

## Blood Product Reimbursement Report

### Changes to Outpatient Reimbursement

On March 4, 2005, the Centers for Medicare and Medicaid Services (CMS) clarified Medicare coding, billing and payment policies by adding Section 231 to Chapter 4 of the Medicare Claims Processing Manual to Hospital Outpatient Prospective Payment Systems (OPPS). These changes will be effective on July 1, 2005, and implemented on July 5, 2005. The billing instructions for section §231.1 address how OPPS providers should bill for blood or blood products that are procured from a community blood bank, and how OPPS providers, who administer their own blood bank, should charge for blood or blood products collected. Section 231 also includes billing guidelines for:

- Autologous blood (salvage blood) and direct donor blood §231.3;
- Split blood unit §231.4;
- Irradiation of blood products §231.5;
- Frozen and thawed blood and blood products §231.6;
- Unused blood §231.7;
- Transfusion services §231.8; and
- Pheresis and apheresis services §231.9.

### Medicare Blood Deductible

CMS also issued another clarification to Chapter 4 of the Medicare Claims Processing Manual to Hospital Outpatient Prospective Payment Systems (OPPS). Only services billed with revenue code 38x series would be subject to Medicare blood deductible. In §20.5.3, CMS defines items that are subject to blood deductibles. The Medicare blood deductible applies only if the OPPS provider either procures whole blood or packed red cells from a community blood bank, or charges for blood collected in its own blood bank that reflects more than expense for blood processing and storage. According to §10.4.1, an OPPS provider may only bill the beneficiary for the first three pints of blood or units of packed red blood supplied during the calendar year. Additionally, the provider is not allowed to charge for any whole blood or packed red cells under the following circumstances:

- “The provider obtained the blood or red blood at no charge other than processing and service charge;
- The blood or packed red cells have been replaced; or

- The provider (or its blood supplier) receives from an individual a replacement offer.” Medicare Claims Processing Manual Chapter 4 §10.4.1 (3-04-05). CMS will implement these changes on July 5, 2005.

More information on the Medicare blood deductible can be found at:

[www.cms.hhs.gov/manuals/pm\\_trans/R18GI.pdf](http://www.cms.hhs.gov/manuals/pm_trans/R18GI.pdf)

More information on CMS transmittals on Chapter 4 of the Medicare Claims Processing Manual to Hospital Outpatient Prospective Payment Systems is available at:

[www.cms.hhs.gov/manuals/pm\\_trans/R496CP.pdf](http://www.cms.hhs.gov/manuals/pm_trans/R496CP.pdf)

### Taking a Closer Look at the New Billing Changes For Autologous Blood (Salvage Blood) and Direct Donor Blood

According to §231.3, there are different scenarios for billing for autologous blood. For autologous (predeposited or obtained through intra- or post-operative salvage) or directed-donor transfusion, OPSS providers should bill for the transfusion service, and the blood product HCPCS code. Also, the OPSS providers should bill for the procedure on the date that the transfusion(s) took place (only once per day) and not on the date when the autologous blood was collected.

However, for an autologous blood product that is collected, but not transfused, OPSS providers should bill CPT 86890 or 86891 with the total number of units collected and not the total number units transfused. The CPT codes 86890 and 86891 are intended to compensate providers for the administration cost incurred during collection of autologous blood and not the costs incurred when the autologous blood is transfused. Also, the OPSS provider should bill 86890 or 86891 on the date when the OPSS provider is certain the blood will not be transfused.

### New Modifier/Billing Requirement

CMS also proposed a new modifier and billing requirement that reflects more than blood processing and storage. Under §231.2, if an OPSS provider pays for the actual blood or blood product obtained from a community blood bank or from the OPSS provider’s own blood bank in addition to paying for the processing and storage costs, then the OPSS provider must separate the charge for the unit(s) of blood or blood product(s) from the charge for processing and storage services. CMS also recommends that “[t]he OPSS provider reports charges for the blood and blood product 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 OPSS provider reports 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 product HCPCS code and HCPCS modifier BL.” Medicare Claims Processing Manual Chapter 4 § 231.2 (3-04-05). CMS also reinforced that, effective July 1, 2005, it will deny any claims that report a charge for blood or blood products using Revenue Code 038X without a separate line using Revenue Code 0390 or 0399 for processing and storage services. Illustrated in Figure 1 is the new modifier and billing requirement for charging blood or blood product(s) with blood processing and storage.

Revenue Code	Description	HCPCS	Units	Date of Service	Charge
038X	Blood/Blood Product	P-Code with modifier BL	1	xx/xx/05	\$AB.CD
039X	Blood/Blood Component Administration Processing Storage	P-code with Modifier BL	1	xx/xx/05	\$WX.YZ