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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.

Proposed Changes CY 2008 Hospital Outpatient Prospective Payment System (OPPS) Blood Reimbursement

The Centers for Medicare and Medicaid Services (CMS) published the CY 2008 Medicare Hospital Outpatient Prospective Payment System (OPPS) proposed rule on August 2, 2007. The rule contains Medicare's proposed payment updates for blood and blood products transfused in the hospital outpatient setting, which would take effect on January 1, 2008. CMS is expected to publish the OPPS final rule in November.

CMS currently recognizes Healthcare Common Procedure Coding System (HCPCS) code G0627, *Bone marrow or peripheral stem cell harvest, modification or treatment to eliminate cell type(s)*, for stem cell processing procedures rather than the more specific Current Procedural Terminology (CPT) codes. The 2008 OPPS proposed rule will recognize the six stem cell transplant processing CPT codes for the first time. The recognition of the individual CPT codes will yield more specific claims data and potentially will allow CMS to set more appropriate payment rates for these services in the future.

The table to the right includes the proposed APC payment changes for several blood-related services, including stem cell transplant processing codes, and common blood products. If the proposed rule is adopted, there would be modest payment increases for most frequently used blood products and more dramatic increases for some bone marrow and stem cell related procedures.

HCPCS/ CPT Code	Short Descriptor	2007 APC	2008 Proposed APC	2007 APC Payment	Proposed 2008 APC Payment	Percent Change
36430	Blood transfusion service	0110	0110	\$212.58	\$222.44	4.43%
36511	Apheresis WBC	0111	0111	\$720.00	\$776.94	7.33%
38206	Harvest autologous stem cells	0111	0111	\$720.00	\$776.94	7.33%
38210	T-cell depletion of harvest	--	0110	--	\$222.44	NA
38211	Tumor cell deplete of harvest	--	0110	--	\$222.44	NA
38212	RBC depletion of harvest	--	0110	--	\$222.44	NA
38213	Platelet deplete of harvest	--	0110	--	\$222.44	NA
38214	Volume deplete of harvest	--	0110	--	\$222.44	NA
38215	Harvest stem cell concentrate	--	0110	--	\$222.44	NA
38221	Bone marrow biopsy	0003	0003	\$147.59	\$206.30	28.46%
38230	Bone marrow collection	0123	0112	\$1,251.38	\$2,035.93	38.54%
38240	Bone marrow/stem transplant	0123	0112	\$1,251.38	\$2,035.93	38.54%
G0267	Bone marrow or psc harvest	0110	--	\$212.58	--	NA
P9010	Whole blood for transfusion	0950	0950	\$131.98	\$282.63	53.30%
P9011	Blood split unit	0967	0967	\$137.22	\$135.26	-1.45%
P9012	Cryoprecipitate each unit	0952	0952	\$48.59	\$43.59	-11.47%
P9016	RBC leukocytes reduced	0954	0954	\$175.74	\$188.47	6.75%
P9017	Plasma 1 donor frz w/in 8 hr	9508	9508	\$70.21	\$69.44	-1.11%
P9019	Platelets, each unit	0957	0957	\$58.95	\$69.00	14.57%
P9021	Red blood cells unit	0959	0959	\$129.53	\$129.57	0.03%
P9022	Washed red blood cells unit	0960	0960	\$211.03	\$268.10	21.29%
P9031	Platelets leukocytes reduced	1013	1013	\$95.08	\$109.60	13.25%
P9032	Platelets, irradiated	9500	9500	\$129.57	\$132.11	1.92%
P9033	Platelets leukoreduced irrad	0968	0968	\$125.33	\$129.17	2.97%
P9034	Platelets, pheresis	9507	9507	\$452.93	\$448.44	-1.00%
P9035	Platelet pheres leukoreduced	9501	9501	\$488.74	\$509.25	4.03%
P9036	Platelet pheresis irradiated	9502	9502	\$418.52	\$446.33	6.23%
P9037	Plate pheres leukoredu irrad	1019	1019	\$617.40	\$639.53	3.46%
P9038	RBC irradiated	9505	9505	\$197.00	\$211.84	7.01%
P9040	RBC leukoreduced irradiated	0969	0969	\$217.56	\$243.25	10.56%
P9044	Cryoprecipitatereducedplasma	1009	1009	\$82.39	\$83.64	1.49%
P9051	Blood, /r, cmv-neg	1010	1010	\$156.70	\$152.00	-3.09%
P9052	Platelets, hla-m, /r, unit	1011	1011	\$671.62	\$616.33	-8.97%
P9055	Plt, aph/pher, /r, cmv-neg	1017	1017	\$396.81	\$496.26	20.04%

CMS Finalizes NCD On ESAs

On July 30, 2007, CMS posted the final national coverage determination (NCD) for the use of erythropoiesis stimulating agents (ESA) in cancer and related neoplastic conditions. The NCD was opened in response to the Food and Drug Administration's (FDA) black box warning regarding the use of ESAs. The final NCD was modified from the proposed NCD posted on May 14, 2007. CMS no longer distinguishes between cancers that have erythropoietin receptors and cancers without those receptors. Additionally, CMS made no determination on the use of ESAs for myelodysplastic syndrome (MDS).

The final NCD, effective July 30, 2007, provides coverage with restrictions for the treatment of anemia secondary to myelosuppressive anticancer chemotherapy in certain cancer conditions including solid tumors, multiple myeloma, lymphoma, and lymphocytic leukemia. The coverage restrictions include limiting initiation of ESA therapy to hemoglobin levels less than 10 g/dL, limiting the duration of ESA treatment to a maximum of 8 weeks after a chemotherapy session ends, limiting the starting dose to the FDA recommended starting dose, and limiting dose escalation levels.

In addition to the NCD on ESA use for cancer and related neoplastic conditions, Medicare is also modifying the ESA monitoring policy for end stage renal disease (ESRD) patients. Effective January 1, 2008, payment will be made at 50 percent of the reported ESA dose for claims for ESRD patients reporting a hematocrit level exceeding 39.0 percent (or hemoglobin exceeding 13.0g/dL) for three or more consecutive billing cycles. In addition, claims must report modifiers ED or EE.

Changes in the CY 2008 Final Inpatient Prospective Payment System

The Hospital Inpatient Prospective Payment System (IPPS) was finalized on August 1, 2007. As outlined in the proposed rule, CMS will create 745 new severity-adjusted diagnosis-related groups (Medicare Severity DRGs or MS-DRGs) to replace the current 538 DRGs. However, the final rule states that the new MS-DRGs will be phased in over a two-year period, rather than the one-year period stated in the proposed rule.

The final rule also changes the manner in which Medicare pays hospital capital-related costs. The proposed rule included a suggestion to provide a zero payment update for urban hospitals to correct substantial positive margins related to payment for hospital-related capital costs. Instead, the final rule provides a full update to all hospitals but eliminates the large urban add-on payment. The final rule also adopts a policy of discontinuing the teaching adjustments to capital payments over a three-year period.

CMS Finalizes Changes to the ASC Payment System

CMS recently made significant changes to the ambulatory surgical center (ASC) payment system. In July 2007, CMS published a final rule aligning ASC payments with the OPPS payment system. Beginning CY 2008, payment for procedures performed in the ASC setting will be based on a percentage of the OPPS payment rates. For 2008, ASC rates will be approximately 65 percent of the corresponding APC payment rate. In addition, payment for services that are frequently performed in a physician's office will be capped at the nonfacility practice expense component of the physician payment under the Medicare Physician Fee Schedule.

The final rule provides for separate payment of covered ancillary services that are provided in the ASC. To be eligible for payment, the services must be integral to covered surgical procedures and must be provided immediately before, during, or after the procedure. Covered ancillary services include radiology services, drugs and biologicals that are separately payable under the OPPS, devices eligible for pass-through payments under the OPPS, brachytherapy services, and corneal tissue acquisition. The final rule also extends access to procedures in the ASC setting by providing payment for approximately 790 additional surgical procedures in CY 2008.

Finally, starting in 2008, future ASC payment system updates will be made under the OPPS proposed and final rules.

Finally, the rule implements a provision of the Deficit Reduction Act of 2005 that requires hospitals to begin reporting secondary diagnoses that are present on admission, beginning with discharges on or after October 1, 2007. Starting in FY 2009, cases with specified conditions would not be paid at a higher rate unless the conditions were present upon admission. The final rule identified eight conditions that meet the statutory criteria and states that 3 conditions will be added for the 2009 rule.

Additional information on the FY 2008 IPPS final rule and the rule itself can be found on CMS's website at: <http://www.cms.hhs.gov/AcutelnpatientPPS/>.

Did you know... that CMS awarded the second A/B MAC contract to TrailBlazer?

On August 2, 2007, CMS announced that TrailBlazer will be the A/B MAC for Jurisdiction 4 comprised of Colorado, New Mexico, Oklahoma, and Texas. As the J4 A/B MAC, Trailblazer will immediately begin implementation activities and will assume full responsibility of Medicare Part A and Part B claims for all four states no later than Spring 2008. A Background Sheet and questions and answers related to the award are available at CMS's website http://www.cms.hhs.gov/MedicareContractingReform/02_What's%20New.asp#TopOfPage.