MISSISSIPPI VALLEY
REGIONAL BLOOD CENTER

Blood Product Reimbursement Report

1st Quarter *March 2013* *Volume 11, Number 1*

In This Issue:

This information is provided as a service to assist hospitals and other providers of blood products and blood services. Providers are responsible for accurately coding and billing for services rendered as appropriate to their situation and payer-specific requirements. Please contact your blood center with any questions pertaining to this newsletter.

Healthcare Reform Update: Impact of the 2012 Elections and the Path Forward

Given President Barack Obama's re-election in November, it is all but certain that "Healthcare Reform" or the Patient Protection and Affordable Care Act (ACA) will remain law for the foreseeable future. Despite this, the path forward for the implementation of many of the law's provisions remains unclear.

The Supreme Court's decision regarding the constitutionality of the ACA rendered Medicaid expansion optional at the state level. Currently, 18 states and the District of Columbia have decided to expand their Medicaid programs, 10 states have decided against expansion, and 22 states have yet to make a decision on the issue. Of states that remain undecided, 5 have indicated that they are leaning toward not expanding their Medicaid programs, while 5 have stated that they are leaning towards moving forward with expansion.

As is the case with Medicaid expansion, the continued effort to create and operationalize health insurance exchanges likely will continue to move forward as it was prior to the election. There is a general consensus that, despite the outcome of the elections, a majority of state exchanges likely will not be operational by January 2014—the current deadline for exchange creation established by the ACA. This will result in either an increased role of the Federal government in exchange creation and operation, or an extension of the deadline by the Department of Health and Human Services (HHS).

The ACA afforded states the options to create their own exchanges, to partner with the Federal government to create an exchange, or to opt out of creating an exchange entirely in favor of having the Federal government do so on their behalf. Eighteen states and the District of Columbia plan to create their own health insurance exchange; 7 states plan to collaborate with the federal government to do so; and 25 states plan to have the federal government do so on their behalf.

Did you know… Refresher on the Medicare Part B Blood Deductible

As has been the case for more than two decades, payment under the Medicare Part B benefit may not be made for the first three pints of whole blood, or equivalent units of packed red cells, received by a Medicare beneficiary in a calendar year. The blood deductible only applies to whole blood or packed red cells. Other blood products, such as platelets, fibrinogen, plasma, gamma globulin, and serum albumin are not subject to the blood deductible.

Generally, blood and packed red cells are donated by volunteers. Because of this, charges usually are not reported for these items. After donation, the blood is processed, stored and administered. Charges for the administration, processing, and storage of blood are not subject to the blood deductible. The blood deductible applies only to charges reported for blood and/or packed red cells themselves. Accordingly, although payment may not be made for the first three pints of blood and/or units of packed red cells furnished to a beneficiary in a calendar year, payment may be made for the administration, processing, and storage for all covered pints or units including the first three furnished in a calendar year.

It is important to not confuse the blood deductible with the standard Medicare Part B deductible. Charges for blood after the first three pints are still subject to the standard Part B deductible. Further, expenses incurred meeting the blood deductible do not count toward meeting the standard Part B deductible.

CMS Issues 2013 Outpatient Final Rule, Finalizes 1.8% Payment Increase

In November 2012, the Centers for Medicare and Medicaid Services (CMS) issued the calendar year (CY) final rule for the Medicare Hospital Outpatient Prospective Payment System (OPPS). This rule presents the final updates to payment rates for hospital outpatient departments and ambulatory surgery centers for CY 2013. The rule's provisions took effect on January 1, 2013.

The final rule increases OPPS payment by 1.8 percent from 2012. The rule also finalizes the proposal that hospitals failing to meet the Hospital Outpatient Quality Reporting (Hospital OQR) program requirements will continue to receive a two-percentage-point reduction of the following year's payment update.

The final rule continues separate payments for blood and blood products through ambulatory payment classifications (APCs). For 2013, CMS will continue to use this payment methodology, establishing payment rates for blood and blood products using blood-specific cost-to-charge ratios (CCRs), and the CCR calculation methodology continues to remain unchanged since its implementation in 2005.

For 2013, the APC payment amount for several of the more commonly-used blood products increased. Overall, APC payment amounts for 18 of 34 blood products increased for 2013. For example, the APC payment amount for P9011 *Blood split unit* increased from $117.23 per unit in 2012 to $136.36 per unit in 2013. As is often the case, products with lower-volume use were subject to more drastic payment changes due to the high variability in year to year usage.

HCPCS /CPT Code	Short Descriptor	2013 APC	2013 APC Payment	2012 APC Payment	Percent Change
P9010	Whole blood for transfusion	950	$169.83	$190.57	-10.9%
P9011	Blood split unit	967	$136.36	$117.23	16.3%
P9012	Cryoprecipitate each unit	952	$78.64	$82.70	-4.9%
P9016	RBC leukocytes reduced	954	$193.24	$198.69	-2.7%
P9017	Plasma 1 donor frz w/in 8 hr	9508	$78.71	$79.79	-1.4%
P9019	Platelets, each unit	957	$91.61	$89.68	2.2%
P9020	Platelet rich plasma unit	958	$175.62	$141.68	24.0%
P9021	Red blood cells unit	959	$151.79	$149.00	1.9%
P9022	Washed red blood cells unit	960	$296.39	$287.08	3.2%
P9023	Frozen plasma, pooled, sd	949	$72.23	$66.77	8.2%
P9031	Platelets leukocytes reduced	1013	$118.34	$130.94	-9.6%
P9032	Platelets, irradiated	9500	$134.23	$128.28	4.6%
P9033	Platelets leukoreduced irrad	968	$156.45	$139.85	11.9%
P9034	Platelets, pheresis	9507	$431.99	$441.67	-2.2%
P9035	Platelet pheres leukoreduced	9501	$511.27	$538.27	-5.0%
P9036	Platelet pheresis irradiated	9502	$675.77	$554.34	21.9%
P9037	Plate pheres leukoredu irrad	1019	$674.16	$691.05	-2.4%
P9038	RBC irradiated	9505	$201.95	$198.78	1.6%
P9039	RBC deglycerolized	9504	$479.74	$238.38	101.3%
P9040	RBC leukoreduced irradiated	969	$273.19	$260.94	4.7%
P9043	Plasma protein fract,5%,50ml	956	$20.31	$17.99	12.9%
P9044	Cryoprecipitatereducedplasma	1009	$67.97	$74.29	-8.5%
P9048	Plasmaprotein fract,5%,250ml	966	$47.16	$72.47	-34.9%
P9050	Granulocytes, pheresis unit	9506	$1,618.09	$1,339.23	20.8%
P9051	Blood, l/r, cmv-neg	1010	$185.29	$188.36	-1.6%
P9052	Platelets, hla-m, l/r, unit	1011	$775.45	$802.19	-3.3%
P9053	Plt, pher, l/r cmv-neg, irr	1020	$660.47	$615.03	7.4%
P9054	Blood, l/r, froz/degly/wash	1016	$122.44	$104.83	16.8%
P9055	Plt, aph/pher, l/r, cmv-neg	1017	$336.54	$383.29	-12.2%
P9056	Blood, l/r, irradiated	1018	$175.91	$146.64	20.0%
P9057	RBC, frz/deg/wsh, l/r, irrad	1021	$368.69	$448.34	-17.8%
P9058	RBC, l/r, cmv-neg, irrad	1022	$286.56	$305.65	-6.2%
P9059	Plasma, frz between 8-24hour	955	$75.53	$72.75	3.8%
P9060	Fr frz plasma donor retested	9503	$56.82	$80.87	-29.7%

AMA Expands CPT Codes with the Addition of Molecular Pathology Codes

Over the past two years, the Current Procedural Terminology® (CPT) code set has been expanded to include more than 100 new codes for molecular pathology procedures. According to the American Medical Association (AMA)—the organization that maintains the CPT coding system—this represents one of the largest single expansions of the CPT code set to date. The AMA states that this expansion was necessary due to the recent increase in the medical community's understanding of the molecular basis of disease, and the large number of new molecular pathology procedures and diagnostic approaches that this has brought about. Starting in 2013, CMS and many private payers will require providers to bill for molecular pathology procedures using these new codes only.

The molecular pathology codes approved by the CPT Editorial Panel are organized into two tiers. The most commonly performed molecular pathology tests are described by Tier 1 codes, which are unique and analyte-specific. Somewhat lower-volume but still commonly used molecular pathology tests are captured by Tier 2 codes. While Tier 2 codes do not describe unique procedures, it is important to note AMA's guidance that Tier 2 codes are not to be self-assigned—a Tier 2 code cannot be used to code for a procedure unless that procedure is listed under the code in its official description. The 2013 CPT code set contains 105 Tier 1 codes (81200-81383) and 9 Tier 2 codes (81400-81408). Together, Tier 1 and Tier 2 codes describe approximately 90 to 95 percent of existing molecular pathology procedures. The few molecular pathology procedures not described by Tier 1 or Tier 2 codes should be reported with the unlisted molecular pathology code 81479.

This newsletter was compiled by **Covance Market Access Services** (http://www.covance.com/marketaccess).