REIMBURSEMENT UPDATE
December 2019

CMS Finalizes Hospital Outpatient Payment Changes for CY 2020, Excludes Blood Banks from Laboratory DOS Exception

Download the OPPS final rule:
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices-Items/CMS-1717-FC

On November 12, 2019, the Centers for Medicare and Medicaid Services (CMS) published the calendar year (CY) **2020 Medicare hospital outpatient prospective payment system (OPPS) final rule**. This rule finalizes ambulatory payment classification (APC) payment changes for blood products and blood-related services, as well as clinical services like therapeutic apheresis and cellular therapy, furnished in the hospital outpatient setting.[1] In addition, the rule includes a change to Medicare's laboratory date of service (DOS) policy that represents a major "win" for the blood banking community.

➢ Final OPPS Payment Changes for Blood and Blood Products

The impact of the CY 2020 payment changes varies based on the type of blood product.

- As compared to the 2019 rates, payments have increased for more than half of the blood product P-codes.
- The final 2020 payment rate for leukoreduced red blood cell code P9016—the most frequently transfused blood product—is $188.33 (a 1.9% increase from the 2018 rate).
- The final CY 2020 APC payment rates for all blood product P-codes are listed in Appendix A.

➢ Final OPPS Payment Changes for Blood-Related Services

The APC payment rates for transfusion CPT code 36430 and most therapeutic apheresis and cellular therapy services have increased slightly as compared to the 2019 rates.

- The final CY 2020 unadjusted APC payment rates for these services are listed in Appendix B.

➢ Blood Banks Excluded from Laboratory DOS Exception

In the final rule, **CMS revises the laboratory DOS policy to exclude blood banks and blood centers from the laboratory DOS exception** for molecular pathology tests and advanced diagnostic laboratory tests (ADLTs).

- **Background:** The laboratory DOS exception requires that the date of service for a molecular pathology test be the date that the test was performed; for specimens collected from hospital outpatients, this has the effect of separating the molecular pathology test from the hospital outpatient encounter for billing purposes.
- **Why This Is Important:** The laboratory DOS exception had been a source of confusion for the blood banking community, because it appeared to limit hospitals' ability to bill Medicare for molecular pathology tests performed by blood suppliers such as the American Red Cross. Making the changes needed to comply with this policy would have created significant administrative burden for both hospitals and blood suppliers.
- **What Has Changed:** According to CMS, the policy change in the final rule "categorically excludes molecular pathology testing performed by laboratories that are blood banks or blood centers from the laboratory DOS exception…. Under our final policy, molecular pathology

[1] OPPS, APCs, and MS-DRGs do not apply to critical access hospitals, which are reimbursed based on reasonable costs.

All codes and payment rates are provided for informational purposes only. Providers must determine the appropriate setting in which to furnish a service, as well as the appropriate and proper way in which to code and bill for all products and services that they provide to patients. All payment amounts for procedures are Medicare national unadjusted rates. Actual payment amounts for procedures (but not for blood products) are subject to geographic adjustments.

testing performed by blood banks or centers on a specimen collected during a hospital outpatient encounter is never subject to the laboratory DOS exception…."[2]

- **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. In the final rule, CMS states: "… blood banks and centers typically perform molecular pathology testing to identify the most compatible blood product for the patient, which enables hospitals to prevent adverse conditions associated with blood transfusions and is inherently tied to a hospital service."[2]
- **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.**

➢ **Reminder: Importance of Reporting Appropriate Charges**

CMS continues to base APC payment rates for blood products on the charges that hospitals have reported on past Medicare claims.

- CMS's commitment to its charge-based ratesetting methodology makes it crucial for hospitals to ensure that their processing charges for blood products are set at appropriate levels.
- Hospital processing charges for blood products always should reflect acquisition cost (that is, the blood supplier's processing fees for the units) plus an appropriate mark-up.
- **Reporting appropriate charges now will help to ensure that future Medicare payment rates reflect more accurately the true costs of blood and blood products.**

For more information

More information on billing for blood products and related services can be found on our website at http://www.redcrossblood.org/hospitals/educational-resources/reimbursement.

Please send reimbursement inquiries or requests for reimbursement assistance to reimburse@usa.redcross.org.

Note: This notice needs to appear on the bottom of the first page and the bottom of Appendix B:

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[2] 84 Federal Register 218, November 12, 2019, p. 61444.

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Appendix A
Comparison of Final CY 2020 and CY 2019 Medicare APC Payment Rates for Blood and Blood Products

HCPCS Code	Description	Final CY 2019 APC Payment	Final CY 2020 APC Payment	% Change 2020 vs. 2019
P9010	Whole blood for transfusion	$111.18	$127.19	14.4%
P9011	Blood split unit	$126.06	$134.46	6.7%
P9012	Cryoprecipitate each unit	$49.40	$50.43	2.1%
P9016	Rbc leukocytes reduced	$184.78	$188.33	1.9%
P9017	Plasma 1 donor frz w/in 8 hr	$71.53	$83.74	17.1%
P9019	Platelets, each unit	$107.96	$108.02	0.1%
P9020	Plaelet rich plasma unit	$125.23	$141.22	12.8%
P9021	Red blood cells unit	$140.12	$139.75	-0.3%
P9022	Washed red blood cells unit	$355.93	$379.68	6.7%
P9023	Frozen plasma, pooled, sd	$75.96	$80.13	5.5%
P9031	Platelets leukocytes reduced	$136.61	$126.34	-7.5%
P9032	Platelets, irradiated	$171.91	$139.64	-18.8%
P9033	Platelets leukoreduced irrad	$167.14	$217.10	29.9%
P9034	Platelets, pheresis	$337.08	$323.98	-3.9%
P9035	Platelet pheres leukoreduced	$486.30	$499.55	2.7%
P9036	Platelet pheresis irradiated	$552.91	$692.30	25.2%
P9037	Plate pheres leukoredu irrad	$624.93	$634.62	1.6%
P9038	Rbc irradiated	$221.36	$190.80	-13.8%
P9039	Rbc deglycerolized	$331.14	$320.42	-3.2%
P9040	Rbc leukoreduced irradiated	$255.58	$262.73	2.8%
P9043	Plasma protein fract,5%,50ml	$26.95	$18.43	-31.6%
P9044	Cryoprecipitatereducedplasma	$88.73	$91.40	3.0%
P9048	Plasmaprotein fract,5%,250ml	$76.98	$111.68	45.1%
P9050	Granulocytes, pheresis unit	Not paid by Medicare		
P9051	Blood, l/r, cmv-neg	$175.94	$188.09	6.9%
P9052	Platelets, hla-m, l/r, unit	$844.83	$854.32	1.1%
P9053	Plt, pher, l/r cmv-neg, irr	$492.31	$502.19	2.0%
P9054	Blood, l/r, froz/degly/wash	$298.37	$281.07	-5.8%
P9055	Plt, aph/pher, l/r, cmv-neg	$445.06	$485.12	9.0%
P9056	Blood, l/r, irradiated	$225.47	$203.31	-9.8%
P9057	Rbc, frz/deg/wsh, l/r, irrad	$224.51	$241.62	7.6%
P9058	Rbc, l/r, cmv-neg, irrad	$229.29	$246.78	7.6%
P9059	Plasma, frz between 8-24hour	$76.66	$75.90	-1.0%

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P9060	Fr frz plasma donor retested	$62.81	$49.98	-20.4%
P9070	Pathogen reduced plasma pool	$41.43	$32.30	-22.0%
P9071	Pathogen reduced plasma sing	$78.35	$80.10	2.2%
P9073	Platelets pheresis path redu	$624.93	$611.94	-2.1%
P9099*	Blood component/product noc	N/A	Not paid by Medicare	
P9100**	Pathogen test for platelets	$25.50	$35.50	39.2%

*P9099 is a new code effective for dates of service on or after January 1, 2020

**Note that P9100 is a testing code and not a product code.

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Appendix B

Comparison of Final CY 2020 and CY 2019 Medicare Unadjusted APC Payment Rates for Transfusion Procedure, Therapeutic Apheresis, and Cellular Therapy

CPT Code	Description	Final CY 2019 APC Payment	Final CY 2020 APC Payment	% Change 2020 vs. 2019
Transfusion Procedure:				
36430	Blood transfusion service	$382.90	$388.00	1.3%
Therapeutic Apheresis:				
36511	Apheresis wbc	$1,247.00	$1,323.47	6.1%
36512	Apheresis rbc	$1,247.00	$1,323.47	6.1%
36513	Apheresis platelets	$382.90	$388.00	1.3%
36514	Apheresis plasma	$1,247.00	$1,323.47	6.1%
36516	Apheresis immunoads slctv	$3,922.50	$3,817.93	-2.7%
36522	Photopheresis	$3,922.50	$3,817.93	-2.7%
Cellular Therapy Services:				
38205	Harvest allogeneic stem cell	Not paid separately		
38206	Harvest auto stem cells	$1,247.00	$1,323.47	6.1%
38207	Cryopreserve stem cells	$382.90	$388.00	1.3%
38208	Thaw preserved stem cells	$382.90	$388.00	1.3%
38209	Wash harvest stem cells	$382.90	$388.00	1.3%
38210	T-cell depletion of harvest	$382.90	$388.00	1.3%
38211	Tumor cell deplete of harvst	$382.90	$388.00	1.3%
38212	Rbc depletion of harvest	$382.90	$388.00	1.3%
38213	Platelet deplete of harvest	$382.90	$388.00	1.3%
38214	Volume deplete of harvest	$382.90	$388.00	1.3%
38215	Harvest stem cell concentrte	$382.90	$388.00	1.3%

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