Medicare Hospital Manual

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

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REFER TO CHANGE REQUEST 2037

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
460.1(Cont.) – 460.1 (Cont.)	4-552.15 – 4-552.17 (3 pp.)	4-552.15 – 4-552.16 (2 pp.)

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

Section 460.1, 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 4-552.16; and
- Provide reporting requirements for HCPCS code J7199.

If you have administered hemophilia blood clotting factors with HCPCS codes J7193 or J7195, submit your bill without the blood clotting factor. When your intermediary's system can process HCPCS codes J7193 and J7195, your intermediary will notify you. At that time, submit an adjustment request including these blood clotting factors. When your intermediary processes the adjustment bill, you will receive an incremental payment covering the hemophilia blood clotting factor.

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.

J7196	Other Hemophilia clotting Factor, (anti-inhibitors)	- 1.10 per IU
Q0160	Factor IX (Anti-Hemophilic Factor, purified, non-recombinant)	- .93 per IU
Q0161	Factor IX (Anti-Hemophilic Factor, purified, recombinant)	- 1.00 per IU

These prices will be effective for add-on payments for blood clotting factor administered to inpatients who have hemophilia for discharges beginning on or after October 1, 1999 through September 30, 2000.

J7190	Factor VIII (Antihemophilic) Factor, Human)	.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)	.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)**	.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 MCGs
Q2022	Von Willebrand Factor Complex (**Effective 7/1/2000**)	1.05 per IU

NOTE: For HCPCS code J7199, you must report the name of the drug and how the drug is dispensed in the remarks section of the claim.

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)

Report one hundred IUs of any of the clotting factors except Q0187, Factor VIIa as one unit. (100 IUs - one billing unit.) Therefore, the 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, report HCPCS Q0187 based on 1 billing unit per 1.2 mg.

If the number of units is between even hundreds, 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, 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 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.) Enter 12 in FL 46 of the HCFA-1450. 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.) Round down to the nearest whole number to obtain the billing units, and enters 34 in FL 46. 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. The payment amount will be $5406 (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 (report as 9,999,999, report the excess as a second line for revenue code 636 and repeat the HCPCS code. One billion fifty million (1,050,000,000) units are reported on one line as 9,999,999, and another line as 500,001.

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

Use Revenue Code 636. This requires HCPCS. Continue to bill other inpatient drugs without HCPCS codes under pharmacy.

In order to qualify for the add-on payment for hemophilia blood clotting factor, the claim must contain a hemophilia diagnosis code, either as principal or secondary diagnosis. One of the following ICD-9-CM diagnosis codes must be present on the claim.

Final rule (58 FR 46304) states that payment will be made for blood clotting factor only if there is an ICD-9-CM diagnosis code for hemophilia included on the bill. Since blood clotting factors are only covered for beneficiaries with hemophilia, list one of the following hemophilia diagnosis codes on the bill:

286.0	Congenital factor VIII disorder
286.1	Congenital factor IX disorder
286.2	Congenital factor XI disorder
286.3	Congenital deficiency of other clotting factors
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