



Do you have your NPI? National Provider Identifiers (NPIs) will be required on claims sent on or after May 23, 2007. Every health care provider needs to get an NPI. Learn more about the NPI and how to apply for an NPI by visiting <http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/NationalProvdentStand/index.html> / on the CMS website.

MLN Matters Number: MM5464

Related Change Request (CR) #: 5464

Related CR Release Date: March 16, 2007

Effective Date: December 19, 2006

Related CR Transmittal #: R1206CP and R66NCD

Implementation Date: April 2, 2007

Extracorporeal Photopheresis

Note: This article was revised on September 18, 2014, to add a reference to MLN Matters® article MM8808 available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8808.pdf>, which clarifies requirements that covers extracorporeal photopheresis for the treatment of bronchiolitis obliterans syndrome (BOS), following lung allograft transplantation, only when provided under a clinical research study that meets specific requirements to assess the effect of extracorporeal photopheresis for the treatment of BOS, following lung allograft transplantation. All other information is unchanged.

Provider Types Affected

This article is intended for all providers who bill Medicare Carriers, Fiscal Intermediaries (FI), or Part A/B Medicare Administrative Contractors (A/B MACs) for rendering extracorporeal photopheresis services

Provider Action Needed



STOP – Impact to You

Effective For services provided on or after December 19, 2006, coverage for extracorporeal photopheresis is now expanded to include additional health conditions.



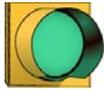
CAUTION – What You Need to Know

Change Request (CR) 5464, from which this article is taken, announces (effective December 19, 2006), the expansion of coverage of extracorporeal photopheresis to

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include patients with acute cardiac allograft rejection and chronic graft versus host disease whose disease is refractory to standard immunosuppressive drug treatment.



GO – What You Need to Do

Make sure that your billing staffs are aware of this expanded coverage for extracorporeal photopheresis, and bill accordingly.

Background

Extracorporeal photopheresis is a medical procedure in which a patient's white blood cells are exposed first to a drug called 8-methoxypsoralen (8-MOP) and then to an ultraviolet A (UVA) light. The procedure starts with the removal of the patient's blood, which is centrifuged to isolate the white blood cells. The drug is typically administered directly to the white blood cells after they have been removed from the patient (referred to as *ex vivo* administration), but the drug can alternatively be administered directly to the patient before the white blood cells are drawn. After UVA light exposure, the treated white blood cells are then re-infused into the patient.

Formerly, Medicare covered extracorporeal photopheresis only when used in the palliative treatment of the skin manifestations of cutaneous T-cell lymphoma that has not responded to other therapy. On April 6, 2006, a request for reconsideration of this national coverage determination (NCD) to allow additional indications initiated a national coverage analysis.

CR 5464 announces the NCD resulting from that analysis. It provides that CMS has reviewed the evidence and determined that extracorporeal photopheresis is reasonable and necessary under section 1862(a)(1)(A) of the Social Security Act for patients with acute cardiac allograft rejection whose disease is refractory to standard immunosuppressive drug treatment, and for patients with chronic graft versus host disease whose disease is refractory to standard immunosuppressive drug treatment. Therefore, effective December 19, 2006, coverage has been expanded to include these conditions.

Billing Requirements for Extracorporeal Photopheresis

You should use Healthcare Common Procedure Coding System (HCPCS) procedure code 36522 (Photopheresis, extracorporeal) when submitting your outpatient or physician claims for this service under these expanded coverage guidelines. Effective for dates of service on or after December 19, 2006, Medicare contractors will pay hospital inpatient, including CAH, claims for extracorporeal photopheresis, based on the normal payment methodology for type of bills (TOBs) 11X, 13X or 85X, according to the expanded coverage conditions. Specifically, Medicare will accept claims for extracorporeal photopheresis:

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- With HCPCS code 36522 when submitted for the treatment of hospital outpatients and for physician services with ICD-9-CM diagnosis codes: 996.83 or 996.85; and
- With ICD-9-CM procedure code 99.88 when submitted for the treatment of hospital inpatients, including CAHs, with ICD-9-CM DX codes: 996.83 or 996.85.

Medicare contractors will not search for claims for services on or after December 19, 2006, but processed prior to the April 2, 2007, implementation date for this change. However, they will adjust such claims if you bring them to their attention.

Note: All other indications for extracorporeal photopheresis remain noncovered. Further, note that contractors will edit for an appropriate oncological and autoimmune disorder diagnosis prior to paying **according to the NCD**.

Medicare Summary Notices (MSNs), Remittance Advice Remark Codes (RAs) and Claim Adjustment Reason Code

Contractors will continue to use the appropriate existing messages that they have in place when denying claims submitted that do not meet the Medicare coverage criteria for extracorporeal photopheresis.

Contractors will deny claims when the service is not rendered to an inpatient or outpatient of a hospital, including CAHs, using the following codes:

- Claim adjustment reason code: 58 – “Claim/service denied/reduced because treatment was deemed by payer to have been rendered in an inappropriate or invalid place of service.”
- MSN 16.2 - “This service cannot be paid when provided in this location/facility.” Spanish translation: “Este servicio no se puede pagar cuando es suministrado en esta sitio/facilidad.” (Include either MSN 36.1 or 36.2 dependant on liability.)
- RA MA 30 - “Missing/incomplete/invalid type of bill.” (FIs and A/MACs only)
- Group Code - CO (Contractual Obligations) or PR (Patient Responsibility) dependant on liability.

Advance Beneficiary Notice and Hospital Issued Notice of Noncoverage Information

If this service is not reasonable and necessary under 1862(a)(1)(A) of the Act (falls outside the scope of the revised NCD found in Publication 100-03, Chapter 1, Section 110.4), the physicians and/or hospital outpatient departments, including CAHs, will be held liable for charges unless the physician and/or hospital has the beneficiary sign an Advance Beneficiary Notice (ABN) in advance of providing the service.

If this service is provided to a hospital inpatient, including CAHs, for a reason unrelated to the admission (outside of the bundled payment), the hospital billing for the inpatient services will be held liable for charges unless the hospital has the beneficiary sign a Hospital Issued Notice of Noncoverage (HINN) letter 11 in advance of providing the service.

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Note: This addition/revision of section 110.4 of the Medicare National Coverage Determinations Manual (100-03) is a national coverage determination (NCD). NCDs are binding on all carriers, fiscal intermediaries, quality improvement organizations, qualified independent contractors, the Medicare Appeals Council, and administrative law judges (ALJs) (see 42 CFR section 405.1060(a)(4) (2005)). An NCD that expands coverage is also binding on a Medicare advantage organization. In addition, an ALJ may not review an NCD. (See section 1869(f)(1)(A)(i) of the Social Security Act.)

Additional Information

You can find the official instruction, CR 5464, issued to your carrier, FI or A/B MAC by visiting <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1206CP.pdf> for the updated *Medicare Claims Processing Manual* (100.04), Chapter 32 (Billing Requirements for Special Services), Section 190 (Billing Requirements for Extracorporeal Photopheresis).

If you have any questions, please contact your carrier, FI, or A/B MAC 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.

Flu Shot Reminder

It's Not Too Late to Give and Get the Flu Shot!

The peak of flu season typically occurs between late December and March; however, flu season can last until May. **Protect yourself, your patients, and your family and friends by getting and giving the flu shot.** Each office visit presents an opportunity for you to talk with your patients about the importance of getting an annual flu shot and a lifetime pneumococcal vaccination. Remember - influenza and pneumococcal vaccination and their administration are covered Part B benefits. Note that influenza and pneumococcal vaccines are NOT Part D covered drugs. For more information about Medicare's coverage of adult immunizations and educational resources, go to CMS' website: <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE0667.pdf> on the CMS website.

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