AABB BILLING GUIDE FOR TRANSFUSION AND CELLULAR THERAPY SERVICES

Advancing Transfusion and
Cellular Therapies Worldwide

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The codes listed in this guide represent possible coding options. It is always the provider's responsibility to determine and submit appropriate codes, charges, and modifiers for services that were rendered. Since local payers may have their own coding requirements, before filing any claims, providers should verify coding in writing with such payers.

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I. INTRODUCTION

AABB has published this billing guide to assist hospitals, clinicians, and billing and coding professionals involved with the utilization and subsequent billing of the services and procedures associated with the use of blood and blood products as well as cellular therapies. This guide should help answer coverage, coding, and reimbursement questions about blood and blood products and cellular therapies. It was produced with the support of a group of manufacturer members of the Advanced Medical Technology Association (AdvaMed) that manufacture a broad range of blood safety, testing, collection, and transfusion technologies.

Blood and blood products comprise a vital resource in modern health care, and are integral to a broad range of urgent care procedures as well as palliative and therapeutic interventions that save and enhance patients' lives. However, ensuring the safety and quality of blood products is a formidable task, and blood collectors and providers must continually update their processes to ensure that the blood supply is as safe as possible.

In recent years, economic pressures on our health care system have underscored the importance of appropriate third-party payment for blood products and services. National advisory bodies, such as the Advisory Committee on Blood Safety and Availability of the Department of Health and Human Services, have recognized the importance of appropriate reimbursement for blood under the federal Medicare program to ensure patient access to quality health care.[1] At the same time, billing practices for blood at some hospitals may not capture the volume or diversity of products and services actually used.

The information in this guide is compiled primarily from Medicare guidelines, for two reasons. First, Medicare is the most significant payer for hospital inpatient blood-related care, covering approximately 57 percent of inpatient admissions with intensive blood use.[2] Second, Medicare's coverage guidelines and payment policies pave the way for other insurers, including state Medicaid programs and private payers.

The publishers of this Guide provide specific instructions to support the most accurate billing for each beneficiary recipient of blood products or related services. As a larger number of hospitals address this issue, it is the hope of AABB that improved accuracy in Medicare records on the total transfusion services provided and their costs will, in turn, help to make the available payments to hospitals for these services more appropriate.

This Guide is intended to help hospitals bill accurately and completely for blood products and services. Though AABB does not provide any guarantees of reimbursement, the intent of this publication is to assist hospitals in understanding the billing rules and procedures that apply for Medicare and other

[1] DHHS Advisory Committee on Blood Safety and Availability, unanimous resolution on Medicare Outpatient Prospective Payment System (OPPS) payment, September 5, 2002. For more information, please visit the DHHS Advisory Committee on Blood Safety and Availability's website at http://www.hhs.gov/bloodsafety/.

[2] PAREXEL analysis of 2000-2001 National Hospital Discharge Survey data; payer mix data includes cases in DRGs for lymphoma and leukemia, and disorders of red blood cells (RBCs), cranial and peripheral nerves, connective tissues, and the immune system.

payers. Moreover, hospitals are responsible for the selection of billing and procedure codes and physicians are responsible for maintaining the documentation in the medical record of the codes selected.

II. OVERVIEW OF INSURER COVERAGE AND REIMBURSEMENT OF BLOOD PRODUCTS AND RELATED SERVICES

Coverage of a blood product or service refers to a decision by an insurer organization to provide program benefits for a specific product and/or related medical services. Coverage policies will vary by payer; we focus here primarily on the coverage requirements of the Medicare program.

Coverage policies for hospital and physician services typically relate to whether the patient's condition or proposed course of treatment is **medically necessary** and therefore eligible for reimbursement under that patient's health care plan. As defined by Medicare, a medically necessary service is one that is "**reasonable and necessary** for the diagnosis or treatment of an illness or injury, or to improve the functioning of a malformed body member."[3]

Because blood is considered a biological, to be covered under Medicare Part B, blood and blood products must be furnished "incident to" a physician's service, meaning that the services or supplies are furnished as an integral, although incidental, part of the physician's personal professional services in the course of diagnosis or treatment of illness or injury.[4]

The Medicare program has historically applied a *blood deductible* that requires beneficiaries to pay or replace the first three pints [units] of whole blood or packaged red blood cells received within a calendar year. However, the blood deductible applies *only* to those units of blood carrying additional charges (example: blood replacement fee) in addition to processing and storage costs. Because the majority of hospitals do not incur these additional charges (see below and section III), they may begin submitting all charges for blood and blood products to Medicare with the first unit transfused to a patient. See Appendix B, "The Medicare Blood Deductible Explained," for a detailed discussion of when the blood deductible may apply.

Medically necessary transfusion of blood, regardless of type, generally is a Medicare covered service in the hospital inpatient and hospital outpatient settings. Medicare's specific coverage policy for blood transfusions identifies which blood products and related services will be considered reasonable costs by the Medicare program.[5] These products and services include the following:

- processing fees for all blood units—whether allogeneic (homologous), autologous, or donor-directed—incurred by the blood supplier that are passed along to the hospital; and
- costs incurred by the hospital itself in order to process and administer the blood after it has been procured.

Processing fees are described in detail in the following section, "Blood Costs Versus Blood Processing Costs."

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[3] Social Security Act, 42 U.S.C. 1395ff, §1862(a)(1)(A).

[4] Medicare Benefit Policy Manual (MBPM), Chapter 15 §60.1, "Incident To Physician's Professional Services." Available for download at http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf. This section was last revised August 12, 2005.

[5] Internet-Only Medicare National Coverage Determinations Manual (NCDM) §110.7 (Blood Transfusions). Providers are encouraged to access the NCDM on line at http://www.cms.hhs.gov/manuals/downloads/ncd103c1_Part2.pdf.

Hospital and physician reimbursement for blood will vary by payer. A summary of predominant payment mechanisms is illustrated in Table 1.

Table 1

Payment Mechanisms			
Payer	**Hospital Inpatient**	**Hospital Outpatient**	**Physician**
Medicare	Diagnosis-related group (DRG)-based prospective payment system	Ambulatory Payment Classification (APC)	Resource-based relative value scale (RBRVS) fee
Private	DRG-based, *per diem*, case rate, or discounted charges	APC-based payment, case rate, or discounted charges	RBRVS, percent of allowable charges, negotiated rates, case rates

III. BLOOD COSTS VERSUS BLOOD PROCESSING COSTS

The distinction between reporting the costs of blood processing and storage—as opposed to the cost of the blood itself—impacts the selection of the appropriate revenue code on claims for transfused blood and blood products. Reporting charges under the correct revenue code for each unit of blood transfused is essential in order to receive adequate reimbursement. Each category of blood costs is described in detail below.

When a hospital obtains blood from a supplier that charges only for blood processing costs, Medicare recognizes the ***blood***-processing ***fee*** charged to the hospital by the supplier, not a charge for the blood itself.

The Medicare Intermediary Manual defines blood processing costs as "amounts spent to process and administer blood after it has been procured," including the following:

- **cost of such activities as storing, typing, cross-matching, and transfusing blood;**
- **cost of spoiled or defective blood; and**
- **where a provider purchases blood from an outside blood source, the portion of the outside blood source's blood fee which remains after credit is given for replacement; i.e., the amount which cannot be credited or rebated by replacement of the blood. Thus, where an outside blood source charges the provider the same amount, whether or not the blood is replaced, the entire blood fee is a blood processing cost to the provider.[6]**

Medicare recognizes any costs that the hospital itself incurs to process and administer the blood after it has been delivered to the hospital. The hospital may charge for these processing and administration costs, which include the costs of such activities as storing, type cross matching, and transfusing the blood.

Medicare defines the cost of spoiled or defective blood as a blood processing cost; however, this particular category of costs should not be reported on claims for services rendered to patients. Instead, these costs should be transferred to a blood processing, storage, and administration account and reported on the hospital cost report, to be shared proportionately by all patients. However, while hospitals may not bill for the cost of unused blood (with the exception of unused autologous blood – refer to "Reimbursement Updates and Highlights for Blood and Blood Products," page 27), it is appropriate to bill for the costs of medically necessary processing or preparation services for unused blood related to a specific patient—for example, any medically necessary cross matching—even if the blood ultimately is not transfused.[7]

Blood suppliers typically charge hospitals the same amount, regardless of whether the blood units were considered replaced. In this case, no portion of the supplier's fee would be considered to be in excess of the processing fee, and the entire charge would represent a blood processing cost to the provider.

[6] Medicare Intermediary Manual (MIM), Chapter 3, §3235.5 "Distinction Between Blood Costs and Blood Processing Costs."
[7] Medicare Claims Processing Manual, Chapter 4, §231.7.

Hospitals that acquire blood from suppliers that compensate donors or that charge for the product itself should bill for each unit transfused as a ***blood cost***.

The Medicare Intermediary Manual states that a provider's blood costs consist of "amounts it spends to procure blood," including the following:

- **the cost of such activities as soliciting and paying donors and drawing blood for its own blood bank; and**
- **where a provider purchases blood from an outside blood source—such as a commercial or voluntary blood bank, or a blood bank operated by another provider—an amount equal to the amount of credit which the outside blood source customarily gives the provider if the blood is replaced.**[8]

With respect to blood replacement credits, as described in the second bullet above, hospitals must report the portion of the supplier's fee equal to the replacement credit as a blood cost.

[8] Medicare Intermediary Manual (MIM), Chapter 3, §3235.5 "Distinction Between Blood Costs and Blood Processing Costs."

IV. REIMBURSEMENT FOR BLOOD PRODUCTS AND SERVICES: HOSPITAL INPATIENT SETTING

Medicare and some private insurers reimburse for hospital inpatient care using diagnosis-related groups (DRGs). DRGs are assigned based on a patient's primary and secondary diagnoses and the procedures performed during an inpatient stay, as identified by the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) diagnosis and procedure codes billed on the claim form. Note: for a more detailed explanation of ICD-9-CM codes, please see Appendix A, "Fundamentals of Coding."

Hospitals generally receive a fixed, pre-determined payment for each DRG, regardless of the actual services rendered. The DRG payment typically includes all costs, and other physician services, associated with the patient's hospital stay, including hospital payment for certain services performed three days prior to admission. A particular hospital's DRG payment is adjusted for many hospital-specific and geographic factors.

Even though the costs associated with blood and blood products are rolled into the DRG that a particular patient case is assigned to—and this reimbursement does not change regardless of the resources that actually are utilized for a particular patient—it is critical that hospitals thoroughly and accurately code all resources used, including blood products and blood-related services.

Private insurers and Medicaid programs also may reimburse hospitals for inpatient care on a per diem or case rate basis. A per diem rate is a negotiated prospective payment for each day for care, regardless of the resources used. Per diem rates vary within geographic markets and are plan-specific; payers can use a single per diem for all types of patient services such as surgical and medical services. Case rates, like DRGs, are a pre-determined dollar amount usually defined or categorized by the type of diagnosis(es) assigned or procedure(s) performed. Unlike DRGs, case rates often bundle hospital and physician payments together.

Coding For Blood Products and Services In The Hospital Inpatient Setting

Inpatient hospital billing for blood and blood services requires several types of codes:

- ICD-9-CM **diagnosis** codes,
- ICD-9-CM **procedure** codes,
- Medicare **revenue** codes to describe the category of service performed, and
- Medicare **value** codes to assign amounts or values for blood (not applicable when the provider does not charge for the blood itself, but only for blood processing).

ICD-9-CM Diagnosis Codes Are Used in All Settings, Including Hospital Inpatient

ICD-9-CM **diagnosis** codes are used to describe patient diagnoses in all settings. All payers require hospital and physician billing staff to use ICD-9-CM codes to document patients' diagnoses to the highest level of specificity based on the patient's medical record. Use of blood is associated with many possible diagnoses. Putting such diagnoses on a claim form, when appropriate, optimizes the likelihood of receiving the full, appropriate reimbursement for blood and blood products. Furthermore, assignment of a case to the correct DRG often depends on the proper coding of co-morbidities and complications identified by diagnosis codes.

There is no single diagnosis code that will always justify the use of blood or blood products on the claim form. Diagnosis codes are used by hospitals on the Uniform Billing form (formally known as the UB-92; now called UB-04) to reflect procedures done in the hospital inpatient setting.

- **Identifying the Specific Inpatient Transfusion Procedure Using ICD-9-CM Procedure Codes**

Medicare and private payers require ICD-9-CM procedure codes on the UB-04 claim form to describe surgical and medical procedures performed in the hospital inpatient setting. These procedure codes also are essential for assignment of a case to the correct DRG. Procedure codes that may be used to reflect the transfusion procedure are summarized in Table 2.

Please Note: Despite national Medicare policies, local Fiscal Intermediaries (FI) that serve as Medicare contractors still have discretion to interpret and implement the national Medicare rules. As a result, there may be specific local requirements that vary for certain blood billing procedures. To help identify the applicable local policies in your area, consult your local Fiscal Intermediary Web site, or see http://www.cms.hhs.gov/mcd/search.asp

Table 2

ICD-9-CM Procedure Codes Associated with Blood Transfusions[9]	
99.0 **Transfusion of blood *and blood components***	
99.00	Perioperative autologous transfusion of whole blood or blood components *Intraoperative blood collection* *Postoperative blood collection* *salvage* ***DEF**: Salvaging patient blood with reinfusion during preoperative period.*
99.01	Exchange transfusion *Transfusion:* *exsanguination* *replacement* ***DEF**: Repetitive withdrawal of blood, replaced by donor blood.*
99.02	Transfusion of previously collected autologous blood *Blood component* ***DEF**: Transfusion with patient's own previously withdrawn and stored blood.*
99.03	Other transfusion of whole blood *Transfusion:* *blood NOS* *hemodilution* *NOS*
99.04	Transfusion of packed cells
99.05	Transfusion of platelets *Transfusion of thrombocytes*
99.06	Transfusion of coagulation factors *Transfusion of antihemophilic factor*
99.07	Transfusion of other serum *Transfusion of plasma* ***EXCLUDES:** injection (transfusion) of :* *Antivenin (99.16)* *Gamma globulin (99.14)*
99.08	Transfusion of blood expander *Transfusion of Dextran*
99.09	Transfusion of other substances *Transfusion of:* *blood surrogate* *granulocytes* ***EXCLUDES**: transplantation (transfusion) of bone marrow (41.0)*

[9] International Classification of Diseases ICD-9-CM 2007, Volumes 1, 2 and 3, 9th Revision – Clinical Modification. ICD-9-CM code descriptions are issued by the CMS ICD-9-CM Coordination and Maintenance Committee; some terminology used in code descriptions may not reflect current clinical practices or terminology. This table only lists codes relevant to transfusable blood products. Other types of products may require other codes.

- **Identifying the Type of Blood Service Using Revenue Codes in the Hospital Inpatient Setting**

The National Uniform Billing Committee, overseen by the American Hospital Association, developed a detailed set of accounting codes to standardize major revenue-producing centers in an institutional setting. Revenue codes are only used on the UB-04 (CMS 1450) for hospital inpatient and outpatient services. These four-digit codes identify categories of service like surgical supplies, blood, pharmacy, and laboratory. Hospitals use these codes to group the charges for itemized hospital services. Revenue codes generally appear on the hospital bill processed by most insurers.

Revenue codes for blood and blood products transfused will vary depending on whether the hospital incurs a blood cost or a blood processing cost. When blood centers do not charge for the blood itself, but for processing charges only, hospitals use the revenue codes listed in Table 3 below (as illustrated on Sample Claim #1, page 18).

Table 3

Revenue Codes Used to Bill for Blood Processing and Services, Including Transfusions[10]	
0390	General Classification
0391	Blood Administration
0392	Blood Processing and Storage
0399	Other Blood Handling

When providers obtain blood or blood products from blood banks that charge for the blood product itself—or run their own blood bank and assess a charge for blood or blood products—hospitals report blood and blood products in Revenue Code Series 038x "Blood". The amount billed should reflect the hospital's charge. The revenue codes listed in Table 4 on the following page likely will capture blood and blood products, storage, and processing for providers who can bill for the blood product in Revenue Code Series 038x "Blood."

[10] National Uniform Billing Committee Official UB-04 Specifications Manual, 2007, Version 1.0. Revenue code descriptions are issued by the National Uniform Billing Committee (NUBC); some terminology used in code descriptions may not reflect current clinical practices or terminology.

Table 4

Revenue Codes Used to Bill for Blood Products Carrying a Charge For the Blood Itself[11]	
0380	General Classification
0381	Packed Red Cells
0382	Whole Blood
0383	Plasma
0384	Platelets
0385	Leukocytes
0386	Other Blood Components
0387	Other Derivative (Cryoprecipitates)
0389	Other Blood and Blood Components
0391	Blood Administration

The use of the above revenue codes is illustrated on Sample Claim #2 (page 19). Revenue Codes for blood derivatives may be found on pages 34-36. Revenue Codes for selected tissues may be found on page 38 and 40. Revenue Codes for apheresis may be found on page 47.

OTHER IMPORTANT ISSUES:

- Because most blood is supplied by blood centers that do not charge for the blood itself, hospitals most commonly bill for blood products under revenue code 0390. However, some FIs may only accept revenue code 0391. Please verify appropriate coding with your FI.
- Regardless of whether a blood product is billed under revenue code 038x or 0390, hospitals bill for the transfusion administration under revenue code 0391.
- In addition to blood and blood products, providers may incur costs relative to the performance of pre-transfusion tests, blood matching and/or other laboratory diagnostic services. Revenue codes reported on the claim form are those typically associated with laboratory and pathology services, (e.g. 03XX)

The codes listed in this guide represent possible coding options. It is always the provider's responsibility to determine and submit appropriate codes, charges, and modifiers for services that were rendered and for these codes, charges and modifiers to be supported by the patient's medical record. Since local payers may have their own coding requirements, before filing any claims, providers should verify coding in writing with such payers.

[11] National Uniform Billing Committee Official UB-04 Specifications Manual, 2007, Version 1.0. Revenue code descriptions are issued by the National Uniform Billing Committee (NUBC); some terminology used in code descriptions may not reflect current clinical practices or terminology.

The revenue codes listed in Tables 5 and 6 are commonly encountered on claims for transfusion medicine services.

Table 5

Revenue Codes for Laboratory Tests[12]	
0300	Laboratory – General Classification
0301	Chemistry
0302	Immunology
0303	Renal Patient/(Home)
0304	Non-routine Dialysis
0305	Hematology
0306	Bacteriology & Microbiology
0307	Urology
0309	Other Laboratory

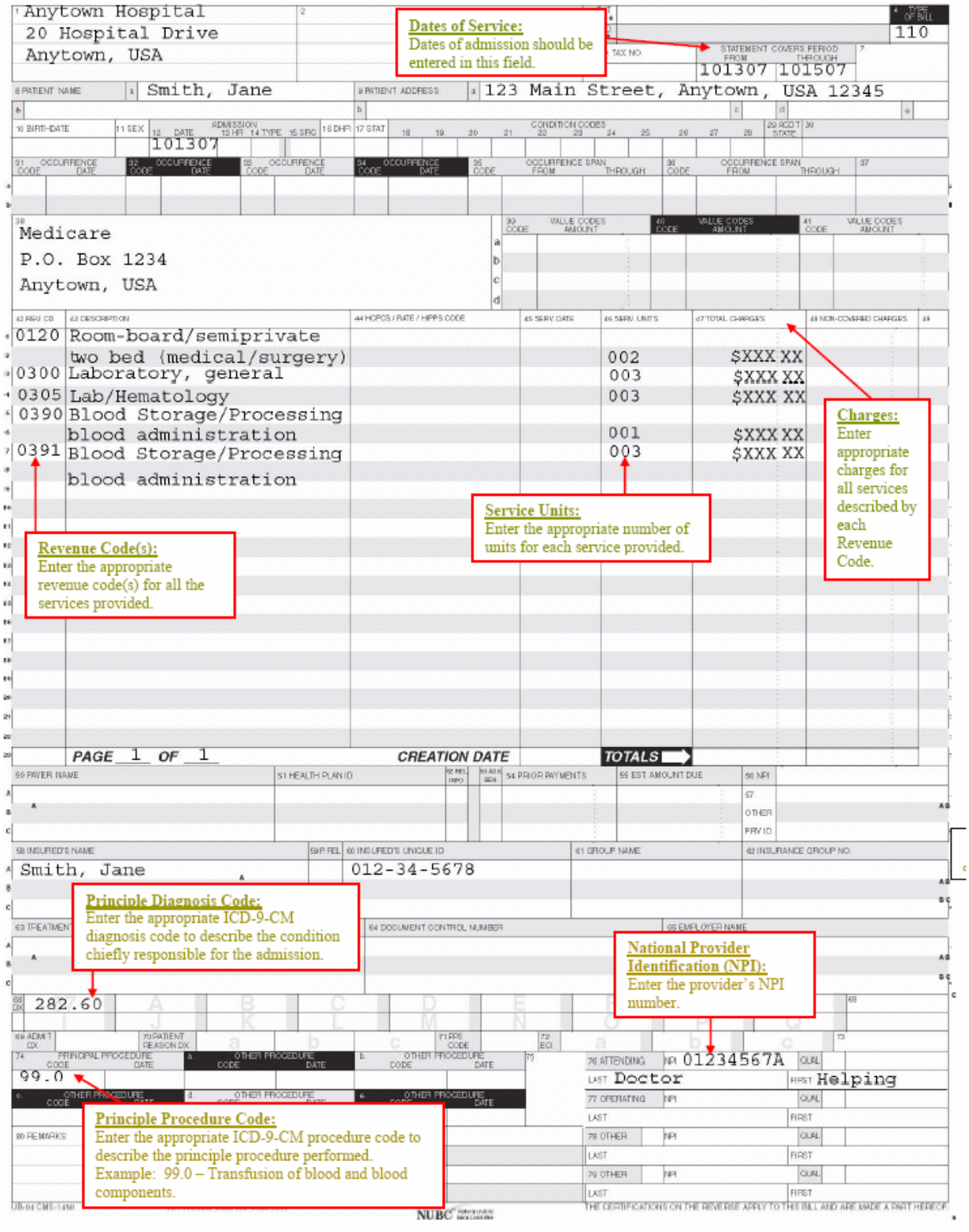
Table 6

Revenue Codes for Laboratory Pathological Procedures[12]	
0310	Laboratory Pathological – General Classification
0311	Cytology
0312	Histology
0314	Biopsy
0319	Other Laboratory

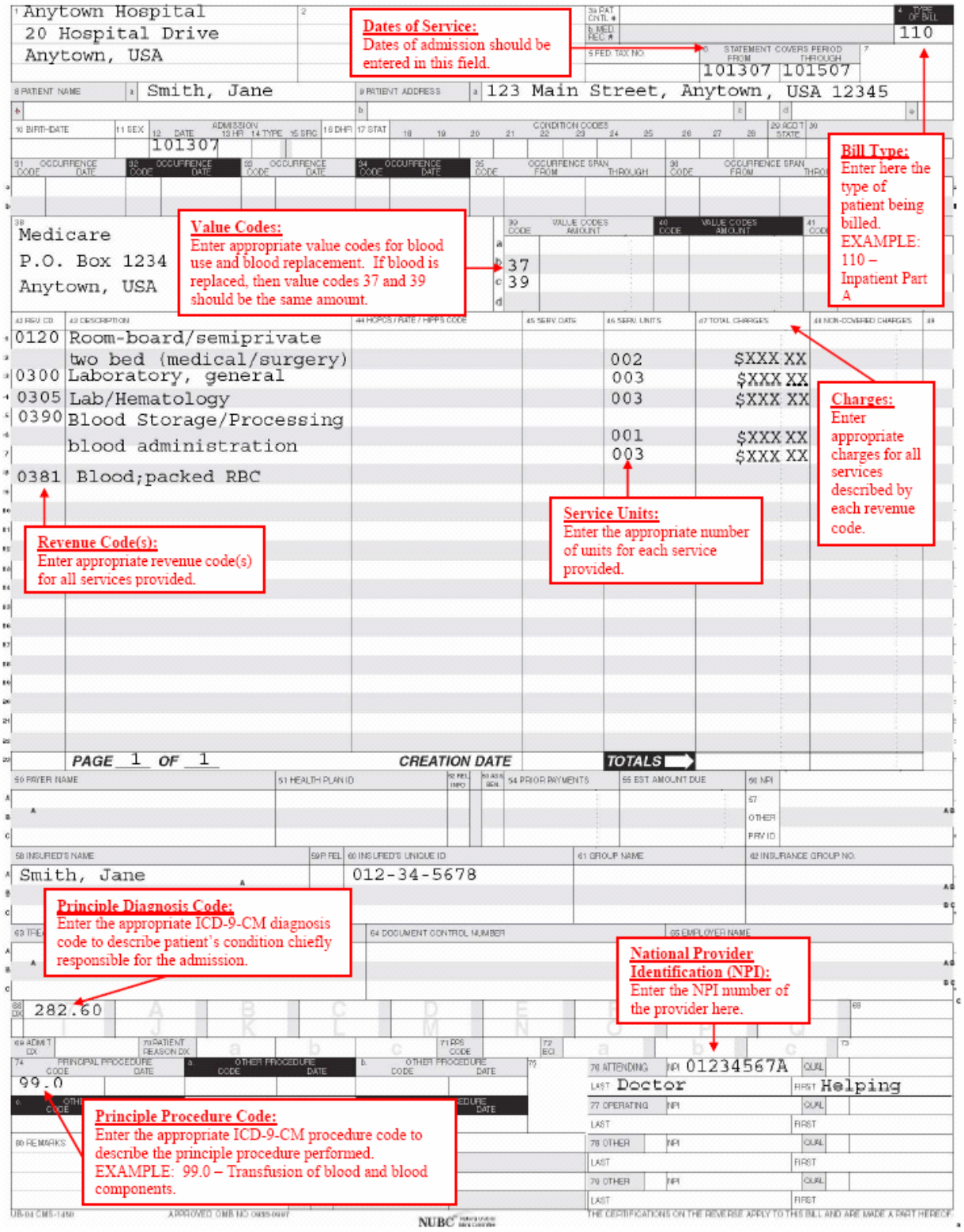
Please select the most appropriate code from each revenue series for the services provided to the patient. Hospital billing staff should determine which revenue codes to use at its facility. Please see Appendix C for examples of the correct use of value codes for all hospital claims.

[12] National Uniform Billing Committee Official UB-04 Specifications Manual, 2007, Version 1.0. Revenue code descriptions are issued by the National Uniform Billing Committee (NUBC); some terminology used in code descriptions may not reflect current clinical practices or terminology.

Sample 1: UB-04 Claim Form
For Hospital Inpatient Services When
Hospitals Charge for Blood Processing
Only



Sample 2: UB-04 Claim Form
For Hospital Inpatient Services When
Hospitals Charge for Blood Itself



V. REIMBURSEMENT FOR BLOOD PRODUCTS AND SERVICES: HOSPITAL OUTPATIENT SETTING

In August of 2000, Medicare changed the way hospital outpatient services are reimbursed. Medicare now reimburses hospitals under the hospital outpatient prospective payment system (OPPS), commonly known as the ambulatory payment classification (APC) system. Payment under the APC system is determined by the services provided during the outpatient visit, similar to the DRG system. Cases will be assigned to APC groups based on the Current Procedural Terminology (CPT) codes and correct Healthcare Common Procedure Coding System (HCPCS) codes noted on the facility UB-04 claim.[13] Each APC is associated with a specific payment amount that covers the hospital's cost related to the services provided. One hospital outpatient case may qualify for multiple APC payments. (Note: For more details on HCPCS and CPT codes, please see Appendix A, "Fundamentals of Coding.")

Transfused blood and blood products are reimbursed separately on a permanent basis under their own APCs. In other words, unlike inpatient DRGs, transfused blood and blood products are not "rolled in" to the APC payment rated associated with the procedure(s) provided.

To receive APC payment, a hospital must bill using the correct HCPCS codes to designate the services performed and blood products transfused. Although ICD-9-CM diagnosis codes also are required on hospital outpatient claims, they do not determine the payment for most outpatient services. Further details on outpatient coding are provided below.

Private insurers and Medicaid programs typically cover hospital outpatient services that are considered medically necessary. Once medical necessity has been established, payment for the procedure is often based on a percentage of billed or allowable charges, a pre-negotiated payment rate, or preset *per diems*. Facilities will need to check their agreements with payers to determine what payment arrangements have been made for blood products used during hospital outpatient procedures.

Coding In the Hospital Outpatient Setting

Outpatient hospital billing for blood and blood services requires several types of codes:

- ICD-9-CM diagnosis codes,
- CPT codes, and
- HCPCS codes.

- **ICD-9-CM Diagnosis Codes Are Used in All Settings, Including Hospital Outpatient**

Diagnosis codes reflect procedures done in the hospital outpatient setting. There is no single diagnosis code that will always justify the use of blood or blood products on the claim form. ICD-9-CM diagnosis

[13] Current Procedural Terminology: CPT® 2007 American Medical Association. All rights reserved. CPT codes are issued by the American Medical Association; some terminology used in code descriptions may not reflect current clinical practices or terminology.

codes are reported on the UB-04 claim form to describe patient diagnoses in the hospital outpatient setting.

- **Billing for Specific Outpatient Procedures Using HCPCS Codes**

HCPCS codes are most important for items covered by Medicare, either administered in the physician office or hospital outpatient settings. HCPCS codes also are used to describe items related to physician services or laboratory tests in the hospital outpatient setting. Appendix A provides greater detail on the HCPCS coding system.

- **CPT Codes for Outpatient Billing[14]**

CPT codes—also occasionally referred to as Level I HCPCS codes—are used on the CMS-1500 for a physician's services and on the UB-04 when a procedure is done in the hospital outpatient setting. Claims for physician services and hospital outpatient procedures must be billed with the appropriate CPT code to describe the services. At this time, there are several procedures that are associated with the use of blood and blood products, which include blood transfusions and services associated with providing blood suitable for transfusion.

Medicare (Part A and Part B) generally covers medically necessary transfusion of blood, regardless of type. Under Medicare Part B, the collection, processing, and storage of blood for later transfusion into the beneficiary is not recognized as a separate service and no blood supplier can receive direct payment under Medicare Part B for blood donation services. If a blood transfusion CPT code is billed on a UB-04 for hospital outpatient services, then a blood or blood product must also be billed using a HCPCS code (see next section on HCPCS codes) and the appropriate revenue codes (see previous section on Revenue codes). Medicare claims incorrectly coded will be returned to the provider. The CPT codes for blood transfusions are summarized in table 7 below.

Table 7

Current CPT Procedure Codes for Blood Transfusions[14]	
CPT Codes	**Description of Codes**
36430	Transfusion, blood or blood components
36440	Push transfusion, blood, 2 years or under
36450	Exchange transfusion, blood; newborn
36455	Exchange transfusion, blood; other than newborn
36460	Transfusion, intrauterine, fetal

Other common blood-related procedures are summarized in Table 8 on the following two pages.

[14] Current Procedural Terminology. CPT® 2007. American Medical Association. All rights reserved.

Table 8
Current CPT Procedure Codes for Common Blood-Related Procedures[15]

CPT Codes	Description of Codes
36511	Therapeutic apheresis; for white blood cells
36512	Therapeutic apheresis; for red blood cells
36513	Therapeutic apheresis; for platelets
36514	Therapeutic apheresis; for plasma pheresis
36515	Therapeutic apheresis; with extracorporeal immunoadsorption and plasma reinfusion
36516	Therapeutic apheresis; with extracorporeal selective adsorption or selective filtration and plasma reinfusion
36522	Photopheresis, extracorporeal
38205	Blood-derived hematopoietic progenitor cell harvesting for transplantation, per collection; allogenic
38206	Blood-derived hematopoietic progenitor cell harvesting for transplantation, per collection; autologous
38207*	Transplant preparation of hematopoietic progenitor cells; cryopreservation and storage
38208*	Transplant preparation of hematopoietic progenitor cells; thawing of previously frozen harvest, without washing
38209*	Transplant preparation of hematopoietic progenitor cells; thawing of previously frozen harvest, with washing
38210*	Transplant preparation of hematopoietic progenitor cells; specific cell depletion within harvest, T-cell depletion
38211*	Transplant preparation of hematopoietic progenitor cells; tumor cell depletion
38212*	Transplant preparation of hematopoietic progenitor cells; red blood cell removal
38213*	Transplant preparation of hematopoietic progenitor cells; platelet depletion
38214*	Transplant preparation of hematopoietic progenitor cells; plasma (volume) depletion
38215*	Transplant preparation of hematopoietic progenitor cells; cell concentration in plasma, mononuclear, or buffy coat layer
38230	Bone marrow harvesting for transplantation
38231	*Has been deleted. To report, use 38205-38206.*
38240	Bone marrow or blood-derived peripheral stem cell transplantation; allogenic
38241	Bone marrow or blood-derived peripheral stem cell transplantation; autologous
38242	Bone marrow or blood-derived peripheral stem cell transplantation; allogeneic donor lymphocyte infusion
86850	Antibody screen, RBC, each serum technique
86860	Antibody elution, RBC, each elution

* CMS recently proposed to recognize these codes and pay for the services under the Medicare Hospital Outpatient Prospective Payment System.

[15] Current Procedural Terminology. CPT® 2007. American Medical Association. All rights reserved.

Table 8 (Continued)

CPT Codes	Description of Codes
86870	Antibody identification, RBC antibodies, each panel for each serum technique
86880	Antihuman globulin test (Coombs test); direct, each antiserum
86885	Antihuman globulin test (Coombs test); indirect, qualitative, each antiserum
86886	Antihuman globulin test (Coombs test); indirect, titer, each antiserum
86890	Autologous blood or component, collection processing and storage; predeposited
86891	Autologous blood or component, collection processing and storage; intra- or postoperative salvage
86900	Blood typing; ABO
86901	Blood typing; Rh (D)
86903	Blood typing; antigen screening for compatible blood unit using reagent serum, per unit screened
86904	Blood typing; antigen screening for compatible unit using patient serum, per unit screened
86905	Blood typing; RBC antigens, other than ABO or Rh(D), each
86906	Blood typing; Rh phenotyping, complete
86920	Compatibility test each unit; immediate spin technique
86921	Compatibility test each unit; incubation technique
86922	Compatibility test each unit; antiglobulin technique
86923	Compatibility test each unit; electronic
86927	Fresh frozen plasma, thawing, each unit
86930	Frozen blood, each unit; freezing (includes preparation)
86931	Frozen blood, each unit; thawing
86932	Frozen blood, each unit; freezing (includes preparation) and thawing
86940‡	Hemolysins and agglutinins; auto, screen, each
86941‡	Hemolysins and agglutinins; incubated
86945	Irradiation of blood product, each unit
86950	Leukocyte transfusion
86960	Volume reduction of blood or blood product (eg, red blood cells or platelets), each unit
86965	Pooling of platelets or other blood products
86970	Pretreatment of RBCs for use in RBC antibody detection, identification, and/or compatibility testing; incubation with chemical agents or drugs, each
86971	Pretreatment of RBCs for use in RBC antibody detection, identification, and/or compatibility testing; incubation with enzymes, each
86972	Pretreatment of RBCs for use in RBC antibody detection, identification, and/or compatibility testing; by density gradient separation
86975	Pretreatment of serum for use in RBC antibody identification; incubation with drugs, each
86976	Pretreatment of serum for use in RBC antibody identification; by dilution
86977	Pretreatment of serum for use in RBC antibody identification; incubation with inhibitors, each
86978	Pretreatment of serum for use in RBC antibody identification; by differential red cell absorption using patient RBCs or RBCs of known phenotype, each absorption
86985	Splitting of blood or blood products, each unit
86999	Unlisted transfusion medicine procedure

‡ Paid under Medicare Clinical Laboratory Fee Schedule

Please select the most appropriate codes for the services provided to the patient. AABB does not recommend the use of any particular procedure code for any particular patient. The patient's medical record must support all procedures on a claim form. CPT and ICD-9-CM codes should match-up and support each other to justify medical necessity. Submittal of claims using CPT or ICD-9-CM codes that are not supported by the patient's medical record is prohibited by law.

Level II HCPCS Codes for Outpatient Billing

Level II HCPCS codes are an alphanumeric group of one letter and four numbers that reflect a supply or service provided by the physician in his office or by staff in the hospital outpatient setting. Currently blood services use P codes in the hospital outpatient settings. HCPCS codes may reflect the following services:

Table 9

Level II HCPCS Code Summary of Commonly Used Codes	
Codes that begin with:	Indicate the following type of service:
A	Medical and surgical supplies and Transportation services
C†‡	Code section created for Medicare to administrate the hospital outpatient PPS and special payments for pass-through items that would not otherwise have codes
E	Durable medical equipment (DME)
J	Drugs administered other than oral method (assigned by generic name)
P	Pathology and laboratory services
Q†‡	Unique temporary codes for CMS administrative need or that is needed outside of the usual code assignment cycle
Other codes include: B, D, E, G‡, H, J, K‡, L, M, R, S‡, T, and V	
† Updated quarterly ‡ Temporary codes	

The HCPCS codes currently available for billing blood and blood products are summarized in Table 10 below.

Table 10
Current HCPCS Codes for Billing Blood and Blood Products[17,18]

HCPCS Code	Description of Codes
P9010	Blood (whole), for transfusion, per unit
P9011	Blood (split unit)
P9012	Cryoprecipitate, each unit
P9016	Red blood cells, leukocytes reduced, each unit
P9017	Fresh frozen plasma (single donor), frozen within 8 hours of collections, each unit
P9019	Platelets, each unit
P9020	Platelet rich plasma, each unit
P9021	Red blood cells, each unit
P9022	Red blood cells, washed, each unit
P9023	Plasma, pooled multiple donor, solvent/detergent treated, frozen, each unit
P9031	Platelets, leukocytes reduced, each unit
P9032	Platelets, irradiated, each unit
P9033	Platelets, leukocytes reduced, irradiated, each unit
P9034	Platelets, pheresis, each unit
P9035	Platelets, pheresis, leukocytes reduced, each unit
P9036	Platelets, pheresis, irradiated, each unit
P9037	Platelets, pheresis, leukocytes reduced, irradiated, each unit
P9038	Red blood cells, irradiated, each unit
P9039	Red blood cells, deglycerolized, each unit
P9040	Red blood cells, leukocytes reduced, irradiated, each unit
P9044	Plasma, cryoprecipitate reduced, each unit
P9050	Granulocytes, pheresis, each unit
P9051	Whole blood or red blood cells, leukoreduced, CMV-negative, each unit
P9052	Platelet, HLA-matched leukoreduced, apheresis/pheresis, each unit
P9053	Platelets, pheresis, leukocyte-reduced, CMV negative, irradiated, each unit
P9054	Whole blood or red blood cells, leukocyte reduced, frozen, deglycerol, washed, each unit
P9055	Platelet, leukoreduced, CMV-negative, apheresis/pheresis, each unit
P9056	Whole blood, leukoreduced, irradiated, each unit
P9057	Red blood cells, frozen/deglycerolized/washed, leukocyte-reduced, irradiated, each unit
P9058	Red blood cells, leukocyte-reduced, CMV negative, irradiated, each unit
P9059	Fresh frozen plasma between 8-24 hours of collection, each unit
P9060	Fresh frozen plasma, donor retested, each unit

[17] HCPCS 2007 Medicare's National Level II Codes
[18] Claims for transfused blood products in the outpatient setting must include both a CPT code for the transfusion and a HCPCS code for the blood unit.

Revenue Codes

Revenue codes identify categories of services and hospitals use these codes to group the charges for itemized hospital services. Hospital outpatient service revenue codes for blood and blood products are the same as hospital inpatient service revenue codes. For more detailed information on revenue codes, please refer to the previous section titled, "Revenue Codes in the Hospital Inpatient Setting." Please refer to Tables 3 through 6 for a list of appropriate revenue codes that capture blood and blood products, storage and processing of blood and blood products, and laboratory and pathology services associated with blood products. In addition, see Sample Claims #3 and #4 for illustrations of the use of all codes on claims, for situations when blood is considered a processing charge only and for when blood itself carries a charge.

Value Codes

Value codes are used to report the units of blood furnished, units of blood replaced, and units of blood applied to the blood deductible, only when a hospital is charged for blood (not blood processing). Value codes do not apply when blood is only charged a processing fee. Value codes used for outpatient billing are the same as for inpatient billing. For more information on value codes and to view the value codes that are specific to blood used for billing in the outpatient setting, please refer to Appendix C.

The codes listed in this guide represent possible coding options. It is always the provider's responsibility to determine and submit appropriate codes, charges, and modifiers for services that were rendered. Since local payers may have their own coding requirements, before filing any claims, providers should verify coding in writing with such payers. Submittal of claims using CPT or ICD-9-CM codes that are not supported by the patient's medical record is prohibited by law.

REIMBURSEMENT UPDATES AND HIGHLIGHTS FOR BLOOD AND BLOOD PRODUCTS

The CMS Manual System, Pub. 100-04 Medicare Claims Processing, Chapter 4 §231 - Billing and Payment for Blood and Blood Products Under the Hospital Outpatient Prospective Payment System (OPPS) provides updated guidance pertaining to proper billing and reimbursement for blood and blood products in the Medicare hospital outpatient setting. That guidance is summarized below.

Billing for Transfusions[19]

- Hospitals should bill for transfusion services using revenue code 391 (Blood Administration) and the appropriate CPT code (typically from CPTs 36430 through 36460) and the appropriate HCPCS code for the blood product. A transfusion APC will be paid to the hospital for transfusing blood once per day (per patient), regardless of the number of units transfused.
- To properly bill for transfusions of frozen blood or blood products or to bill for blood or blood products that were frozen and/or thawed prior to the transfusion, the hospital should bill the CPT transfusion code in addition to the specific HCPCS code, which describes the frozen or thawed blood product. If such HCPCS code does not exist, the provider may bill the appropriate HCPCS blood product code and a separate CPT code that describes thawing and/or freezing only (86927, 86930-86932).

Billing Storage and Processing Fees For Non-purchased Blood and Blood Products[20]

- If a hospital obtains blood, or blood products from a community blood bank and it is only charged a processing and storage fee, or runs its own blood bank for which only storage and processing fees are charged, it would not be appropriate to bill for a blood bank storage and processing fee in revenue code 0390 and an additional blood charge in revenue code series 038X. It would only be appropriate to bill for the blood storage and processing charge in revenue code 0390. However, the hospital may also bill the laboratory revenue codes (030x or 031x) along with HCPCS codes for blood typing and cross-matching and other laboratory services related to the patient who receives the blood.

When To Use The BL Modifier[21]

- If a hospital provider pays for the actual blood or blood product itself obtained from a community blood bank, or collects the blood or blood product in the provider's own blood bank and also assesses a charge for the blood, in addition to paying for processing and storage costs, the provider must separate the charge for the unit(s) of blood or blood product(s) from the charge for processing and storage services.
- The provider reports charges for the blood or blood product itself using Revenue code series 038X with the line item date of service (LIDOS), the number of units transfused, and the appropriate blood product HCPCS code and HCPCS modifier BL.
- The provider must also report charges for processing and storage services on a separate line using Revenue code 0390 or 0399 with the LIDOS, the number of units transfused, and the appropriate blood HCPCS code and HCPCS modifier BL.
- CMS's instructions summarize that whenever a provider reports a charge for blood or blood products using Revenue Code 038X, the provider must also report a charge for processing and storage services on a separate line using Revenue Code 0390 or 0399. Further, the same LIDOS, the same number of units, the same HCPCS code, and HCPCS modifier BL must be reported on both lines. (See sample claim #4)
- Effective for services furnished on or after July 1, 2005, the Outpatient Code Editor (OCE) will return to providers any claim that reports a charge for blood or blood products using Revenue Code 038X without a

[19] Medicare Claims Processing Manual, Chapter 4, §231.8, §231.6
[20] Medicare Claims Processing Manual, Chapter 4, §231.1
[21] Medicare Claims Processing Manual, Chapter 4, §231.2

separate line for processing and storage services using Revenue Code 0390 or 0399. In order to process payment, both lines must report the same line item date of service, the same number of units, and the same HCPCS code accompanied by modifier BL.

Autologous Blood and Directed Donor Blood Billing[22]

- Hospitals should use the appropriate transfusion and blood product codes to bill for autologous blood (including salvaged blood) and directed donor blood. The date of service should reflect the date of transfusion and not the date of blood collection. Additionally, the hospital can bill 86890 (autologous blood or component, collection, processing, and storage; predeposited) or 86891 (autologous blood or component, collection, processing and storage; intra-or postoperative salvage) when the autologous blood or blood component has been collected and not transfused. A provider should bill 86890 or 86891 on the date it is certain the blood will not be transfused (i.e., date of a procedure or date of outpatient discharge), rather than on the date of the product's collection or receipt from the supplier.
- CPT code 86891 could be used in the inpatient setting only. However, many hospitals contract this service to perfusionists and would be included in the contract price for bundled "intra- or postoperative salvage" services. Those hospitals that perform autologous cell salvage with Transfusion Services personnel also usually bundle all charges in their Chargemaster (CDM) code.
- Although *Medicare Claims Processing, Chapter 4 §231* does not address autologous platelet-rich plasma (PRP) fibrin glue, Medicare does not currently pay for autologous platelet-rich plasma (PRP) fibrin glue collections/processes for skin applications. Refer to Appendix G for additional information on this item.

Billing for Split Unit of Blood[23]

- CMS provided instructions on billing for split units transfused to patients in the outpatient setting. CMS directed hospitals to report charges for split units with HCPCS code P9011 (Blood, split unit), as well as CPT 86985 (Splitting of blood or blood products, each [whole] unit), each time the procedure is performed. However, the last aliquot remaining from a component that has been split several times cannot have a P9011 code as it is considered an "unsplit" aliquot.

Billing for Apheresis Services[24]

- Apheresis and Pheresis services should be billed on a per patient per visit (per day) basis. Billing an E&M CPT code in addition to an apheresis service may be appropriate only when the E&M code is a separately identifiable service performed which involves more than the evaluation and management portion of the apheresis service. (An E&M service must involve a different diagnosis than the diagnosis for which the apheresis is being performed.) In this case the E&M code would be billed with a 25 modifier (Significant, separately identifiable evaluation and management service by the same physician on the same day of a procedure or other service).

Billing for Unused Blood[25]

- Medicare does not reimburse for unused blood nor can the beneficiary be billed for unused blood. However, a provider may bill for medically necessary lab tests like blood typing and cross-matching under revenue codes 30X or 31X. Additionally, the hospital should report unused blood costs in it's Medicare Cost Report.

[22] Medicare Claims Processing Manual, Chapter 4, §231.3
[23] Medicare Claims Processing Manual, Chapter 4, §231.4
[24] Medicare Claims Processing Manual, Chapter 4, §231.9
[25] Medicare Claims Processing Manual, Chapter 4, §231.7

Billing for Frozen and Thawed Blood and Blood Products[26]

- To properly bill for transfusions of frozen blood or blood products or to bill for blood or blood products that were frozen and/or thawed prior to the transfusion, the hospital should bill the CPT transfusion code in addition to the specific HCPCS code, which describes the frozen or thawed blood product. If such HCPCS code does not exist, the provider may bill the appropriate HCPCS blood product code and a separate CPT code that describes thawing and/or freezing only (86927, 86930-86932).
  CMS clarified for the AABB products that are considered to include both freezing and thawing and for which hospitals cannot also bill CPT codes for freezing and thawing. Table 11 defines which products allow for separately billing the freezing and thawing.

Billing for Irradiation of Blood Products[27]

- Irradiated blood must be medically necessary and billed using the appropriate irradiated blood product code. If the irradiated blood product does not have a specific irradiated blood product code then the provider may bill a blood product code in addition to CPT code 86845 (irradiation of blood product).

[26] Medicare Claims Processing Manual, Chapter 4, §231.6
[27] Medicare Claims Processing Manual, Chapter 4, §231.5

Table 11[28]
Billable Freezing/Thawing Codes

HCPCS/CPT	Short Descriptor	Billing of Freezing/Thawing
P9010	Whole blood for transfusion	Freezing and thawing are separately billable
P9011	Blood split unit	Freezing and thawing are separately billable
P9012	Cryoprecipitate each unit	**Freezing and thawing codes not separately billable**
P9016	RBC leukocytes reduced	Alternative P-code for frozen/thawed product available
P9017	Plasma 1 donor frz w/in 8 hr	**Freezing and thawing codes not separately billable**
P9019	Platelets, each unit	Concept not applicable
P9020	Platelet rich plasma unit	Concept not applicable
P9021	Red blood cells unit	Alternative P-code for frozen/thawed product available
P9022	Washed red blood cells unit	Freezing and thawing are separately billable
P9023	Frozen plasma, pooled, s/d	**Freezing and thawing codes not separately billable**
P9031	Platelets leukocytes reduced	Concept not applicable
P9032	Platelets, irradiated	Concept not applicable
P9033	Platelets, leukoreduced irrad	Concept not applicable
P9034	Platelets, pheresis	Concept not applicable
P9035	Platelet pheres leukoreduced	Concept not applicable
P9036	Platelet pheresis irradiated	Concept not applicable
P9037	Platelet pheresis l/r irradiated	Concept not applicable
P9038	RBC irradiated	Freezing and thawing are separately billable
P9039	RBC deglycerolized	**Freezing and thawing codes not separately billable**
P9040	RBC leukoreduced irradiated	Alternative P-code for frozen/thawed product available
P9041	Albumin (human), 5%, 50 ml	Concept not applicable
P9043	Plasma protein fract, 5%, 50 ml	Concept not applicable
P9044	Cryoprecipitate reduced plasma	**Freezing and thawing codes not separately billable**
P9048	Plasma protein fract, 5%, 250 ml	Concept not applicable
P9050	Granulocytes, pheresis unit	Concept not applicable
P9051	Blood, l/r, cmv neg	Freezing and thawing are separately billable

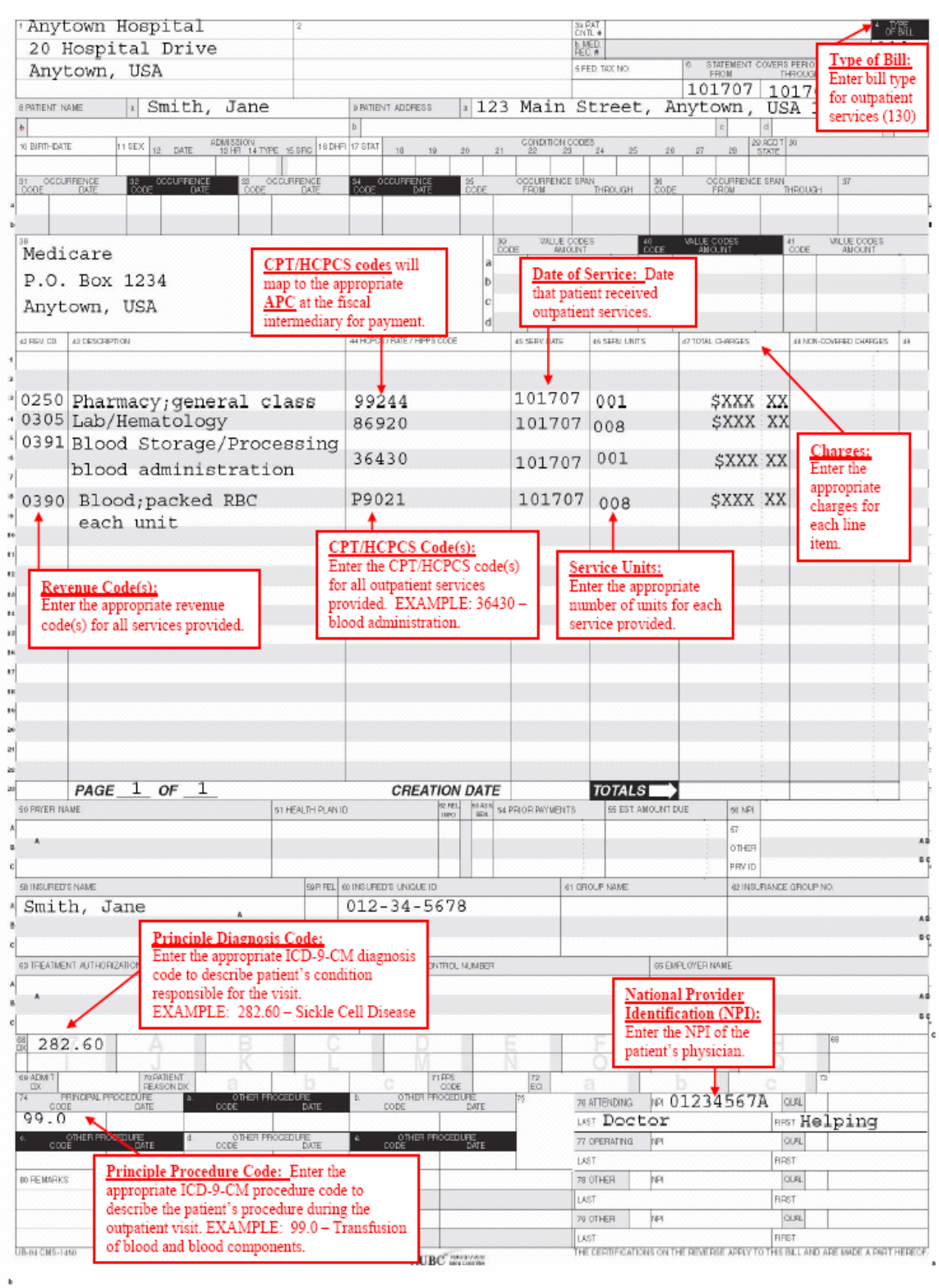
[28] CMS Letter from Elizabeth Richter, Director, Hospital and Ambulatory Policy Group, Centers for Medicare Management, to Theresa Wiegmann, AABB, received September 29, 2006.

Table 11 (Continued)[29]
Billable Freezing/Thawing Codes

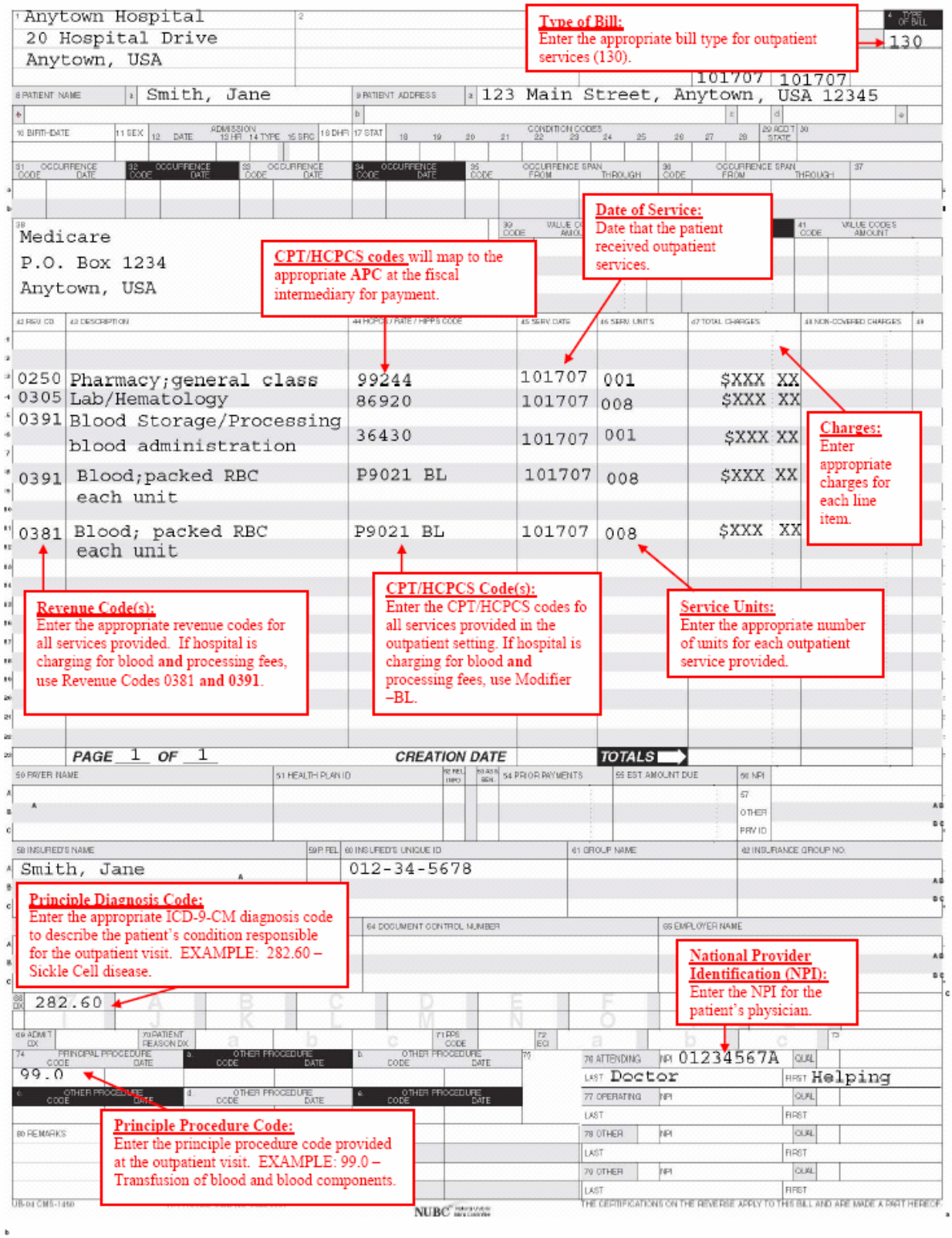
HCPCS/CPT	Short Descriptor	Billing of Freezing/Thawing
P9052	Platelets, hla-m, l/r, unit	Concept not applicable
P9053	Plt, pher, l/r, cmv-neg, irr	Concept not applicable
P9054	Blood, l/r, froz/degly/wash	**Freezing and thawing codes not separately billable**
P9055	Plt, aph/pher, l/r, cmv-neg	Concept not applicable
P9056	Blood, l/r, irradiated	Freezing and thawing are separately billable
P9057	RBC, frz/deg/wsh, l/t, irrad	**Freezing and thawing codes not separately billable**
P9058	RBC, l/r, cmv-neg, irrad	Freezing and thawing are separately billable
P9059	Plasma,frz between 8-24 hour	**Freezing and thawing codes not separately billable**
P9060	FR fz plasma donor retested	**Freezing and thawing codes not separately billable**

[29] CMS Letter from Elizabeth Richter, Director, Hospital and Ambulatory Policy Group, Centers for Medicare Management, to Theresa Wiegmann, AABB, received September 29, 2006.

Sample 3: UB-04 Claim Form
For Hospital Outpatient Services When the
Hospital Charges for Blood Processing Only



Sample 4: UB-04 Claim Form
For Hospital Outpatient Services When
Hospitals Charge for the Blood Itself



VI. BILLING FOR BLOOD DERIVATIVES, TISSUE AND BONE

- **Blood Derivatives**

The hospital provider blood bank/transfusion service, rather than the hospital pharmacy, may be responsible for storing and issuing blood derivatives. Billing for these blood products under the Hospital Outpatient Prospective Payment System (HOPPS) is similar to procedures for billing other blood components using CPT Level I or HCPCS Level II codes.

However, the Revenue Codes will be either 0250 (General Pharmacy) for Varicella Zoster Immune Globulin (VZIG), Rh Immune Globulin (RhIG) and Albumin, or 0636 (Pharmacy-Drugs Requiring Detailed Coding) for clotting factors.

Procedure Codes should be utilized when billing certain derivatives. The CPT and HCPCS product, and procedure codes (usually billed by nursing unit), currently available for billing blood derivatives are summarized in Table 12.

The codes listed in this Guide represent possible coding options. It is always the provider's responsibility to determine and submit appropriate codes. Providers should always refer to official coding manuals to address specific questions and select the proper code.

Table 12[30,31]

Current CPT and HCPCS Codes for Billing Blood Derivatives (Effective January 1, 2007)

HCPCS Code	Revenue Code	Description of Codes	Comments[32]
J2788	0250	Injection, Rho D immune globulin, human, minidose, 50 mcg (RhoGam, BAYRho-D, HYPRho-D, MICRhoGAM Ultra-Filtered)	Generally required by Medicare and some state Medicaid programs. We recommend you consult your payers. Paid under OPPS with a separate APC payment
90385	0250	Rho(D) immune globulin (Rhlg), human, minidose, for intramuscular use	Generally required for non-Medicare/MD office**.**
J2790	0250	Injection, Rho D immune globulin, human, full dose, 300 mcg (Gammulin RH, HypRho-D, BayRho-D, RhoGam, Rhophylac)	Paid under OPPS with a separate APC payment Generally required by Medicare and some state Medicaid programs. We recommend you consult your payers.

[30] HCPCS 2007 Medicare's National Level II Codes.
[31] Current Procedural Terminology. CPT® 2007 American Medical Association. All rights reserved.
[32] CMS OPPS Final Rule 2007 Addendum B.

Table 12 (Continued)

HCPCS Code	Revenue Code	Description of Codes	Comments[33]
90384	0250	Rho(D) immune globulin, (Rhlg), human, full-dose, for intramuscular use	Generally required for non-Medicare/MD office.
J7187	0636	Injection, von Willebrand Factor complex, human, ristocetin cofactor, per IU VWF:RCO	
J7189	0636	Factor VIIa (antihemophilic factor, recombinant), per 1 mcg (NovoSeven)	Paid under OPPS with a separate APC payment
J7190	0636	Factor VIII (antihemophilic factor, human), per IU (Monarc-M, Koate-HP, Alphanate, Hemophil-M, Koate-DVI, Kogenate, Monoclate-P)	Paid under OPPS with a separate APC payment
J7191	0636	Factor VIII (antihemophilic factor, porcine), per IU (Hyate:C)	Paid under OPPS with a separate APC payment
J7192	0636	Factor VIII (antihemophilic factor, recombinant), per IU (Recombinate, Kogenate, Bioclate, Hexilate, Advate rAHF-PFM, Antihemophilic Factor Human Method M Monoclonal Purified, Genarc, Refacto)	Paid under OPPS with a separate APC payment
J7193	0636	Factor IX (antihemophilic factor, purified, non-recombinant), per IU (Alphanine SD, Mononine)	Paid under OPPS with a separate APC payment
J7194	0636	Factor IX complex, per IU (Konyne-80, Profilnine Heat-Treated, Proplex T, Proplex SX-T, Alphanine SD, Bebulin VH, factor IX+ complex, Profilnine SD)	Paid under OPPS with a separate APC payment
J7195	0636	Factor IX (antihemophilic factor, recombinant), per IU (Benefix, Konyne 80, Proplex T)	Paid under OPPS with a separate APC payment
J7197	0636	Antithrombin III (human), per IU (Thrombate III, ATnativ)	Paid under OPPS with a separate APC payment
J7198	0636	Antiinhibitor, per IU (Autoplex T, FEIBA IMMUNO/VH AICC)	Paid under OPPS with a separate APC payment
J7199	0636	Hemophilia clotting factor, not otherwise classified	Generally required for non-Medicare/MD office

[33] CMS OPPS Final Rule 2007 Addendum B.

Table 12 (Continued)

HCPCS Code	Revenue Code	Description of Codes	Comments[34]
P9041	0250	Infusion, albumin (human), 5%, 50 mL	Paid under OPPS with a separate APC payment
P9043	0250	Infusion, plasma protein fraction (human), 5%, 50 mL	Paid under OPPS with a separate APC payment
P9045	0250	Infusion, albumin (human), 5%, 250 mL	Paid under OPPS with a separate APC payment
P9046	0250	Infusion, albumin (human), 25%, 20mL	Paid under OPPS with a separate APC payment
P9047	0250	Infusion, albumin (human), 25%, 50 mL	Paid under OPPS with a separate APC payment
P9048	0250	Infusion, plasma protein fraction (human), 5%, 250 mL	Paid under OPPS with a separate APC payment
90765	Specific codes available depending on location of services	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour	Medicare and some private payers will not pay 90765-90774 in addition to an office visit on the same day. Cannot be reported without direct physician supervision. Medicare payment guidelines allow payment of the drug and the office visit, but not the injection procedure. [Medicare Claims Processing Manual, Chapter 12, Sec. 20.3B]
90766		Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); each additional hour, (List separately in addition to code for primary procedure	
90772		Therapeutic, prophylactic or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	
90774		Therapeutic, prophylactic or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug	
99211-99215		Office visit (depending on service rendered)	

[34] CMS OPPS Final Rule 2007 Addendum B.

Table 13
Current ICD-9-CM Diagnosis Codes for Billing Blood Derivatives[35]

ICD-9-CM Code	Description of Codes
286	Coagulation Defects
286.0	Congenital Factor VIII disorder
286.1	Congenital Factor IX disorder
286.2	Congenital Factor XI deficiency
286.3	Congenital deficiency of other clotting factors
286.4	von Willebrand disease
286.5	Hemorrhagic disorder due to intrinsic circulating anticoagulants
286.6	Defibrination syndrome
286.7	Acquired coagulation factor deficiency
656	Other fetal and placental problems affecting management of mother
656.1	Rhesus isoimmunization Anti-D [Rh] antibodies RH incompatibility
999.7	Rh incompatibility reaction

Table 14[35]
ICD-9-CM Procedure Codes

Code	Description of Code
99.11	Injection of Rh immune globulin

[35] International Classification of Diseases, ICD-9-CM 2007, Volumes 1, 2 and 3. Ninth Revision, Clinical Modification

- **Tissue (non-bone marrow related)**

The hospital blood bank/transfusion service may be responsible for receiving, storing and issuing non-bone marrow related tissue. Hospital surgery departments have traditionally maintained oversight of autologous and purchased allogeneic/xenogeneic tissue.

Recently, the Food and Drug Administration (FDA) issued regulations addressing Current Good Tissue Practices (cGTP) and the Joint Commission for Accreditation of Healthcare Organizations (the Joint Commission) issued standards regarding tissue.

Due to increased scrutiny by such regulatory and accrediting organizations, several hospital providers have moved quality oversight of these tissues to the blood bank/transfusion service. Activities vary from purchasing, and/or storing, and distributing lyophilized and/or frozen (liquid nitrogen and/or ultra-low) tissue.

Billing for such tissue will depend on which component of the activities associated with the tissue oversight is handled by the blood bank/transfusion services, and which are maintained by the surgery department. Specific HCPCs codes are not currently well developed for many of these tissue services as the services are bundled into the appropriate surgical CPT procedure code related to the tissue implant. Revenue Codes used for tissue bank services include the following (except for corneas, see page 40):

Table 15
Current Revenue Codes for Billing Bone and Tissue[36]

Revenue Code	Description of Codes
0810	Acquisition of Body Components-General
0811	Acquisition of Body Components-Living Donor
0812	Acquisition of Body Components-Cadaver Donor
0813	Acquisition of Body Components-Unknown Donor
0814	Acquisition of Body Components-Unsuccessful organ search-donor bank charges
0819	Acquisition of Body Components-Other donor

- **Skin Grafts**

Allogeneic and xenogeneic skin substitutes have specific CPT codes for physician application services designating both site of use and size of allograft (15300-15431). Purchased skin is coded using HCPCS codes. Table 15 summarizes these codes for purchased skin products.

[36] National Uniform Billing Committee Official UB-04 Specifications Manual 2007 Version 1.0. Revenue code descriptions are issued by the National Uniform Billing Committee (NUBC); some terminology used in code descriptions may not reflect current clinical practices or terminology.

Table 16[37]

Current HCPCS Codes Available for Allogeneic/Xenogeneic Skin Grafts (effective January 1, 2006)

CPT Code	Description of Codes
J7340	Dermal and epidermal, (substitute) tissue of human origin, with or without bioengineered or processed elements, with metabolically active elements, per square centimeter (Apligraf, Orcel, TransCyte)
J7341	Dermal (substitute) tissue of non-human origin, with or without other bioengineered or processed elements, with metabolically active elements, per square centimeter
J7342	Dermal (substitute) tissue of human origin, with or without other bioengineered or processed elements, with metabolically active elements, per square centimeter (Dermagraft, Dermagraft TC)
J7343	Dermal and epidermal, (substitute) tissue of non-human origin, with or without other bioengineered or processed elements, without metabolically active elements, per square centimeter (Integra)
J7344	Dermal (substitute) tissue of human origin, with or without other bioengineered or processed elements, without metabolically active elements, per square centimeter (AlloDerm)
J7345	Dermal (substitute) tissue of non-human origin, with or without other bioengineered or processed elements, without metabolically active elements, per square centimeter
J7346	Dermal (substitute) tissue of human origin, injectable, with or without other bioengineered or processed elements, but without metabolically active elements, 1 cc

- **Bone/Soft Tissue**

The hospital blood bank/transfusion service may also be involved in the oversight of current good tissue practices (cGTP) for autologous and/or purchased bone and soft tissue material (frozen or room temperature storage).

Currently there are no bone-specific CPT or HCPCs codes to utilize in billing these materials. The bone material is bundled into the specific DRG surgery procedure CPT code. Therefore, billing for these services will usually be the responsibility of surgery or Operating Room personnel/nursing.

In most cases where the blood bank/transfusion service is receiving, testing (culture for autologous bone), storing, and issuing, there will be no coding responsibility. Internal hospital budgetary arrangements may be made between the parties purchasing allogeneic bone and managing the bone as to "revenue reimbursement" for services rendered.

For soft tissue such as human connective tissue (including fascia lata), there is currently only one HCPCs code available for use (C1762- Connective tissue, human (including fascia lata)). For non-human

[37] HCPCS 2007 Medicare's National Level II Codes

material (including synthetic), use HCPCs code C1763 (Connective tissue, non-human (includes synthetic)).

- **Corneas**

Billing for corneal tissue for transplant differs from that of other tissue. Medicare payment for hospital outpatient departments provides for a payment separate from the corneal transplant surgical procedure; instead, the payment is based on the hospital's "reasonable costs" incurred to acquire corneal tissue. It is commonly referred to as a "pass through," as the actual cost to acquire the corneal tissue for surgical transplant is reimbursed.

The HCPCS code is V2785. A table follows.

Table 17
Current Revenue Code for Billing Corneas

Revenue Code	Description of Codes
V2785	Cornea

VII. REIMBURSEMENT FOR BLOOD PRODUCTS AND SERVICES: PHYSICIAN OFFICES AND CLINICS

The most appropriate CPT codes for blood transfusions and other common blood-related procedures that physicians may use to report services on the CMS-1500 form are included in Table 8.

Physicians use the CMS-1500 claim form to report their work in all settings of care. Claims for physician services must be billed with the appropriate CPT code to describe the service. Medicare compensates physicians for their professional services and those payments may be made to the physician directly or to another entity where the physician has entered an assignment agreement, whereas private insurers may group physician services with the hospital payment. In most cases, private insurers will reimburse physicians for the professional component of the procedure as well for physician services rendered in the hospital outpatient or hospital inpatient settings.

Medicare and some private insurers reimburse physicians for inpatient and outpatient care according to a **resource-based relative value scale (RBRVS)** fee schedule. Each CPT code has a fee associated with it that is based on the physician work, practice expenses, and liability costs required for that particular service the physician performs, and it is adjusted for the geographic variations associated with medical practice.

Some procedures that have been modified but not changed in their description are identified with modifiers. For example, if a service involves equipment, it may be identified with a modifier to show the technical component where an actual service/test is performed, and then a professional component to show the interpretation of the service/test performed.

Physicians may bill globally for services when provided in their office or may submit a claim only for the professional component of services provided in other settings.

Physicians may enter into contracts—sometimes referred to as *assignment agreements*—with Medicare-enrolled entities (such as hospitals) to perform transfusions in settings other than their own offices. As noted above, previously these physicians could only submit claims for the professional component of their services. However, a more recent instruction from the Medicare program found in the Medicare claims Processing Manual Chapter 1 section 30.2.7 Payment for Services Provided Under a Contractual Arrangement – Carrier Claims Only (available online at http://www.cms.hhs.gov/manuals/downloads/clm104c01.pdf), now allows physicians to bill globally – for both the technical and professional components of transfusion services – where the physician has a contractual agreement with an entity enrolled in the Medicare program.

Private insurers and Medicaid also may use a percent of allowable charges or negotiated rates to reimburse for physician services. The allowable charge is the maximum amount an insurer will allow when paying for a specified supply or service. Typically, the allowed amount is the lower of the provider's submitted charge or the payer's own maximum fee schedule amount. If the payer does not have a fee schedule, the allowed charge usually is set at some percentage of the provider's submitted charge. A negotiated rate is insurer specific.

Blood Costs Versus Blood Processing Costs Under Medicare Part B (Physician Services)[38]

The charges for blood and charges for blood administration under Medicare Part B must be considered separately, and the charges should be broken down in accordance with the supplier's customary charges for the blood. For example, if the supplier does not customarily bill separately for blood and blood administration, the blood charge is determined by reference to the "established reasonable charge in the locality as it applies to blood," and the rest of the charge is considered the blood administration charge.

[38] Medicare General Information, Eligibility, and Entitlement Manual (MGIM), Chapter 3, §20-5.4.1, "Part B Deductible," available for download at http://www.cms.hhs.gov/manuals/downloads/ge101c03.pdf. This section was last revised August 12, 2005.

VIII. Reimbursement And Coding for Apheresis and HPC and BMT Services

In 2003, the CPT editorial panel approved 18 new or revised bone marrow transplant (BMT) and apheresis codes. As a result, billing to non-governmental payers would be appropriate with the new codes.

CMS accepted the Relative Value Scale Update Committee's (RUC) recommendations for relative value units (RVUs) for Tissue (non-bone marrow related): the new apheresis codes (36511-36516, 38205-38206) and one infusion code (38242). However, until recently, CMS did not approve all of the cell processing codes (38207-38215) and CMS still has not approved the unrelated donor searches code (38204).

Recently, CMS recognized cell processing codes 38207-38215 for facility compensation and will pay for these processing services under the hospital outpatient prospective payment system in 2008. These codes may be billed daily for each use. Non-governmental payers may be billed for professional services. However, CMS' payment does not include physician services, but the cellular therapy community will continue to engage CMS in discussions regarding the RVUs attached to these codes for compensation.

CMS has concluded that for code 38204, the donor search is already reimbursed under another service (38240). Therefore, there is no separate APC payment for this service. Codes 38205 and 38230 should not be used to bill invoicing of the National Marrow Donor Program or other donor registry provision of allogeneic progenitor cells or bone marrow. These codes should only be used for collection for related family donors. Codes for cell processing (38207-38215) can be used for cell processing required after a product is collected and transferred to the center in which it will be transplanted. The codes listed in Table 18 should be billed under the CPT code and CMS has proposed that in 2008 these procedures will be paid under APCs. CMS has proposed in 2008 to pay for codes 38207-38209 under APC 0110.[39] After these APCs are used, CMS should collect better cost data which will be used to adjust APC payment levels for these procedures. Facilities are strongly encouraged to use the new codes (38207-38215) so that CMS can collect accurate data on which future payments will be based. CMS Transmittal 1143, issued December 22, 2006, listed the relative values for the non-covered codes thus making the RVUs available for private payers' consideration.

Table 18
Relative Value Units BMT

Code	Relative Value Unit (RVU)
38204	Transitional Non-Facility PE RVU = 0.91 Fully Implemented Non-Facility PE RVU = 0.91 **(Informational Only)** Transitional Facility PE RVU = 0.91 Fully Implemented Facility PE RVU = 0.91 **(Informational Only)**
38207	WRVU = 0.89 Transitional Non-Facility PE RVU = 0.41

[39] Federal Register, August 2, 2007, pages 42728-43129. CMS-1392-P. Proposed Changes to the Hospital Outpatient Prospective Payment System and CY 2008 Rates.

	Fully Implemented Non-Facility PE RVU = 0.41 **(Informational Only)** Transitional Facility PE RVU = 0.41 Fully Implemented Facility PE RVU = 0.41 **(Informational Only)**
38208	Transitional Non-Facility PE RVU = 0.25 Fully Implemented Non-Facility PE RVU = 0.25 **(Informational Only)** Transitional Facility PE RVU = 0.25 Fully Implemented Facility PE RVU = 0.25 **(Informational Only)**
38209	Transitional Non-Facility PE RVU = 0.11 Fully Implemented Non-Facility PE RVU = 0.11 **(Informational Only)** Transitional Facility PE RVU = 0.11 Fully Implemented Facility PE RVU = 0.11 **(Informational Only)**
38210	WRVU = 1.57 Transitional Non-Facility PE RVU = 0.72 Fully Implemented Non-Facility PE RVU = 0.72 **(Informational Only)** Transitional Facility PE RVU = 0.72 Fully Implemented Facility PE RVU = 0.72 **(Informational Only)**
38211	WRVU = 1.42 Transitional Non-Facility PE RVU = 0.65 Fully Implemented Non-Facility PE RVU = 0.65 **(Informational Only)** Transitional Facility PE RVU = 0.65 Fully Implemented Facility PE RVU = 0.65 **(Informational Only)**
38212	WRVU = 0.94 Transitional Non-Facility PE RVU = 0.43 Fully Implemented Non-Facility PE RVU = 0.43 **(Informational Only)** Transitional Facility PE RVU = 0.43 Fully Implemented Facility PE RVU = 0.43 **(Informational Only)**
38213	Transitional Non-Facility PE RVU = 0.11 Fully Implemented Non-Facility PE RVU = 0.11 **(Informational Only)** Transitional Facility PE RVU = 0.11 Fully Implemented Facility PE RVU = 0.11 **(Informational Only)**
38214	WRVU = 0.81 Transitional Non-Facility PE RVU = 0.37 Fully Implemented Non-Facility PE RVU = 0.37 **(Informational Only)** Transitional Facility PE RVU = 0.37 Fully Implemented Facility PE RVU = 0.37 **(Informational Only)**
38215	WRVU = 0.94 Transitional Non-Facility PE RVU = 0.43 Fully Implemented Non-Facility PE RVU = 0.43 **(Informational Only)**

	Transitional Facility PE RVU = 0.43 Fully Implemented Facility PE RVU = 0.43 **(Informational Only)**

- **Apheresis Services**

Therapeutic apheresis has been split into several distinct services with new codes 36511-36516 (See Table 20). Apheresis services (36511-36516) and photopheresis (36522) are currently reimbursed under OPPS with a separate APC payment. These services are bundled under APCs 0111 and 0112, as indicated in Table 20. The procedures only require that the physician be available during the apheresis procedure (e.g., physician must be on hospital grounds) and not in direct supervision. There must be some documentation of supervision, but to bill a professional fee, the physician does not need to be the individual performing the procedure. The patient's medical record should clearly reflect the physician's availability in the facility during the apheresis service.

An evaluation and management (E&M) code in addition to an apheresis service may be appropriate only when the E&M code is a separately identifiable service and a separately identified management of a medical problem performed, which involves more than the evaluation and management portion of the apheresis service. In this case, the E&M code would be billed with a 25 modifier (significant, separately identifiable evaluation and management service by the same physician on the same day of a procedure or other service).[40]

For example, if photopheresis is done for management of graft versus host disease (GVHD), and E&M service cannot be provided the same day for management of GVHD, but an E&M service can be done for management of diabetes induced by steroid therapy of GVHD or management of complications of immunosuppression.

The new and old apheresis codes are compared in Table 19.

[40] Medicare Claims Processing Manual, Chapter 4, §231.9.

Table 19[40]
Apheresis Codes

Old Codes		New Codes	
36520*	Therapeutic apheresis; plasma and/or Cell exchange	36511	Apheresis for leukapheresis
		36512	Apheresis for red cell exchange
		36513	Apheresis for platelet pheresis
		36514	Apheresis for plasma pheresis
36521*	Therapeutic apheresis; with extracorporeal affinity	36515	Apheresis for plasma pheresis with extracorporeal immunoabsortion and plasma reinfusion
		36516	Apheresis for plasma pheresis with extracorporeal selected filtration and plasma reinfusion

* Deleted Code

Table 20[40]
APCs for Apheresis

CPT Code	Description of Codes	APC
36511	Therapeutic apheresis; for white blood cells	0111
36512	Therapeutic apheresis; for red blood cells	
36513	Therapeutic apheresis; for platelets	
38205	Blood-derived hematopoietic progenitor cell harvesting for transplantation, per collection; allogeneic	
38206	Blood-derived hematopoietic progenitor cell harvesting for transplantation, per collection; autologous	
36514	Therapeutic apheresis; for plasma pheresis	
36515	Therapeutic apheresis; with extracorporeal immunoadsorption and plasma reinfusion	0112
36516	Therapeutic apheresis; with extracorporeal selective adsorption or selective filtration and plasma reinfusion	
36522	Photopheresis, extracorporeal	

[40] Current Procedural Terminology. CPT® 2007 American Medical Association. All rights reserved.

Table 21[41]

Revenue Codes Commonly Used with Apheresis Services

Revenue Code	Description of Codes
300	Laboratory – General Classification
309	Other Laboratory
510	Clinic - General Classification
519	Other Clinic
390	Blood Storage and Processing –General
392	Blood Processing and Storage
280	Oncology- General Classification
289	Other Oncology
940	Other Therapeutic Services –General Classification
949	Other Therapeutic Services

- **Unrelated Donor Search and Hematopoietic Progenitor Cell Acquisition**

A new code (38204) was created to report the management involved and physician supervision in carrying out an unrelated donor search to locate a suitable and matching donor. In the past this service was not billed by providers due to a lack of code or the service was coded under an unlisted hemic or lymphatic system code (38999).

Code 38204 is intended to be used only once per search, regardless of the outcome of the transplant. The medical records should reflect the physician's participation and work effort in reviewing the donor search and donor selection as well as the negotiations with the appropriate collection center for the service.

Currently, Medicare does not reimburse for code 38204. CMS rejected the AMA's Specialty Society RVS Update Committee's (RUC) recommendations and stated that the service was reimbursed under the infusion code 38240. See Table 18 for Relative Value units for code 38204. Services using a donor registry should be billed under 38299 with explanation.

- **Allogeneic and Autologous Peripheral Hematopoietic Cell Collection**

Allogeneic and autologous peripheral blood stem cell collection by apheresis (38205-38206) should be billed on a once per day (per patient) basis. Additionally, the code does not require the physician in the room for the entire procedure but he or she must examine the patient during the procedure, demonstrate active supervision of the procedure and be available on site (hospital or blood center) for the entirety of the procedure. 38205 should not be used for an unrelated peripheral blood stem cell harvest when the harvest is done through a registry at another institution.

[41] National Uniform Billing Committee Official UB-04 Specifications Manual 2007, Version 1.0.

An E&M visit code may be billed on the same day of the apheresis service if it extends beyond the scope of the evaluation and management of the apheresis service. Billing a modifier 25 would be appropriate in this case. Currently, Medicare reimburses 38205-38206 under OPPS with a separate APC payment. (See Table 20 for APCs.)

Table 22[42]
Stem Cell Collection Codes

Old Code		New Codes	
38231	Blood-derived peripheral stem cell harvesting for transplantation, per collection	38205	Allogenic peripheral blood progenitor cell collection
		38206	Autologous peripheral blood progenitor cell collection

Insurers review claims for HPC harvesting to confirm the presence of a diagnosis for which both the harvesting and transplantation procedures are "reasonable and necessary." A claim for outpatient stem cell harvesting should identify the diagnosis (e.g., the aplastic anemia, leukemia or other ICD-9-CM coded condition) for which the transplantation is intended. This should be done for allogeneic, as well as autologous donations.

- **Cell-Processing (Cryopreservation, Freezing, Thawing, Storage and Processing)**

In 2003, the CPT Editorial Panel approved codes 38207-38215 for bone marrow or stem cell services and procedures. These codes describe numerous steps in the harvesting and transplantation of cells. However, due to CMS's concerns about the amount of physician work involved in the above codes, Medicare does not currently recognize these codes in the physician fee schedule. (See Table 18)

Codes 88240 (Cryopreservation, freezing, and storage of cells, each cell line) and 88241 (Thawing and expansion of frozen cells, each aliquot) can be used to bill for services related to the harvesting and transplantation of cells for diagnostic purposes.

[42] Current Procedural Terminology. CPT® 2007 American Medical Association. All rights reserved.

Table 23[43]
Cell Processing Codes

Old Codes		New Codes	
88240	Cryopreservation, freezing, and storage of cells, each cell line	38207	Transplant preparation of hematopoietic progenitor cells; cryopreservation and storage
88241	Thawing and expansion of frozen cells, each aliquot	38208	Transplant preparation of hematopoietic progenitor cells, thawing of previously frozen harvest, without washing
		38209	Transplant preparation of hematopoietic progenitor cells, thawing of a previously frozen harvest; with washing
86915*	Modification, treatment and processing of bone marrow or blood-derived stem cell for transplantation	38210	Transplant preparation of hematopoietic progenitor cells; specific cell depletion within a harvest; T-cell deletion
		38211	Transplant preparation of hematopoietic progenitor cells; tumor cell depletion
		38212	Transplant preparation of hematopoietic progenitor cells; red blood cell removal
		38213	Transplant preparation of hematopoietic progenitor cells; platelet depletion
		38214	Transplant preparation of hematopoietic progenitor cells; plasma (volume) depletion
		38215	Transplant preparation of hematopoietic progenitor cells; cell concentration in plasma, mononuclear, or buffy coat layer

* Deleted Code

[43] Current Procedural Terminology. CPT® 2007 American Medical Association. All rights reserved.

APPENDIX A: FUNDAMENTALS OF CODING – ICD-9-CM, CPT, HCPCS, REVENUE CODES, AND EDITS

Coding systems provide a uniform language for describing medical and surgical services and patient conditions. Proper coding of any procedure, using the five major coding systems described below, is necessary to secure appropriate Medicare reimbursement:

- Current Procedural Terminology (CPT)[44]
- Healthcare Common Procedure Coding System (HCPCS)
- International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) diagnosis codes
- ICD-9-CM procedure codes
- Revenue Codes

Table 11 and Table 12 summarize the coding systems relevant to blood and blood products used on Medicare claim forms.

Table 24
Description of Coding Systems

Coding System	Description
CPT (HCPCS Level I)	Physician services (and some supplies) in all settings; Medicare hospital outpatient services.
HCPCS (Levels II & III)	Supplies, devices, and drugs not described by a CPT code (often starts with a letter such as C, G, or A)
ICD-9-CM Diagnosis	Patient diagnoses in all settings.
ICD-9-CM Procedure	Patient procedures only in hospital inpatient setting
Revenue Code	Used on facility claim forms for cost-center reporting

Table 25
Appropriate Coding Systems for Claim Forms

Insurance Claim Item	Hospital Inpatient Services	Hospital Outpatient Services	Physician Services
Claim Form	• CMS 1450 (UB-04)	• CMS 1450 (UB-04)	• CMS 1500
Patient Diagnoses	• ICD-9-CM diagnosis	• ICD-9-CM diagnosis	• ICD-9-CM diagnosis
Procedures	• ICD-9-CM procedure • Revenue code	• CPT • Revenue code	• CPT
Drug and Supplies (includes Blood and Blood Products)	• Revenue code	• HCPCS • Revenue code	• HCPCS

[44] Current Procedural Terminology: CPT® 2007. American Medical Association. All rights reserved.

MORE ON HCPCS CODES

HCPCS codes (pronounced "hick-picks") were originally created to allow for billing and tracking of services and supplies not described by CPT codes (described below). The HCPCS system is managed by a panel that consists of the Centers for Medicare and Medicaid Services (CMS), the Blue Cross and Blue Shield Association of America, and the Health Insurance Association of America. The Medicare program and most other payers require HCPCS codes for claims submitted by physicians, providers, and medical suppliers to document services provided, including durable medical equipment (DME) and pharmaceuticals.

There are three levels of HCPCS codes:

- **Level I—CPT Codes**. In creating the HCPCS system, the HCPCS panel decided to adopt CPT codes as the first level of HCPCS rather than duplicate the system.
- **Level II—HCPCS codes.** National codes are created CMS to supplement CPT for services and supplies covered by Medicare, such as physician-administered drugs and DME. See the summary of HCPCS Level II codes that apply to blood and blood products in the section titled Reimbursement for Blood Products and Services in the Hospital Outpatient Setting.
- **Level III—Local codes.** Local codes were created for specific local plans, like Medicaid agencies, Medicare contractors, and private plans. Due to the Health Insurance Portability and Accountability Act (HIPAA) administrative simplification requirements, the HCPCS panel disallowed the use of HCPCS Level III codes after October 2003.

Although specific coding requirements vary by insurer, most public and private payers rely on the major coding systems to process claims for hospital inpatient and physician services. It is worth noting that CPT, HCPCS, and ICD-9-CM codes all have been selected under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) for industry-wide adoption.[45] Please check with your payer's coding requirements before submitting any claims.

CMS National Correct Coding Initiative (NCCI) and Medically Unlikely Edits of Claims

CMS developed the National Correct Coding Initiative (NCCI) to promote national correct coding methodologies and to control improper coding leading to inappropriate payment in Part B claims. CMS developed its coding policies based on coding conventions defined in the American Medical Association's CPT manual, national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practices, and a review of current coding practices. The NCCI edits were implemented in 1996.

The purpose of the NCCI edits is to ensure the most comprehensive groups of codes are billed rather than the component parts. Additionally, NCCI edits check for mutually exclusive code pairs. These edits were implemented to ensure that only appropriate codes are grouped and priced.

[45] U.S. Public Law 104-191.

The Medically Unlikely Edits (MUEs) are CMS established units of service edits. The MUE edit table version 1.0 became effective January 2007. The edits auto-deny all units of service billed in excess of the CMS determined criteria for the number of units. Excess charges due to excess units of service may not be billed to the beneficiary. The criteria CMS uses to determine the MUE edits include anatomic consideration, code descriptor, CPT coding instruction and CMS policies. The MUE table will not be published or available on the CMS website. However, professional organizations including AABB review and may comment on all proposed edits before they become effective.

APPENDIX B: THE MEDICARE BLOOD DEDUCTIBLE EXPLAINED

Deductibles represent out-of-pocket expenditures that beneficiaries must pay for covered health care services before their insurance benefits kick in. Thus, for example, a beneficiary would need to pay $100 out-of-pocket before Medicare Part B (Medical Insurance) services are reimbursed and $840 for Medicare Part A (Hospital Insurance) services.

Although blood and blood products are covered by the Medicare program (when such products meet the coverage criteria discussed in section II of this guide), Medicare beneficiaries may be responsible for payment for the first three pints [units] of whole blood or red blood cells that they receive.[46] This requirement of payment for the first three pints is known as the **Medicare blood deductible**. It is important to note that some suppliers do not **charge** for the blood or blood product itself, but merely charge for blood processing costs. If the provider also does not charge for the blood—therefore the blood or blood product itself is considered "free"—the Medicare blood deductible does not apply.

Other Important Issues Concerning the Medicare Blood Deductible

- To reiterate, the provider may not charge the beneficiary for the first three pints [units] of whole blood or red blood cells if the provider obtained the units at no charge other than a processing or service charge.

- The blood deductible only applies to the first three pints [units] of whole blood or red blood cells furnished in a calendar year, **even if more than one provider (e.g., hospital, SNF, physician, clinic) furnished the blood**.[46]

- Although the deductibles for Medicare Part A and Medicare Part B are applied separately, blood deductible requirements satisfied under one part of the Medicare program reduce the blood deductible requirements of the other part. For example, if a beneficiary has received one unit under Medicare Part B, and later in the same benefit period received three units under Medicare Part A, Medicare Part A would pay for the third of the latter units.[47]

- The blood deductible does not apply to other blood components [products] such as platelets, fibrinogen, plasma, gamma globulin, or serum albumin. [48]

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[46] Current Medicare manuals refer to "pints"; for transfusable blood products, this is commonly interpreted to be equivalent to the term "units".

[47] Medicare General Information, Eligibility, and Entitlement Manual (MGIM), Chapter 3, §5, "Blood Deductibles (Part A and Part B)," available for download at http://www.cms.hhs.gov/manuals/downloads/ge101c03.pdf. This section was last revised August 12, 2005.

[48] Medicare General Information, Eligibility, and Entitlement Manual (MGIM), Chapter 3, §20-5.4.3, "Items Subject to Blood Deductibles," available for download at http://www.cms.hhs.gov/manuals/downloads/ge101c03.pdf. This section was last revised August 12, 2005. Products listed here appear in the Medicare manuals, as listed; these may differ from products considered to be "components" under current clinical terminology.

APPENDIX C: DOCUMENTING THE BLOOD USE AND THE BLOOD DEDUCTIBLE USING VALUE CODES

Value codes are used on claim forms to identify the units of blood furnished, the units of blood replaced, and the units of blood applied to the blood deductible. Medicare requires the use of value codes for purposes of tracking the blood deductible, but other payers may require them as well. **Note: value codes are not applicable when the provider does not charge for the blood itself, but only for blood processing.** The value codes specific to blood are as follows:

Table 26[49]

Value Codes Associated with the Use of Blood When Blood Itself Carries a Charge	
06	Medicare blood deductible. The amount reported for this value code is the result of multiplying the number of unreplaced pints of blood supplied by the charge per pint.[31]This represents the total cash blood deductible amount.
37	Pints of blood furnished. This code indicates the total number of pints of whole blood or units of packed red cells furnished for which the patient is responsible (regardless of whether the hospital charges for blood or not).
38	Blood deductible pints. This code indicates the number of unreplaced pints of whole blood or units of packed red cells furnished for which the patient is responsible.
39	Pints of blood replaced. This code indicates the total number of pints of whole blood or units of packed red cells furnished to the patient that have been replaced by or on behalf of the patient.

Note: The payer applies value code 06 (blood deductible). Providers do not have to include value code 06 on the claim.

AABB does not recommend the use of any particular codes for any particular patient. The patient's medical record must support all diagnoses and procedures used on a claim form. Only a physician is qualified to make such decisions, which must be documented in the patient's medical record.

[49] National Uniform Billing Committee Official UB-04 Specifications Manual 2007, Version 1.0. Value code descriptions are issued by the National Uniform Billing Committee (NUBC); some terminology used in code descriptions may not reflect current clinical practices or terminology.

APPENDIX D: OTHER REIMBURSEMENT GUIDANCE

Private managed care organizations and Medicaid programs often will implement utilization control requirements for specialist services as well as hospital inpatient and outpatient procedures. These insurers may require that you prior authorize or pre-certify procedures in the hospital outpatient department. For private insurers, remember to:

- obtain a valid referral from the primary care physician (PCP) if necessary;
- prior authorize or pre-certify the procedure, if necessary;
- request and confirm the billing codes for the surgical procedure, the professional service, as well as the disposable device; and
- establish medical necessity for the service. Insurance companies will need to understand what this service is, why this service has been recommended for this patient, and what other therapies the patient has tried.

APPENDIX E: INSTRUCTIONS FOR APPEALING DENIED CLAIMS

Some of the most common reasons for denials or underpayment of claims include:

- use of incorrect codes,
- omission of an accurate description of services, and
- omission of special coding requirements like the use of a modifier.

Appealing Denied Claims

Payers may deny coverage and claims because of variations in policies, confusion or lack of knowledge about the services provided, or because of technical billing, such as code omissions, misspellings, or transposed numbers or the lack of documentation in the patient's medical record to support the claim. Therefore, appropriate supporting documentation should be included along with requests for coverage for a patient, and claims should be carefully reviewed if they have been denied to see if there were technical errors.

Patients enrolled in a Medicare managed care plan should contact the consumer affairs hotline at their plan to ask for reconsideration. Patients insured by Medicaid can contact their state Medicaid program office to obtain information on appeals.

Payers maintain widely varying payer-specific appeals procedures, and may impose strict time limitations or other requirements necessary for the preservation or exercise of appeal rights. Appeals that fail to meet these payer-specific requirements may result in waiver or loss of appeal rights. Therefore, you should carefully review a payer's specific appeals rules upon receipt of a denial, and promptly file appeals in the manner required by payer rules. The following steps may serve as a guide for appealing coverage or claims denials.

Step One

Review the insurer's rationale for the denial. Discuss the denial reasons with the insurer. Document the subject of the call, the person with whom you spoke, and the time and date of the call. Often claims are denied because the insurer is not familiar with the procedure or because the claim is missing identification numbers, patient names, or signatures. Review the claim for submission errors.

Step Two

If you rule out claims submission errors, or if you determine that the insurer denied coverage because it was not convinced the therapy is necessary, you will need to submit documentation to justify medical necessity for the procedure. With your appeal, submit a letter of medical necessity. Make sure the letter highlights the following information:

- the patient's medical history,
- other therapies that have been tried unsuccessfully,
- reasons why procedure was recommended for this particular patient, and

and

- the risks of foregoing the recommended procedure.

In addition, include the following information with the resubmitted claim:

- a package insert; and

- peer-reviewed clinical articles (as appropriate).

Step Three

If a second denial is received, please contact the insurer's medical director or claims manager to request another review or a hearing. This individual may ask you for a copy of all the paperwork, so be prepared to resubmit the materials.

Step Four

Encourage patients to contact their benefits office when coverage is denied and talk to the benefits manager if necessary. Although the process may be lengthy, remember that many efforts to pursue coverage and payment are successful, and that efforts for one patient may ensure that the next patient will not experience similar problems with the insurer.

APPENDIX F: GLOSSARY OF REIMBURSEMENT TERMS[50]

Allowable Charge. The maximum amount an insurer will allow from both the insurer and the patient for a specific supply or service. The amount the insurer pays typically is 80 percent of this amount and the patient is responsible for the remainder.

CMS. The Centers for Medicare and Medicaid Services (CMS)--formerly the Health Care Financing Administration (HCFA)--is the federal agency that administers the Medicare, Medicaid, and Child Health Insurance Programs.

CMS-1450. This is a standard claim form required by Medicare and other payers for billing hospital facility services; also referred to as **UB**-**04** (formerly UB-92).

CMS-1500. This is a standard claim form required by Medicare and other payers for billing physician services.

Carrier. Insurance company that contracts with Medicare to process claims from physicians and freestanding facilities paid under Medicare Part B benefits.

Cost-to-Charge Ratio. The ratio of total expenses, including overhead, incurred by a hospital to provide services to total hospital charges. While charge information is readily available from hospital bills, costs generally are estimated using the Medicare cost report. The cost-to-charge ratio is used in Medicare's year-end reconciliation of reimbursement for care provided in the hospital outpatient department.

Current Procedural Terminology (CPT). A listing of descriptive terms and codes for reporting medical services and procedures performed by physicians. The American Medical Association maintains this coding system.

Diagnosis-Related Group (DRG). A method of grouping inpatient hospital stays by medical diagnoses, procedures, patient age, patient sex, and discharge status. These groupings are used in the Medicare hospital inpatient prospective payment system to establish the predetermined fixed payment for each inpatient episode of care (regardless of the resources utilized).

Explanation of Benefits (EOB). Also called explanation of medical benefits (EOMB). The statement sent to covered persons by their health plan listing services provided, amount billed, and payment made.

Fiscal Intermediary. Insurance company that contracts with Medicare to process claims from hospitals and other facilities paid under Medicare Part A (and selected Part B) benefits.

Global Period. Additional procedures following and directly related to the procedures that are performed during a defined **global period** are considered to be part of the initial procedure and are not eligible for separate reimbursement. Global periods can be either 0, 10 or 90 days.

[50] Definitions provided by Covance Health Economics and Outcome Services.

International Classification of Disease, Ninth Revision, Clinical Modifications (ICD-9-CM). A coding system used to describe both patient diagnoses in all settings and surgical and medical procedures performed in a hospital setting.

Medically Necessary. A medically necessary service is one that is reasonable and necessary for the diagnosis or treatment of an illness or injury, or to improve the functioning of a malformed body member.

Medically Unlikely Edits (MUE). CMS established unit of service edits that may be billed per patient per day. MUE units of service are defined based on medical necessity and edit for units that exceed the reasonably expected number of units for a specific CPT code.

Medicare. A federally funded program that provides health insurance benefits to the elderly (aged 65 or older), disabled Americans, and patients with end stage renal disease. Medicare is administered by the Centers for Medicare and Medicaid Services (CMS).

Medicare Part A. Hospital insurance under Medicare.

Medicare Part B. Medical insurance under Medicare.

Modifier. A modifier is shown if there is a technical component (modifier TC) and professional component (modifier 26) for a particular service, typically for radiology and pathology services. Physicians can only bill for both components (known as the global value) if they furnish both services.

National Correct Coding Initiative (NCCI). A CMS program to evaluate through claim edits that HCPCS/CPT codes are being billed appropriately. NCCI edits for unbundling and mutually exclusive codes.

National Provider Identifier (NPI). A standard unique health identifier for health care providers The NPI must be used by covered entities under HIPAA (generally, health plans, health care clearinghouses, and health care providers that conduct standard transactions). These transactions include claims, eligibility inquiries and responses, claim status inquiries and responses, referrals, and remittance advices.

Resource-Based Relative Value Scale (RBRVS). A physician fee schedule based on the resources associated with individual procedures. It was initially adopted as the basis for physician payment for Medicare Part B services and is now also used by many private insurers.

Revenue Codes. A coding system used for categorizing and billing hospital services maintained by the National Uniform Billing Committee.

UB-04. Formerly known as UB-92, this is a standard claim form required by Medicare and other payers for billing hospital services (CMS Form 1450). This claim form must be submitted electronically unless the facility is exempted and CMS will accept a manual form.

Value Codes. A code structure to relate amounts or values to identify data elements necessary to process a claim as qualified by the payer organization.

APPENDIX G: NATIONAL NON-COVERAGE OF PLATELET AUTOLOGOUS GELS

CMS announced (July 30, 2004) that Medicare would not cover autologous platelet rich plasma for the treatment of chronic non-healing cutaneous wounds.[51] However, the decision is not a blanket non-coverage decision for all uses of platelet autologous gels. For all other indications involving this product, CMS will consider coverage but has no formal guidelines for what the Medicare program considers medically necessary. Coverage then would be subject to the decision of the local Medicare contractor that processes claims.

[51] CMS Manual System, Pub. 100-3 Medicare National Coverage Determinations, Transmittal 496, July 30, 2004.

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