DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

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MLN Matters® Number: MM8808 | **Related Change Request (CR) #: CR 8808**

Related CR Release Date: August 22, 2014 | **Effective Date: September 23, 2014**

Related CR Transmittal #: R3050CP | **Implementation Date: September 23, 2014**

New Manual Correction for Extracorporeal Photopheresis

Provider Types Affected

This MLN Matters® Article is intended for physicians and providers submitting claims to Medicare Administrative Contractors (MACs) for extracorporeal photopheresis services to Medicare beneficiaries.

Provider Action Needed

This article is based on Change Request (CR) 8808 which clarifies certain requirements for providers that are effective for claims with dates of service on or after April 30, 2012, the Centers for Medicare & Medicaid Services (CMS) 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. Make sure your billing staffs are aware of the changes.

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Background

CR 8808 reformats language in the "Medicare Claims Processing Manual" (Publication 100-04), Chapter 32, Section 190, to make instructions clearer and to avoid misinterpretation. Additionally, ICD-9 diagnosis code 996.88 (complications of transplanted organ, stem cell) and ICD-10 diagnosis code T86.5 (complications of stem cell transplant) are added for correctness and to align with coding implemented in CR8197, TR1199, dated March 14, 2013, and effective and implemented July 1, 2013. An article related to CR8197 is available at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8197.pdf** on the CMS website.

Accordingly, Chapter 32, Section 190.3, of the "Medicare Claims Processing Manual" is reformatted to clearly state that:

- Medicare coverage for extracorporeal photopheresis is restricted to the inpatient or outpatient hospital settings specifically for BOS, and not for the other covered diagnosis (including chronic graft versus hosts disease) which remain covered in the hospital inpatient, hospital outpatient, and non-facility (physician-directed clinic or office settings) settings.
- MACs will deny claims for extracorporeal photopheresis for BOS when the service is not rendered to an inpatient or outpatient setting of a hospital, including critical access hospitals using the following codes:
    - Claim Adjustment Reason Code (CARC) 96 – Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present;
    - CARC 171 – Payment is denied when performed/billed by this type of provider in this type of facility. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present;
    - Remittance Advice Remark Code (RARC) N428 – Not covered when performed in this place of service. (A/MACs only) ; and
    - Group Code CO (Contractual Obligations) or PR (Patient Responsibility) dependent on liability.
- MACs will return to provider/return as unprocessable claims for BOS containing HCPCS procedure code 36522 along with one of the following ICD-9-CM diagnosis codes: 996.84, 491.9, 491.20, 491.21, and 496 but is missing diagnosis code V70.7 (as primary/secondary diagnosis, institutional only), condition code 30 (institutional claims only), clinical trial modifier Q0/Q1, and value code D4 with an 8-digit clinical trial identifier number (A/MACs only). In doing so, MACs will use the following messages:

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- CARC 4 – The procedure code is inconsistent with the modifier used or a required modifier is missing. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- RARC N517 – Resubmit a new claim with the requested information.

Additional Information

The official instruction, CR 8808, issued to your MAC regarding this change is available at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3050CP.pdf** on the CMS website.

If you have any questions, please contact your MAC at their toll-free number. That number is available at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html** under - How Does It Work.

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