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Reimbursement for Blood and Related Services: Current Policies and Challenges to Providers

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Allentown, Pennsylvania
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Health Policy & Strategic Reimbursement
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Today's session is sponsored by the following organizations:



- AABB,
- Miller-Keystone Blood Center, and
- Terumo Medical Corporation
- *With the generous support of the member companies of AdvaMed.*

By the end of today's session we want you to be able to do the following:



- Understand the major reimbursement challenges facing providers of blood-related care;
- Become familiar with the *AABB Reimbursement Guide for Blood Products and Services*, what it covers, and how it can help your facility;
- Recognize the importance of reporting accurate blood cost and utilization data;
- Spot common billing and coding errors that impact payment for services; and
- Develop real-world strategies for implementing coding and billing changes in your hospitals.

Today's session has three parts.



- We will begin with an overview of current policies and challenges, then address the complexities of coding, and finally close with a review of advanced topics.
- Please feel free to ask questions at any time.
- There will also be a question-and-answer session at the end of the seminar today.



We recommend that you review the *Reimbursement Guide*.



- The *Reimbursement Guide* is 37 pages of in-depth information and resources on billing and coding for blood, blood components, and blood-related services. It is available in your packets.
 - Additional copies are available for download at the following site: http://www.aabb.org/About_the_AABB/Reimbursement/reimbursement.htm#1.
 - With the support of AdvaMed, AABB will soon make an updated, revised version of the *Reimbursement Guide* available online and in print.
- *Be sure to share this resource with your colleagues.*

Your copy of the *Reimbursement Guide* is a valuable supplement to the information in this presentation.



- Most of the issues that we will discuss today are addressed in your copy of the guide, which we will use as a starting point for advanced learning and discussion.
- Throughout the presentation, references to specific sections of the *Reimbursement Guide* are provided for your reference.
- After today's session, you should be able to refer to the *Reimbursement Guide* quickly in order to refresh your memory about the topics that we covered today.

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As you know, coding and reimbursement information is complex and constantly changing.



- The information contained in this presentation is provided for informational purposes only.
 - Providers are encouraged to contact their local payers for specific information if they have questions.
 - Healthcare providers make the ultimate determination as to when to use a specific product based on clinical appropriateness for a particular patient, and this presentation is not intended to provide specific guidance on how to utilize, code, bill, or charge for any product or service.
 - Third-party payment for medical products and services is affected by numerous factors, and neither PAREXEL nor the session's sponsors can guarantee success in obtaining insurance payments.



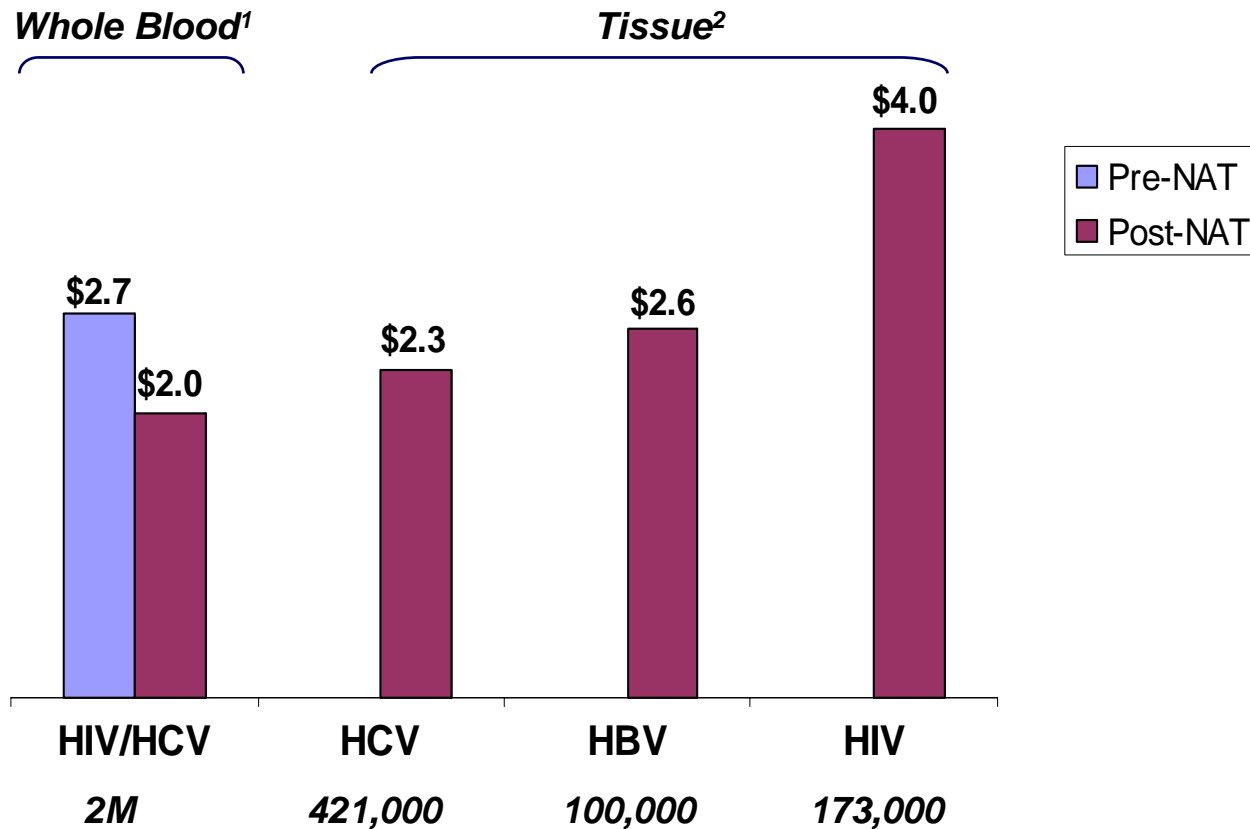
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**Part I:
Update on Current
Reimbursement Policies and
Challenges for Hospitals**

Why focus on reimbursement for blood and related services?



Cost (In Millions) to Eliminate One Infected Donor



Sources: Jackson BR, Busch MP, Stramer SL, AuBuchon JP, "The Cost-Effectiveness of NAT for HIV, HCV, and HBV in Whole-Blood Donations," *Transfusion*, 2003, 43: 721-29 (1); Zou S, Dodd RY, Stramer SL, Strong DM, "Probability of Viremia With HBV, HCV, and HTLV Among Tissue Donors in the United States," *New England Journal of Medicine*, 2004, 351, 8: 751-59 (2).

Why focus on reimbursement for blood and related services? (continued)

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- New and sophisticated safety tests have increased blood costs in recent years; these costs now exceed historical reimbursement levels.
- Adequate reimbursement is crucial to ensure blood safety and availability.
 - In an attempt to curb escalating costs, Medicare and other third-party payers are maintaining payment for blood and blood components at or below historical levels.
 - Appropriate reimbursement should be considered as essential in helping to maintain access to the safest possible blood supply.

Why focus on reimbursement for blood and related services? *(continued)*

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- Although blood is used in nearly every hospital setting, payers have historically not provided detailed billing and coding guidance.
 - By attending today's session, you will learn steps to help your facility to secure appropriate reimbursement under existing guidelines.
- The information provided in this session is compiled primarily from Medicare guidelines.
 - The Centers for Medicare and Medicaid Services (CMS) oversees the Medicare program.
 - Other payers tend to follow coding, coverage, and payment policies set by CMS.

Why focus on reimbursement for blood and related services? (continued...)



- Providers need appropriate reimbursement in order to provide blood safely and reliably to patients.
- However, payers have traditionally not provided sufficient guidance on securing reimbursement for blood.
- To help address this shortfall, providers require
 - comprehensive education on blood reimbursement, and
 - guidance on how to communicate their reimbursement needs with public and private payers.

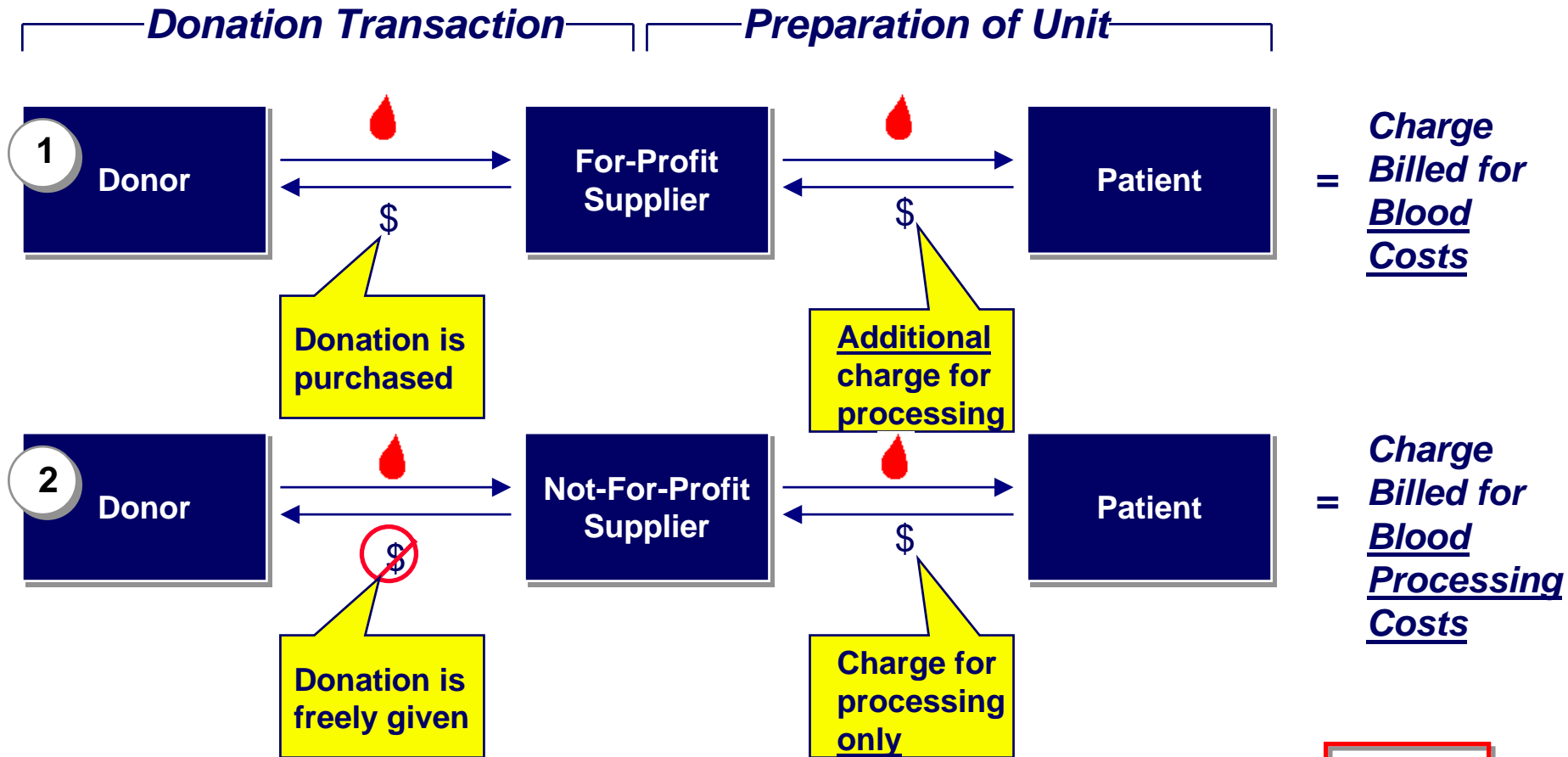


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Reimbursement Policy Issue:
Two Types of Blood Charges

The type of blood charges that a provider bills depends on how the blood was obtained.

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What do *providers and suppliers* report as *blood processing costs*?



- If blood is obtained from not-for-profit suppliers, providers typically are billed only for the processing.
- *Blood processing* refers to confirmatory, preparatory, collections, or safety activities performed prior to transfusion and reported on a per-unit basis to third-party payers.
- Both blood suppliers and hospitals can perform blood processing.
 - Suppliers incur the costs of testing the blood supply before it is distributed to hospitals.
 - Hospitals incur their own costs to process the blood after it has been procured.
 - According to Section 45-27 of the Medicare Coverage Issues Manual, these hospital processing costs include “the cost of such activities as storing, type crossmatching [sic], and ... the cost of spoiled or defective blood.”

What do *providers and suppliers* report as *blood processing costs?* (continued)



- General administrative costs are passed along in the form of charges related to the blood supply, including charges for:
 - time required to manage the hospital’s blood bank;
 - blood bank specific capital costs (such as refrigerators and equipment); and
 - general overhead for space, utilities, and other hospital support.
- These charges are allowable because blood bank staff and equipment must be functioning properly in order to ensure the safety of the blood supply.
- A specific processing cost that should *not* be reported on a patient’s claim in the form of a charge is the cost of spoiled or defective blood.

Source: Medicare Coverage Issues Manual 45-27.

Providers must report charges for a unit of blood with only ONE of two possible revenue codes on the UB-92.



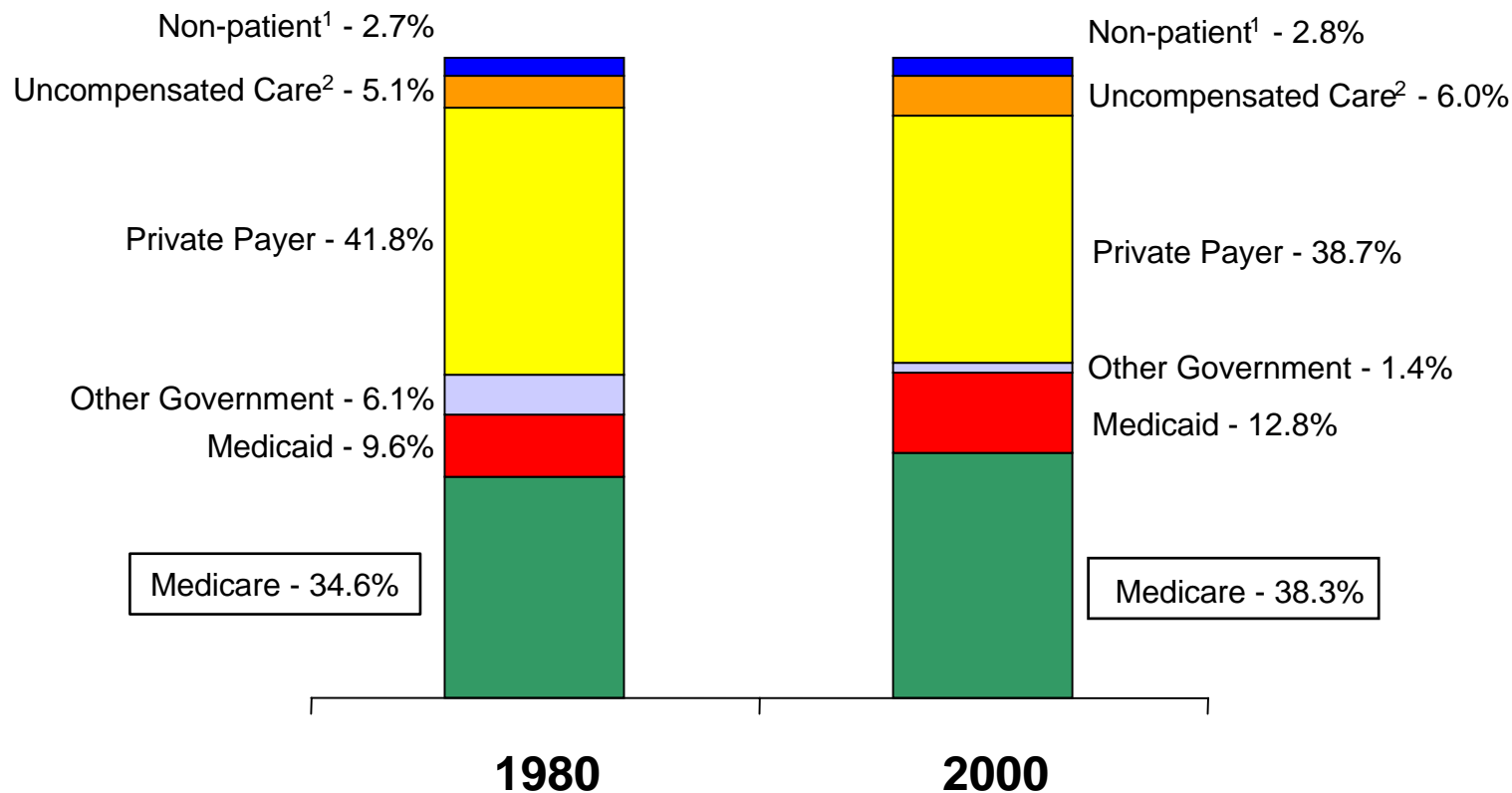
- According to Medicare program memorandum A-01-50, hospitals report blood product charges in two different ways:
 - Hospitals that bill for *blood costs* report charges under revenue code series 038x (blood).
 - Hospitals that bill for *blood processing costs* report charges under revenue code 0390 (blood storage, administration, and processing).
- These revenue codes are considered mutually exclusive.
- ➔ *More information on the appropriate use of revenue codes is provided in the following sections of the presentation.*



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Reimbursement Policy Issue:
Expanding Influence of Medicare

The Medicare program is responsible for the largest percentage of hospital costs, and its share is increasing steadily.



¹ This category represents costs for cafeterias, parking lots, gift shops and other non-patient care operating services and are not attributed to any one payer.

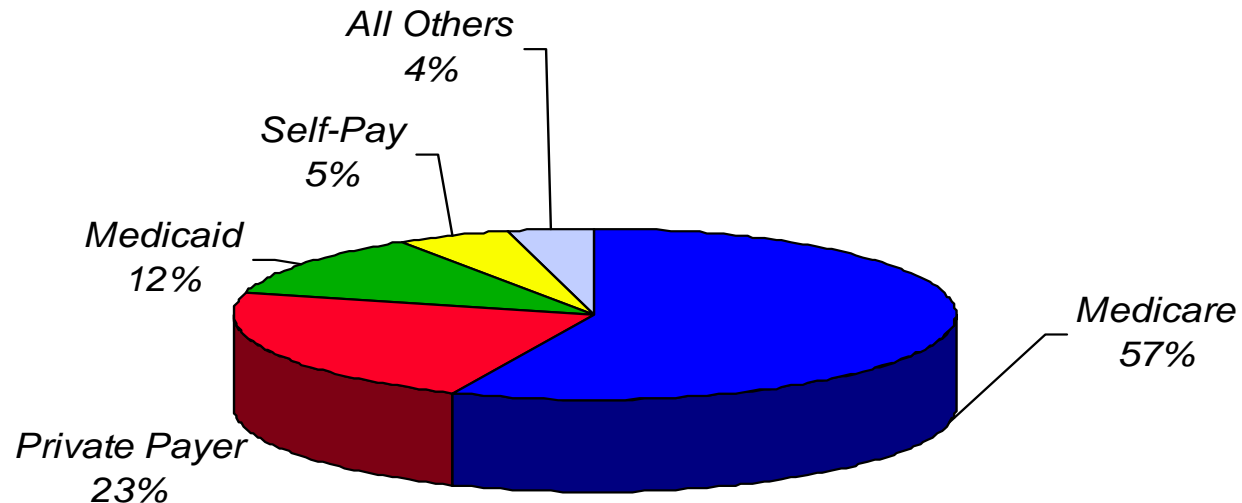
² This category represents bad debt expense and charity care.

Data source: *TrendWatch Chartbook 2002: Trends Affecting Hospitals and Health Systems*, American Hospital Association (November 2002).

Medicare is the most significant payer for hospital inpatient blood-related care.



National Payer Mix for Hospital Discharges with Intensive Blood Use



→ ***Payer mix data includes cases in DRGs for lymphoma and leukemia, and disorders of red blood cells (RBCs), cranial and peripheral nerves, connective tissues, and the immune system.***

Source: PAREXEL analysis of 2000-2001 *National Hospital Discharge Survey* data. Due to rounding, values do not sum to 100.

Medicare's coverage guidelines and payment policies pave the way for other insurers.



- Although its policies are defined and executed at the state level, Medicaid tends to follow CMS policies.
 - For example, in most cases Medicaid does not pay separately for blood transfused to inpatients.
- Medicare's methods for reimbursing providers are also increasingly being adopted by private insurers.
 - For example, instead of paying for outpatient services on a per diem basis, some commercial insurers are using Medicare's ambulatory payment classifications (APCs), which allow multiple payments to be paid for different services in one outpatient visit.



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**Provider Reimbursement Challenge:
*Adapting to Prospective Payment
Systems***

The U.S. healthcare system has shifted from cost-based and fee-for-service to prospective payment systems (PPSs).



Traditional Payment Systems

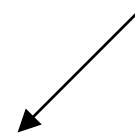
Billed Charges



Insurance Payment

Prospective Payment Systems

Billed Charges → *Pre-Set Payment Amounts*



Insurance Payment

- *PPS examples include diagnosis-related groups (DRGs) and per diems.*
- *CMS has instituted a PPS for hospital services, skilled nursing services, and home health services, among others.*

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It is important to report charges accurately.

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Before PPS

Providers report charges to payers



Medicare contracts claims review to intermediaries, who review charges for itemized services



Payment to provider based on percentage of submitted charges

After PPS

Providers report charges to payers



Medicare converts charges to costs



Medicare assigns payment rates; intermediaries apply these rates to categories of services on claims



Payment to provider based on imputed costs

→ To help ensure appropriate payment levels in the future, facilities must code properly, so that payers have accurate cost data and can set reimbursement at reasonable levels.

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Prospective payment is used for hospital inpatient and outpatient services.



Typical Payment Mechanisms for Services by Setting of Care

<i>Payer</i>	<i>Medicare</i>	<i>Medicaid</i>	<i>Private Insurers</i>
Hospital Inpatient	DRGs (Established in 1983)	Per diems or DRGs	Per diems or DRGs
Hospital Outpatient	APCs (Established in 2000)	Per diems, APCs, or APGs ¹	Per diems or APCs
Physician Services	Medicare physician fee schedule	Fee schedules	Fee schedules or contracted rates

¹ APGs are ambulatory payment groups and are similar to APCs.

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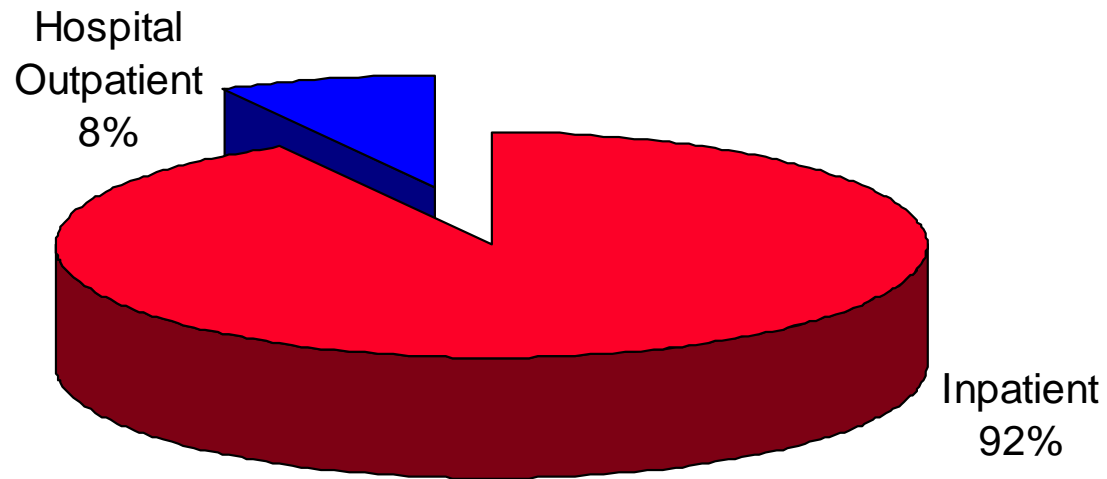
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**Provider Reimbursement Challenge:
*Making the Case for Increasing Blood
Payments***

The vast majority of blood and blood components is provided in the hospital inpatient setting.

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Transfusions by Setting of Care



Data source: PAREXEL analysis of 1999-2000 *National Hospital Discharge Survey* and 1999-2000 *National Hospital Ambulatory Medical Care Survey* data.

Changes in reimbursement for inpatient blood use occur over the long term.



- The Medicare program traditionally has not kept pace with reimbursing hospitals for blood in light of the costs of implementing new safety measures.
- When a new safety measure—such as a test, screening measure, or a processing improvement—is implemented in the blood bank, the earliest that the change in costs could be recognized is two years.
 - This is because CMS does not look at current cost data for blood when updating payment rates.
 - Providers also are slow to update their charges, so it often takes much longer before CMS has updated cost information.

Until recently, CMS had no way to measure increases in the cost of blood.



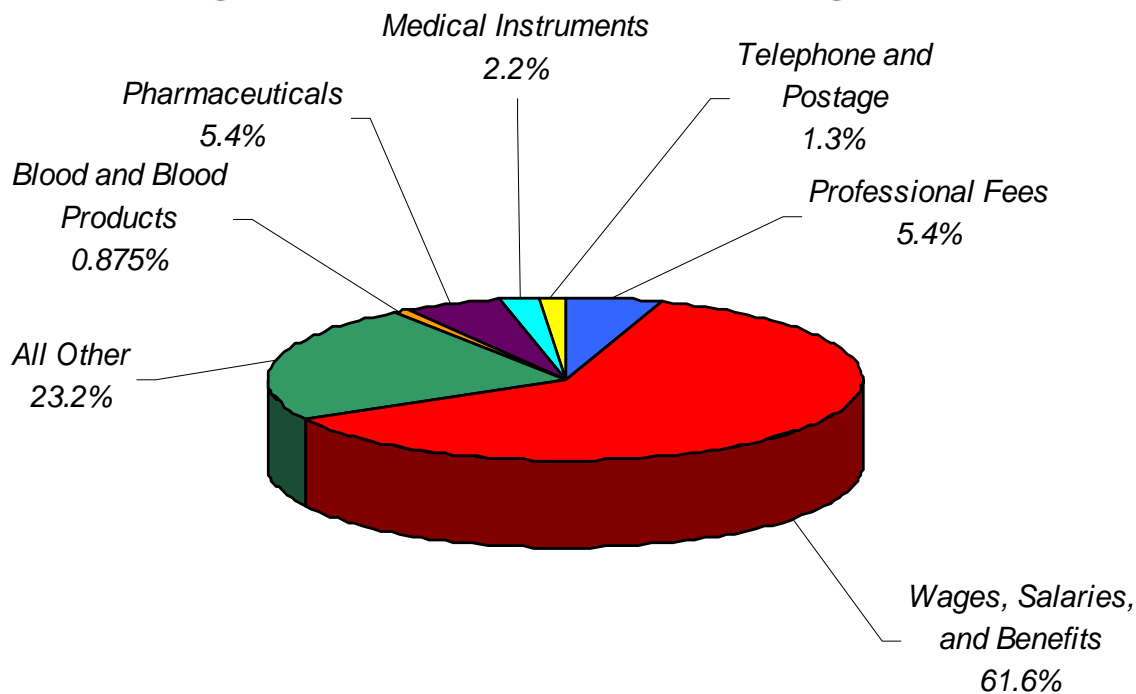
- CMS uses a market basket of hospital-purchased goods and services to determine how much to increase inpatient payments each year.
 - Before FY 2003, the costs of blood and blood components were included in a general category labeled *industrial chemicals*.
 - While CMS still does not track blood costs directly, the agency now uses a *blood derivative* category that is more relevant.
- The changes allocate just under one percent of total annual Medicare hospital inpatient spending for blood and blood components.
 - In FY 2004, CMS has proposed to spend approximately \$100 billion on inpatient acute care.¹

¹ Source: Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2004 Rates (May 9, 2003).

Blood is a relatively minor portion of hospital operating costs in the aggregate.



Categories of Hospital Operating Costs



→ Changes to inpatient reimbursement will only take effect if providers report charges for blood appropriately.

Source: 67 Federal Register 50036. Based on hospital-reported operating costs. Due to rounding, weights may not sum to total.



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Provider Reimbursement Challenge:
Reporting Blood Use Under DRGs

CMS uses the hospital inpatient PPS to reimburse for acute inpatient care.



- Hospital discharges are classified into one of over 500 diagnosis-related groups (DRGs).
 - There is one DRG assigned per stay, regardless of the number of procedures that the hospital performs.
 - DRGs are assigned reimbursement amounts, which are lump-sum payments for a patient's entire inpatient stay. The DRG covers all blood, components, and derivatives administered, excluding antihemophilic clotting factors (AHFs).
 - DRGs are both a payment mechanism and an efficiency reward system that encourages hospitals to cut costs in order to be profitable.
- DRG payments are updated annually.
 - CMS reviews hospitals' costs under existing DRGs. If hospitals fail to report charges accurately, costs may be under-represented, leading to a less-than-adequate payment update.
 - Also, there is at least a two-year lag between when hospitals report data and when CMS reviews these data.

Providers can most directly improve reimbursement by reporting costs accurately on inpatient claims.

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- A recent study by CMS found that only 48 percent of hospitals were even charging for blood at all on inpatient claims.
 - Because the vast majority of blood is transfused to inpatients, this statistic is alarming.
 - An informal review of hospital billing practices conducted in 2002 found that most hospitals did not bill correctly for a commonly administered plasma derivative in the majority of cases.
- In order to make long-term improvements over current reimbursement levels, providers should focus first on reporting all blood use and charging appropriately.



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Provider Reimbursement Challenge: *Mastering APCs*

CMS now uses a PPS for hospital outpatient services.



- Under Medicare hospital outpatient PPS, most hospital procedures and medical services are classified into one of over 700 distinct ambulatory payment classifications (APCs).
 - APCs are assigned reimbursement amounts, which pay for services such as blood transfusions as well as infusions or injections of plasma derivatives.
- Blood, blood components, and antihemophilic clotting factors are paid separately under the APC system.

APCs are only somewhat like DRGs for services performed in the hospital outpatient setting.



DRGs	APCs
One DRG assignment per inpatient stay	Possibility of multiple APC assignments per outpatient visit
DRG assignment based on International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) diagnosis and procedure codes	APC assignment based on Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes
Blood and blood components paid under the DRG assigned	Blood and blood components paid separately under their own APCs

There are various reimbursement systems for blood, blood components, and plasma derivatives.



Blood or Derivative	CMS Classification	Basis for Payment
Whole Blood or Red Blood Cells	Blood	Separate APC payment for blood transfused in hospital outpatient setting – Established CY 2001
Platelets	Blood component	
Plasma	Blood component	
Antihemophilic Factor	Blood component	
Immune Globulin, Intravenous	Blood component	
Albumin	Drugs/Biologicals	Separate APC assigned to high-cost drugs and biologicals (>\$50 per episode of care)¹ – Established CY 2004
Plasma Protein Fraction	Drugs/Biologicals	
WinRho SDF/RhoGAM	Drugs/Biologicals	
Alpha₁ Proteinase Inhibitor	Orphan Drugs/Biologicals	At discretion of CMS – Established CY 2004

¹ APC payment for non-pass-through drugs and biologicals is based on a percentage of AWP assigned to drugs and biologicals as follows: single-source drugs-88-95% AWP; innovator multiple-source drug-68% AWP; generic drugs and biologicals-46% AWP. If drugs and biologicals are currently approved for transitional pass-through payment status (i.e., first paid *after* April 1, 2003 and first furnished to patients *before* January 1, 2004), payment in the hospital outpatient setting is set at 88% of AWP in 2004 and 83% of AWP in 2005.

Mastering APCs is difficult but essential in order to avoid outpatient losses.



- A recent report found that eighty percent of hospitals have problems related to outpatient claims.
 - Coding errors alone comprised 56 percent of reported problems with claims.
- These problems are costly to hospitals, for three reasons:
 1. Payment may be denied.
 2. Re-submitting and appealing claims costs hospitals approximately \$75 to \$125 per claim.
 3. Most importantly: as with DRGs, APC payments are updated annually. If hospitals fail to report charges accurately, costs may be under-represented, leading to a less-than-adequate payment update.

Source: *Healthcare Financial Management*, "Issues in Outpatient PPS: Keys to Successful Revenue Cycle Management," July 2003.



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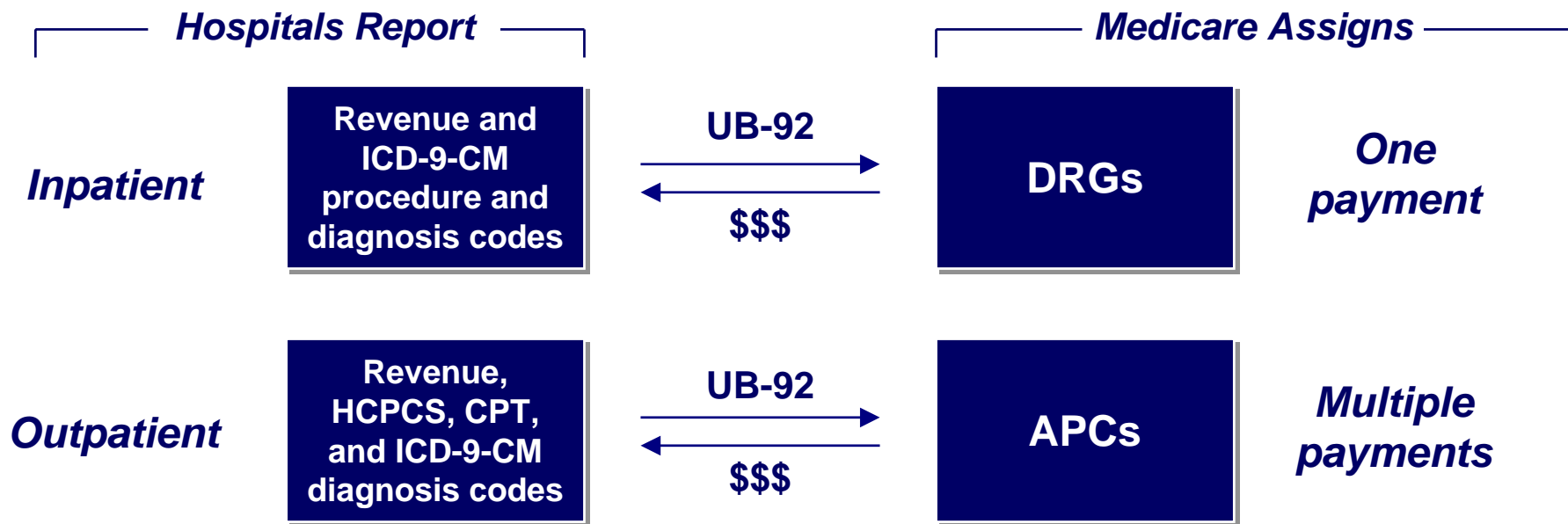
Part II: Coding and Claim Submission Requirements

Hospitals use five code sets to bill for blood product utilization.



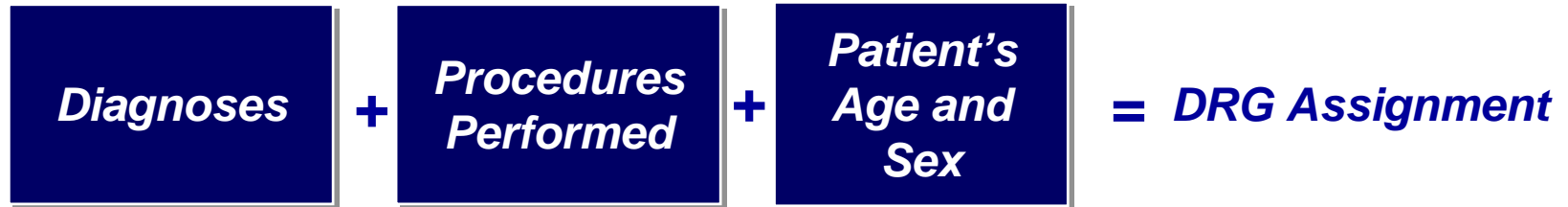
1. Revenue codes are used to bill facility charges.
 - One revenue code represents one hospital cost center.
 - Revenue codes are used on inpatient and outpatient claims.
2. Healthcare Common Procedure Coding System (HCPCS) codes are used to bill costs for blood, blood components, and plasma derivatives.
 - HCPCS codes typically are needed only on hospital outpatient claims.
3. Current Procedural Terminology (CPT) codes are used to bill for procedural services.
 - CPT codes typically are needed only on hospital outpatient claims.
- Two additional code sets are not used to bill charges but are required in order to assign proper payment and determine medical necessity:
 4. International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) diagnosis codes
 5. ICD-9-CM procedure codes

Hospitals use these codes to report goods, services, and charges; the Medicare program assigns DRGs and APCs to make payment.



- **Facilities use revenue codes on both hospital inpatient and outpatient claims.**
- **Though they do not affect APC assignment, ICD-9-CM diagnosis codes are still required for hospital outpatient claims for medical necessity purposes.**

Payers review ICD-9-CM codes in order to assign the appropriate DRG for payment.



- Hospitals use ICD-9-CM codes to report a patient's diagnosis(es) and procedure(s).
 - ICD-9-CM codes are not used to report charges, but to document medical necessity and describe procedures performed.
- Based on this information, one DRG is assigned per inpatient stay.
- ➔ *Unless all appropriate ICD-9-CM codes are reported, hospitals will not receive appropriate payment.*

Revenue codes alone are used to report charges for blood on most inpatient claims.



Product or Service	Billing Method
Blood or blood component	<ul style="list-style-type: none"> → Bill facility charges under revenue code 0390 (<i>blood and blood component administration, processing and storage; general classification</i>) for Medicare and most private insurers. → If billing for the cost of blood and not a processing cost, use revenue code 038x (<i>blood</i>).
Plasma derivatives	<ul style="list-style-type: none"> → Bill facility charges under revenue code series 025x (<i>pharmacy</i>). → For antihemophilic clotting factors, use revenue code 0636 (<i>drugs requiring detailed coding</i>).
Transfusion procedure (blood and blood components)	<ul style="list-style-type: none"> → Bill facility charges under revenue code 0391 (<i>blood and blood component administration, processing and storage; administration</i>).
Infusion procedure (plasma derivatives)	<ul style="list-style-type: none"> → Bill facility charges under revenue code 026x (<i>IV therapy</i>).
Blood typing, cross matching, and other laboratory services	<ul style="list-style-type: none"> → Bill facility charges under revenue code 030x (<i>laboratory</i>) or 031x (<i>laboratory and pathology</i>).

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Product-specific HCPCS codes are required for antihemophilic clotting factors (AHF).



- Hospitals do not submit HCPCS codes on the vast majority of inpatient claims.
- There is an important exception for AHF. By law, AHFs are separately reimbursed under Medicare in addition to DRGs, but hospitals must code properly.
 - However, claims must be filed correctly.
- Drugs typically are billed under revenue code series 025x; however, AHFs are billed under revenue code 0636 (drugs requiring detailed coding).
 - This revenue code requires a product-specific HCPCS code.

Source: Medicare Hospital Manual, Section 460.1—Payment for Blood Clotting Factor Administered to Hemophilia Inpatients.

APC assignment for outpatient services is based on HCPCS and CPT codes.



- On outpatient claims, facility charges—reported with revenue codes—must be broken out into line-item charges for goods and services.
- For each revenue code, hospital outpatient claims must also report two additional codes.
 - HCPCS codes typically are used to report charges associated with drugs, biologicals (including plasma derivatives), and devices.
 - CPT codes typically are used to report charges associated with procedures or services.

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Coding requires a greater level of detail on outpatient claims than on inpatient claims.

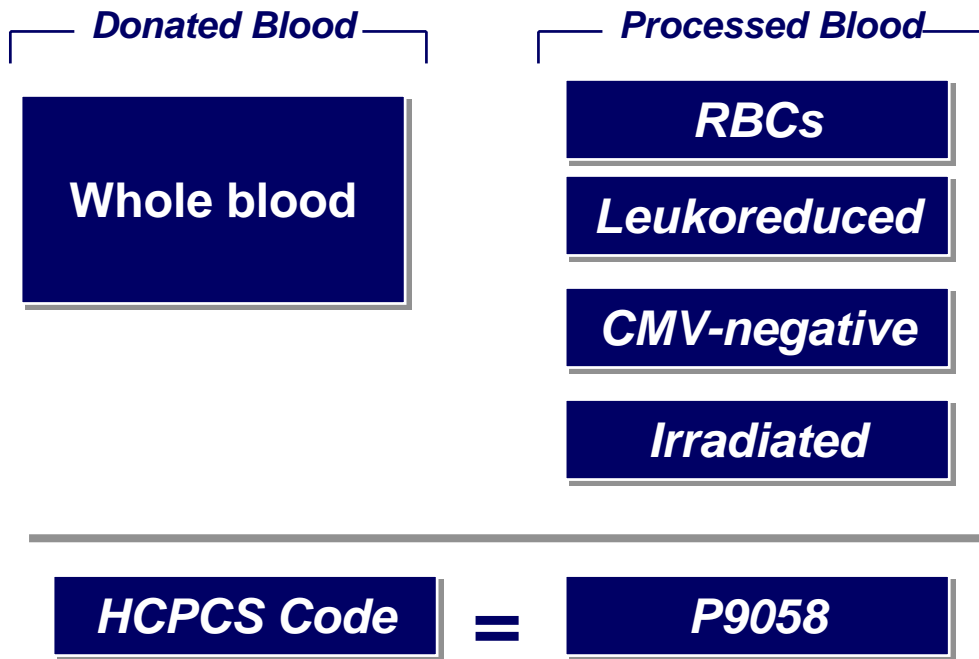


Product or Service	Billing Method
Blood or blood component	<ul style="list-style-type: none"> → Bill under revenue code 0390 (<i>blood and blood component administration, processing and storage; general classification</i>) and include the product-specific HCPCS code; bill per unit. → If billing for the cost of blood and not a processing cost, use revenue code 038x (<i>blood</i>).
Plasma derivatives	<ul style="list-style-type: none"> → Bill facility charges under revenue code series 025x (<i>pharmacy</i>) and include the product-specific HCPCS code. → <i>For antihemophilic clotting factors, use revenue code 0636 (drugs requiring detailed coding).</i>
Transfusion procedure	<ul style="list-style-type: none"> → Bill under revenue code 0391 (<i>blood and blood component administration, processing and storage; administration</i>) and include the applicable CPT code. → <i>CMS allows the transfusion procedure to be billed once per day/per visit.</i>
Infusion procedure (plasma derivatives)	<p>Bill facility charges under revenue code 026x (<i>IV therapy</i>) and include the specific CPT code (typically Q0081, <i>infusion, other than chemotherapeutic</i>).</p>
Blood typing, cross matching, and other laboratory services	<ul style="list-style-type: none"> → Bill under revenue code series 030x (<i>laboratory</i>) or 031x (<i>laboratory and pathology</i>) and include specific lab CPT codes.

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Hospitals bill with the HCPCS code that best describes all the attributes of an individual blood unit.

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- Under the current coding system, each blood unit has been assigned a unique HCPCS code that describes all the processing that has been performed on that product.

Providers are in the best position to lead to reimbursement changes.



- CMS remains committed to using provider-submitted data as a basis for payment.
 - Private payers may adopt DRG and APC systems to issue payment, but actual payment levels will be negotiated under contracts with providers (not pre-set as under Medicare).
- However, guidance from CMS will not suffice to address inadequate payment levels.
- This is why suppliers, blood banking associations, and pharmaceutical companies are developing reimbursement expertise—so that they can assist providers where payers cannot.

Auditing current billing practices may help identify problems.



- It is important to focus on changes you can make within your institution to improve the accuracy of your hospital bills.
 - Focusing on the currently low payment levels and giving up does not address the problem.
- The ten questions on the following slides may be an excellent starting point for a thorough investigation of blood product reimbursement in your institution.

The first five questions are based on what you have learned so far today.



1. Do I know where most of the blood in my institution is used?
2. Are we billing under the correct revenue codes for every unit of blood on inpatient claims?
3. Are we using both HCPCS and CPT codes on outpatient claims? Are we auditing payments for accuracy?
4. Do we know our blood processing costs, and are we reporting the costs correctly to payers?
5. Are reporting charges for AHF correctly on inpatient claims? Are we auditing AHF payments for accuracy?

The next five questions take these issues one step further and will be discussed before the end of our session today.



6. Do we consult with our compliance officer about billing issues?
7. Are we submitting charges for all covered services?
8. Should we be collecting a patient deductible for units of blood?
9. Do we use the correct codes to bill for blood units with special attributes (e.g., irradiated, CMV-negative)?
10. Have we updated our chargemaster software and billing processes within the last quarter?



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**Part III:
Advanced Topics for
Discussion and
Question-and-Answer
Session**

The Medicare blood deductible does not apply to the majority of providers.



- Many providers have heard that Medicare requires beneficiaries to pay a deductible for the first three units (or pints) of blood received in a calendar year. This is true *only* if the hospital paid a supplier for the blood itself.
- However, the majority of blood procured by hospitals comes from not-for-profit suppliers, which do not typically charge for the blood itself. Because the blood was freely given, suppliers normally only bill for the processing of the blood.
- This is important because units that carry only a processing cost are exempt from the blood deductible, and hospitals can begin billing Medicare with the first such unit supplied to a beneficiary.
 - “...Exception. The beneficiary is not responsible for the first 3 units of whole blood or packed red cells if the provider obtained the blood or red cells at no charge other than a processing or service charge. In that case, the blood or red cells is deemed to have been replaced.”

Source: Code of Federal Regulations § 409.87 (Blood deductible).

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CMS carried over several HCPCS coding changes for blood from CY 04 into CY 05 (effective January 1, 2005).



HCPCS	Description	Notes
Whole Blood and Red Blood Cells		
P9051	WHOLE BLOOD OR RED BLOOD CELLS, LEUKOCYTES REDUCED, CMV-NEGATIVE, EACH UNIT	New in CY 2004.
P9054	WHOLE BLOOD OR RED BLOOD CELLS, LEUKOCYTES REDUCED, FROZEN, DEGLYCEROL, WASHED, EACH UNIT	New in CY 2004.
P9056	WHOLE BLOOD, LEUKOCYTES REDUCED, IRRADIATED, EACH UNIT	New in CY 2004.
P9057	RED BLOOD CELLS, FROZEN/DEGLYCEROLIZED/WASHED, LEUKOCYTES	New in CY 2004.
P9058	RED BLOOD CELLS, LEUKOCYTES REDUCED, CMV-NEGATIVE, IRRADIATED, EACH UNIT	New in CY 2004.
Plasma		
P9059	FRESH FROZEN PLASMA BETWEEN 8-24 HOURS OF COLLECTION, EACH UNIT	New in CY 2004.
P9060	FRESH FROZEN PLASMA, DONOR RETESTED, EACH UNIT	New in CY 2004.
Platelets		
P9052	PLATELETS, HLA-MATCHED LEUKOCYTES REDUCED, APHERESIS/PHERESIS, EACH UNIT	New in CY 2004.
P9053	PLATELETS, PHERESIS, LEUKOCYTES REDUCED, CMV-NEGATIVE, IRRADIATED, EACH UNIT	New in CY 2004.
P9055	PLATELETS, LEUKOCYTES REDUCED, CMV-NEGATIVE, APHERESIS/PHERESIS, EACH UNIT	New in CY 2004.
Platelets		
P9011	BLOOD (SPLIT UNIT), SPECIFY AMOUNT	New in CY 2004.
Infusion of Plasma and Derivatives		
Q0081	INFUSION THERAPY, USING OTHER THAN CHEMOTHERAPEUTIC DRUGS, PER VISIT	Replaced with CPT codes 90780 and 90871.*
*Q0081 will be de-activated effective January 1, 2005, with no grace period. In addition, the multiple-procedure discount will apply to APC payments for multiple outpatient infusions reported with 90780 (IV Infusion therapy, up to 1 hour) and 90781 (IV Infusion therapy, up to 1 hour) and 90781 (IV Infusion therapy, each additional hour). © 2004 CPT Only. American Medical Association (AMA). All Rights Reserved.		

Source: CMS-1427-FC, Medicare Program; Changes to the Hospital Outpatient Prospective Payment System and Calendar Year 2005 Payment Rates, on display with the *Federal Register* November 2, 2004.

CMS only recently provided instructions on billing differently for split units, which take effect for 2004.



- In calendar year (CY) 2003 and earlier, hospitals could not use HCPCS code P9011 (*Blood, split unit*) because it was not recognized by CMS.
- However, effective January 1, 2004, hospitals are able to bill charges with HCPCS code P9011.
 - According to CMS, the payment for split units will be made under the separately payable blood product APC that pays approximately 50 percent of the payment for the whole unit of blood.
- Costs associated with the splitting procedure may be reported with CPT 86985 (*Splitting of blood or blood products, each [whole] unit*), each time the procedure is performed (typically once).
 - HCPCS code P9011 was created by CMS “to identify situations where one unit of red blood cells or whole blood, for example, is split and half of the unit is transfused to one patient and the other half to another patient.”

Hospitals cannot receive reimbursement for units that are not transfused.



- CMS currently allows hospitals to bill only for units transfused, not all units ordered.
 - This applies to allogenic, autologous, and directed units.
 - CMS policy states:

“Another situation requiring blood credits occurs when a provider bills a patient's account for blood prepared for transfusion but, for whatever medical reason, all or part of the blood is not transfused. In situations such as this, the patient's account must be credited for the amount of unused blood, because the blood was not furnished to the patient.”
- Providers often ask whether they can bill for autologous units that are not transfused.
 - Based on CMS policy, hospitals cannot bill for unused autologous units; however, medically necessary cross matching and preparation charges are allowed if an autologous unit is not used.

Source: Medicare Provider Reimbursement Manual, Section 2125 (Blood).

AABB Guide:
p. 8

Although there is no formal guidance from CMS, certain codes are occasionally used to bill for preparation charges related to autologous blood.



- Providers often ask if CPT 86890 (*Autologous blood or component, collection, processing, and storage, predeposited*) is appropriate to bill Medicare to recoup the supplier's surcharge.
- Medicare has not addressed this billing practice in its formal guidance to date; however, many facilities have reported billing this code on hospital outpatient claims and receiving payment.
- However, because almost all autologous blood use is reported on inpatient claims, where CPT codes are *not* reported, this code would not be necessary in most cases.
 - Autologous blood is paid under the DRG when the blood is transfused to an inpatient, not when the autologous unit is drawn.

Hospitals that serve as blood depots for other hospitals or for non-hospital providers typically would not bill for the blood they supplied.



- Hospitals often have compliance concerns related to billing for units of blood when another provider—such as a dialysis center—performs the transfusion.
 - Because it is impossible to know if another provider will actually transfuse the blood, the hospital supplying the blood runs the risk of billing a third-party payer for unused blood, which is not allowed.
- For this reason, many hospitals are providing blood to these other providers and billing the providers instead of billing the Medicare program or other third-party payers.
 - The supplying hospital bills the other provider for the blood internally.
 - The provider who actually performs the transfusion then bills the third-party payer for the blood and for the transfusion.

For outpatient claims,
transfusions must be co-billed
with blood units.



- In Medicare program memorandum A-01-98, CMS announced that Outpatient Code Editor claims processing software edit 43 links the transfusion and HCPCS blood unit codes.
 - Failure to bill both codes on the same claim can lead to denials.
 - If a hospital reports a HCPCS blood unit code and no accompanying transfusion CPT code, payment will be denied.

Source: Medicare program memorandum A-01-98.

Medicare's Correct Coding Initiative (CCI) requires providers to use modifiers to avoid denied payments for some blood products.



- CCI edits are pairs of CPT or HCPCS codes that CMS generally does not allow to be reimbursed when billed on the same date of service in the hospital outpatient setting.
- Beginning in April 2002, some of the CCI edits denied payment for widespread and clinically acceptable blood transfusion practices.
 - Providers occasionally transfuse an irradiated unit of red blood cells and a non-irradiated unit to the same patient because the irradiated unit is the only unit available or has a shorter out-date than a non-irradiated unit.
 - Because blood is chronically in short supply, blood bankers try to ensure that units are not needlessly wasted.
 - However, as a result of the CCI edits, some hospitals were denied payment for the irradiated units, and in some cases for the entire claim!

(Continued) Use modifier –59 to avoid denials related to CCI edits affecting irradiated blood components.



- When providers can document that “clinical circumstances justify” that it is appropriate to transfuse irradiated and non-irradiated components, it is possible to over-ride CCI edits by using modifier –59 (distinct procedural service).
- The modifier is added to the HCPCS code for the non-irradiated component, as follows:

Description	Code	Modifier	Service Units
Irrad leukoreduced RBCs	P9040		1
Leukoreduced RBCs	P9016	-59	1
Transfusion service	36430		1

Source: *Terms and Definitions That Apply to CCI*, available at: www.cms.hhs.gov/medlearn/ncci.asp.

(Continued) This interim solution required providers to seek out additional reimbursement support.



- Because hospitals had no way to appeal these denied payments, they engaged the help of blood suppliers.
 - Hospitals did not understand why Medicare was denying payment for the irradiated units. Several hospitals approached their blood suppliers and asked what could be done.
 - After careful review, the suppliers determined that payment for the irradiated units should not be denied when given in combination with non-irradiated units to the same patient.
- The suppliers contacted CMS on behalf of the hospitals.
- After several months, CMS agreed to review the guidelines.

(Continued) Why was the supplier's assistance needed in this case?



- The hospitals affected by the CCI edits had unclear and limited grounds on which to appeal the denied payments themselves.
- In this case, the supplier, as an expert in blood care, was able to establish with CMS that the CCI edits ran counter to widespread clinical practice.
 - The supplier was quickly able to survey clinical practice and recommend a revision of the problematic edits.
- ➔ ***As systemic, troublesome reimbursement issues arise, please email govt&legal@aabb.org so that AABB is aware of the problem.***



PAREXEL

Breakout Sessions

I will now break you up into 3 groups and assign each group a number. For the next 15 minutes, please discuss the scenarios described below, using the information from the previous slides. When we reconvene, I will ask you to discuss your findings.



- A patient with Medicare Part A and Part B insurance received 3 units of RBCs in February while admitted as an inpatient, and 2 units as an outpatient in March. The hospital obtains blood from a local not-for-profit supplier. **How many units of blood may be billed to Medicare on this patient account?**
- A patient undergoing elective prostate surgery pre-deposits 3 units of his own blood. During the procedure, the patient requires transfusion of only 2 of the units. **Can the hospital submit processing charges for the remaining unit?**
- Two patients each require less than a full unit (1 pint or 50 cc) of RBCs. The first patient receives half of a unit, and the second patient receives the other half. The billing department had previously instructed the blood bank that charges for units must be reported with a service unit of 1 or greater. **How should the hospital bill Medicare for the units transfused to these patients?**



PAREXEL

Closing Comments and Suggestions

How can hospitals keep pace with reimbursement changes?



- For coding and reimbursement updates, check the AABB website at http://www.aabb.org/about_the_aabb/reimbursement/reimbursement.htm.
 - Review blood bank and laboratory chargemaster files frequently and implement needed coding changes routinely.
 - Monitor compliance and billing rule changes.
 - Be active in your trade and professional groups, such as AABB, CLMA, HFMA, AHIMA, and AAPC.
- ***If you have questions relating to reimbursement for blood and related services or AABB's work in arena, please contact govt&legal@aabb.org.***



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