CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 3050	**Date: August 22, 2014**
	Change Request 8808

SUBJECT: Extracorporeal Photopheresis

I. SUMMARY OF CHANGES: This CR reformats language in the Claims Processing Manual (Pub. 100-04), Chapter 32, section 190, so that the instructions are clearer and to avoid misinterpretation. Additionally, ICD-9 diagnosis code 996.88, complications of transplanted organ, stem cell, ICD-10 diagnosis code T86.5, complications of stem cell transplant, are added for correctness and to align with coding implemented in CR8197, Transmittal 1199, dated March 14, 2013, and effective and implemented July 1, 2013. Additionally, messaging changes were made to align with CR8691, Transmittal 1388, dated May 23, 2014. NOTE: This is a corresponding Manual clarification only. There are no edits associated with this CR.

EFFECTIVE DATE: September 23, 2014
ICD-10: Upon implementation of ICD-10.
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: September 23, 2014

ICD-10: Upon implementation of ICD-10.

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	32/190/Billing Requirement for Extracorporeal Photopheresis
R	32/190.2/Healthcare Common Procedure Coding System (HCPCS), Applicable Diagnosis Codes, and Procedure Codes
R	32/190.3/Medicare Summary Notices (MSNs), Remittance Advice Remark Codes (RARCs), and Claim Adjustment Reason Codes (CARCs)

III. FUNDING:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC statement of Work. The contractor is not obliged to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-04	Transmittal: 3050	Date: August 22, 2014	Change Request: 8808

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I. GENERAL INFORMATION

A. Background: This CR reformats language in the Claims Processing Manual (Pub. 100-04), Chapter 32, section 190, so that the instructions are clearer and to avoid misinterpretation. Additionally, ICD-9 diagnosis code 996.88, complications of transplanted organ, stem cell, ICD-10 diagnosis code T86.5, complications of stem cell transplant, are added for correctness and to align with coding implemented in CR8197, Transmittal 1199, dated March 14, 2013, and effective and implemented July 1, 2013. Additionally, messaging changes were made to align with CR8691, Transmittal 1388, dated May 23, 2014.

B. Policy: Effective for claims with dates of service on or after April 30, 2012, the Centers for Medicare & Medicaid (CMS) covers extracorporeal photopheresis for the treatment of bronchiolitis obliterans syndrome (BOS) following lung allograft transplantation only when provided under a clinical research study that meets specific requirements to assess the effect of extracorporeal photopheresis for the treatment of BOS following lung allograft transplantation. Following implementation, it was brought to CMS' attention that the instructions in the Claims Processing Manual (Pub. 100-04), Chapter 32, section 190, were being misinterpreted and causing inappropriate denials of existing covered diagnosis.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
8808.1	Contractors shall be aware that Pub. 100-04, Claims Processing Manual, Chapter 32, section 190.3, is reformatted to clearly state that 'Medicare coverage for extracorporeal photopheresis is restricted to the inpatient or outpatient hospital settings specifically for BOS, and not for the other covered diagnosis (including chronic GVHD) which remain covered in the hospital inpatient, hospital outpatient, and non-facility (physician-directed clinic or office settings)	X	X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	settings.									

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
8808.2	MLN Article: A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web sites and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in the contractor's next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X	X			

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Kim Long, 410-786-5702 or kimberly.long@cms.hhs.gov (Coverage), Patricia Brocato-Simons, 410-786-0261 or Patricia.brocatosimons@cms.hhs.gov (Coverage)

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 0

190 – Billing Requirements for Extracorporeal Photopheresis

(Rev.3050, Issued: 08-22-14, Effective: 09-23-14, ICD-10: Upon Implementation of ICD-10, Implementation: 09-23-14, ICD-10: Upon Implementation of ICD-10)

Effective for dates of services on and after December 19, 2006, Medicare has expanded coverage for extracorporeal photopheresis for patients with acute cardiac allograft rejection whose disease is refractory to standard immunosuppresive drug treatment and patients with chronic graft versus host disease whose disease is refractory to standard immunosuppresive drug treatment. (See *the National Coverage Determinations (NCD) Manual,* Pub. 100-03, Chapter 1, *part 2,* section 110.4, for complete coverage guidelines.)

Effective for claims with dates of service on or after April 30, 2012**,** the Centers for Medicare & Medicaid Services has expanded coverage for extracorporeal photopheresis for the treatment of bronchiolitis obliterans syndrome (BOS) following lung allograft transplantation only when extracorporeal photopheresis is provided under a clinical research study that meets specific requirements to assess the effect of extracorporeal photopheresis for the treatment of BOS following lung allograft transplantation. Further coverage criteria is outlined in *Pub.* 100-03, *Chapter 1, part 2,* section 110.4 of the *NCD Manual*.

190.2 – Healthcare Common Procedural Coding System (HCPCS), Applicable Diagnosis Codes, and Procedure Codes

Rev.3050, Issued: 08-22-14, Effective: 09-23-14, ICD-10: Upon Implementation of ICD-10, Implementation: 09-23-14, ICD-10: Upon Implementation of ICD-10)

The following HCPCS procedure code is used for billing extracorporeal photopheresis
• 36522 - Photopheresis, extracorporeal

The following are the applicable ICD-9-CM diagnosis codes for the new expanded coverage:

- 996.83 - Complications of transplanted heart, or,
- 996.85 - Complications of transplanted bone marrow, *or,*
- *996.88 – Complications of transplanted organ, stem cell*

Effective for services for BOS following lung allograft transplantation the following is a list of applicable ICD-9-CM diagnosis codes:
• 996.84 – Complications of transplanted lung
• 491.9 - Unspecified chronic bronchitis
• 491.20 – Obstructive chronic bronchitis without exacerbation
• 491.21 – Obstructive chronic bronchitis with (acute) exacerbation
• 496 – Chronic airway obstruction, not elsewhere classified

The following is the applicable ICD-9-CM procedure code for the new expanded coverage:
• 99.88 - Therapeutic photopheresis

NOTE: Contractors shall edit for an appropriate oncological and autoimmune disorder diagnosis for payment of extracorporeal photopheresis according to the *NCD.*

Effective for claims with dates of service on or after April 30, 2012, in addition to HCPCS 36522, the following ICD-9-CM codes are applicable for extracorporeal photopheresis for the treatment of BOS following lung allograft transplantation only when *extracorporeal photopheresis* is provided under a clinical research study as outlined in Section 190 above:

A reference listing of ICD-9 CM and ICD-10-CM coding and descriptions is listed below:

ICD9 CODE	**LONG DESCRIPTION**	**ICD10 CODE**	**ICD10 Description**
491.20	Obstructive chronic bronchitis without exacerbation	J44.9	Chronic obstructive pulmonary disease, unspecified
491.21	Obstructive chronic bronchitis with (acute) exacerbation	J44.1	Chronic obstructive pulmonary disease with (acute) exacerbation
491.9	Unspecified chronic bronchitis	J42	Unspecified chronic bronchitis
496	Chronic airway obstruction, not elsewhere classified	J44.9	Chronic obstructive pulmonary disease, unspecified
996.84	Complications of transplanted lung	T86.810	Lung transplant rejection
996.84	Complications of transplanted lung	T86.811	Lung transplant failure
996.84	Complications of transplanted lung	T86.812	Lung transplant infection (not recommended for *extracorporeal photopheresis* coverage)
996.84	Complications of transplanted lung	T86.818	Other complications of lung transplant
996.84	Complications of transplanted lung	T86.819	Unspecified complication of lung transplant
996.88	*Complications of Transplanted organ, Stem cell*	*T86.5*	*Complications of Stem Cell Transplant*
V70.7		Z00.6	Encounter for examination for normal comparison and control in clinical research program (needed for CED)

Contractors must also report modifier Q0 - (investigational clinical service provided in a clinical research study that is in an approved research study) or Q1 (routine clinical service provided in a clinical research study

that is in an approved clinical research study) as appropriate on these claims. Contractors must use diagnosis code V70.7/Z00.6 and condition code 30 (A/B MAC (A) only), along with *value code D4* and the 8-digit clinical identifier number (A/MACs only) for these claims.

190.3 – Medicare Summary Notices (MSNs), Remittance Advice Remark Codes (RARCs), and Claim Adjustment Reason Codes (CARCs)

Rev.3050, Issued: 08-22-14, Effective: 09-23-14, ICD-10: Upon Implementation of ICD-10, Implementation: 09-23-14, ICD-10: Upon Implementation of ICD-10)

Contractors shall continue to use the appropriate existing messages that they have in place when denying claims submitted that do not meet the Medicare coverage criteria for extracorporeal photopheresis.

Medicare coverage for extracorporeal photopheresis is restricted to the inpatient or outpatient hospital settings specifically for BOS, and not for the other covered diagnosis (including chronic graft versus host disease) which remain covered in the hospital inpatient, hospital outpatient, and non-facility (physician-directed clinic or office settings) settings.

Contractors shall deny claims for *extracorporeal photopheresis* for BOS when the service is not rendered to an inpatient or outpatient of a hospital, including critical access *hospitals using* the following codes:

- Claim Adjustment Reason *C*ode *(CARC) 96 – Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code, or Remittance Advice Remark Code that is not an ALERT.) **NOTE**: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.*

- *CARC 171 – Payment is denied when performed/billed by this type of provider in this type of facility. **NOTE**: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.*
- *Medicare Summary Notice* 16.2 - This service cannot be paid when provided in this location/facility." Spanish translation: "Este servicio no se puede pagar cuando es suministrado en esta sitio/facilidad. (Include either MSN 36.1 or 36.2 dependent on liability.)

- *Remittance Advice Remark Code (RARC) N428 – Not covered when performed in this place of service.* (A/MACs only)

- Group Code CO (Contractual Obligations) or PR (Patient Responsibility) dependent on liability.

Contractors shall return to provider/ return as unprocessable claims for BOS containing HCPCS procedure code 36522 along with one of the following ICD-9-CM diagnosis codes: 996.84, 491.9, 491.20, 491.21, and 496 but is missing *d*iagnosis code V70.7 (as *primary/*secondary diagnosis*, i*nstitutional only), *c*ondition code 30 (institutional claims only), clinical trial modifier Q0/Q1, and *value code D4* with an 8-digit clinical trial identifier number (A/MACs only). Use the following messages:

- CARC 4 – The procedure code is inconsistent with the modifier used or a required modifier is missing. **NOTE**: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

- *RARC N517 – Resubmit a new claim with the requested information.*