (Antihemophilic) Factor, Human)	.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)	.45 per IU
J7196	Other Hemophilia clotting Factors (e.g., anti-inhibitors) **(Discontinued 12/31/1999)**	1.43 per IU
J7198	Anti-Inhibitor **(effective 1/1/2000)**	1.43 per IU
J7199	Hemophilia Clotting Factor, Not Otherwise Classified **(effective 1/1/2000)**	
Q0160	Factor IX (Antihemophilic Factor, purified, nonrecombinant)	.97 per IU
Q0161	Factor IX (Antihemophilic Factor, recombinant)	1.00 per IU
Q0187	Factor VIIa (Coagulation Factor, Recombinant)	1.19 per MCGs
Q2022	Von Willebrand Factor Complex (**Effective 7/1/2000**)	1.05 per IU

Report one hundred IUs of any of the clotting factors except Q0187, Factor VIIa as one unit. (100 IUs - one billing unit.) Therefore, the 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. For discharges occurring on or after October 1, 2000, report HCPCS Q0187 based on 1 billing unit per 1.2 mg.

If the number of units is between even hundreds, 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, 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.) Enter 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.) Round 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 will be $5406 (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 1000 to convert the MCGs to MGs (4,850 divided by 1000 = 4.85). The hospital calculates the number of billing units represented by 4.85 and divides by 1.2 (4.85 divided by 1.2 = 4.04 or 4 billing units) and enters 4 in FL 46. The payment amount is $4,760 (4 billing units x $1190 (1000 x $1.19)).

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

NOTE: For discharges occurring on or after October 1, 2000, report HCPCS Q0187 based on 1 billing unit per 1.2 mg.

Use Revenue Code 636. This requires HCPCS. Continue to bill other inpatient drugs without HCPCS codes under pharmacy.

In order to qualify for the add-on payment for hemophilia blood clotting factor, the claim must contain a hemophilia diagnosis code, either as principal or secondary diagnosis. One of the following ICD-9-CM diagnosis codes must be present on the claim.

Final rule (58 FR 46304) states that payment will be made for blood clotting factor only if there is an ICD-9-CM diagnosis code for hemophilia included on the bill. Since blood clotting factors are only covered for beneficiaries with hemophilia, list one of the following hemophilia diagnosis codes on the bill:

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

Effective for discharges on or after August 1, 2001, payment may be made if one of the following diagnosis codes is reported:

286.5	Hemorrhagic disorder due to circulating anticoagulants
286.7	Acquired coagulation factor deficiency