

Reimbursement for Blood Products and Related Services in 2020

Covance Market Access Services Inc.
For the American Red Cross
Biomedical Services National Headquarters

As you know, reimbursement is complex and constantly evolving.

- The materials in this presentation are intended to provide a broad overview of very complex and evolving payment systems and other issues that may have many implications for your facility.
- The information presented is not intended to serve as specific advice on how to utilize, bill, or charge for any product or service acquired from the American Red Cross or other entity. Each healthcare provider must make the ultimate determination as to when to use a specific product for an individual patient.
- In addition, each provider must determine the most appropriate and proper way to bill for all products and services provided to patients.

Most of the information in this presentation is based on Medicare blood billing guidelines. Coverage and billing policies for other payers may vary and are not addressed in this presentation.

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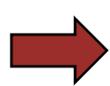


Agenda



- 1 Reimbursement Fundamentals
- 2 Billing for Blood Products and Transfusions
- 3 Billing for Patient-Specific Laboratory Services
- 4 Billing for Irradiated Units and Pooled Blood Products
- 5 Billing for Pathogen Reduced Units and Pathogen Testing
- 6 Best Practices

Reimbursement Fundamentals



1

Reimbursement Fundamentals

2

Billing for Blood Products and Transfusions

3

Billing for Patient-Specific Laboratory Services

4

Billing for Irradiated Units and Pooled Blood Products

5

Billing for Pathogen Reduced Units and Pathogen Testing

6

Best Practices

Medicare Reimbursement for Acute Care Hospitals vs. Critical Access Hospitals (CAHs)

	Acute Care Hospitals	CAHs
Inpatient Payment	Medicare hospital inpatient prospective payment system (IPPS) <i>Payment based on MS-DRGs</i>	Reasonable Costs <i>MS-DRGs do not apply</i>
Outpatient Payment	Medicare hospital outpatient prospective payment system (OPPS) <i>Payment based on APCs</i>	Reasonable Costs <i>APCs do not apply</i>
Coding	Same for both types of facilities	
Billing / Reporting Charges	Same for both types of facilities	

**Most of the payment information in this presentation applies only to acute care hospitals.
The coding and billing information in the presentation applies to both acute care hospitals and CAHs.**

MS-DRGs = Medicare Severity Diagnosis-Related Groups
 APCs = Ambulatory Payment Classifications



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Different coding systems are used in each setting of care to describe various services, items, or conditions.

	Hospital Inpatient	Hospital Outpatient
Patient Diagnoses	ICD-10-CM	ICD-10-CM
Procedures	ICD-10-PCS Revenue	CPT Revenue
Blood, Other Biologicals, Drugs, and Supplies (except clotting factors)	Revenue	HCPCS Revenue
Hemophilia Clotting Factors	HCPCS Revenue	HCPCS Revenue

Hospitals must report a revenue code for each charge line item on both inpatient and outpatient claims.

CMS's ratesetting methodology makes it crucial for hospitals to ensure that their processing charges for blood products are set at appropriate levels.

- When setting hospital payment rates, CMS adjusts charges to costs using cost-to-charge ratios (CCRs).



- In order to have a positive impact on future Medicare payment rates, it is very important for hospitals to:
 - set appropriate charges for blood processing,
 - report these charges consistently on claim forms, and
 - bill for blood processing using the correct codes.
- Although Medicare's ratesetting methodology for CAHs is different than for other hospitals, it is equally important for CAHs to ensure that their charges are set at appropriate levels.

Reporting proper charges now will help to ensure that future Medicare payment rates reflect more accurately the true costs of blood and blood products.

Billing for Blood Products and Transfusions



- 1 Reimbursement Fundamentals
- ➔ 2 **Billing for Blood Products and Transfusions**
- 3 Billing for Patient-Specific Laboratory Services
- 4 Billing for Irradiated Units and Pooled Blood Products
- 5 Billing for Pathogen Reduced Units and Pathogen Testing
- 6 Best Practices

General Medicare Billing Rules for Transfused vs. Non-Transfused Blood

WHAT IS BILLABLE?

Transfused Blood	Non-Transfused Blood
 Blood Units	 Blood Units
 Transfusion	 Transfusion
 Patient-specific laboratory services	 Patient-specific laboratory services

“Billable” does not always mean *separately* billable. For example, some patient-specific laboratory services must be incorporated into the charge for the unit, and inpatient transfusions are separately billable only in certain circumstances.

Hospitals may never bill Medicare for unused blood units.

- This means that hospitals may not submit charges for units that are ordered but not transfused.
- This is a longstanding policy that applies to both the inpatient and outpatient settings.
- Hospitals also may not bill for a transfusion procedure (if no transfusion was performed).
- However, hospitals may:
 - bill for medically necessary laboratory services related to a specific patient (such as cross matching), even if the blood is not transfused; and
 - take the overall cost of unused blood into account when setting charges for units that are transfused.



Inpatient vs. Outpatient Coding for Blood Products and Related Services

In which setting of care did the transfusion take place?

Hospital Inpatient	
	Revenue Codes
	CPT
	HCPCS

Hospital Outpatient	
	Revenue Codes
	CPT
	HCPCS

More than 90 percent of blood is transfused in the inpatient setting. CPT and HCPCS codes are not used on inpatient claims; charges are reported using only revenue codes.

When billing only for blood processing, hospitals should report charges for blood units using revenue code 0390.

- The Red Cross does not charge hospitals for blood itself; rather, it charges only for processing and handling.
- CMS has clarified that this is true of most U.S. blood suppliers (not just the Red Cross):
 - “Most OPPS providers obtain blood or blood products from community blood banks that charge only for processing and storage, and not for the blood itself.”¹
- Under Medicare, the appropriate revenue code for blood carrying only a processing fee is 0390 (Blood and Blood Component Administration, Processing, and Storage; General Classification).
 - Revenue code series 038X should not be used by hospitals reporting only blood processing charges.

Unless otherwise indicated, the information in the remainder of this presentation applies specifically to the hospital outpatient setting.

¹Source: CMS Transmittal 1702, March 13, 2009.

Medicare's Core Billing Guidelines for Blood Transfusions in the Hospital Outpatient Setting

Product or Service	OPPS Billing Guidance
Blood or blood component	<ul style="list-style-type: none"> • Bill for blood processing under revenue code 0390 and include the product-specific P-code. • Bill per unit.
Transfusion procedure	<ul style="list-style-type: none"> • Bill under revenue code 0391 and include the appropriate CPT code. • CMS allows the transfusion procedure to be billed <u>only once per day/per visit</u>.
Blood typing, cross matching, and other laboratory services	<ul style="list-style-type: none"> • Bill under revenue code series 030X (Laboratory) or 031X (Laboratory, Pathological) and include the specific CPT codes for blood typing, cross matching, and other patient-specific laboratory services performed on the unit.

In order for hospitals to receive appropriate reimbursement under OPPS, a claim for a transfusion must include *both* a transfusion CPT code and a blood product P-code.

When billing only for blood processing, OPPS providers should not use revenue code 0380 or the BL modifier, and should not apply the Medicare blood deductible.



Billing for the Transfusion Procedure

- In the hospital outpatient setting, the following CPT codes can be used to bill for the transfusion of blood:
 - 36430 - Transfusion, blood or blood components
 - 36440 - Push transfusion, blood, 2 years or under
 - 36450 - Exchange transfusion, blood, newborn
 - 36455 - Exchange transfusion, blood, other than newborn
 - 36460 - Transfusion, intrauterine, fetal
- In the hospital outpatient setting, Medicare's once-per-day rule always applies; therefore, hospitals should always report 1 unit of the transfusion procedure.
 - The once-per-day rule is enforced through a medically unlikely edit (MUE), and through retrospective reviews by Recovery Audit Contractors (RACs).
 - The once-per-day rule does not apply in the inpatient setting, although many hospitals voluntarily choose to follow the rule in both settings.

This is the most commonly used code for transfusion procedures.

Case Study 1: Transfusion of Leukoreduced RBCs

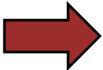
Scenario: A hospital transfuses 2 units of leukoreduced red blood cells to a patient during a hospital outpatient visit.

	Revenue Code	HCPCS or CPT Code	Number of Units
Unit	0390	P9016	2
Transfusion	0391	36430	1
Additional Services	N/A	N/A	N/A

Although several HCPCS P-codes describe leukoreduced units, P9016 (Red blood cells, leukocytes reduced, each unit) is by far the most commonly transfused blood product.

Billing for Patient-Specific Laboratory Services



- 1 Reimbursement Fundamentals
- 2 Billing for Blood Products and Transfusions
-  3 **Billing for Patient-Specific Laboratory Services**
- 4 Billing for Irradiated Units and Pooled Blood Products
- 5 Billing for Pathogen Reduced Units and Pathogen Testing
- 6 Best Practices

Hospitals may not bill for laboratory services that are not patient-specific.

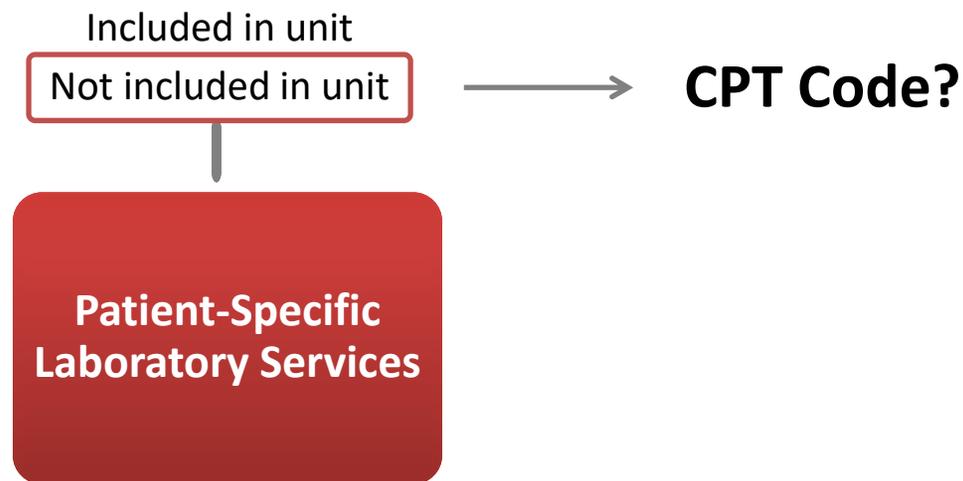
If a patient-specific laboratory service was performed on the unit, is the service included in the HCPCS code for the unit?



Hospitals should not bill separately for laboratory services that already are described by a product-specific P-code.

Irradiation, freezing/thawing, and leukoreduction are examples of services that are often included in the charge for the unit.

If a patient-specific laboratory service was performed on the unit, is the service included in the HCPCS code for the unit?



If the laboratory service is not included in the HCPCS code for the unit, check to see if there is a CPT code that accurately describes the service.

If there is a specific CPT code that accurately describes the laboratory service:

- CPT codes for blood-related laboratory services can be found in the Transfusion Medicine code series of the Pathology and Laboratory section of the CPT manual, which consists of CPT codes 86850-86999.
 - For example, cross matching is described by CPT codes 86920-86923.
- Medicare's OPPS blood billing guidelines instruct hospital outpatient departments to bill these services under revenue code series 030X (Laboratory) or 031X (Laboratory, Pathological).
- Patient-specific laboratory services can be billed even if blood units are not transfused.

Antigen screening is an example of a patient-specific laboratory service that is not included in the HCPCS code for the unit, and is described by a specific CPT code.

CPT Coding for Antigen Screening Using Reagent Serum

CPT Code 86902*

Blood typing; antigen testing of donor blood using reagent serum, each antigen test

Providers should bill for CPT code 86902 based on the number of antigen tests X the number of blood units screened.

Note: CPT code 86902 has an MUE of 40 units.**

*CPT code 86902 replaced previous antigen screening code 86903, which was deleted in 2011. CPT code 86903 should no longer be used.

** Source: CMS. Facility Outpatient Hospital Services MUE Table – Effective 01-01-2020. Available at: <https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/MUE.html>

Case Study 2: Antigen Screening

Scenario: In preparation for transfusion to a specific patient, the blood supplier performs antigen screening using reagent serum on 2 units of leukoreduced red blood cells. The units were tested for 3 antigens. Both units were transfused in the hospital outpatient setting.

	Revenue Code	HCPCS or CPT Code	Number of Units
Unit	0390	P9016	2
Transfusion	0391	36430	1
Additional Services	0300	86902	6

Case Study 3: Antigen Screening

Scenario: In preparation for a transfusion to a specific patient, the blood supplier performs antigen screening using reagent serum on 6 units of leukoreduced red blood cells. The units were tested for 2 antigens. Two of the units were ultimately transfused in the hospital outpatient department.

	Revenue Code	HCPCS or CPT Code	Number of Units
Unit	0390	P9016	2
Transfusion	0391	36430	1
Additional Services	0300	86902	12

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Case Study 4: Antigen Screening

Scenario: In preparation for a hospital outpatient transfusion to a specific patient, the blood supplier performs antigen screening using reagent serum on 5 units of leukoreduced red blood cells. The units were tested for 2 antigens, but ultimately were not transfused.

	Revenue Code	HCPCS or CPT Code	Number of Units
Unit	N/A	N/A	N/A
Transfusion	N/A	N/A	N/A
Additional Services	0300	86902	10

If a specific CPT code is not available:

- Hospitals can incorporate the cost of the laboratory service into their processing charges for the blood units, which would be billed under:
 - revenue code 0390 in the hospital inpatient setting, and
 - revenue code 0390 + P-code in the hospital outpatient setting.
- Examples of laboratory services without a CPT code include (but are not limited to):
 - search fees,
 - special requests,
 - call-in fees,
 - rare unit charges,
 - import fees, and
 - after-hour charges.

We do not recommend using an unlisted CPT code, as this frequently results in claims processing problems.

Case Study 5: Billing for Services without a CPT Code

Scenario: A hospital transfuses 2 units of leukoreduced red blood cells to a patient during a hospital outpatient visit. The fees charged to the hospital included a separate line item from the blood supplier for a rare unit charge.

	Revenue Code	HCPCS or CPT Code	Number of Units
Unit	0390	P9016	2
Transfusion	0391	36430	1
Additional Services	N/A	N/A	N/A

Blood banks excluded from Medicare's laboratory date of service (DOS) exception for molecular pathology tests

- **Background:** The laboratory DOS exception requires that the date of service for a molecular pathology test be the date that the test was performed.
- **Why This Is Important:** For many years, the laboratory DOS exception had been a source of confusion for hospitals, because it appeared to limit their ability to bill Medicare for molecular pathology tests performed by blood suppliers such as the Red Cross.
- **Example of Molecular Pathology Test Performed by Blood Supplier:**
PreciseType HEA testing, reported with CPT code 0001U (Red blood cell antigen typing, DNA, human erythrocyte antigen gene analysis of 35 antigens from 11 blood groups, using whole blood, common RBC alleles reported)

Blood banks excluded from Medicare's laboratory DOS exception for molecular pathology tests (cont'd)

- **What Has Changed:** In November 2019, CMS revised the laboratory DOS exception to **categorically exclude molecular pathology testing performed by blood banks and blood centers:**
*"Under [the] final policy, molecular pathology testing performed by blood banks or centers on a specimen collected during a hospital outpatient encounter is never subject to the laboratory DOS exception..."**
- **How This Happened:** As a result of **strong and persistent advocacy from the Red Cross** and others in the blood banking community, CMS recognized that the purpose of molecular pathology testing performed by blood banks is fundamentally different from that of molecular testing performed by diagnostic laboratories.
- **What This Means for Hospitals:** Hospitals do not have to change their billing practices for Red Cross-performed molecular pathology tests in order to comply with the laboratory DOS exception.

As with other patient-specific laboratory tests that blood suppliers perform on blood units intended for transfusion (such as cross matching), hospitals should continue to bill Medicare "under arrangements" for molecular pathology testing performed by the Red Cross.

*CMS. Calendar Year 2020 OPPS Final Rule with Comment Period. November 12, 2019. 84 Federal Register 218, p. 61444.

Billing for Irradiated Units and Pooled Blood Products



- 1 Reimbursement Fundamentals
- 2 Billing for Blood Products and Transfusions
- 3 Billing for Patient-Specific Laboratory Services
-  4 **Billing for Irradiated Units and Pooled Blood Products**
- 5 Billing for Pathogen Reduced Units and Pathogen Testing
- 6 Best Practices

When transfusing irradiated units, hospitals should use an irradiated P-code if available.

- It is not appropriate to bill irradiation CPT code 86945 (Irradiation of blood product, each unit) in addition to an irradiated P-code.
- However, hospitals may report CPT code 86945 in conjunction with a non-irradiated P-code if an appropriate irradiated P-code is not available.
- This guidance does not differentiate between irradiating units in-house vs. obtaining irradiated units from the blood supplier.

In the hospital outpatient setting, if an irradiated unit is intended for a specific patient but is not transfused, hospitals may bill for the irradiation using CPT code 86945 (but may not bill for the blood product or the transfusion procedure).

Case Study 6: Billing for Irradiated Units

Scenario: A hospital transfuses 1 unit of leukoreduced irradiated red blood cells to a hospital outpatient. The physician had specifically ordered an irradiated unit for this patient.

	Revenue Code	HCPCS or CPT Code	Number of Units
Unit	0390	P9040	1
Transfusion	0391	36430	1
Additional Services	N/A	N/A	N/A

How should hospitals bill for irradiated units that are not specifically ordered?

- We are not aware of any Medicare contractors that address billing for irradiated units in their local policies.
- Although CMS provides instructions on billing for irradiated units in its OPPS blood billing guidelines (i.e., use an irradiated P-code when available), the guidelines do not address the issue of how to handle situations in which irradiated units are not specifically ordered.
- Therefore, each hospital must make the ultimate determination regarding how to bill for irradiated units in these scenarios.



How should hospitals bill for irradiated units that are not specifically ordered (cont'd)?

- We have found that different hospitals handle this situation differently:
 - Approach #1: Some hospitals may be comfortable billing an irradiated P-code even when an irradiated unit was not ordered.
 - Approach #2: Other hospitals will not use an irradiated P-code if the patient did not require an irradiated unit.
 - In these situations, the hospitals will typically "downcode" and bill a non-irradiated P-code.
 - This approach can present administrative challenges (in terms of matching the HCPCS code to the product inventory), which may become even greater when ISBT enters the equation.
 - However, there unfortunately is no easy answer for how to address these challenges.
 - In some cases, a manual workaround may be required if a hospital feels that its automated system will not allow for proper coding.
- There is no single “correct” approach for how to bill for irradiated units that are not specifically ordered.
 - This is a decision that must be made by each hospital based on the approach that it is most comfortable with.

It is important that hospitals develop (and be able to defend) their policies based on clinical factors rather than reimbursement factors.

Regardless of which approach a hospital chooses to take, hospitals must always follow CMS's OPPI blood billing guidelines for irradiated units (see slide 26).



There is no specific blood product P-code to describe pooled blood products.

- Hospitals have the option of charging:
 - one unit of CPT code 86965 (Pooling of platelets or other blood products) for the pooling, and
 - the appropriate number of units of the applicable HCPCS P-code.
- For example, if a hospital uses a pooled product that includes five units of cryoprecipitate, the facility could bill:
 - one unit of pooling CPT code 86965, and
 - five units of HCPCS code P9012 (Cryoprecipitate, each unit).
- However, since CMS has not specifically addressed this issue, each provider must make the ultimate determination as to how to bill for these products.
 - If a provider is uncomfortable billing for all of the units in a pooled product, a conservative approach would be to bill for only one unit of the HCPCS P-code.

Case Study 7: Billing for Pooled Platelets

Scenario: A facility obtains a pool of 5 leukoreduced platelet units from the blood supplier and transfuses the pooled product to a hospital outpatient.

	Revenue Code	HCPCS or CPT Code	Number of Units
Unit	0390	P9031	5
Transfusion	0391	36430	1
Additional Services	0300	86965	1

Billing for Pathogen Reduced Units and Pathogen Testing



- 1 Reimbursement Fundamentals
- 2 Billing for Blood Products and Transfusions
- 3 Billing for Patient-Specific Laboratory Services
- 4 Billing for Irradiated Units and Pooled Blood Products
-  5 **Billing for Pathogen Reduced Units and Pathogen Testing**
- 6 Best Practices

Billing for Pathogen Reduced Units

- In recent years, CMS has created three HCPCS P-codes that specifically describe pathogen reduced blood products:
 - P9070 – **Plasma, pooled multiple donor**, pathogen reduced, frozen, each unit
 - P9071 – **Plasma (single donor)**, pathogen reduced, frozen, each unit
 - P9073 – **Platelets**, pheresis, pathogen reduced, each unit*
- When billing for pathogen reduced units, it is important for hospitals to use the codes listed above, and to ensure that they set their charges for these codes at appropriate levels.

* The previous codes for pathogen reduced platelets (P9072 and Q9988) have been deleted, and should not be used for dates of service on or after January 1, 2018.



Billing for Pathogen Testing for Platelets

- HCPCS code P9100 is a **testing** code that describes pathogen test(s) for platelets, such as rapid bacterial testing.
 - P9100 – Pathogen test(s) for platelets*
- In contrast to other P-codes, P9100 is not a product code.
- Like other laboratory testing codes, P9100 should be billed in addition to the appropriate blood product P-code (assuming the blood is transfused).
- If pathogen-tested platelets are ordered for a specific patient but are not transfused, hospitals would not be able to bill the P-code for the blood product (or the transfusion procedure), but could still bill P9100 for the pathogen testing.
- As with other types of laboratory tests performed on blood units, we recommend that hospitals report P9100 with revenue code 030X.

Important Note:

It is not appropriate to use P9100 for standard pathogen testing performed on all platelet units. According to CMS, the code “should be reported to describe the test used for the detection of bacterial contamination in platelets as well as any other test that may be used to detect pathogen contamination.... [the code] should not be used for reporting donation testing for infectious agents such as viruses.”**

* The previous codes related to pathogen testing for platelets (P9072 and Q9987) have been deleted, and should not be used for dates of service on or after January 1, 2018.

** Source: 82 Federal Register 239, December 14, 2017, p. 59232.

Case Study 8: Billing for Pathogen Reduced Platelets

Scenario: A facility transfuses 2 units of pathogen reduced platelets to a hospital outpatient.

	Revenue Code	HCPCS or CPT Code	Number of Units
Unit	0390	P9073	2
Transfusion	0391	36430	1
Additional Services	N/A	N/A	N/A

Case Study 9: Billing for Rapid Bacterial Testing

Scenario: A facility transfuses 2 units of rapid bacterial tested leukoreduced platelets to a hospital outpatient.

	Revenue Code	HCPCS or CPT Code	Number of Units
Unit	0390	P9031	2
Transfusion	0391	36430	1
Additional Services	0300	P9100	2

Best Practices



- 1 Reimbursement Fundamentals
- 2 Billing for Blood Products and Transfusions
- 3 Billing for Patient-Specific Laboratory Services
- 4 Billing for Irradiated Units and Pooled Blood Products
- 5 Billing for Pathogen Reduced Units and Pathogen Testing
-  6 **Best Practices**

Best Practices

- ✓ Determine the setting of care before deciding how to bill
- ✓ Make sure your billing practices are in compliance with Medicare guidelines
- ✓ Remember: Molecular pathology tests performed by blood banks are excluded from the laboratory DOS exception; hospitals should bill Medicare for these tests directly
- ✓ Always use the same date of service for the transfusion procedure and blood units (date of service = date of transfusion)
- ✓ Make sure you are using the applicable code for the date of service
- ✓ Only bill 1 unit for the transfusion procedure
- ✓ Never double-bill (e.g., for irradiation)
- ✓ Be aware of how your hospital handles billing for units that are different from what was ordered; manual workarounds may sometimes be required to ensure compliance
- ✓ Never bill for unused blood
- ✓ Bill for blood processing consistently (i.e., every time blood is transfused)
- ✓ Set charges at appropriate levels



Discussion

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www.redcrossblood.org/hospitals/educational-resources/reimbursement