CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 2332	**Date: October 28, 2011**
	Change Request 7553

SUBJECT: Diagnosis Code Update for Add-on Payments for Blood Clotting Factor Administered to Hemophilia Inpatients

I. SUMMARY OF CHANGES: This instruction provides updates to diagnosis codes required in order to allow add-on payments under the Inpatient Prospective Payment System (IPPS).

EFFECTIVE DATE: October 1, 2011
IMPLEMENTATION DATE: April 2, 2012

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	3/20.7.3/Payment for Blood Clotting Factor Administered to Hemophilia Inpatients

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: 2332	Date: October 28, 2011	Change Request: 7553

SUBJECT: Diagnosis Code Update for Add-on Payments for Blood Clotting Factor Administered to Hemophilia Inpatients

Effective Date: **October 1, 2011**

Implementation Date: April 2, 2012

I. GENERAL INFORMATION

A. Background: Section 20.7.3, Payment for Blood Clotting Factor Administered to Hemophilia Inpatients, of Chapter 3, Inpatient Hospital Billing, is updated with the following diagnosis codes required in order to allow add-on payments under the Inpatient Prospective Payment System (IPPS):

ADD

Effective October 1, 2011:

286.52	Acquired hemophilia
286.53	Antiphospholipid antibody with hemorrhagic disorder
286.59	Other hemorrhagic disorder due to intrinsic circulating anticoagulants, antibodies, or inhibitors

Effective October 1, 2013:

D6831	Hemorrhagic disorder due to intrinsic circulating anticoagulants

TERMINATE

Effective September 30, 2011:

286.5	Hemorrhagic disorder due to circulating anticoagulants

NOTE: The add-on payment criteria for blood clotting factors administered to hemophilia inpatients will not be updated until April 2, 2012. Therefore, providers that include diagnosis codes 286.52, 286.53 or 286.59 on inpatient claims with discharge dates after October 1, 2011 prior to the April 2012 implementation will not receive the add-on payment. Providers may contact their contractors to have any affected claims adjusted once this instruction is implemented.

B. Policy: 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-CM diagnosis code for hemophilia is included on the bill.

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
							FISS	MCS	VMS	CWF	
7553.1	Effective for discharges on or after October 1, 2011, Medicare contractors shall add diagnosis codes 286.52, 286.53 and 286.59 to the conditions required to receive the hemophilia clotting factor add-on payment.	X		X			X				
7553.1.1	Contractors shall note that the appropriate ICD-10 code(s) are listed below. Contractors shall track the ICD-10 code/edits (and add the code(s)/edit(s) to their system when applicable) and ensure that the updated edit is functional as part of the ICD-10 implementation. **NOTE: You will not receive a separate Change Request instructing you to implement updated edits.** - D6831	X		X			X				
7553.1.2	Medicare contractors shall add a termination date of September 30, 2011, for diagnosis code 286.5 in the hemophilia clotting factor add-on payment criteria.	X		X			X				
7553.2	Medicare contractors need not search claims history but shall adjust affected claims when brought to their attention.	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	
7553.3	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:

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

Section B: All other recommendations and supporting information, use this space: N/A

V. CONTACTS

Pre-Implementation Contact(s): Cindy Pitts, Cindy.Pitts@cms.hhs.gov or Jason Kerr, Jason.Kerr@cms.hhs.gov

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

VI. FUNDING

Section 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 operating budgets.

Section B: *For Medicare Administrative Contractors (MACs)*, include the following statement:

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.

20.7.3 - Payment for Blood Clotting Factor Administered to Hemophilia Inpatients

(Rev. 2332, Issued: 10-28-11, Effective: 10-01-11, Implementation: 04-02-12)

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 (IPPS), 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 *Shared* 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*/A/B MAC* Action

The *contractor* 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, *contractors* 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 *(terminate effective September 30, 2011)*
286.7 Acquired coagulation factor deficiency

Effective for discharges on or after October 1, 2011, payment may also be made if one of the following diagnosis codes is reported:

286.52 Acquired hemophilia
286.53 Antiphospholipid antibody with hemorrhagic disorder
286.59 Other hemorrhagic disorder due to intrinsic circulating anticoagulants, antibodies, or inhibitors

Effective for discharges on or after October 1, 2013, payment may also be made if the following ICD-10 diagnosis code is reported:

D6831 Hemorrhagic disorder due to intrinsic circulating anticoagulants

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.

Contractors 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.

Contractors 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.

Contractors 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.