American Red Cross

Reimbursement Update

April 2005

New CMS OPPS Billing Guidelines: Summary of Changes (HM 0-00)

On March 4, 2005, Centers for Medicare and Medicaid Services (CMS) published its long-awaited Medicare hospital outpatient blood billing guidelines for hospitals.

The new Outpatient Prospective Payment System (OPPS) blood billing guidelines are more comprehensive than the previous guidance issued by CMS in 2001. *However, the most significant provision of the guidelines, which changes the coding requirements for hospitals that bill for blood product costs, does not apply to blood supplied by the American Red Cross.* This is because the Red Cross charges only for blood *processing*, rather than for the blood products themselves. Therefore, *we expect this aspect of the new guidelines to have a minimal impact on most Red Cross customers.*

Other provisions of the guidelines—such as the sections related to billing for autologous blood and billing for split units—will apply to all hospitals paid under OPPS, including Red Cross customers. The effective date of the guidelines is *July 1, 2005*, which should give hospitals sufficient time to make any necessary changes to their billing practices

The policies included in the guidelines apply specifically to Medicare hospital *outpatient* services (with the exception of Medicare's prohibition on billing for unused blood, which applies to all settings); the guidelines *do not address inpatient billing.* Since critical access hospitals are not paid under OPPS, they should check with their local FI to determine whether they are expected to follow the new guidelines.

The following is a summary of the highlights:
(The complete guidelines are available at:
http://www.cms.hhs.gov/manuals/pm_trans/R496CP.pdf)

- **No New Billing Requirements When Hospitals Bill Only for Blood *Processing:*** You may have noticed that much of the new guidelines is related to the new coding requirements—specifically, the use of dual revenue codes and a new modifier "BL"—that apply to hospital outpatient departments that bill Medicare for blood *product* costs. It is important to emphasize that these new billing requirements apply *only* to hospitals that obtain blood from a community blood bank and pay for the blood itself, and to hospitals that self-collect and assess a product charge that reflects more than processing and storage; the requirements do not apply to blood obtained from a supplier like the Red Cross that charges *only* for processing and storage. When billing for Red Cross-supplied blood, OPPS providers should continue billing for blood processing using revenue code 390, the appropriate HCPCS code, the number of units transfused, and the date of service. *Hospitals should not report revenue code series 38X or the new modifier "BL" when billing for Red Cross-supplied blood.*

- **Billing for Autologous Blood:** OPPS providers can bill 86890 (Autologous blood or component, collection processing and storage; predeposited)[1] to report autologous processing (for example, the autologous surcharge) but only if the blood units are *not* transfused. When autologous blood is transfused, providers should bill the transfusion CPT code and the blood product P-code, but not 86890. CMS's rationale for this policy is that if the units are transfused, the ambulatory payment classification (APC) payment for the blood product P-code is intended to cover the costs associated with providing the autologous blood. Because billing 86890 is indicated *only* when

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autologous blood is not transfused, the OPPS provider should bill 86890 on the date when the hospital is certain that the blood will not be transfused, rather than on the date of collection or receipt from the blood supplier.

- **Applicability of the Medicare Blood Deductible:** Units of whole blood or packed red cells for which only processing and storage charges are reported are not subject to the blood deductible. *Therefore, the blood deductible does not apply to Red Cross-supplied blood.*
- **Billing for Split Units:** When a patient receives a transfusion of a split unit of blood or blood product, OPPS providers should bill P9011 (Blood, split unit, specify amount) for the blood product transfused, as well as Current Procedural Terminology (CPT) code 86985 (Splitting of blood or blood products, each unit) for each splitting procedure performed to prepare the blood product for a specific patient. *The guidelines provide an example of a possible billing scenario involving split units.*
- **Billing for Irradiation of Blood Products:** If possible, providers should use an irradiated P-code that accurately describes the blood product; if an appropriate irradiated P-code is not available, providers can use a non-irradiated P-code in conjunction with irradiation CPT code 86945 (irradiation of blood product, each unit).
- **Billing for Frozen and Thawed Blood Products:** OPPS providers should use a P-code that describes freezing and thawing, if one exists; otherwise, hospitals can bill the appropriate freezing and thawing CPT code(s) in addition to the blood product P-code. If a blood product has been frozen and/or thawed in preparation for a transfusion, but the blood is not transfused, hospitals may bill the appropriate freezing and thawing CPT code(s), but not the blood product P-code or the transfusion CPT code. In this situation, hospitals should bill the freezing and/or thawing service(s) on the date when the provider is certain the blood product will not be transfused, rather than on the date of the freezing and/or thawing service(s).
- **No Change in Policy for Billing for Unused Blood:** Hospitals *may not* bill Medicare for unused blood units; this is a longstanding Medicare policy that remains intact in the new guidelines.
- **Billing for Transfusion Procedures:** As stated in the original 2001 guidance, hospital outpatient departments may bill Medicare for the transfusion procedure *only once per day*, regardless of the number of units or different types of blood products transfused. Providers should bill the appropriate CPT code for the specific transfusion procedure (for example, CPT 36430) under revenue code 391. In order for hospitals to be paid for the transfusion procedure, the claim also must include a blood product P-code.

The Red Cross encourages hospitals to comply with the provisions of the new CMS guidelines. *If you have concerns about the guidelines, we encourage you to share these concerns directly with CMS* by writing to Cindy Yen (cindy.yen@cms.hhs.gov), the CMS staff member assigned to hospital outpatient blood and blood product issues.

Any questions regarding the new blood billing guidelines should be directed to *reimburse@usa.redcross.org*