CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 2193	**Date: April 22, 2011**
	Change Request 7385

SUBJECT: Updates to Pub 100-04, Medicare Claims Processing Manual, Chapter 3: Inpatient Hospital Billing.

I. SUMMARY OF CHANGES: CMS is including the following correction and clarifications to Pub 100-04, Medicare Claims Processing Manual, Chapter 3: Inpatient Hospital Billing:

- Corrects hemophilia diagnosis code descriptions in Section 20.7.3 - Payment for Blood Clotting Factor Administered to Hemophilia Inpatients.
- Clarifies billing instructions for the non-outlier period after regular benefit days are exhausted in Section 40 - Billing Coverage and Utilization Rules for PPS and Non-PPS Hospitals.
- Clarifies application of the Code First policy in Section 190.5.2- Application of Code First.

EFFECTIVE DATE: July 23, 2011
IMPLEMENTATION DATE: July 23, 2011

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.

II. CHANGES IN MANUAL INSTRUCTIONS:
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	3/20.7.3/Payment for Blood Clotting Factor Administered to Hemophilia Inpatients
R	3/40/Billing Coverage and Utilization Rules for PPS and Non-PPS Hospitals
R	3/190.5.2/Application of Code First

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

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.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

**Unless otherwise specified, the effective date is the date of service.*

Attachment - Business Requirements

Pub. 100-04	Transmittal: 2193	Date: April 22, 2011	Change Request: 7385

SUBJECT: Updates to Pub 100-04, Medicare Claims Processing Manual, Chapter 3: Inpatient Hospital Billing

Effective Date: **July 23, 2011**

Implementation Date: July 23, 2011

I. GENERAL INFORMATION

A. Background: CMS is including the following correction and clarifications to Pub 100-04, Medicare Claims Processing Manual, Chapter 3, Inpatient Hospital Billing:

- Corrects hemophilia diagnosis code descriptions in Section 20.7.3 - Payment for Blood Clotting Factor Administered to Hemophilia Inpatients
- Clarifies instructions for the nonoutlier period after regular benefit days are exhausted in Section 40 - Billing Coverage and Utilization Rules for PPS and Non-PPS Hospitals
- Clarifies application of the Code First policy in Section 190.5.2 – Application of Code First

B. Policy: There are no policy changes with this instruction.

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
							FISS	MCS	VMS	CWF	
7385.1	Contractors shall be aware of the revisions to Pub. 100-04, Chapter 3, Section 20.7.3, diagnosis code descriptions; Section 40, instructions for nonoutlier period after regular benefit days exhaust; and in Section 190.5.2, clarification of Code First policy.	X		X							

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
							FISS	MCS	VMS	CWF	
7385.2	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/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 site 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 your 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

X-Ref Requirement Number	Recommendations or other supporting information:
	N/A

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

V. CONTACTS

Pre-Implementation Contact(s): Cami DiGiacomo, Cami.DiGiacomo@cms.hhs.gov (FI Billing)

Post-Implementation Contact(s): Your Contracting Officer's Technical Representative (COTR) or Contractor Manager, as applicable.

VI. FUNDING

A. *For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers*:

No additional funding will be provided by CMS; contractor activities are to be carried out within their current operating budgets.

B. *For Medicare Administrative Contractors (MAC)*:

The Medicare Administrative Contractor (MAC) is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as changes to the MAC Statement of Work (SOW). The contractor is not obligated to incur costs in excess of the amounts specified 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.

20.7.3 - Payment for Blood Clotting Factor Administered to Hemophilia Inpatients

(Rev.2193, Issued: 04-22-11, Effective: 07-23-11, Implementation:-7-23-11)

Section 6011 of Public Law (P.L.) 101-239 amended §1886(a)(4) of the Social Security Act (the Act) to provide that prospective payment system (PPS) 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 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 factors furnished on or after June 19, 1990, and before December 19, 1991. Section 13505 of P. L. 103-66 amended §6011 (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.

Local carriers shall process non-institutional blood clotting factor claims.

The FIs shall process institutional blood clotting factor claims payable under either Part A or Part B.

A. Inpatient Bills

Under the Inpatient Prospective Payment System (PPS), hospitals receive a special add-on payment for the costs of furnishing blood clotting factors to Medicare beneficiaries with hemophilia, admitted as inpatients of PPS hospitals. The clotting factor add-on payment is calculated using the number of units (as defined in the HCPCS code long descriptor) billed by the provider under special instructions for units of service.

The PPS Pricer software does not calculate the payment amount. The Fiscal Intermediary Standard System (FISS) calculates the payment amount and subtracts the charges from those submitted to Pricer so that the clotting factor charges are not included in cost outlier computations.

Blood clotting factors not paid on a cost or PPS basis are priced as a drug/biological under the Medicare Part B Drug Pricing File effective for the specific date of service. As of January 1, 2005, the average sales price (ASP) plus 6 percent shall be used.

If a beneficiary is in a covered Part A stay in a PPS hospital, the clotting factors are paid in addition to the DRG/HIPPS payment (For FY 2004, this payment is based on 95 percent of average wholesale price.) For a SNF subject to SNF/PPS, the payment is bundled into the SNF/PPS rate.

For SNF inpatient Part A, there is no add-on payment for blood clotting factors.

The codes for blood-clotting factors are found on the Medicare Part B Drug Pricing File. This file is distributed on a quarterly basis.

For discharges occurring on or after October 1, 2000, and before December 31, 2005, report HCPCS Q0187 based on 1 billing unit per 1.2 mg. Effective January 1, 2006, HCPCS code J7189 replaces Q0187 and is defined as 1 billing unit per 1 microgram (mcg).

The examples below include the HCPCS code and indicate the dosage amount specified in the descriptor of that code. Facilities use the units field as a multiplier to arrive at the dosage amount.

EXAMPLE 1

HCPCS	Drug	Dosage
J7189	Factor VIIa	1 mcg

Actual dosage: 13,365 mcg

On the bill, the facility shows J7189 and 13,365 in the units field (13,365 mcg divided by 1 mcg = 13,365 units).

NOTE: The process for dealing with one international unit (IU) is the same as the process of dealing with one microgram.

EXAMPLE 2

HCPCS	Drug	Dosage
J9355	Trastuzumab	10 mg

Actual dosage: 140 mg

On the bill, the facility shows J9355 and 14 in the units field (140 mg divided by 10mg = 14 units).

When the dosage amount is greater than the amount indicated for the HCPCS code, the facility rounds up to determine units. When the dosage amount is less than the amount indicated for the HCPCS code, use 1 as the unit of measure.

EXAMPLE 3

HCPCS	Drug	Dosage
J3100	Tenecteplase	50 mg

Actual Dosage: 40 mg

The provider would bill for 1 unit, even though less than 1 full unit was furnished.

At times, the facility provides less than the amount provided in a single use vial and there is waste, i.e.; some drugs may be available only in packaged amounts that exceed the needs of an individual patient. Once the drug is reconstituted in the hospital's pharmacy, it may have a limited shelf life. Since an individual patient may receive less than the fully reconstituted amount, we encourage hospitals to schedule patients in such a way that the hospital can use the drug most efficiently. However, if the hospital must discard the remainder of a vial after administering part of it to a Medicare patient, the provider may bill for the amount of drug discarded plus the amount administered.

Example 1:

Drug X is available only in a 100-unit size. A hospital schedules three Medicare patients to receive drug X on the same day within the designated shelf life of the product. An appropriate hospital staff member administers 30 units to each patient. The remaining 10 units are billed to Medicare on the account of the last patient. Therefore, 30 units are billed on behalf of the first patient seen and 30 units are billed on behalf of the second patient seen. Forty units are billed on behalf of the last patient seen because the hospital had to discard 10 units at that point.

Example 2:

An appropriate hospital staff member must administer 30 units of drug X to a Medicare patient, and it is not practical to schedule another patient who requires the same drug. For example, the hospital has only one patient who requires drug X, or the hospital sees the patient for the first time and did not know the patient's condition. The hospital bills for 100 units on behalf of the patient, and Medicare pays for 100 units.

When the number of units of blood clotting factor administered to hemophiliac inpatients exceeds 99,999, the hospital reports the excess as a second line for revenue code 0636 and repeats the HCPCS code. One hundred thousand fifty (100,050) units are reported on one line as 99,999, and another line shows 1,051.

Revenue Code 0636 is used. It requires HCPCS. Some other inpatient drugs continue to be billed without HCPCS codes under pharmacy.

No changes in beneficiary notices are required. Coverage is applicable to hospital Part A claims only. Coverage is also applicable to inpatient Part B services in SNFs and all types of hospitals, including CAHs. Separate payment is not made to SNFs for beneficiaries in an inpatient Part A stay.

B. FI Action

The FI is responsible for the following:

- It accepts HCPCS codes for inpatient services;

- It edits to require HCPCS codes with Revenue Code 0636. Multiple iterations of the revenue code are possible with the same or different HCPCS codes. It does not edit units except to ensure a numeric value;

- It reduces charges forwarded to Pricer by the charges for hemophilia clotting factors in revenue code 0636. It retains the charges and revenue and HCPCS codes for CWF; and

- It modifies data entry screens to accept HCPCS codes for hospital (including CAH) swing bed, and SNF inpatient claims (bill types 11X, 12X, 18x, 21x and, 22x).

The September 1, 1993, IPPS 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 inpatient blood-clotting factors are covered only for beneficiaries with hemophilia, the FI must 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 ***XI deficiency***
286.3 Congenital deficiency of other clotting factor***s***
286.4 von Willebrands' disease

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

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

C. Part A Remittance Advice

1. X12.835 Ver. 003030M

For remittance reporting PIP and/or non-PIP payments, the Hemophilia Add on will be reported in a claims level 2-090-CAS segment (CAS is the element identifier) 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.

For remittance reporting PIP payments, the Hemophilia Add On will also be reported in the provider level adjustment (element identifier 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.

The FIs enter MA103 (Hemophilia Add On) in an open MIA (element identifier) 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

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.

For remittances reporting PIP payments, the Hemophilia Add On will be reported in the provider level adjustment PLB segment with the provider level adjustment reason "ZZ" 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 the Hemophilia Add On for future use. However, continue to use PLB adjustment reason code "ZZ" until further notice.

The FIs enter MA103 (Hemophilia Add On) in an open MIA remark code data element. This will alert the provider that the ZK, FL and ZZ entries are related to the Hemophilia Add On. (Effective with version 4010 of the 835, report ZK in lieu of FL in the QTY segment.)

3. Standard Hard Copy Remittance Advice

For paper remittances reporting non-PIP payments involving Hemophilia Add On, add a "Hemophilia Add On" category to the end of the "Pass Thru Amounts" listings in the "Summary" section of the paper remittance. Enter the total of the Hemophilia Add On amounts due for the claims covered by this remittance next to the Hemophilia Add On heading.

The FIs add the Remark Code “MA103” (Hemophilia Add On) to the remittance advice under the REM column for those claims that qualify for Hemophilia Add On payments.

This will be the full extent of Hemophilia Add On reporting on paper remittance notices; providers wishing more detailed information must subscribe to the Medicare Part A specifications for the ANSI ASC X12N 835, where additional information is available.

See chapter 22, for detailed instructions and definitions.

40 - Billing Coverage and Utilization Rules for PPS and Non-PPS Hospitals

(Rev. 2193, Issued: 04-22-11, Effective: 07-23-11, Implementation:-7-23-11,)

HO-415.1

A. General

Days of utilization are charged based upon actual days of coverage including grace and waiver days. The number of covered days used are maintained by CMS to track the beneficiary's eligible days in a benefit period. The hospital collects the coinsurance, if applicable, for only the number of days charged against the beneficiary's utilization record maintained by CMS. For example, if the mean length of stay for a DRG is 10 days and the beneficiary is discharged after 3, only 3 days of utilization is charged. In a like situation, if the DRG mean length of stay is 10 days and the beneficiary is discharged after 15, the 15 days are charged against the utilization record.

NOTE: There are some exceptions to this rule under LTCH PPS. See §150.4.

Coinsurance, if applicable, is payable by the beneficiary for the number of days used. The hospital subtracts the coinsurance amount from the DRG payment. Days after benefits are exhausted are not charged against the beneficiary's utilization even though the hospital may receive the full DRG payment.

The basic prospective payment amount will be paid if:

- There is at least l day of utilization left at the time of admission and that day is also a day of entitlement (e.g., a day before the beneficiary discontinued voluntary Part A entitlement by not paying the premium).

- There is at least l day for which payment may be made under the guarantee of payment. (If benefits are exhausted prior to admission and no payment may be made under guarantee of payment, only Part B benefits are available.)

- The beneficiary becomes entitled after admission. The hospital may not bill the beneficiary or other persons for days of care preceding entitlement except for days in excess of the outlier threshold.

Utilization is not counted for any days treated as noncovered, except as described below:

- Utilization is not counted for any nonentitlement days, or days after benefits are exhausted (including guarantee of payment days), even if those days are treated as covered for outlier calculation or treated as Medicare patient days for the cost report.

- The length of stay exceeds the day outlier threshold (Day outliers were discontinued at the end of FY 1997), utilization is counted for medically unnecessary days which are noncovered but for which the hospital may not charge the beneficiary because the requirements of §40.2 were not met. See §40.2.2 for identification of these days.

- If the adjusted cost of the stay exceeds the cost outlier threshold, utilization is counted for any medically unnecessary days on which all Part A services are treated as noncovered under §40.2.B and for which the hospital may not charge the beneficiary. (Where only ancillary services are denied, all days are counted as covered.)

Lifetime reserve days for an inpatient hospital stay for which prospective payment may be made is subject to the following:

If the beneficiary had one or more regular benefit days remaining in the spell of illness when admitted, there is no advantage in using lifetime reserve days. The beneficiary is deemed to have elected not to use lifetime reserve days for the nonoutlier (Day outliers were discontinued at the end of FY 1997) portion of the stay. ***IPPS uses Occurrence Span code 70 for the covered non-utilization period after regular benefit days are exhausted. For example:***

Beneficiary has 2 coinsurance days left
Admit date = 09/01/10
Discharge date = 09/30/10
Occurrence Span code 70 = 09/03/10 to 09/30/10

After regular benefits have been exhausted, lifetime reserve days will be used automatically for outlier days unless the beneficiary elects not to use them, or the average daily charges for outlier days to be reimbursed as lifetime reserve days do not exceed the lifetime reserve day coinsurance amount. (In the latter case the beneficiary is deemed to have elected not to use lifetime reserve days for outlier days.) An election not to use lifetime reserve for outlier days applies to all outlier days in an admission.

- If the beneficiary had no regular benefit days remaining when admitted, available lifetime reserve days are used automatically for each day of the stay. Exceptions exist if the beneficiary elects not to use lifetime reserve days, or the charges for which the beneficiary is liable, if electing not use lifetime reserve days, do not exceed the charges for which the beneficiary would be liable if the lifetime reserve days were used. Using

lifetime reserve days, the beneficiary would be responsible for the sum of the coinsurance amounts for the lifetime reserve days that would be used plus the total charges for outlier days, if any, for which no lifetime reserve days are available. (In the latter case the beneficiary will be deemed to have elected not to use any lifetime reserve days.)

An election by the beneficiary not to use lifetime reserve days applies to the entire stay and precludes any payment for the stay. A deemed election not to use lifetime reserve days applies to the entire stay and precludes any payment for the stay unless payment may be made under the guarantee of payment.

The number of days for which utilization is charged may be different from the number used in Pricer to compute outlier status or the number of Medicare patient days shown on the cost report.

190.5.2 - Application of Code First

(Rev. 2193, Issued: 04-22-11, Effective: 07-23-11, Implementation:-7-23-11,)

According to the ICD-9-CM Official Guidelines for Coding and Reporting, when a principal diagnosis code has a Code First notation, the provider follows the applicable ICD-9-CM coding convention, which requires the underlying condition (etiology) to be sequenced first, followed by the manifestation due to the underlying condition. Therefore, CMS considers Code First diagnoses to be the principal diagnosis. The submitted claim goes through the IPF PPS claims processing system that identifies the principal diagnosis code as non-psychiatric and searches ***only the first "secondary" code*** for a psychiatric code to assign the DRG/MS-DRG in order to pay Code First claims properly.

For more coding guidance, refer to the ICD-9-CM Official Guidelines for Coding and Reporting which can be located on the CMS Web site at http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/.

The most current Code First list is posted on the IPF PPS Web site at www.cms.hhs.gov/InpatientPsychFacilPPS

Code First Example

Diagnosis code 294.11 "Dementia in Conditions Classified Elsewhere with Behavioral Disturbances" is designated as "NOT ALLOWED AS PRINCIPAL DX" code.

Four digit code 294.1 "Dementia in Conditions Classified Elsewhere", is designated as a Code First diagnosis indicating that all 5 digit diagnosis codes that fall under the 294.1 category (codes

294.10 and 294.11) must follow the Code First rule. The 3 digit code 294 “Persistent Mental Disorders Due to Conditions Classified Elsewhere” appears in the ICD-9-CM as follows:

294 PERSISTENT MENTAL DISORDERS DUE TO CONDITIONS CLASSIFIED ELSEWHERE

294.1 Dementia in Conditions Classified Elsewhere

Code First any underlying physical condition, as:

Dementia in:

Alzheimer’s disease (331.0)
Cerebral lipidosis (330.1)
Dementia with Lewy bodies (331.82)
Dementia with Parkinsonism (331.81)
Epilepsy (345.0 – 345.9)
Frontal dementia (331.19)
Frontotemporal dementia (331.19)
General paresis [syphilis] (094.1)
Hepatolenticular degeneration (275.1)
Huntington’s chorea (333.4)
Jacob-Creutzfeldt disease (046.1)
Multiple sclerosis (340)
Pick's disease of the brain (331.11)
Polyarteritis nodosa (446.0)
Syphilis (094.1)

294.10 Dementia in Conditions Classified Elsewhere Without Behavioral Disturbances
NOT ALLOWED AS PRINCIPAL DX

294.11 Dementia in Conditions Classified Elsewhere With Behavioral Disturbances
NOT ALLOWED AS PRINCIPAL DX

According to Code First requirements, the provider would code the appropriate physical condition first, for example, 333.4 “Huntington’s Chorea” as the principal diagnosis code and 294.11 “Dementia In Conditions Classified Elsewhere With Behavioral Disturbances” as a secondary diagnosis or comorbidity code on the patient claim.

The purpose of this example is to demonstrate proper coding for a Code First situation. However, in this case, the principal diagnosis groups to one of the 15 DRGs, or 17 MS-DRGs, for which CMS pays an adjustment. Had the diagnosis code grouped to a non-psychiatric

DRG/MS-DRG, the PRICER would search the first of the other diagnosis codes for a psychiatric code listed in the Code First list in order to assign a DRG adjustment.