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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.*

## Billing Medicare for Pooled Blood Products

A number of confusing issues can arise when billing Medicare for pooled blood products. To ensure appropriate reimbursement, providers need to pay close attention to coding details.

Hospitals can seek reimbursement from Medicare for blood processing. When billing for the blood processing costs, Medicare requires providers to report the Healthcare Common Procedure Coding System (HCPCS) code for the blood product, the Current Procedural Terminology (CPT®) code for the blood processing and handling, the number of units transfused, and the line item date of service under the revenue code 39X. For providers who purchase the blood product being transfused, Medicare also requires the BL modifier to be appended to all line items.

HCPCS codes are used to describe the various blood products available for transfusion. A variety of codes exist for each blood product. For example, there are 11 HCPCS codes that describe the various platelet products. It is important when billing providers to use the HCPCS code that most accurately describes the product transfused into the patient.

When billing for a pooled blood product, providers should use a HCPCS code that describes both the blood product and pooling if one is available. For blood products that do not have a HCPCS code that includes pooling, the hospital can bill Medicare for pooling costs with CPT code 86985 (*Pooling of platelets or other blood products*).

Platelet and cryoprecipitate are two commonly pooled blood products. Currently, neither product has a HCPCS code that includes pooling. Therefore, providers can bill Medicare for pooling when either pooled platelets or pooled cryoprecipitate are transfused into a Medicare beneficiary.

Below, a scenario demonstrates how billing for a pooled blood product might occur. Note that these are only suggestions and that you always should check your facility's and payer's coding and payment policies.

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An OPPS provider purchases two units of cryoprecipitate from a blood bank and then pools them before a patient transfusion.

P9012 (*Cryoprecipitate, each unit*) is the most appropriate HCPCS code in this situation. The appropriate revenue codes are used for the cryoprecipitate (387), blood storage (399) and processing (390), and transfusion (391) charges. Since the hospital did not obtain the blood already pooled, there is a charge for pooling, CPT 86985. This code is used because the pooling charge is **NOT** included in the P9012 code. The OPPS provider does not need to separately list each unit pooled; instead, the hospital should list the CPT code for pooling once and put the number of units pooled in the service units column.

## Did you know...that hospitals can bill for services provided by an outside laboratory?

Under Medicare, hospitals may bill for patient-specific laboratory services even if such services are performed by another laboratory. This is known as billing under arrangement. In this situation, only the hospital would submit a claim for the arranged services. Therefore, it is critical to establish good communication between the hospital and outside laboratories. It is the responsibility of the hospital to ensure that the outside laboratory does not bill Medicare for the arranged services if the hospital intends to do so.

## Universal Bill (UB-04) to Replace UB-92

Starting March 1, 2007, hospitals submitting paper claims to the Centers for Medicare and Medicaid Services (CMS) will use the UB-04 rather than the UB-92. CMS has established a transition period that will last from March 1, 2007, to May 22, 2007, during which time both the UB-92 and UB-04 paper claim forms will be accepted. After May 22, 2007, all institutional paper claims must be made with the UB-04.

The UB-04 was developed to meet several criteria including the need to collect additional clinical data, the inclusion of the National Provider Identifier (NPI), and the alignment of the paper form to the HIPAA electronic 837i standard. While most of the data elements collected have not changed on the UB-04, the location of many UB-92 data fields has changed. Additional fields have also been added to the UB-04 to allow for additional clinical information. For example, the UB-04 was modified to allow a greater number of diagnosis and procedure codes as well accommodate the International Classification of Diseases 10<sup>th</sup> Revision (ICD-10) codes.

Further information on the UB-04, including a crosswalk between the UB-92 and UB-04, can be found on the CMS Web site.

## New *ISBT 128* Barcode Labelling Requirements for Blood and Blood Products

Recently, the the Food and Drug Administration (FDA) established new label requirements for certain human drugs and biological products. Under Title 21 Code of Federal Regulations 606.121, the labels on blood and blood components intended for infusion must have encoded information in a format that is machine readable and approved for use by the Center for Biologics Evaluation and Research (CBER). In September 2006, the FDA issued a guidance document recognizing the *ISBT 128* version 2.0.0 standard as acceptable for use on the container labels for blood and blood components.

It remains to be seen what, if any, impact the *ISBT 128* barcodes will have on HCPCS and CPT codes for reimbursement of blood and blood products in the hospital setting. Currently, the Centers for Medicare and Medicaid Services has yet to issue anything regarding the new *ISBT 128* labelling requirements.

## The CPT® Code Application Process

The American Medical Association (AMA) is responsible for overseeing the addition, deletion, and revision of all CPT codes. Parties interested in requesting a new or modified CPT code must submit an application to the AMA's CPT staff.

Applications for new and revised CPT codes are reviewed four times annually. The CPT application should include a complete description of the procedure or service for which the new or revised code is being requested, peer-reviewed published literature, clinical vignettes, evidence of FDA approval, the support of a medical specialty society, and a rationale for why current CPT codes do not accurately describe the procedure or service.

The decision to add, modify, or delete a CPT code is a multi-step process that can be quite lengthy. The CPT application deadlines fall in March, July, and November each year for updates that will be made to the CPT code in two years' time. For example, if the March, 2007 deadline is met, any changes in the CPT code will be effective in the CPT 2009 book and the 2010 Medicare Physician Payment Fee Schedule.

Once a decision has been reached by the CPT Editorial Panel, the requester is notified. The requestor can appeal the decision with a written request for reconsideration. The request should include the reason why the requestor believes the decision is incorrect and should respond to the panel's stated rationale. The request then is taken to the CPT Executive Committee for a decision. At this point, unless new information becomes available, a requestor must wait until one year has passed from the first reconsideration before submitting a request for a second reconsideration.

Beginning May 23, 2007, HIPAA requires that covered entities (*i.e.*, health plans, health care clearinghouses, and those health care providers who transmit any health information in electronic form in connection with a transaction for which the Secretary of Health and Human Services has adopted a standard) use NPIs in standard transactions. The purpose of the NPI is to uniquely identify a health care provider in standard transactions, such as health care claims. The only exception is for small health plans; the compliance date for small health plans is May 23, 2008.