

## CMS Proposes CY 2010 OPPS Payment Rates for Blood and Blood Products

On July 1, 2009, the Centers for Medicare and Medicaid Services (CMS) released the calendar year (CY) 2010 Medicare Hospital Outpatient Prospective Payment System (OPPS) proposed rule. The rule contains Medicare's proposed payment updates for blood and blood products transfused in the hospital outpatient setting, which, if finalized, would take effect on January 1, 2010.

Payment for medical and surgical services provided under OPPS is updated annually and based on the conversion factor and the relative weight assigned to each ambulatory payment classification (APC) group. For commonly used blood products, the CY 2010 proposed payment rates would result in modest payment increases from CY 2009 for some products and slight decreases for others. For example, APC payment for P9021 Red blood cells unit would increase from \$136.82 per unit in CY 2009 to \$141.53 per unit in CY 2010. On the other hand, APC payment for P9019 Platelets, each unit would decrease almost 10 percent, from \$73.25 per unit in CY 2009 to \$66.20 per unit in CY 2010. Because OPPS payments are based on hospital claims data, low-volume products are sometimes subject to drastic year-to-year payment changes,

depending on the number of claims and the range of charges submitted.

For some less frequently used blood products, proposed payment rates for CY 2010 showed more variability from their respective CY 2009 payments. For example, the APC payment for P9050 Granulocytes, pheresis unit would decrease from \$1,669 per unit in CY 2009 to \$48.64 per unit in CY 2010. Conversely, the APC for P9011 Blood split unit would increase from \$31.12 in CY 2009 to \$91.05 in CY 2010.

If finalized, payment for most blood-related services would increase in CY 2010. Payment increases for apheresis services, described by Current Procedural Terminology (CPT) codes 36512-36516, were more generous than proposed increases for stem cell transplant services (CPT 38207-38215), which would increase only slightly from CY 2009.

**Comments on the CY 2010 OPPS proposed rule will be accepted through August 31, 2009.** For additional information on the changes proposed in the OPPS proposed rule, visit: [http://www.cms.hhs.gov/HospitalOutpatientPPS/01\\_overview.asp#TopOfPage](http://www.cms.hhs.gov/HospitalOutpatientPPS/01_overview.asp#TopOfPage)

## Billing for Frozen and Thawed Blood Products

When billing for frozen and thawed blood products, questions often arise regarding whether the freezing and thawing are separately billable from the blood product itself. When a beneficiary receives a transfusion of a blood product that has been frozen and thawed prior to the transfusion, the appropriate codes to use will depend on whether or not the product-specific HCPCS code reflects the freezing and/or thawing services.

According to CMS guidance, if a specific HCPCS code for the frozen and thawed blood or blood product exists, then the provider should use that code and not include additional codes for freezing and/or thawing. For example, if an OPPS provider transfuses the product described by P9039 RBC de-glycerolized, it would not be appropriate to bill additional

CPT codes for freezing and/or thawing, since payment for P9039 accounts for the costs of freezing and thawing.

If a specific HCPCS code describing the freezing and/or thawing does not exist, then in addition to the transfusion CPT code, the OPPS provider should bill the appropriate HCPCS code for the blood product along with CPT codes for freezing and/or thawing services. For example, if an OPPS provider transfuses a product described by P9011 Blood split unit, that has been frozen and then thawed, a CPT code for freezing and thawing should be billed since the freezing and thawing services are not reflected in the HCPCS code.

If a blood product has been frozen and/or thawed in preparation for a transfusion but the beneficiary does not receive the transfusion, the OPPS provider may bill the beneficiary for the freezing and/or thawing services specifically provided for that patient using an appropriate CPT code on the 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.



# A Guide for Blood-Related Revenue Codes

## Overview of Revenue Codes

When billing for blood and blood processing, hospitals and other institutional providers use four-digit revenue codes to designate the types of services provided within each department. When billing for products and services administered in the inpatient and outpatient settings, revenue codes must be reported for each blood product and blood processing line-item charge on the claim form. Failure to report the correct revenue code may result in claim delays and denials; therefore, it is important for hospitals to be familiar with CMS guidance on appropriate reporting of revenue codes used for blood and related services. As explained in further detail below, the appropriate revenue code to use when billing for blood and blood processing in the outpatient setting will depend on whether the hospital is charging for blood processing fees only, or for the blood itself. Note that providers should select the appropriate codes for the services rendered to the patient, as the codes below may not be appropriate for all billing scenarios.

**Table 1: Revenue Codes Used to Bill for Blood Processing and Storage**

Revenue Code	Description
0390	General Classification
0391	Blood Administration
0392	Blood Processing and Storage
0399	Other Blood Handling

As shown in Table 1 below, revenue code series 039X should be reported for blood storage and processing charges only. Hospitals utilize this group of revenue codes when obtaining blood products from an outside source where there is no cost for the actual blood product. Because blood is often supplied by blood centers that do not charge for the blood itself, hospitals most commonly bill with the 039X series of revenue codes. Under this scenario, hospitals would only charge for the storage and processing services related to the product, but not the blood product itself. The revenue code should be billed along with the appropriate blood HCPCS code, the number of units transfused, and the line item date of service.

## Revenue Codes for Blood Storage and Processing

To report charges for transfusion services, OPSS providers should bill the appropriate CPT code for the specific

transfusion service provided under revenue code 391 Blood Administration.

## Revenue Codes for Blood Products

Revenue code series 038X, as shown in Table 2 below, should be used when the blood or blood product itself is purchased. Hospitals that incur a charge for the blood or blood product itself in addition to the charge for processing and storage should follow the coding requirements outlined in the Medicare claims processing manual, which instructs hospitals to report charges for the blood or blood product using revenue code series 038X (excluding 0380) with the line item date of service, the number of units transfused, and the appropriate blood product HCPCS code, and HCPCS modifier BL (special acquisition of blood and blood products). The hospital also should report charges for processing and storage services on a separate line using the appropriate revenue code. Note that a hospital with its own blood bank should not bill separately for the blood product. For these hospitals, CMS considers the cost of the blood product to be included in the processing and storage cost. Therefore, CMS has clarified that these hospitals should bill only for the storage and processing fees, using revenue code series 039X.

**Table 2: Revenue Codes Used to Bill for Blood Products**

Revenue Code	Description
0380	General Classification
0381	Packed Red Cells
0383	Plasma
0384	Platelets
0385	Leukocytes
0386	Other Blood Components
0387	Other Derivatives (Cryoprecipitates)
0389	Other Blood and Blood Components
0391	Blood Administration

**My hospital procures blood through a local blood bank. What revenue codes are acceptable when billing for blood furnished to a Medicare patient?**

The correct revenue code will depend on the charges incurred by the local blood bank. CMS has acknowledged that most hospitals obtain blood from blood centers that charge only for processing and storage, not for the blood itself. These hospitals may use revenue codes 0390, 0392 or 0399, plus the HCPCS code, total units transfused, and date of service. Under this scenario, 038X would not be appropriate since the blood bank did not purchase the blood.

## Did you know...

**that CMS is proposing to remove allogeneic bone marrow transplant procedures from the list of covered OPSS services?**

CMS is proposing to update coverage guidelines for allogeneic bone marrow transplant procedures, including the related harvesting procedure, to be payable only in the inpatient setting. If finalized, this policy would apply to CPT codes 38205 Blood-derived hematopoietic progenitor cell harvesting for transplantation, per collection; allogenic; 38240 Bone marrow or blood-derived peripheral stem cell transplantation; allogenic; and 38242 Bone marrow or blood-derived peripheral stem cell transplantation; allogeneic donor lymphocyte infusions. Providers are encouraged to submit comments about the updated payment rates and other policies proposed in the rule. **Comments will be accepted through August 31, 2009.**