Medicare
Intermediary Manual
Part 3 - Claims Process

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

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CHANGE REQUEST 2037

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
3610.18 (Cont.) – 3610.19	6-113 – 6-118 (6 pp.)	6-113 – 6-118 (6 pp.)

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

Section 3610.18, Payment for Blood Clotting Factor Administered to Hemophilia Inpatients, is revised to:

- Discontinue HCPCS codes Q0160 and Q0161 for discharges occurring on or after January 1, 2002;
- Add HCPCS codes J7193 and J7195 effective January 1, 2002;
- Correct the date given in Example 4 on page 6-115; and
- Provide reporting and claims processing requirements of HCPCS code J7199.

Instruct your hospitals to submit the inpatient bills without the add-on for HCPCS codes J7193 and J7195. When you have added the new codes and tested that they will process correctly, notify your hospitals to send the adjustment request bills containing these new codes.

Do not reopen and reprocess any claims that have not been brought to your attention.

DISCLAIMER: The revision date and transmittal number only apply to the redlined material. All other material was previously published in the manual and is only being reprinted.

These instructions should be implemented within your current operating budget.

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

J7190	Factor VIII	- $ .64 per IU
J7194	Factor IX, complex,	- .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 charges are:

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

The prices per unit for discharges October 1, 1992, through September 30, 1993, are:

J7190	Factor VIII	- $ .76 per IU
J7194	Factor IX	- .30 per IU
J7196	Other Hemophilia blooding clotting factors	- l.02 per IU

The prices per unit for discharges October 1, 1993, through September 30, 1994, are:

J7190	Factor VII	- $ .76 per IU
J7194	Factor IX	- .33 per IU
J7196	Other Hemophilia blooding clotting factors	- 1.02 per IU

Effective January 1, 1994, there is an additional covered clotting factor:

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

For discharges occurring on or after October 1, 1997 through September 30, 1998.

J7190	Factor VIII	- $ .76 per IU
J7192	Factor VIII	- 1.00 per IU
J7194	Factor IX	- .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-recombinant)	- $ .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, nonrecombinant)	.93 per IU
Q0161	Factor IX (Anti-Hemophilic Factor, purified, recombinant)	1.00 per IU

For discharges October 1, 1999 through September 30, 2000, the following prices apply to add-on payments for blood clotting factor administered to inpatients with hemophilia:

J7190	Factor VIII (Antihemophilic Factor, Human)	$0.79 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)	$0.45 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) **(Discontinued 12/31/2001)**	$0.97 per IU
Q0161	Factor IX (Antihemophilic Factor, recombinant) **(Discontinued 12/31/2001)**	$1.00 per IU
Q0187	Factor VIIa (Coagulation Factor, Recombinant)	$1.19 per MCG
Q2022	Von Willebrand Factor Complex (**effective 7/1/2000**)	$1.05 per IU

Beginning FY 2001 the payment for blood clotting factor administered to hemophilia inpatients is equal to 95 percent of the AWP. The payment amounts will be determined using the most recent AWP data available to the carrier at the time you perform these annual update calculations. For discharges on and after October 1, 2000, obtain the payment allowances from the carrier in the jurisdiction of the provider.

NOTE: For HCPCS code J7199, providers must report the name of the drug and how the drug is dispensed in the remarks section of the claim. Using the information provided, obtain the payment allowance, for that drug, from the carrier in the jurisdiction of the provider.

Effective for services on or after January 1, 2002, two new HCPCS billing codes are established for purified and recombinant Factor IX.

J7193	Factor IX (Antihemophilic Factor, Purified, nonrecombinant)
J7195	Factor IX (Antihemophilic Factor, recombinant)

PRICER does not calculate the payment amount. Calculate the payment amount and subtract the charge from those submitted to PRICER so it is not included in cost outlier computations.

One hundred IUs of any of the clotting factors except HCPCS Code Q0187, Factor VIIa, are reported as one unit. (100 IUs = one billing unit.) Therefore, 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, providers report HCPCS Code Q0187 based on 1 billing unit per 1.2 mg.

If the number of units provided is between even hundreds, hospitals 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, hospitals 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 formula for calculating the payment amount is: # of units x 100 x price per IU= payment amount. 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.) The hospital enters 12 in FL 46 of the HCFA-1450. 1 unit x 100 x price = payment amount. 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.) The hospital rounds down to the nearest whole number to obtain the billing units and enters 34 in FL 46. 1 unit x 100 x price = payment amount. 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. 1 unit x 100 x price = payment amount. The payment amount is $5,406 (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, 2000. 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 (reported as 9,999,999), the hospital reports the excess as a second line for revenue code 636 and repeats the HCPCS code. One billion fifty million (1,050,000,000) units are reported on one line as 9,999,999, and another line shows 500,001.

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

Revenue Code 636 is used. It requires HCPCS. Other inpatient drugs continue to be billed without HCPCS codes under pharmacy. Electronic billers must enter the HCPCS code in field 5 of Record Type 60. (See Addendum A.)

No changes in beneficiary notices are required. Coverage is applicable to hospital Part A claims only. Coverage is not applicable to inpatient Part B claims. Separate payment is not made to SNFs.

B. Intermediary Action.--Make the following changes to your systems:

o Accept HCPCS codes for inpatient services;

o Edit to require HCPCS codes with Revenue Code 636. Multiple iterations of the revenue code are possible with the same or different HCPCS codes. Units provided generally range from about 600 IUs (reported as 6) to over 10,000 (reported as 100 on the bill). Do not edit units except to ensure a numeric value;

o Develop inpatient fee tables based on HCPCS codes and revenue code 636. Pay the fee amount regardless of the charges;

o Reduce charges forwarded to PRICER by the charges for revenue code 636. Retain the charges and revenue and HCPCS codes for CWF, and for PS&R;

o Determine what changes you need in your remittance record to hospitals;

o Modify your data entry screens to accept HCPCS codes for hospital inpatient claims (bill types 110, 111, 112, 113, 114, 115, 117, & 118);

o Include the HCPCS code and payment amount in the following records for each HCPCS code billed under revenue code 636:

RECORD	HCPCS CODE	PAYMENT AMOUNT
PS&R UNIBILL	Financial Data Corresponding to CWF	Field 79
CWF (HUIP)	Field 90	Field 99

o Treat the bill as a single bill for MSP, and for charging deductible and coinsurance. Use total charges for deductible and coinsurance calculations.

Changes are not planned for MSP pay. Where MSP recovery is made, the PS&R system allocates MSP primary payer payments between revenue code 636 and the remainder of the charges. It will delete the primary payment applicable to the final revenue code 636 payment from the primary payment amount carried forward to the PS&R detail record. PS&R will do this allocation based on charges for revenue code 636 and total covered Medicare charges.

The PS&R provides a separate revenue code report for charges under revenue code 636 for your use at cost report review.

The September 1, 1993 PPS 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 blood clotting factors are only covered for beneficiaries with hemophilia, 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 IX disorder
286.3 Congenital deficiency of other clotting factor
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

C. Part A Remittance Advice.--

1. X12.835 Ver. 003030M.--

a. For remittances reporting PIP and/or non-PIP payments, the Hemophilia Add on will be reported in a claims level 2-090-CAS segment 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.

b. For remittances reporting PIP payments, the Hemophilia Add On will also be reported in the provider level adjustment 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.

c. Enter MA103 (Hemophilia Add On) in an open MIA 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.--

a. 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.

b. 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.

c. 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.--

a. 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.

b. 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 X12 835, where additional information is available.

3610.19 Medicare Rural Hospital Flexibility Program.--

The Medicare Law allows establishment of a Medicare Rural Hospital Flexibility Program by any State that has submitted the necessary assurances and complies with the statutory requirements for designation of hospitals as Critical Access Hospitals (CAHs).

To be eligible as a CAH, a facility must be a currently participating Medicare hospital, a hospital that ceased operations on or after November 29, 1989, or a health clinic or health center that previously operated as a hospital before being downsized to a health clinic or health center. The facility must be located in a rural area of a State that has established a Medicare rural hospital flexibility program, and must be located more than a 35-mile drive from any other hospital or critical access hospital, or be certified by the State to be a "necessary provider". In mountainous terrain or in areas with only secondary roads available, the mileage criterion is 15 miles. In addition, the facility must make available 24 hour emergency care services, provide not more than 15 beds for acute (hospital-level) inpatient care, and maintain a length of stay, as determined on an annual average basis, of no longer than 96 hours.

An exception to the 15-bed requirement is made for swing-bed facilities, which are allowed to have up to 25 inpatient beds that can be used interchangeably for acute or SNF-level care, provided that not more than 15 beds are used at any one time for acute care. The facility is also required to meet the conditions of participation for CAHs (42 CFR Part 485, Subpart F). Designation by the State is not sufficient for CAH status. To participate and be paid as a CAH, a facility must be certified as a CAH by CMS.

3610.20 Grandfathering Existing facilities.--As of October 1, 1997, no new EACH designations can be made. The EACHs designated by CMS before October 1, 1997, will continue to be paid as sole community hospitals for as long as they comply with the terms, conditions, and limitations under which they were designated as EACHs.

3610.21 Requirements for CAH Services and CAH Long-term Care Services.--

A. Effective November 29, 1999, CAHs are no longer required to maintain documentation showing that individual stays longer than 96 hours were needed because of inclement weather or other emergency conditions, or submit a case-specific waiver of the 96-hour limit from a peer review organization (PRO) or equivalent entity. Thus, intermediaries are not required to obtain documentation showing that a PRO or equivalent entity has, on request, approved stays beyond 96 hours in specific cases. A CAH may provide acute inpatient care for a period that does not exceed, as determined on an annual average basis, 96 hours per patient. A patient is considered discharged when the admission's office records the discharge and (1) the patient has been discharged by the appropriate practitioner on the medical chart and (2) the patient is no longer receiving services. The patient would have to be out of the room and the room available for occupancy.