

RACs to Target Accurate Billing for Blood Transfusions

In an effort to combat fraud in Medicare billing, Congress created the recovery audit contractor (RAC) program under the Tax Relief and Health Care Act of 2006 to identify improper payments made to Medicare physicians and hospitals. RACs are private entities that operate on behalf of the centers for Medicare and Medicaid Services (CMS) to identify and recoup both overpayments and underpayments made to Medicare providers. There are currently four RAC contractors in operation, each assigned to a different region of the U.S.

Issues identified by the contractors must be approved by CMS and should be posted to the RAC Website before widespread review. With the exception of Diversified Collection Services (DCS), the RAC covering the northeast region of the U.S., the other three RACs—CGI (midwest), Connolly Healthcare (south), and HealthDataInsights (west)—have posted on their respective Websites their intent to examine claims that include charges for blood transfusion services. Specifically, these RACs are looking to ensure that on claims for blood transfusion services, a maximum of one service per patient, per date of service, is billed. Note that the 1 blood administration charge per day applies to services related to the blood transfusion, not to the blood product being transfused. Connolly Healthcare has gone a step further to notify hospitals that it will specifically be examining claims that include Current Procedural Technology (CPT) codes describing common transfusion procedures, including 36430 (transfusion, blood or blood components), 36440 (Push transfusion, blood, 2 years or younger), 36450 (Exchange transfusion, blood; newborn), and 36455 (Exchange transfusion, blood; other than newborn).

RACs review claims on a post-payment basis, and review is subject to a maximum look-back period of three years. Overpayments are identified through two types of review: automated or complex. Automated reviews identify claims that the RAC is certain include overpayments. Complex reviews identify claims where the RAC believes there most likely are overpayments but require further review of medical records. When an overpayment is identified, the provider will receive notification from the RAC, and the type of notification will depend on what type of review was conducted. Once records are requested by the RAC, hospitals have 45 days to provide

them. The RAC then has 60 days to review the records.

Hospitals and physicians have an opportunity to resolve the issue during a discussion period, which begins with receipt of the review results letter for complex reviews or the demand letter for automated reviews. However, regardless of what type of review was conducted, a provider still has the same right to appeal the RAC's final determination that it would have for any other Medicare coverage determination.

To prepare for RAC audits, hospitals should monitor areas that may be subject to RAC scrutiny, review coding guidelines designate personnel responsible for RAC audits, and ensure that responses are submitted within 45 days of receiving the initial RAC audit letter. For additional information about RACs, please visit: <http://www.cms.hhs.gov/RAC/>

Recent Regulations Signal Hospitals to Prepare for EHR

In a series of recently issued regulations, CMS and the newly created Office of the National Coordinator for Health Information Technology (ONC) have signaled to hospitals and physicians their intent to implement provisions of the American Recovery and Reinvestment Act (ARRA) of 2009 that encourage the use of electronic health records (EHR). Among other provisions, the ARRA legislation provides incentive payments to eligible physicians and hospitals that

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Did you know...

that a CT hospital was recently accused of overcharging Medicare for blood transfusions?

Johnson Memorial Hospital in Stafford Springs, Connecticut, has agreed to pay nearly \$200,000 to resolve allegations of over-billing Medicare for blood transfusion and chemotherapy administration services between 2001 and 2005. According to the U.S. Attorney's Office, the hospital failed to bill for these services in accordance with Medicare regulations, which require that providers bill for one unit of infusion therapy and chemotherapy administration per patient visit, and one blood transfusion administration service per day. In a written response following the settlement, U.S. Attorney Nora R. Dannehy stated that "Billing for inflated charges relating to chemotherapy, infusion, and blood transfusion services siphons critical resources away from the Medicare program, which relies on hospitals to bill Medicare honestly and accurately. Health care fraud is a national problem that the United States Attorney's Office is devoted to combating."



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adopt and “meaningfully use” certified electronic health record (EHR) technology. The criteria for meaningful use focus on electronically capturing health information in a coded format, using it to track key clinical conditions, communicating it for care coordination purposes, and initiating the reporting of clinical quality measures and public health information.

In addition to the advantages of EHR implementation, including quick and easy access to patient records, rapid transfer of information, and increased efficiencies in patient care, there is a significant financial incentive for providers to implement EHR systems. Eligible hospitals (including critical access hospitals [CAHs]) that meet the requirements of the EHR incentive program may receive up to five years of incentive payments, beginning in fiscal year (FY) 2011 (October 2010). The maximum amount of incentive payments will be available to hospitals that put an EHR system into practice within the first three implementation years (2011-2013), after which the funds will decrease by 25 percent each year. Providers failing to adopt EHR technology and meet the objectives by 2015 will face financial penalties.

CMS and ONC will be rolling out EHR incentive measures in three stages. For stage 1, which begins in FY 2011, hospitals must meet 23 proposed objectives related to the use of

EHR to qualify as meaningful users. Stages 2 and 3 will expand the list in 2013 and 2015, and the added requirements will be proposed through future rulemaking.

The most recent regulations, issued on March 2, 2010, describe in more detail the proposed approach to help hospitals and providers ensure that their technology meets the necessary certification requirements. The proposed rule issued by ONC outlines a two-phased, temporary-to-permanent solution for EHR certification. The first program would create a temporary certification process under which ONC would authorize organizations to test and certify complete EHRs and/or EHR modules. This temporary program would expire in the first quarter of 2012. The second phase would replace the temporary certification program with a permanent certification process. The permanent certification program would introduce accreditation requirements and would create certification bodies to conduct surveillance activities to ensure ongoing compliance with EHR regulations.

Comments on the temporary certification program must be submitted by April 9, 2010. Comments on the permanent certification program are due May 10, 2010. For more information about the EHR initiative, and to access the recent series of regulations, visit: <http://healthit.hhs.gov>

Reimbursement for Common Blood Products to Decline in 2010

According to the Bureau of Labor Statistics Producer Price Index (PPI), costs for blood products increased approximately 3 percent from 2009 to 2010. However, despite written requests to CMS to increase blood product reimbursement to match increased costs, reimbursement for frequently used blood and blood products declined on average in 2010. The table below illustrates the differences in outpatient reimbursement between 2009 and 2010 for commonly used blood products.

Despite the decreases in reimbursement for common blood products, reimbursement for transfusion services has increased

slightly from 2009. Now, more than ever, it is important that hospitals accurately bill for blood products, transfusions, and other related services to ensure adequate reimbursement.

As a reminder, outpatient claims for blood transfusions should include the appropriate CPT code to identify the transfusion procedure and the HCPCS P-code to identify the blood product. The hospital also should report the appropriate revenue code based on the services performed. A common error outpatient hospitals make when billing for transfusions is billing the HCPCS product P-code without the CPT code describing the transfusion procedure. Also, transfusion services codes are billed on a per-service basis, and not by the number of units of blood product transfused. Therefore, providers should bill blood transfusions with a maximum of one blood administration charge per patient, per date of service. Note that the 1 blood administration charge per day applies to services related to the blood transfusion, not to the number of blood products being transfused. In turn, a transfusion APC will be paid to the outpatient provider for transfusing blood products once per day, regardless of the number of units or different types of blood products transfused.

Reimbursement Rates for Common Blood Products 2009 to 2010

HCPCS	Description	2009 Payment	2010 Payment
P9016	RBC, leuko-reduced	\$188.92	\$186.73
P9017	Plasma, 1 donor frz w/in 8 hr	\$76.73	\$76.02
P9019	Platelets, each unit	\$73.25	\$66.61
P9021	Red blood cells unit	\$136.82	\$141.73
P9031	Platelets, leuko-reduced	\$111.67	\$104.76
P9032	Platelets, irradiated	\$164.42	\$150.45
P9034	Platelets, pheresis	\$468.66	\$469.11
P9035	Platelets, pheresis leuko-reduced	\$514.82	\$512.11