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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. Please contact your blood center with any questions pertaining to this newsletter.

Medicare Proposes Significant Changes to the Hospital Inpatient Prospective Payment System

Changes would alter DRG weighting method, and adjust payment by severity level

On April 12, 2006, the Centers for Medicare and Medicaid Services (CMS) released the fiscal year (FY) 2007 Medicare Hospital Inpatient Prospective Payment System (IPPS) proposed rule. If fully implemented, the changes within the rule would significantly transform the Medicare diagnosis-related group (DRG) payment system for the first time since its creation in 1983.

CMS outlines a two-step process to reform the IPPS. The first would involve altering the way the agency assigns weights to DRGs for payment. Under its new proposal, CMS would assign DRG weights based on estimated hospital costs, rather than charges. The new DRG weights would go into effect on October 1, 2006.

The second step would introduce a refined DRG classification system intended to more accurately reflect services provided by hospitals. Under the proposal, CMS would replace the current 525 DRGs with 861 consolidated severity-adjusted DRGs designed to differentiate between inpatients with various severity levels. CMS will also consider alternative severity adjusted DRG systems based on the public comments it receives on the proposed rule. The transition to severity adjusted DRGs would not fully take effect until FY 2008.

The proposed changes underscore the importance of accurately coding and billing for inpatient services, including blood and blood products, despite the fact that hospitals do not receive separate "line item" reimbursement for each item and service (see *Take a Closer Look* box on page 2).

The FY 2007 IPPS proposed rule also contains several other provisions that may be of interest to providers of blood and blood products.

CMS estimates a FY 2007 market basket increase of 3.4 percent that will be applied to overall hospital payments. Hospitals in rural areas could see an average increase of 6.4 percent. Market basket increases take into account the cost of blood and blood products.

CMS proposes to continue paying separately for hemophilia clotting factors administered to hospital inpatients. Payment for these products is based on average sales price (ASP) plus 6 percent, plus a furnishing fee. The furnishing fee, which is \$0.146 per IU in FY 2006, will be adjusted by the Consumer Price Index (CPI) for the FY 2007 update.

CMS also proposes to increase the outlier threshold for hospitals to qualify for extra payment for unusually high cost cases to \$25,530, up from \$23,600 in FY 2006.

Comment on the IPPS Proposed Rule... CMS will accept public comments on various provisions of the IPPS proposed rule until June 12, 2006. Comments may be submitted electronically or by mail. Complete instructions for submitting public comments, as well as a full version of the proposed rule, can be downloaded through the following Web site:
<http://www.cms.hhs.gov/AcuteInpatientPPS/IPPS/list.asp#TopOfPage>

Coding Focus: Hospital Outpatient Coding and Billing for Autologous Blood, Split Units, and Irradiation

In guidance released last year, CMS clarified several coding and billing scenarios for blood and blood products under the Medicare Hospital Outpatient Prospective Payment System (OPPS). Below are some highlights from this guidance that hospitals may find useful.

Autologous Blood: In general, when autologous blood transfusions are performed, providers should bill for the transfusion service and applicable Healthcare Common Procedure Coding System (HCPCS) code for the blood product. Payment for the blood product is intended to cover the associated collection, processing, and storage costs. However, when autologous blood product is collected but not transfused, hospitals should bill Current Procedural Terminology (CPT) code 86890 (*Autologous blood or component, collection, processing, and storage*) or 86891 (*Autologous blood or component, collection, processing, and storage; intra- or postoperative salvage*). The payments for these codes are intended to cover the costs incurred for these services, which are not reimbursed when a blood product HCPCS code is not billed.

Split Units: When patients receive a split unit of blood, providers should bill P9011 for the blood product transfused as well as CPT 86985 (*Splitting blood products*) for the each splitting procedure performed to prepare blood for a specific patient.

Irradiation: Where possible, hospitals may bill for a specific irradiated blood product using a HCPCS code in addition to the CPT code for the transfusion. If a specific HCPCS code for the irradiated product does not exist, providers should bill the applicable HCPCS code for the blood product, along with CPT code 86945 (*Irradiation of blood product, each unit*).

For a more complete description of these and other OPPS blood product-related billing issues, please refer to the Medicare Claims Processing Manual, Chapter 4, Section 231 or CMS Transmittal 496 (March 4, 2005) available at: <http://www.cms.hhs.gov/transmittals/downloads/R496CP.pdf>

Take a Closer Look...The importance of accurate coding and billing for inpatient services

Blood and blood products (except for hemophilia clotting factors) are not reimbursed separately in the inpatient setting under the Medicare IPPS. This is also typically the case for other non-Medicare payers, such as Medicaid and private managed care organizations. For this and other reasons, hospitals have traditionally underreported blood cost and utilization data. In fact, CMS once reported that over 50 percent of hospitals do not accurately report blood data. However, the Medicare DRG system and many other prospective payment systems base future payment updates on cost and utilization data collected from hospitals on claim forms. Therefore, it is imperative that hospitals submit complete and accurate information to fiscal intermediaries on the CMS-1450 (UB-92) claim form using the proper revenue codes, regardless of whether or not they receive separate payment for each specific line item or service. Medicare's proposed revisions to the DRG system make this fact even more relevant. As the relative weight calculation methodology and DRG classification system evolve and to become more refined, accurate coding and billing will ensure that your facility receives appropriate reimbursement for each inpatient case.