CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1564	**Date: July 25, 2008**
	Change Request 6006

NOTE: Transmittal 1551 dated July 18, 2008 is rescinded and replaced with Transmittal 1564, dated July 25, 2008. In the Recurring Update Notification Attachment all instances of the "the October release" should state "the January release" and all instances of "October 6, 2008" should be "January 5, 2009." All other information remains the same.

SUBJECT: New Hemophilia Clotting Factor and HCPCS Code

I. SUMMARY OF CHANGES: Effective for claims with dates of service on or after April 1, 2008, Health Care Procedure Code System (HCPCS) code Q4096 (Injection, Von Willebrand Factor Complex, Human, Ristocetin Cofactor) will be payable for Medicare. Appropriate systems changes for editing hemophilia clotting factors on inpatient claims will be made by FISS in the January 2009 release. This factor is payable on outpatient claims effective April 1, 2008.

New / Revised Material
Effective Date: April 1, 2008
Implementation Date: January 5, 2009

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	Chapter / Section / Subsection / Title
R	17/80.4/ /Billing for Hemophilia Clotting Factors

III. FUNDING:

SECTION A: For Fiscal Intermediaries and Carriers:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

SECTION B: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Recurring Update Notification

Manual Instruction

**Unless otherwise specified, the effective date is the date of service.*

Attachment – Recurring Update Notification

Pub. 100-04	Transmittal: 1564	Date: July 25, 2008	Change Request: 6006

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SUBJECT: New Hemophilia Clotting Factor and HCPCS Code

Effective Date: April 1, 2008

Implementation Date: January 5, 2009

I. GENERAL INFORMATION

A. Background:

Effective for claims with dates of service on or after April 1, 2008, the following new Health Care Procedure Code System (HCPCS) will be payable for Medicare.

HCPCS	Short Descriptor	Long Description
Q4096	VWF complex, not Humate-P (NOS)	INJECTION, VON WILLEBRAND FACTOR COMPLEX, HUMAN, RISTOCETIN COFACTOR (NOT OTHERWISE SPECIFIED), PER I.U. VWF:RCO VWF complex, NOS

Appropriate systems changes for editing Q4096 on inpatient claims will be made by FISS and CWF in the January 2009 release. This factor (Q4096) is payable on inpatient claims effective April 1, 2008.

B. Policy:

During the period between April 1, 2008 and January 5, 2009 FISS implementation of the hemophilia inpatient edit change in the January 2009 release, the following are the procedures to be followed:

- Providers shall submit claims for hospital inpatient care [this includes hospitals paid under the inpatient prospective payment system (IPPS), paid under the long term care prospective payment system (LTCH PPS), paid under the inpatient rehabilitation facility prospective payment system (IRF PPS), and those paid on the basis of reasonable cost (TEFRA hospitals, critical access hospitals (CAHs), and Indian Health Service (IHS) hospital inpatient services (actually paid on a DRG basis)] omitting Q4096. This does not apply to claims from inpatient psychiatric facilities (IPFs) paid under IPF PPS; IPFs receive a comorbidity adjustment under IPF PPS based on the presence of a hemophilia diagnosis on the claim. IPFs should refrain from including Q4096 on their inpatient claims.
- Once the provider has received PPS payment for the inpatient claim, the provider shall immediately submit an adjustment request (TOB = 117), this time including Q4096.
- Contractors shall hook any provider initiated adjustment requests containing Q4096 with discharge dates between April 1, 2008 and January 5, 2009.
- FISS shall add Q4096 in all inpatient editing for hemophilia clotting factors with dates of service on and after April 1, 2008.
- FISS shall include this coding update in its January 2009 release.
- Once FISS has been updated for the clotting factor edits to include Q4096, contractors shall release all held adjustment requests.

There is no impact on outpatient hospital claims or on any SNF claims as payment is made under different methodologies. Q4096 is payable in those settings effective April 1, 2008.

II. BUSINESS REQUIREMENTS TABLE

Use "Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER Hospital providers
							FISS	MCS	VMS	CWF	
6006.1	Contractors shall make the changes in their edits to include the new hemophilia clotting factor code (Q4096) effective for dates of discharge on and after April 1, 2008.						X			X	
6006.2	Contractors shall include these changes in the January 2009 release.						X			X	
6006.3	During the period of April 1, 2008 through January 5, 2009 contractors shall process inpatient claims (TOB 11x) without making payment for Q4096.	X		X							
6006.3.1	Hospital providers shall submit claims to FIs and A/B MACs for inpatient hospital stays during which Alphanate® for the purposes of treating Von Willebrand disease was given, omitting the line item(s) for Q4096 for dates of discharge on and after April 1, 2008 but prior to January 5, 2009.	X		X							Hospital providers
6006.4	Contractors shall accept inpatient claims without Q4096 for dates of discharge on or after April 1, 2008.	X		X			X				
6006.5	As soon as hospital providers receive the PPS payment for the affected claim, they shall immediately submit adjustment requests (TOB = 117) including a line for Q4096.	X		X							Hospital providers
6006.6	Contractors shall hook and hold adjustment requests (TOB 117) containing Q4096 with discharge dates on and after April 1, 2008 but prior to January 5, 2009.	X		X							
6006.7	Contractors shall return to provider (RTP) any inpatient claims (TOB 11x) containing Q4096 with discharge dates on and after April 1, 2008 but prior to January 5, 2009.	X		X							
6006.8	Contractors shall release the held inpatient	X		X							

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER Hospital providers
							FISS	MCS	VMS	CWF	
	adjustment requests containing Q4096 once the FISS edit changes for the hemophilia clotting factor provided to inpatients are in production.										

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
6006.9	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X		X								

IV. SUPPORTING INFORMATION

A. For any recommendations and supporting information associated with listed requirements, use the box below:

Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

X-Ref Requirement Number	Recommendations or other supporting information:

B. For all other recommendations and supporting information, use the space below:

V. CONTACTS

Pre-Implementation Contact(s): Cindy Murphy, 410-786-5733, Cindy.Murphy@cms.hhs.gov, Maria Durham, 410-786-6978, Maria.Durham@cms.hhs.gov

Post-Implementation Contact(s): Regional Offices

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Carriers, and Regional Home Health Carriers (RHHIs)* use only one of the following statements:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: *For Medicare Administrative Contractors (MACs)*, use the following statement:

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

80.4 - Billing for Hemophilia Clotting Factors

(Rev.1564, Issued: 07-25-08, Effective: 04-01-08, Implementation: 01-05-09)

Blood clotting factors not paid on a cost or prospective payment system basis are priced as a drug/biological under the drug pricing fee schedule effective for the specific date of service. As of January 1, 2005, the average sales price (ASP) plus 6 percent shall be used.

If a beneficiary is in a covered part A stay in a PPS hospital, the clotting factors are paid in addition to the DRG/HIPPS payment. For FY 2005, this payment is based on 95 percent of AWP. *For FY 2006, the add-on payment for blood clotting factor administered to hemophilia inpatients is based on average sales price (ASP) + 6 percent and a furnishing fee. The furnishing fee is updated each calendar year.* For a SNF subject to SNF/PPS, the payment is bundled into the SNF/PPS rate.

For hospitals subject to OPPS, the clotting factors, when paid under Part B, are paid the APC. For SNFs the clotting factors, when paid under Part B, are paid based on cost.

Local carriers *and Part B MACs* shall process non-institutional blood clotting factor claims.

The FIs *and Part A MACs* shall process institutional blood clotting factor claims (Part A and Part B institutional).