

Reimbursement for Blood Products and Related Services

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

1

© 2013 Covance Market Access Services Inc. (Covance) and the American Red Cross (Red Cross)



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.**

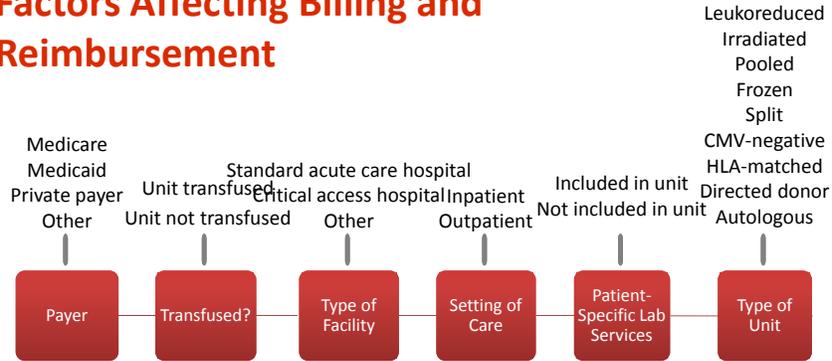
CPT copyright 2012 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association. Applicable FARS/DFARS Restrictions Apply to Government Use. Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein.

2

© 2013 Covance and Red Cross



Factors Affecting Billing and Reimbursement

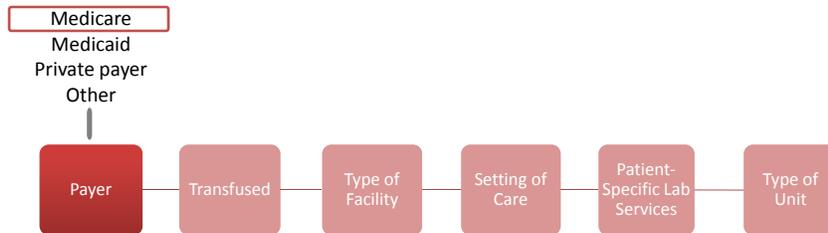


3

© 2013 Covance Market Access Services Inc. (Covance) and the American Red Cross (Red Cross)



Who is the payer?



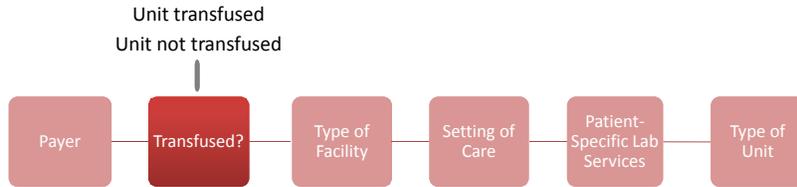
Most of the information in this presentation is based on Medicare blood billing guidelines. Coverage and billing policies for other payers may vary and are not addressed in this presentation.

4

© 2013 Covance Market Access Services Inc. (Covance) and the American Red Cross (Red Cross)



Was the unit transfused to a patient?



Whether a transfusion takes place generally determines what a facility can bill for.

5

© 2013 Covance Market Access Services Inc. (Covance) and the American Red Cross (Red Cross)



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

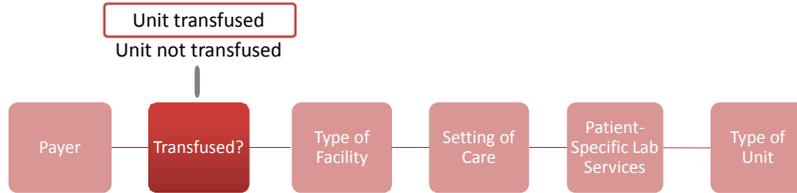
WHAT IS BILLABLE?

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.

6

Was the unit transfused to a patient?

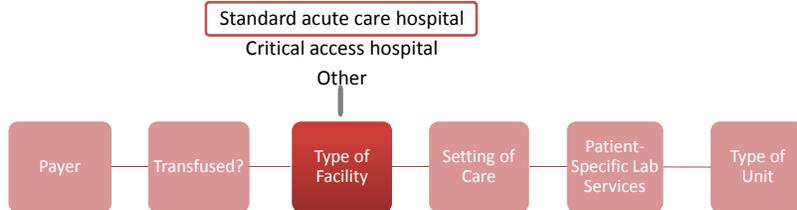


7

© 2013 Covance Market Access Services Inc. (Covance) and the American Red Cross (Red Cross)



What type of hospital performed the transfusion?



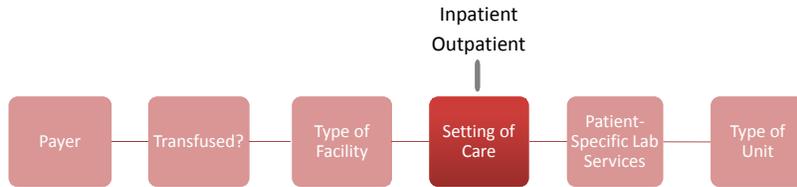
Most of the **payment** information in this presentation applies to standard acute care hospitals; which are paid under the Medicare inpatient prospective payment system (IPPS) and outpatient prospective payment system (OPPS).
Although different reimbursement methodologies may apply to other hospitals (such as critical access hospitals), **coding** generally is similar across facilities.

8

© 2013 Covance Market Access Services Inc. (Covance) and the American Red Cross (Red Cross)



In what setting of care did the transfusion take place?



9

© 2013 Covance Market Access Services Inc. (Covance) and the American Red Cross (Red Cross)



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

	Hospital Inpatient	Hospital Outpatient
Patient Diagnoses	ICD-9-CM	ICD-9-CM
Procedures	ICD-9-CM Revenue	CPT Revenue
Blood, Other Biologicals, Drugs, and Supplies (except clotting factors)	Revenue	HCPCS Revenue
Clotting Factors	HCPCS Revenue	HCPCS Revenue

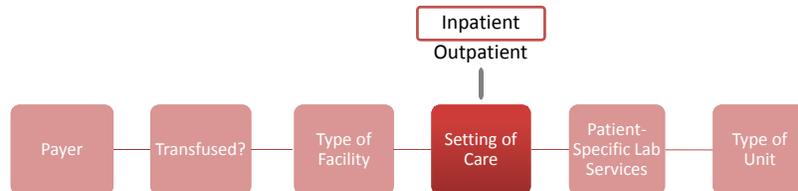
Hospitals must report a revenue code for each charge line item on both inpatient and outpatient claims.

10

© 2013 Covance and Red Cross



In what setting of care did the transfusion take place?



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.

11

© 2013 Covance Market Access Services Inc. (Covance) and the American Red Cross (Red Cross)



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

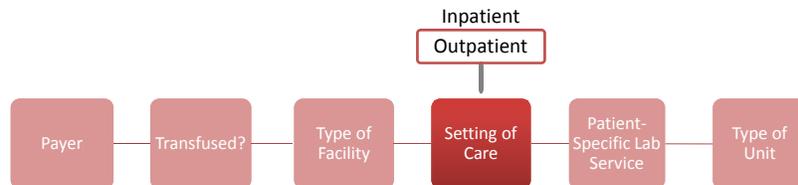
- Under Medicare, the appropriate revenue code for blood carrying only a processing fee is 0390 (Blood and Blood Component Administration, Processing, and Storage; General Classification).
 - The Red Cross does not charge hospitals for blood itself; rather, it charges only for processing and handling.
 - Revenue code series 038X should *not* be used to report Red Cross-supplied blood in the hospital setting.
 - This also applies to most other blood suppliers in the U.S.

12

© 2013 Covance and Red Cross



In what setting of care did the transfusion take place?



Most of the information in this section is based on the 2005 Medicare OPPS blood billing guidelines* and subsequent updates and clarifications.

*CMS Transmittal 496, March 4, 2005.

13

© 2013 Covance Market Access Services Inc. (Covance) and the American Red Cross (Red Cross)



CMS has clarified that most hospitals charge only for blood processing.

- CMS Transmittal 1702 includes the following clarification:
 - “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
- In addition, Medicare hospital outpatient claims data suggest that only 6 percent of hospital outpatient departments billed Medicare for blood product costs (as opposed to only blood processing costs) in 2007.²
- When billing only for blood processing, OPPS providers:
 - should not use revenue code 038X,
 - should not use the BL modifier, and
 - should not apply the blood deductible.
- The 038X revenue code, the BL modifier, and the blood deductible apply only to charges for the blood itself, and do not apply to blood carrying only a processing fee.

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

²Source: Covance analysis of calendar year 2007 OPPS Limited Data Set, conducted May 2009

14



© 2013 Covance and Red Cross

Medicare's billing requirements for blood processing have not changed since 2001.

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.



15

© 2013 Covance and Red Cross

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
- ← This is the most commonly used code for transfusion procedures.
- 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.



16

CPT copyright 2012 American Medical Association. All rights reserved.
CPT is a registered trademark of the American Medical Association.

© 2013 Covance and Red Cross

2013 Update: Spotlight on MUEs

Why is Medicare only paying for 3 units of CPT code 86885?

- CPT code 86885 (Antihuman globulin test [Coombs test]; indirect, qualitative, each reagent red cell) is affected by a medically unlikely edit (MUE).
- An MUE specifies the maximum number of units that Medicare, Medicaid, and some other insurers will allow for a given CPT or HCPCS code on a single line item.
 - Not all codes are affected by MUEs.
- If a hospital bills for units in excess of the MUE limit on the same line item, then the claim will be denied.
- For CPT code 86885, the MUE limit is 3 units.

17

CPT copyright 2012 American Medical Association. All rights reserved.
CPT is a registered trademark of the American Medical Association.



© 2013 Covance and Red Cross

2013 Update: Spotlight on MUEs

How can hospitals can seek appropriate reimbursement for CPT code 86885 in light of the 3-unit limit?

- **Option 1: Accept the MUE and bill no more than 3 units of 86885.** If a hospital consistently finds that it is billed more than 3 units of this code by the blood supplier, then it may want to consider adjusting its charges so that its charges for 3 units reflect what the hospital is typically billed by the blood supplier.  **Recommended Approach**
- **Option 2:** According to CMS, hospitals can **use a modifier** to report units on separate line items (which would override the MUE) when there are "medically reasonable and necessary units of service in excess of an MUE value."
 - The use of modifiers to override edits is heavily scrutinized by payers, so this should not be a common occurrence.
- **Option 3:** Hospitals may **appeal denials** due to an MUE.
- **Option 4:** Hospitals can **submit a request for reconsideration** of an MUE value. Such a request can be sent by fax to 317-571-1745, or by mail to:
 - National Correct Coding Initiative
 - Correct Coding Solutions, LLC
 - P.O. Box 907
 - Carmel, IN 46082-0907

18

Source: CMS FAQs #2277 (modifier FAQ) and #2279 (appeal FAQ)
Available at <http://questions.cms.hhs.gov>



© 2013 Covance and Red Cross

2013 Update: Spotlight on MUEs

What other codes are affected by MUEs?

- A list of publicly available MUEs can be downloaded from the CMS Website:
 - <http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/MUE.html>
 - Hospitals should use the "Facility Outpatient Services MUE Table."
 - The list of MUEs is updated quarterly.

- Even if a code is not included on the publicly available MUE list, it still might be subject to an MUE.
 - Certain MUEs are kept confidential by CMS.
 - The only way to know whether a code is subject to a confidential MUE is to see whether claims are being denied with an MUE-related reason code.



2013 Update: Spotlight on MUEs

The list of publicly available MUEs includes the blood-related services listed below.

- This list is not exhaustive, and does not include confidential MUEs.

CPT	Description	MUE Limit*
36430	Transfusion, blood or blood components	1
36511-36516	Therapeutic apheresis	1
36522	Photopheresis, extracorporeal	1
86850	Antibody screen, RBC, each serum technique	3
86860	Antibody elution (RBC), each elution	2
86885	Antihuman globulin test (Coombs test), indirect, qualitative, each reagent red cell	3
86886	Antihuman globulin test (Coombs test), indirect, each antibody titer	3
86890	Autologous blood or component, collection processing and storage, predeposited	2
86891	Autologous blood or component, collection processing and storage, intra- or postoperative salvage	2
86900	Blood typing, ABO	3
86901	Blood typing, Rh (D)	3
86906	Blood typing, Rh phenotyping, complete	1
86930	Frozen blood, each unit, freezing (includes preparation)	3
86945	Irradiation of blood product, each unit	3



*Source: Facility Outpatient Services MUE Table – Updated 01/13/2013. CPT copyright 2012 American Medical Association. All Rights Reserved.

2013 Update: Spotlight on MUEs

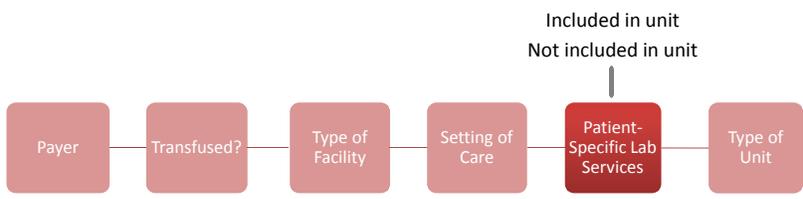
CMS has implemented MUEs for blood product P-codes effective January 1, 2013.

- Nearly all blood product HCPCS codes are affected.
- All of the blood product MUEs are confidential.
- What hospitals can do:
 - Understand your options for dealing with MUEs (see slide 18)
 - Monitor the status of your hospital outpatient claims for blood products to see if P-codes are being denied due to confidential MUEs
 - If you identify an MUE that you believe is inappropriate:
 - Send us an email at reimburse@usa.redcross.org
 - Fax a request for a reconsideration to CMS at 317-571-1745

MUEs do not apply to hospital inpatient services.



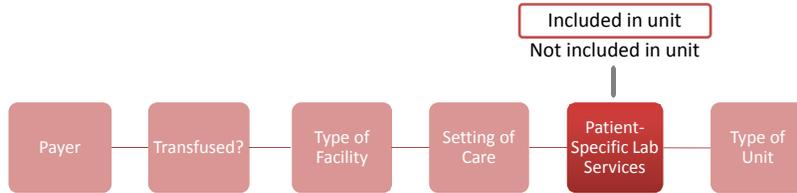
If a patient-specific laboratory service was performed on the unit, is the service included in the HCPCS code for the unit?



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?



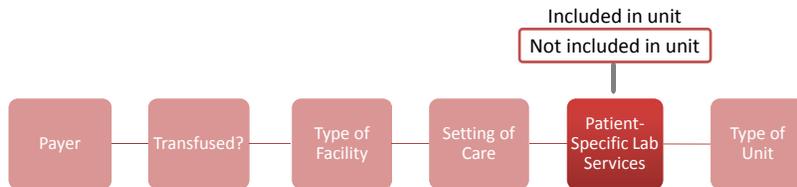
Hospitals should not bill separately for laboratory services that already are described by a product-specific P-code.
Irradiation, freezing/thawing, and leukoreduction are examples of services that are often included in the charge for the unit.

23

© 2013 Covance Market Access Services Inc. (Covance) and the American Red Cross (Red Cross)



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



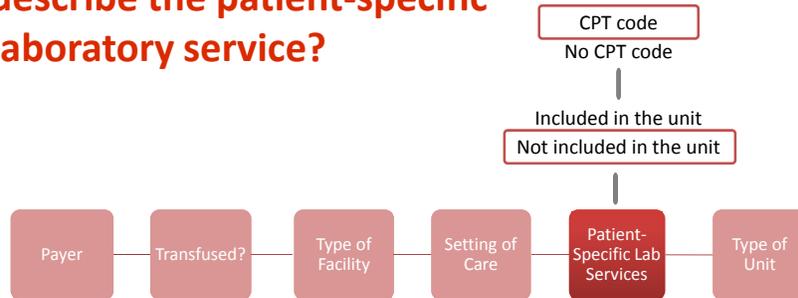
If the laboratory service is not included in the HCPCS code for the unit, check to see if there is a CPT code that accurately describes the service.

24

© 2013 Covance Market Access Services Inc. (Covance) and the American Red Cross (Red Cross)



Is there a CPT code to describe the patient-specific laboratory service?



25

© 2013 Covance Market Access Services Inc. (Covance) and the American Red Cross (Red Cross)



Some patient-specific laboratory services are described by CPT codes.

- 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.
- The March 4, 2005, OPBS 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 HCPCS code for the unit, and is described by a specific CPT code.

26

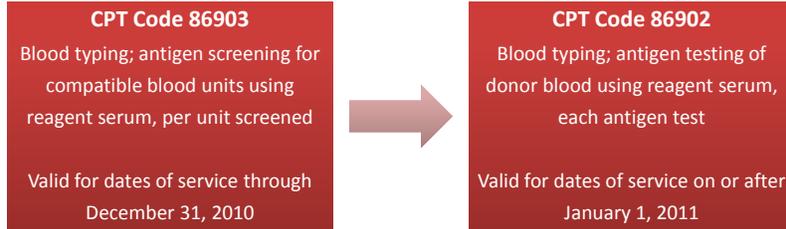
CPT copyright 2012 American Medical Association. All rights reserved.
CPT is a registered trademark of the American Medical Association.

© 2013 Covance and Red Cross



A new CPT code was recently issued for antigen screening using reagent serum.

- The following coding change took effect on January 1, 2011:



- As a result of this coding change, providers should bill for antigen screening based on **the number of antigen tests X the number of units screened** (rather than just the number of units screened).

27

CPT copyright 2012 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association.



© 2013 Covance and Red Cross

Case Study 1: 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			
Transfusion			
Additional Services			

28

CPT copyright 2012 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association.



© 2013 Covance and Red Cross

Case Study 2: 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.

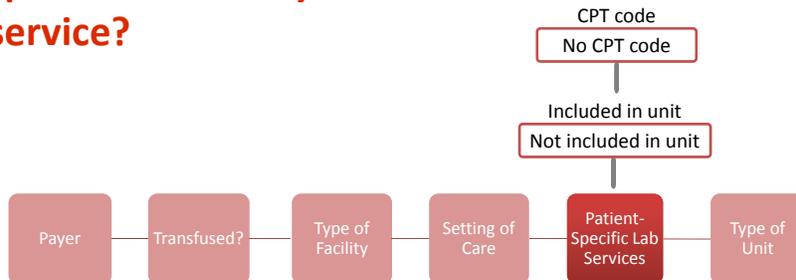
	Revenue Code	HCPCS or CPT Code	Number of Units
Unit	<input type="text"/>	<input type="text"/>	<input type="text"/>
Transfusion	<input type="text"/>	<input type="text"/>	<input type="text"/>
Additional Services	<input type="text"/>	<input type="text"/>	<input type="text"/>

29

CPT copyright 2012 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association.



Is there a CPT code to describe the patient-specific laboratory service?



30



Not all blood-related laboratory services have specific CPT codes.

- Examples include (but are not limited to) services like search fees, special requests, call-in fees, import fees, and after-hour charges.
- Hospitals can use a specific CPT code only if the code exactly describes the service being billed.
- 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.
- Although this will not affect reimbursement in the short term, it will ensure that hospital charges more accurately reflect the true costs of blood-related services.
 - This should help to improve Medicare payment rates over the long term, since Medicare bases its payment rates on the charges reported by hospitals in previous years.

**An alternative approach would be to use an unlisted CPT code, such as 86999 (Unlisted transfusion medicine procedure).
However, because unlisted codes frequently result in claims-processing delays or non-payment, we generally do not recommend this approach.**

31

CPT copyright 2012 American Medical Association. All rights reserved.
CPT is a registered trademark of the American Medical Association.



Case Study 3: 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	<input type="text"/>	<input type="text"/>	<input type="text"/>
Transfusion	<input type="text"/>	<input type="text"/>	<input type="text"/>
Additional Services	<input type="text"/>	<input type="text"/>	<input type="text"/>

32

CPT copyright 2012 American Medical Association. All rights reserved.
CPT is a registered trademark of the American Medical Association.



What type of unit was transfused?

Leukoreduced

Irradiated

Pooled

Frozen

Split

CMV-negative

HLA-matched

Directed donor

Autologous

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.

33

© 2013 Covance Market Access Services Inc. (Covance) and the American Red Cross (Red Cross)

Case Study 4: Billing for Washed Leukoreduced Units

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

	Revenue Code	HCPCS or CPT Code	Number of Units
Unit	<input style="width: 100%; height: 30px;" type="text"/>	<input style="width: 100%; height: 30px;" type="text"/>	<input style="width: 100%; height: 30px;" type="text"/>
Transfusion	<input style="width: 100%; height: 30px;" type="text"/>	<input style="width: 100%; height: 30px;" type="text"/>	<input style="width: 100%; height: 30px;" type="text"/>
Additional Services	<input style="width: 100%; height: 30px;" type="text"/>	<input style="width: 100%; height: 30px;" type="text"/>	<input style="width: 100%; height: 30px;" type="text"/>

There is no HCPCS P-code that says both "washed" and "leukoreduced" for RBCs, and it is not possible to bill separately for washing. An alternative option would be to use P9022 (RBCs, washed) instead of P9016; however, P9016 is the more commonly used code.

34

CPT copyright 2012 American Medical Association. All rights reserved.
CPT is a registered trademark of the American Medical Association.

What type of unit was transfused?

```

graph LR
    Payer --> Transfused?
    Transfused? --> Type of Facility
    Type of Facility --> Setting of Care
    Setting of Care --> Patient-Specific Lab Services
    Patient-Specific Lab Services --> Type of Unit
            
```

Leukoreduced
Irradiated
 Pooled
 Frozen
 Split
 CMV-negative
 HLA-matched
 Directed donor
 Autologous

35 © 2013 Covance Market Access Services Inc. (Covance) and the American Red Cross (Red Cross)

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.

36 CPT copyright 2012 American Medical Association. All rights reserved.
 CPT is a registered trademark of the American Medical Association. © 2013 Covance and Red Cross

Case Study 5: 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	<input type="text"/>	<input type="text"/>	<input type="text"/>
Transfusion	<input type="text"/>	<input type="text"/>	<input type="text"/>
Additional Services	<input type="text"/>	<input type="text"/>	<input type="text"/>

37

CPT copyright 2012 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association.



2013 Update: Billing for Irradiated Units

National Government Services (NGS) recently retired its local coverage determination (LCD) for irradiated blood products.

- NGS is the local Medicare contractor for several states.
- For several years, NGS had used its LCD for Irradiated Blood Products to specify the indications for which irradiated blood products were considered medically necessary and eligible for Medicare coverage.
 - At the time of its retirement, the LCD had applied to hospitals in Connecticut, Illinois, Indiana, Michigan, New York, and Wisconsin.
- However, for dates of service on or after March 15, 2012, the policies in the LCD no longer apply.
 - Hospitals in NGS states are no longer required to follow these guidelines when billing Medicare for irradiated blood products.

38



2013 Update: Billing for Irradiated Units

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

- With the retirement of the NGS LCD, 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.

39



© 2013 Covance and Red Cross

2013 Update: Billing for Irradiated Units

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.

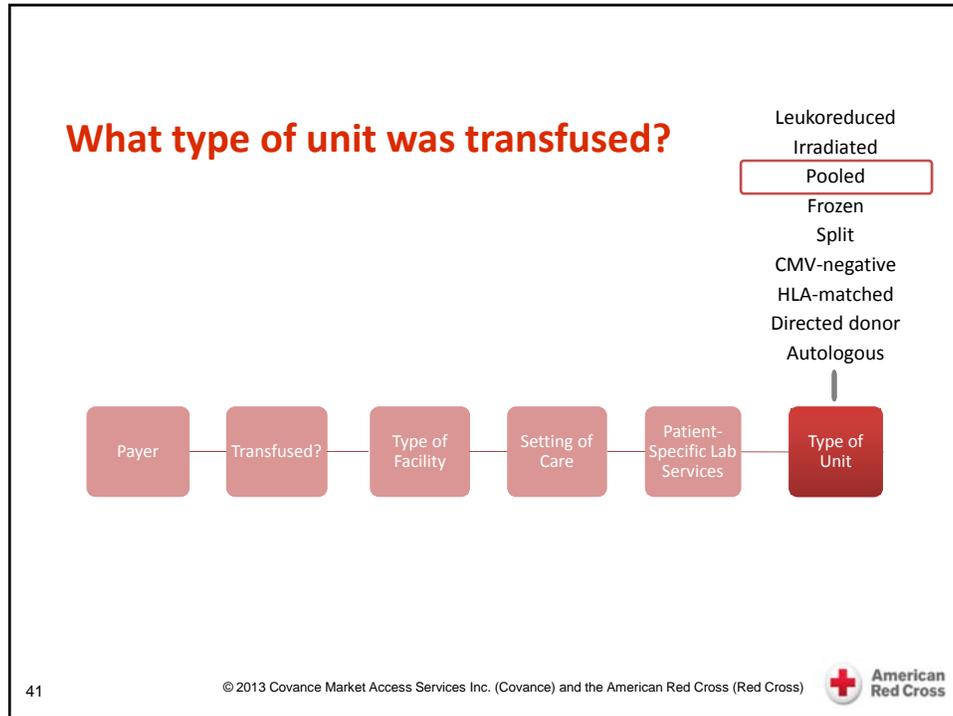
It is important that hospitals develop (and be able to defend) their policies based on clinical factors rather than reimbursement factors.

Regardless of which approach a hospital chooses to take, hospitals must always follow CMS's OPPS blood billing guidelines for irradiated units (see slide 36).

40



© 2013 Covance and Red Cross



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.

42 CPT copyright 2012 American Medical Association. All rights reserved.
CPT is a registered trademark of the American Medical Association.  © 2013 Covance and Red Cross

Case Study 6: 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.

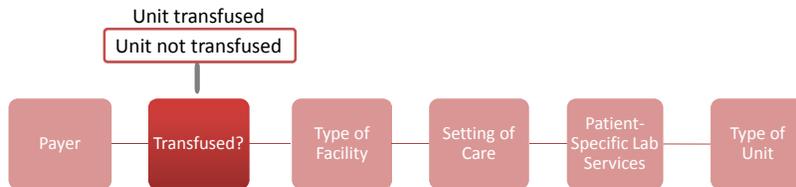
	Revenue Code	HCPCS or CPT Code	Number of Units
Unit	<input type="text"/>	<input type="text"/>	<input type="text"/>
Transfusion	<input type="text"/>	<input type="text"/>	<input type="text"/>
Additional Services	<input type="text"/>	<input type="text"/>	<input type="text"/>

43

CPT copyright 2012 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association.



Was the unit transfused to a patient?



44



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.



45

© 2013 Covance and Red Cross

Case Study 7: 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	<input type="text"/>	<input type="text"/>	<input type="text"/>
Transfusion	<input type="text"/>	<input type="text"/>	<input type="text"/>
Additional Services	<input type="text"/>	<input type="text"/>	<input type="text"/>



46

CPT copyright 2012 American Medical Association. All rights reserved.
CPT is a registered trademark of the American Medical Association.

© 2013 Covance and Red Cross

Special rules apply to scenarios involving unused irradiated, frozen/thawed, or autologous units.

- These services typically can be billed if a unit is not transfused, provided that the service is patient-specific.
- The CPT codes and billing rules listed below apply only to the hospital outpatient setting.
- Each CPT code can be billed with revenue code 0300.

	Irradiation	Freezing/Thawing	Autologous
CPT Code(s):	86945 - Irradiation of blood product, each unit	86927 - FFP, thawing, each unit 86930 - Frozen blood, each unit; freezing (includes preparation) 86931 - Frozen blood, each unit; thawing 86932 - Frozen blood, each unit; freezing (includes preparation) and thawing	86890 - Autologous blood or component, collection processing and storage; predeposited
Date of Service:	Date on which the decision not to use the blood was made and indicated in the patient's medical record.	Date when the OPPS provider is certain the blood product will not be transfused (e.g., date of a procedure or date of outpatient discharge), rather than on the date of the freezing and/or thawing services.	Date when the OPPS provider is certain the blood product will not be transfused (e.g., date of a procedure or date of outpatient discharge), rather than on the date of the product's collection or receipt from the supplier.
Special Notes:	<ul style="list-style-type: none"> • If irradiated units <u>are</u> transfused, CPT code 86945 may be used only if an appropriate "irradiated" HCPCS P-code is not available. 	<ul style="list-style-type: none"> • 86927 is the only CPT code that can be used with FFP (the other 3 CPT codes do not apply). • If frozen/thawed units <u>are</u> transfused, the above codes may be used only if the available HCPCS code does not specify "frozen," "cryoprecipitate," or "deglycerolized." 	<ul style="list-style-type: none"> • CPT code 86890 reflects the autologous surcharge or autologous collection; it does not reflect the product itself. • The units of service for CPT code 86890 should equal the number of autologous units collected but not transfused. • CPT code 86890 can <u>never</u> be billed if autologous units <u>are</u> transfused.

→ It is important for providers to make sure that they never double-bill for any of the services listed above.
 → Reminder: When units are not transfused, it is never appropriate to bill a blood product P-code or transfusion CPT code.

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
- ✓ Always use the same date of service for the transfusion procedure and blood units (date of service = date of transfusion)
- ✓ 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



49

© 2013 Covance and Red Cross

Why did Medicare payment amounts for some blood products decrease in 2013?

- As in previous years, CMS continues to base OPPS payment rates for blood products on the charges that hospitals reported on past Medicare claims.
- This ratesetting methodology has resulted in decreases in payment for certain key blood products in CY 2013.
 - For example, the APC payment rate for leukocyte-reduced red blood cells (HCPCS code P9016), the highest-volume blood product, decreased by approximately 2.8% to \$193.24.
- The Red Cross is concerned about this decrease in payment and—along with other key stakeholders in the blood banking industry—urged CMS to adjust its ratesetting methodology to account for the rising costs of blood products.
- However, CMS ultimately decided to apply its standard methodology without any adjustment.



50

© 2013 Covance and Red Cross

CMS’s rate-setting 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).
 - CMS uses a blood-specific CCR in both the inpatient and outpatient settings.
 - The use of a blood-specific CCR means that reporting proper charges now will help to ensure that future Medicare payment rates reflect more accurately the true costs of blood and blood products.



- 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 rate-setting 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.

51

Hospital charges for blood processing always should reflect acquisition cost (that is, the blood supplier’s processing fees for the units) plus an appropriate mark-up.


© 2013 Covance and Red Cross

Discussion

reimburse@usa.redcross.org

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

52

© 2013 Covance Market Access Services Inc. (Covance) and the American Red Cross (Red Cross) 