BloodNews

United Blood Services

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for our Hospital Customers

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CMS Finalizes 2010 Reimbursement Rates for Blood Products

On October 30, 2009, the Centers for Medicare and Medicaid Services (CMS) released the calendar year (CY) 2010 Medicare Hospital Outpatient Prospective Payment System (OPPS) final rule. The rule contains Medicare's final payment updates for blood and blood products used in hospital outpatient settings. Payment changes will take effect on January 1, 2010.

Payment for medical and surgical services is updated annually and based on the conversion factor and the relative weight assigned to each ambulatory payment classification (APC) group. A limited category of blood products will be reimbursed at slightly higher rates. For example, APC payment for P9021 (Red blood cells unit) will increase from $136.82 per unit in CY 2009 to $141.73 per unit in CY 2010. However, reimbursement for many frequently used blood products will remain at current levels or decrease in CY 2010. For example, APC payment for P9019 (Platelets, each unit) will decrease almost 10 percent, from $73.25 per unit in CY 2009 to $66.61 per unit in CY 2010. Payment for P9022 (Washed red blood cells unit) will decrease from $261.64 to $246.00 per unit. 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.

Interested parties submitted comments to CMS expressing their concern that the proposed payment rates for many blood and blood products are less than the costs hospitals incur acquiring, managing, and processing them. The commenters noted that the producer price index (PPI) for blood, which measures the average change in blood prices over time, had increased by 3.1 percent from July 2008 to July 2009. However, Medicare reimbursement rates have remained the same and even decreased for some products over the same time period. The commenters suggested that, at a minimum, CMS increase payment rates by a minimum of 3.1 percent to match the increased costs incurred by blood and organ banks. However, CMS defended the existing payment methodology and asserted that blood-specific cost-to-charge ratios applied to hospital claims data result in payments that accurately reflect costs.

CMS will continue to establish payment rates for blood and blood products using a blood-specific cost-to-charge ratio that takes into account the unique charging and cost accounting structure of each provider. For additional information on the CY 2010 OPPS final rule, and to access payment rates for additional blood products, visit http://www.cms.hhs.gov/HospitalOutpatientPPS .

CMS Considers Revisions to Payment for Stem Cell Tranplants Blood Products

CMS recently considered restricting the settings of care under which allogeneic stem cell transplant services are administered. Allogeneic stem cell transplantation is a procedure in which stem cells from a healthy donor are acquired and prepared to provide a patient with new stem cells. CMS proposed to change payment policies to reflect that allogeneic stem cell transplant procedures are payable by Medicare as inpatient procedures only, based on what CMS believed at the time to be current clinical practice. CMS also proposed to revise Current Procedural Technology (CPT) billing codes to reflect payment for the harvesting procedure (including National

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Did you know...

that Medicare is considering coverage of stem cell transplantation for myelodysplastic syndrome (MDS)?

At the request of several advocacy groups, Medicare has undertaken a study to determine coverage of allogeneic hematopoietic stem cell transplantation (HSCT) for Medicare beneficiaries with MDS. MDS is a group of diseases that affect the bone marrow and blood. One potential therapy for MDS is allogeneic HSCT from either a related or unrelated donor. Currently, there is no national coverage determination on this condition, and coverage policies are left to the discretion of regional Medicare contractors. Medicare is accepting comments on this proposed coverage determination through December 10, 2009. For additional information, or to submit a comment, visit https://www.cms.hhs.gov/mcd/overview.asp?from2=overview.asp& .

BloodNews is published by United Blood Services. The content in this edition was compiled by Covance Market Access Services (www.covance.com/marketaccess). This information is provided as a service to assist hospitals and other providers of blood products and blood services. Providers are responsible for accurately coding and billing for services rendered as appropriate to their situation and payer-specific requirements. Media inquiries can be made to Barb Kain at bkain@bloodsystems.org.

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Marrow Donor Program fees [if applicable], tissue typing, donor evaluation, and preparation and processing of stem cells), described by CPT code 38205 (Blood-derived hematopoietic progenitor cell harvesting for transplantation, per collection; allogeneic) to be bundled into the MS-DRG inpatient hospital payment, even if the harvesting occurred in an outpatient setting.

Interested parties disagreed with CMS's assertion that allogeneic stem cell transplants are performed on Medicare beneficiaries on an inpatient basis only, and maintained the safety and clinical appropriateness of the procedure when performed on an outpatient basis.

A CMS advisory panel heard from medical experts who stated that revising the billing guidelines to make CPT codes for allogeneic stem cell transplants nonpayable on outpatient claims would impede current clinical practice. The panel agreed with the presenters and recommended that CMS maintain the current policy, which allows payment for allogeneic stem cell transplantation in both inpatient and outpatient settings.

After considering public comments, CMS modified its CY 2010 proposal to reflect current clinical practice and allow payment for allogeneic transplants conducted in both inpatient and outpatient settings. However, CMS noted that payments for acquisition costs will not be paid separately but will be bundled into payment for the recipient's transplant procedure, whether it occurs in the inpatient or outpatient setting. Therefore, hospitals should report all allogeneic stem cell acquisition charges, including costs associated with the harvesting procedure, on the recipient's inpatient or outpatient transplant bill under revenue code 0819 (Other Organ Acquisition). For additional information on the CY 2010 final rule, visit https://www.cms.hhs.gov/HospitalOutpatientPPS/.

A Guide to Billing for Stem Cell Transplants

Billing for stem cell transplantation is based on the source of the stem cells to be transplanted and the setting of care in which the transplant occurs. There are two types of stem cell transplants: autologous and allogeneic. When a person receives stem cells that have come from their own blood, it is referred to as an autologous transplant. An allogeneic stem cell transplant is a procedure in which a patient receives stem cells from a donor.

Stem cell transplantation procedures are described by CPT codes. Some frequently used CPT codes for transplant procedures are described in the table below. When billing for procedures in the outpatient department, providers use both the UB-04 and CMS-1500 billing forms. The UB-04 reports the facility's charges, while physicians bill separately for their professional charges on the CMS-1500. In both cases, providers should choose the CPT code that best describes the specific service being administered and report that CPT code on the claim forms. Additionally, providers should include the revenue code and the appropriate ICD-9 diagnosis codes on the claim forms.

CPT Code	Description
38205	Blood-derived hematopoietic progenitor cell harvesting for transplantation, per collection; allogeneic
38240	Bone marrow or blood-derived peripheral stem cell transplantation; allogeneic
38241	Bone marrow or blood-derived peripheral stem cell transplantation; autologous
38242	Bone marrow or blood-derived peripheral stem cell transplantation; allogeneic donor lymphocyte infusions

Scenario #1: A patient receives an allogeneic stem cell transplant in an outpatient setting. How should this procedure be billed?

If the transplant is performed in the outpatient setting, the facility should bill the appropriate ICD-9-CM diagnosis code, procedure code, and revenue code. Note that the harvesting costs for the acquisition of the stem cells will be bundled according to the APC payment. Most CPT codes for autologous and allogeneic transplants are assigned to APC 0111 (Blood Product Exchange) or 0112 (Apheresis and Stem Cell Procedures).

Scenario #2: A patient receives allogeneic stem cell transplant services in the inpatient setting. The stem cells were harvested from a donor in an outpatient setting. How should the hospital bill for services provided to the patient?

The inpatient facility should bill Medicare by including the appropriate ICD-9-CM diagnosis codes and revenue code on the claim form. Because the patient received the transplant in the inpatient setting, the harvesting costs are bundled into the MS-DRG for the procedure regardless of the setting under which the cells were harvested.

Scenario #3: A patient receives an autologous stem cell transplant in an outpatient setting. How should this procedure be billed?

The outpatient facility may bill for the harvesting, processing, and transplant procedures when the individual services are furnished. The CPT codes describing these services are separately payable when provided in an outpatient setting.