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Payment for Blood Clotting Factors Administered to Hemophilia Inpatients

Note: This article was updated on October 23, 2012, to reflect current Web addresses. This article was previously revised on July 10, 2006, to clarify example 3 on page 2 and make the example consistent with CR4229. All other information remains unchanged.

Provider Types Affected

Providers billing fiscal intermediaries (FIs) for services related to blood clotting factors administered to hemophilia inpatients

Provider Action Needed

This article is based on Change Request (CR) 4229, which clarifies the pricing methodologies used for blood clotting factors. It is especially important to point out that the provider determines the dosage furnished to the patient and, using the definition of the appropriate HCPCS code, translates the dosage into units of service on the claim submitted to Medicare.

Background

The Centers for Medicare & Medicaid Services (CMS) provided CR4229 to clarify billing practices for providers to ensure that units of service for blood clotting factor are reported accurately. Some Medicare providers have been billing units of drugs and biologicals incorrectly on outpatient bills as well as on inpatient claims for hemophilia clotting factors. The erroneous reporting of units of service has resulted in Medicare overpayments.

The provider must determine the actual dosage furnished to the patient and, using the long version of the description of the HCPCS code, translate the dosage into **UNITS OF SERVICE**. **Note:** Not all short version descriptions of HCPCS codes define units for the HCPCS code.

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The examples below include the Healthcare Common Procedure Coding System (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 1

HCPCS Code	Drug	Dosage
J9355	Trastuzumab	10 mg

Actual dosage: 140 mg

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).

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 one as the unit of measure.

Example 2

HCPCS Code	Drug	Dosage
J3100	Tenecteplase	50 mg

Actual Dosage: 40 mg

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)

Example 3

HCPCS Code	Drug	Dosage
J7189	Factor VIIa	1 mcg

Actual Dosage: 13,365 mcg

The provider would bill for J7189 with 13,365 in the units field (13,365 mcg divided by 1 mcg equals 13,365). Note that the process for dealing with one international unit (IU) is the same as the process of dealing with one microgram.

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.

Since an individual patient may receive less than the fully reconstituted amount, CMS encourages hospitals to schedule patients in such a way that the hospital

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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 with the amount administered, as illustrated in Examples 4 and 5.

Example 4

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 5

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.

Additional Requirements

CR4229 further instructs your intermediary 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 Diagnosis Related Group (DRG) payment;

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- Pay the Ambulatory Patient Classification (APC) rate to Outpatient Prospective Payment System (OPPS) 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 (CAHs);
- 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.

Implementation

The implementation date for the instruction is July 14, 2006.

Additional Information

For complete details, please see the official instruction issued to your intermediary regarding this change. That instruction may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R903CP.pdf> on the CMS website.

If you have any questions, please contact your intermediary at their toll-free number, which may be found at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html> on the CMS website.

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