Related MLN Matters Article #: MM5464

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Extracorporeal Photopheresis

Key Words

MM5464, CR5464, R1206CP, Extracorporeal, Photopheresis

Provider Types Affected

All providers who bill Medicare carriers, Fiscal Intermediaries (FI), or Part A/B Medicare Administrative Contractors (A/B MACs) for rendering extracorporeal photopheresis services

Key Points

- The effective date of the instruction is December 19, 2006.
- The implementation date is April 2, 2007.
- Extracorporeal photopheresis is a medical procedure in which a patient's white blood cells are exposed first to a drug called 8-methoxypsoralen (8-MOP) and then to an ultraviolet A (UVA) light.
- The procedure starts with the removal of the patient's blood, which is centrifuged to isolate the white blood cells. The drug is typically administered directly to the white blood cells after they have been removed from the patient (referred to as ex vivo administration), but the drug can alternatively be administered directly to the patient before the white blood cells are drawn. After UVA light exposure, the treated white blood cells are then re-infused into the patient.
- Formerly, Medicare covered extracorporeal photopheresis only when used in the palliative treatment of the skin manifestations of cutaneous T-cell lymphoma that has not responded to other therapy.
- On April 6, 2006, a request for reconsideration of this national coverage determination (NCD) to allow additional indications initiated a national coverage analysis.
- Change Request (CR) 5464 announces the NCD resulting from that analysis. Effective December 19, 2006, Medicare provides coverage for:
    - Patients with acute cardiac allograft rejection whose disease is refractory to standard immunosuppressive drug treatment; and
    - Patients with chronic graft versus host disease whose disease is refractory to standard immunosuppressive drug treatment.

Billing Requirements for Extracorporeal Photopheresis

- Providers should use Healthcare Common Procedure Coding System (HCPCS) procedure code 36522 (photopheresis, extracorporeal) when submitting their outpatient or physician claims for this service under these expanded coverage guidelines.
- Effective for dates of service on or after December 19, 2006, Medicare contractors will pay hospital inpatient, including critical access hospitals (CAHs), claims for extracorporeal photopheresis, based on the normal payment methodology for type of bills (TOBs) 11X, 13X or 85X, according to the expanded coverage conditions. Medicare will accept claims for extracorporeal photopheresis:
  - With HCPCS code 36522 when submitted for the treatment of hospital outpatients and for physician services with International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) diagnosis codes: 996.83 or 996.85; and
  - With ICD-9-CM procedure code 99.88 when submitted for the treatment of hospital inpatients, including CAHs, with ICD-9-CM diagnosis codes: 996.83 or 996.85.
- Medicare contractors will not search for claims for services on or after December 19, 2006, but processed prior to the April 2, 2007, implementation date for this change. Medicare contractors will adjust such claims if providers bring them to their attention.

Note: All other indications for extracorporeal photopheresis remain noncovered. Contractors will edit for an appropriate oncological and autoimmune disorder diagnosis prior to paying according to the NCD.

Medicare Summary Notice (MSN), Remittance Advice Remark Code (RA) and Claim Adjustment Reason Code

- Contractors will 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.
- Contractors will deny claims when the service is not rendered to an inpatient or outpatient of a hospital, including CAHs, using the following codes:
  - Claim adjustment reason code: 58 – “Claim/service denied/reduced because treatment was deemed by payer to have been rendered in an inappropriate or invalid place of service.”
  - Medicare Summary Notice (MSN) 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 depending on liability.)
  - Remittance Advice MA 30 - "Missing/incomplete/invalid type of bill." (FIs and A/MACs only)
  - Group Code - CO (Contractual Obligations) or PR (Patient Responsibility) depending on liability.

Advance Beneficiary Notice and Hospital Issued Notice of Noncoverage Information

- If this service is not reasonable and necessary under Section 1862(a)(1)(A) of the Act (falls outside the scope of the revised NCD found in Publication 100-03, Chapter 1, Section 110.4), the physicians and/or hospital outpatient departments, including CAHs, will be held liable for charges unless the physician and/or hospital has the beneficiary sign an Advance Beneficiary Notice (ABN) in advance of providing the service.

- If this service is provided to a hospital inpatient, including CAHs, for a reason unrelated to the admission (outside of the bundled payment), the hospital billing for the inpatient services will be held liable for charges unless the hospital has the beneficiary sign a Hospital Issued Notice of Noncoverage (HINN) letter 11 in advance of providing the service.

Note: This addition/revision of Section 110.4 of the *Medicare National Coverage Determinations Manual* (100-03) is an NCD. NCDs are binding on all carriers, FIs, quality improvement organizations, qualified independent contractors, the Medicare Appeals Council, and administrative law judges (ALJs). (See 42 CFR Section 405.1060(a)(4) (2005).) An NCD that expands coverage is also binding on a Medicare advantage organization. In addition, an ALJ may not review an NCD. (See Section 1869(f)(1)(A)(i) of the Social Security Act.)

Important Links

The related MLN Matters article can be found at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5464.pdf* on the CMS website.

The official instruction (CR5464) issued can be viewed by visiting *http://www.cms.hhs.gov/Transmittals/downloads/R1206CP.pdf* for the updated Medicare Claims Processing Manual (100.04), Chapter 32 (Billing Requirements for Special Services), Section 190 (Billing Requirements for Extracorporeal Photopheresis on the CMS website.