



Related MLN Matters Article #: MM4229

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Payment for Blood Clotting Factors Administered to Hemophilia Inpatients

Key Words

MM4229, CR4229, R904CP, Prospective, Payment, System, Blood, Clotting, Hemophilia

Provider Types Affected

Providers billing Fiscal Intermediaries (FIs) for services related to blood clotting factors administered to hemophilia inpatients

Key Points

- Both the effective date and the implementation date for the instruction is July 14, 2006.
- CR4229 clarifies the pricing methodologies used for blood clotting factors to ensure that units of service for blood clotting factor are reported accurately.
- The provider must determine the actual dosage furnished to the patient and, using the long version of the description of the Healthcare Common Procedure Coding System (HCPCS) code, translate the dosage into **UNITS OF SERVICE**. (Not all short version descriptions of HCPCS codes define units for the HCPCS code.)
- The examples below include the HCPCS code, and indicate the dosage amount specified in the descriptor of that HCPCS code.
- Facilities are instructed to use the units field as a multiplier to arrive at the dosage amount.

Example One:

HCPCS Code: J9355; Drug: Trastuzumab; Dosage: 10 mg

- Actual dosage: **140 mg**
- When the dosage amount is **greater than** the amount indicated for the HCPCS code, the facility rounds up to determine units.
- On the bill, the facility shows HCPCS Code J9355 and 14 in the units of service field (140 mg divided by 10 mg equals 14).

Example Two:

HCPCS Code: J3100; Drug: Tenecteplase; Dosage: 50 mg

- Actual Dosage: 40 mg
- When the dosage amount is **less than** the amount indicated for the HCPCS code, use one as the unit of measure.
- The provider would bill for one unit, even though less than one full unit was furnished (40 mg divided by 50 mg equals 0.8 mg).

Example Three:

HCPCS Code: J9255; Drug: Paclitaxel; Dosage: 30 mg

- Actual Dosage: 175 mg
- At times, a 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.
- The provider would bill for six units, even though less than six full units were furnished. (175 mg divided by 30 mg equals 5.83).
- 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 with the amount administered, as illustrated in Examples 4 and 5.

Example Four:

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;
 - **30 units** are billed on behalf of the second patient seen; and
 - **40 units** are billed on behalf of the last patient seen because the hospital had to discard 10 units at that point.

Example Five:

Drug X is available only in a 100-unit size.

- 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.

Intermediaries are additionally required to:

- Calculate the payment amount and subtract the charge from those submitted to Pricer so that the clotting factor charges are not included in cost outlier computations;
- Use the blood-clotting factors HCPCS codes from the Medicare Part B Drug Pricing File, which is made available on a quarterly basis;
- Use the Average Sales Price (ASP) plus six percent to make payment to facilities that are not paid on cost or Prospective Payment System (PPS);
- Pay for hemophilia clotting factors during a covered Part A stay in a PPS hospital at ASP plus six percent in addition to the DRG payment;
- Pay the Ambulatory Patient Classification rate to Outpatient Prospective Payment System hospitals for hemophilia clotting factors administered in inpatient Part B and outpatient settings;
- Pay for hemophilia clotting factors to beneficiaries based on cost for Part B Skilled Nursing Facility (SNF) services, including inpatient Part B, and all such factors administered by critical access hospitals;
- Pay for hemophilia clotting factors based on cost for non-PPS swing bed services; and
- **Not** pay a separate add-on under SNF PPS for SNF or swing bed services.

Note: Providers should no longer divide the number of units by 100 when billing for clotting factors.

Important Links

The official instruction issued to intermediaries regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R903CP.pdf> on the CMS website.