

***Hospital Billing, Coding, and
Payment for Blood:
2009 Update***

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As you know, reimbursement is complex and constantly evolving.

The materials in this presentation are intended to provide a broad overview of very complex and evolving payment systems and other issues that may have many implications for your facility.

The information presented is not intended to serve as specific advice on how to utilize, bill, or charge for any product or service acquired from the American Red Cross or other entity. Each healthcare provider must make the ultimate determination as to when to use a specific product for an individual patient.

In addition, each provider must determine the most appropriate and proper way to bill for all products and services provided to patients.

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Introduction to Coding

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Introduction to Coding

Different coding systems are used in each setting of care to describe various services, items, or conditions.

	Hospital Inpatient	Hospital Outpatient
Patient Diagnoses	ICD-9-CM	ICD-9-CM
Procedures	ICD-9-CM Revenue	CPT Revenue
Blood, Other Biologicals, Drugs, and Supplies (except clotting factors)	Revenue	HCPCS Revenue
Clotting Factors	HCPCS Revenue	HCPCS Revenue

→ Hospitals bill Medicare and most other payers for inpatient and outpatient services using the UB-04 (formerly UB-92) claim form.

Revenue codes are used by hospitals to attribute services and supplies to specific cost centers within the facility.

- Format: 4 numbers—for example, 0390
 - Although the first digit sometimes is omitted—for example, 390 instead of 0390—this technically is incorrect.
- Hospitals must report a revenue code for each line item on both inpatient and outpatient claims.
- There are two revenue code series related to transfused blood and blood products:
 - 038X (Blood)
 - 039X (Blood and Blood Component Administration, Processing, and Storage)

CODING TIP:

Under Medicare, the appropriate revenue code for blood carrying only a processing fee is 0390 (Blood and Blood Component Administration, Processing, and Storage; General Classification).

- The Red Cross does not charge hospitals for blood itself; rather, it charges only for processing and handling.
- Revenue code series 038X should *not* be used to report Red Cross-supplied blood in the hospital setting.

International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) codes include both diagnosis and procedure codes.

- ICD-9-CM diagnosis codes are used to identify patient diagnoses in nearly all settings of care.
 - Format: 3 to 5 numbers (with some exceptions)—for example, 286.0
 - Some ICD-9-CM diagnosis codes consist of 1 letter followed by 3 numbers.
 - For example, ICD-9-CM V-codes may be used to describe the reason for a patient’s visit, rather than a condition or illness—for example, V58.1 (Encounter for antineoplastic chemotherapy).
- ICD-9-CM procedure codes are used primarily to report hospital inpatient services.
 - Format: 4 numbers—for example, 99.28
 - ICD-9-CM procedure codes are not used on hospital outpatient claims.
 - Transfusion procedures are described by the 99.0X series of ICD-9-CM codes.

Healthcare Common Procedure Coding System (HCPCS) codes are used to identify various items and some services in the hospital outpatient, physician office/clinic, and certain other settings.

- Format: 1 letter followed by 4 numbers—for example, P9016
- HCPCS codes generally are not used on inpatient claims.
- Transfused blood products are described by P-codes P9010 through P9060.

CODING TIP:

When determining the appropriate blood product P-code, providers should select the code that describes the base product (for example, platelets, red blood cells, or fresh frozen plasma), as well as the attributes that reflect the way in which the product was processed.

- For example, a leukoreduced red blood cell should be reported with a P-code whose descriptor includes both “red blood cells” and “leukocytes reduced,” such as P9016 (Red blood cells, leukocytes reduced, each unit).
- This approach should be used regardless of whether the processing is performed by the blood supplier or the hospital.
- If none of the available P-code descriptors exactly describes all of a product’s attributes, providers should select the code that is the closest match.

Current Procedural Terminology (CPT) codes are used by hospital outpatient departments, physician offices/clinics, physicians (in all settings), and certain other providers to report services and procedures.

- Format: 5 numbers (with some exceptions)—for example, 36430
- CPT codes are not used on inpatient claims.
- Transfusion procedures are described by CPTs 36430 through 36460.
- Transfusion medicine laboratory services (such as cross matching) are described by CPTs 86850 through 86999.

CODING TIPS:

It is important to note how a CPT code's descriptor is defined and report the units of the code accordingly.

- For example, some laboratory codes may be defined as “each antiserum technique,” “each unit,” or “per unit screened”—for example, CPT 86927 (Fresh frozen plasma, thawing, each unit).
- Other laboratory codes may not specify how the units are defined—for example, CPT 86900 (Blood typing, ABO) or 86965 (Pooling of platelets or other blood products). In the absence of specific payer guidance, providers must use their judgment regarding the most appropriate manner for reporting units of service.

The American Medical Association (AMA) instructs providers to select a CPT code with a descriptor “that accurately identifies the service performed,” rather than a code “that merely approximates the service provided.”*

Although critical access hospitals (CAHs) are exempt from Medicare's prospective payment systems, they use the same billing codes as other hospitals.

- In order to be designated as a CAH, a hospital must:
 - be located in a rural area;
 - provide 24-hour emergency care services;
 - have an average length of stay of 96 hours or less;
 - be located more than 35 miles from a hospital or another CAH, or more than 15 miles in areas with mountainous terrain or only secondary roads; and
 - have no more than 25 beds (either acute care beds or swing beds).

- Medicare reimburses CAHs based on 101 percent of reasonable costs; therefore, the diagnosis-related group (DRG) and ambulatory payment classification (APC) systems do not apply to these facilities.

- However, most of the coding information discussed throughout this presentation *does* apply to CAHs.

- Additional CAH resources:
 - CMS* CAH Web Page: www.cms.hhs.gov/center/cah.asp
 - CMS CAH Fact Sheet: www.cms.hhs.gov/MLNProducts/downloads/CritAccessHosp07fctsht.pdf
 - CMS C-Code Transmittal: www.cms.hhs.gov/Transmittals/Downloads/R976CP.pdf

2009 Medicare Hospital Inpatient Update

Medicare has used the hospital inpatient prospective payment system (IPPS) to reimburse most hospitals for inpatient services since 1983.

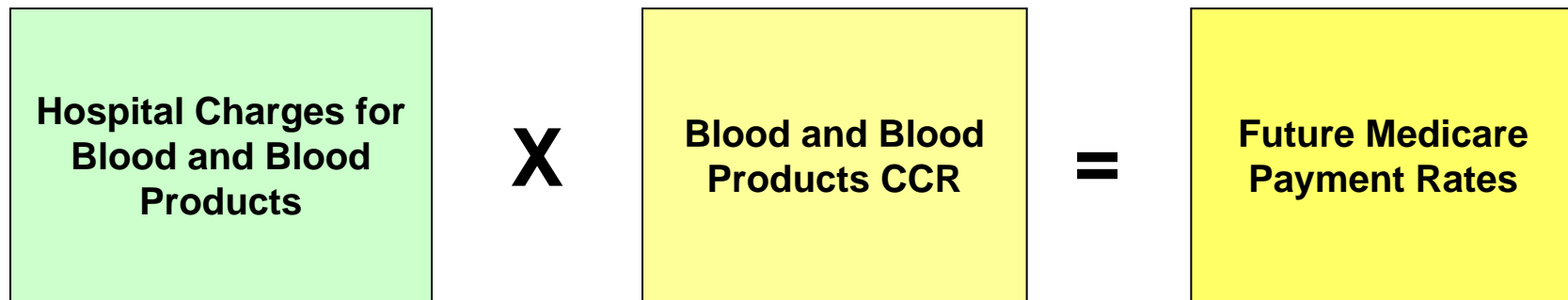
- Under IPPS, one Medicare Severity Diagnosis-Related Group (MS-DRG) is assigned per hospital inpatient stay.



- Reimbursement for transfused blood and blood products is included in the all-inclusive MS-DRG payment amount.
 - The MS-DRG payment also includes most services performed at the hospital within the 72-hour period prior to admission.
- Specific hospital payments are adjusted for geographic region, teaching status, and disproportionate share hospital status.

In 2008, CMS adopted a new inpatient cost-to-charge ratio (CCR) for blood and blood products.

- The new blood and blood products CCR is 1 of 15 hospital department CCRs that CMS uses to set the MS-DRG relative weights.



- The creation of a blood and blood products CCR should reflect more accurately the cost of blood and will help to ensure that future IPPS payment updates account more adequately for these products.
- In order for the benefits of the new blood-specific CCR to be fully realized, it is very important for hospitals to:
 - set appropriate charges for blood and blood products,
 - report these charges consistently on claim forms, and
 - bill for blood using the correct revenue code(s).

CMS recently provided an important clarification regarding proper billing for blood transfusion procedures in the inpatient setting.

- In the FY 2009 IPPS final rule, CMS states that the proper way to bill for inpatient blood transfusions depends on the cost center in which the transfusion is administered.

Routine Cost Center <i>Example: Room and Board</i>
<i>The provider must consider the established practice of the same class of providers in the same State as to whether to include blood transfusion in the routine service charge (for both Medicare and non-Medicare patients)</i> --73 Federal Register 48466

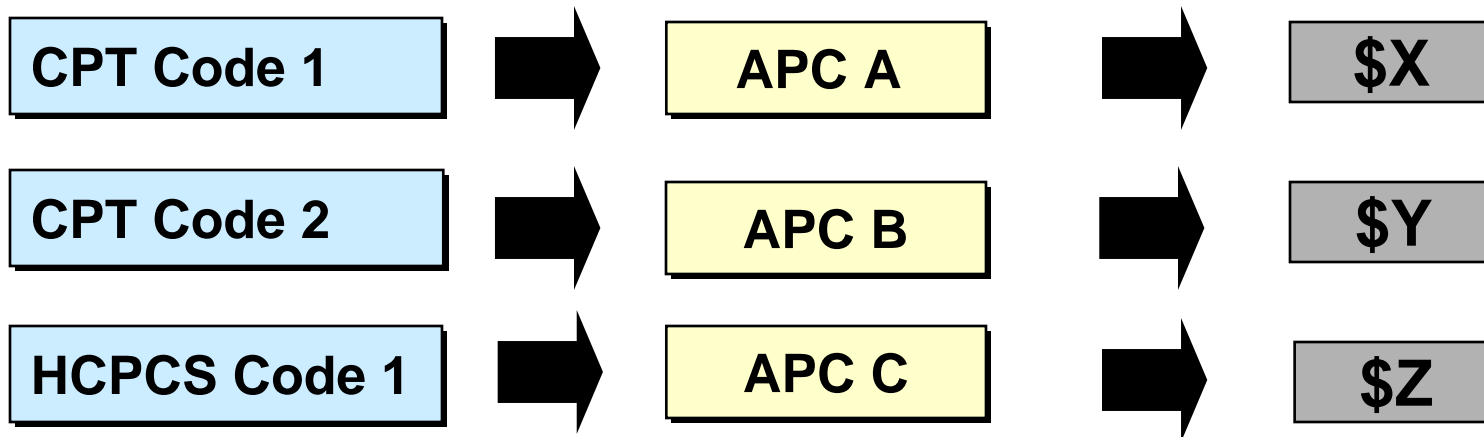
Ancillary Cost Center <i>Example: Operating Room or Emergency Room (ER)</i>
<i>Providers should be billing a separate charge ... under UB revenue code 0391 (Blood Administration).</i> --73 Federal Register 48466

- ➔ **Although not specifically stated in the FY 2009 IPPS final rule, hospitals should separately report inpatient charges for blood units using revenue code 0390 if the blood is obtained from a supplier (such as the Red Cross) that charges only for blood processing.**

2009 Medicare Hospital Outpatient Update

Under the Medicare hospital outpatient prospective payment system (OPPS), hospital outpatient services are assigned to APC groups according to the CPT and HCPCS codes reported on the claim.

- A single hospital outpatient encounter may be described by multiple APC groups.



- Hospitals do not report APC groups on claim forms.
- APC payments and copayments for procedures—but not for blood products—are adjusted for geographic wage differences.
- For Medicare reimbursement purposes, ER visits that do not result in an inpatient admission are paid under OPPS.
 - For ER visits that result in an admission, the entire episode is considered an inpatient stay and is reimbursed under the single DRG payment.

The impact of the 2009 APC payment changes varies by type of blood product.

- Although some products have experienced payment reductions, the payment rates for the most highly utilized blood products have increased.

Comparison of Final 2009 and 2008 APC Payment Rates for the Top 10 Highest-Volume* Blood Products

HCPCS	Description	2009 Final Payment	2008 Final Payment	Percent Change
P9016	RBC leukocytes reduced	\$188.92	\$185.15	2%
P9021	Red blood cells unit	\$136.82	\$129.66	6%
P9040	RBC leukoreduced irradiated	\$251.33	\$240.27	5%
P9035	Platelet pheres leukoreduced	\$514.82	\$499.53	3%
P9037	Plate pheres leukoredu irradiated	\$653.50	\$630.08	4%
P9017	Plasma 1 donor frz w/in 8 hr	\$76.73	\$67.03	14%
P9034	Platelets, pheresis	\$468.66	\$441.03	6%
P9038	RBC irradiated	\$250.69	\$195.18	28%
P9019	Platelets, each unit	\$73.25	\$69.50	5%
P9031	Platelets leukocytes reduced	\$111.67	\$107.51	4%

*Based on total number of units billed under OPPS in CY 2007.

- ➔ **The products listed in this table account for approximately 95 percent of all blood units billed under OPPS in CY 2007.**

CMS recently issued a transmittal that clarifies several provisions of the March 4, 2005, OPPS blood billing guidelines.

CMS Manual System	Department of Health & Human Services (DHHS)
Pub. 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 496	Date: MARCH 4, 2005
	CHANGE REQUEST 3681

SUBJECT: Billing for Blood and Blood Products Under the Hospital Outpatient Prospective Payment System (OPPS)

I. SUMMARY OF CHANGES: This transmittal updates language found in the Medicare Claims Processing Manual, Pub.100-04, Chapter 17, §90.1, and adds a new §231 entitled, "Billing for Blood and Blood Products" to Chapter 4.

NEW/REVISED MATERIAL - EFFECTIVE DATE*: July 1, 2005
IMPLEMENTATION DATE: July 5, 2005

- The 2005 OPPS blood billing guidelines (Transmittal 496) apply to Medicare hospital outpatient claims for facilities reimbursed under OPPS.
 - The guidelines do not apply to blood transfused in the inpatient setting, to CAHs, or to non-Medicare payers.
 - Transmittal 496 is available at: www.cms.hhs.gov/transmittals/downloads/R496CP.pdf.
- On April 8, 2008, CMS issued Transmittal 1487, which includes clarifications related to billing for split units, irradiated units, and frozen/thawed units.
 - Transmittal 1487 is based on a CMS letter to AABB dated September 29, 2006.
 - Transmittal 1487 is available at:
<http://www.cms.hhs.gov/Transmittals/downloads/R1487CP.pdf>.

IMPORTANT CLARIFICATION REGARDING BILLING FOR BLOOD PROCESSING

- In recent months, the Red Cross has received a number of questions regarding appropriate billing for blood.
- As mentioned previously, the Red Cross charges only for blood processing, and not for the blood itself.
- Transmittals from CMS (as well as the original 2005 OPPS blood billing guidelines) have referenced billing requirements related to:
 - revenue code 038X,
 - the -BL modifier, and
 - the Medicare blood deductible.
- However, these requirements apply only to charges for the blood itself, and do not apply to blood carrying only a processing fee.
- Therefore, when billing only for blood processing, OPPS providers:
 - should not use revenue code 038X or the -BL modifier, and
 - should not apply the blood deductible.
- ➔ **In its most recent blood-related transmittal, CMS clarified that “Most OPPS providers obtain blood or blood products from community blood banks that charge only for processing and storage, and not for the blood itself” (Transmittal 1702, dated March 13, 2009).**

When reporting only blood processing costs, the basic blood billing guidelines issued in 2001 still apply.

Product or Service	OPPS Billing Guidance
Blood or blood component	<ul style="list-style-type: none"> • Bill for blood processing under revenue code 0390 and include the product-specific P-code. • Bill per unit.
Transfusion procedure	<ul style="list-style-type: none"> • Bill under revenue code 0391 and include the appropriate CPT code. • CMS allows the transfusion procedure to be billed once per day/per visit.
Blood typing, cross matching, and other laboratory services	<ul style="list-style-type: none"> • Bill under revenue code series 030X (Laboratory) or 031X (Laboratory, Pathological) and include the specific CPT codes for blood typing, cross matching, and other laboratory services related to the patient who receives the blood.

- ➔ **In order for hospitals to receive appropriate reimbursement under OPPS, a claim for a transfusion must include *both* a transfusion CPT code and a blood product P-code.**

The blood billing guidelines confirm that Medicare's policy on unused blood has not changed.

- Hospitals may *not* bill Medicare for unused blood.
 - This means that hospitals may not submit charges for units that are ordered but not transfused.
 - This is a longstanding policy that applies to both the inpatient and outpatient settings.

- However, hospitals may:
 - bill for medically necessary laboratory services related to a specific patient (such as cross matching), even if the blood is not transfused; and
 - take the overall cost of unused blood into account when setting charges for units that are transfused.

Under the OPPS guidelines, billing for autologous blood varies depending on whether the blood is transfused.

Autologous Scenario	CPT/HCPCS Coding Requirements
Hospital outpatient setting—blood transfused	<ul style="list-style-type: none"> • Blood product P-code <ul style="list-style-type: none"> ○ Use whichever P-code would apply if the blood were not autologous ○ Date of service is date of transfusion ○ Report with revenue code 0390 • Transfusion CPT code (for example, CPT code 36430) <ul style="list-style-type: none"> ○ Date of service is date of transfusion ○ Report with revenue code 0391 • CPT codes for separately reportable, patient-specific laboratory services (if applicable) <ul style="list-style-type: none"> ○ Report with revenue code series 030X or 031X <p><i>Do not report CPT code 86890 (Autologous collection, processing, and storage).</i></p>
Hospital outpatient setting—blood not transfused	<ul style="list-style-type: none"> • CPT code 86890 <ul style="list-style-type: none"> ○ Reflects the autologous surcharge or autologous collection; does not reflect the product itself ○ Service units equal the number of units collected but not transfused ○ Date of service can be date of procedure for which blood was intended or date of discharge ○ Revenue code 0300 (Laboratory, General) is appropriate for CPT 86890; 0390 is not • CPT codes for separately reportable, patient-specific laboratory services (if applicable) <ul style="list-style-type: none"> ○ Report with revenue code series 030X or 031X <p><i>Do not report the blood product P-code or transfusion CPT code.</i></p>
Hospital inpatient setting	<ul style="list-style-type: none"> • CPT and HCPCS codes not used on inpatient claims <ul style="list-style-type: none"> ○ In the inpatient setting, there is no separate payment for blood products or related services; the single DRG payment is all-inclusive

When a patient receives a transfusion of a split unit of blood, OPPS providers should bill HCPCS code P9011 (Blood, split unit).

- Splitting CPT code 86985 (Splitting of blood or blood products, each unit) also should be billed for each splitting procedure performed.
- CPT code 86985 often is billed for all but one of the patients who receive portions of the same unit.
 - For example, when a unit is split among three patients, CPT code 86985 would be billed for the first and second patient if the splitting procedure is performed twice.
 - In this scenario, no additional splitting would be necessary to prepare the split unit for the third patient.

When transfusing irradiated units, hospitals should use an irradiated P-code if available.

- It is not appropriate to bill irradiation CPT code 86945 (Irradiation of blood product, each unit) in addition to an irradiated P-code.
- However, hospitals may report CPT code 86945 in conjunction with a non-irradiated P-code if an appropriate irradiated P-code is not available.
- This guidance does not differentiate between irradiating units in-house vs. obtaining irradiated units from the blood supplier.

Transmittal 1487 provides clarification on scenarios involving unused split or irradiated units.

- When a unit of blood is split or irradiated specifically with the intent of transfusion to a beneficiary but is not then transfused:
 - The hospital may bill for the services of splitting (CPT 86985) or irradiating (CPT 86945) the unit of blood.
 - However, the hospital may not bill the HCPCS code for the blood product that was not transfused.
- The date of service must be the date on which the decision not to use the blood was made and indicated in the patient's medical record.
- If the unit of blood is split or irradiated and stored without specific intention to administer it to a Medicare beneficiary at the time of splitting or irradiation and is not subsequently transfused, there is no service to be reported.

Transmittal 1487 also specifies the blood product HCPCS codes for which hospitals may bill separately for freezing and thawing.

Blood Product HCPCS For Which Freezing and Thawing Codes Are Separately Billable

HCPCS/ CPT	Short Descriptor	HCPCS/ CPT	Short Descriptor
P9010	Whole blood for transfusion	P9036	Platelet pheresis irradiated
P9011	Blood split unit	P9037	Plate pheres leukoredu irradi
P9019	Platelets, each unit	P9038	RBC irradiated
P9020	Platelet rich plasma unit	P9051	Blood l/r, cmv-neg
P9022	Washed red blood cells unit	P9052	Platelets, hla-m, l/r, unit
P9031	Platelets leukocytes reduced	P9053	Plt, pher, l/r cmv-neg, irr
P9032	Platelets, irradiated	P9055	Plt, aph/pher, l/r, cmv-neg
P9033	Platelets leukoreduced irradi	P9056	Blood, l/r, irradiated
P9034	Platelets, pheresis	P9058	RBC, l/r, cmv-neg, irradi
P9035	Platelet pheres leukoreduced		

- If a blood product P-code is not included on the above list, the hospital may not bill a freezing or thawing CPT code if the blood is transfused.
- However, if a blood product has been frozen/thawed in preparation for a transfusion, but is not transfused, the hospital may bill the CPT code(s) that describe the freezing and/or thawing services specifically provided for the patient.
 - The hospital must be certain that the frozen/thawed product will not be transfused.

Frequently Asked Questions

Is there a billing code for pooled platelets?

- There is no specific blood product P-code to describe pooled platelets.
- Hospitals have the option of charging:
 - one unit of CPT code 86965 (Pooling of platelets or other blood products) for the pooling, and
 - the appropriate number of units of the applicable platelet HCPCS P-code.
- For example, if a hospital uses a pooled product that includes five units of leukoreduced platelets, the facility could bill:
 - one unit of pooling CPT code 86965, and
 - five units of HCPCS code P9031 (Platelets, leukoreduced, each unit).
- However, since CMS has not specifically addressed this issue, each provider must make the ultimate determination as to how to bill for these products.
 - If a provider is uncomfortable billing for all of the units in a pooled product, a conservative approach would be to bill for only one unit of the platelet HCPCS P-code.
- ➔ **Hospitals may bill pooling CPT code 86965 even if the blood supplier performs the pooling; this is known as billing “under arrangement.”**



What is the appropriate way to bill for antigen screening?

- On November 2, 2007, the American Hospital Association's (AHA's) Central Office on HCPCS issued a letter clarifying the proper use of antigen screening CPT code 86903 (Blood typing; antigen screening for compatible blood units using reagent serum, per unit screened).

... it would be inappropriate to report CPT code 86903 ... for each antigen tested. According to the instructions for CPT code 86903 [it] should be billed for each unit screened. Therefore, if a single unit of blood is tested for multiple antigens, 86903 would be reported only once.

--Letter from AHA dated November 2, 2007

- If a single unit of blood is screened for multiple antigens, only 1 unit of CPT code 86903 should be billed.
- However, if several blood units are screened and only 1 unit is transfused, it would be appropriate to bill 86903 X the total number of blood units screened.

When billing for fresh frozen plasma (FFP), is it appropriate to charge separately for thawing?

- Transmittal 1487 states that freezing and thawing are not separately billable when the following FFP products are transfused:
 - P9017 - FFP (single donor), frozen within 8 hours of collection, each unit
 - P9059 - FFP, frozen between 8-24 hours of collection, each unit
 - P9060 - FFP, donor retested, each unit
- According to CMS, P-codes whose descriptors includes the word “frozen” are assumed to include freezing and thawing.
- However, if one of these units is not transfused and the freezing or thawing is performed for a specific patient, then the freezing/thawing would be separately billable in the hospital outpatient setting.
- Freezing/thawing CPT codes include the following:
 - 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
- ➔ **If in doubt regarding whether freezing/thawing are separately billable for a specific P-code, you can always refer to the table in Transmittal 1487.**



Can hospitals bill separately for all three phases of a cross match?

- In the hospital outpatient setting, it is appropriate to bill the following CPT codes if three phases of cross matching are performed:
 - 86920 – Compatibility test each unit, immediate spin technique
 - 86921 – Compatibility test each unit, incubation technique
 - 86922 – Compatibility test each unit, antiglobulin technique
- Although there also is a code for electronic cross matching (86923 – Compatibility test each unit, electronic), current Correct Coding Initiative (CCI) edits prevent this code from being paid separately when billed with any of the cross matching codes listed above.

Our claims trigger a CCI edit when we transfuse an irradiated product with a non-irradiated product. Is there anything we can do about this?

- CCI edits prevent certain non-irradiated blood products from being paid when billed on the same claim as irradiated blood products.
 - These edits have been in place since 2002.
 - Modifier -59 may be used to override these edits, but only in limited circumstances.
 - According to CMS, the use of a modifier is appropriate only on claims "for patients who received an irradiated direct donor cellular blood product from a blood relative as well as a non-irradiated cellular blood product from a random donor on the same date of service.... It is inappropriate to use a CCI associated modifier if a patient who does not require irradiated cellular blood products receives such a product for the convenience of the blood bank."*
 - If a claim does not meet the requirement for modifier -59, then the only options are:
 - bill (and be paid) only for the irradiated unit(s), or
 - bill for all units using non-irradiated codes and be paid at the non-irradiated rate.
- ➔ **CCI edits do not apply in the inpatient setting, since everything falls under the single DRG payment.**

How should we bill for CMV-negative units?

- There is no CPT code that is appropriate for reporting CMV testing performed on blood products.
 - CPT code 86644 (Antibody, CMV) is a diagnostic test code and may not be used to report blood processing charges.
- However, there are five P-codes available for CMV-negative products in the hospital outpatient setting:
 - P9051, Whole blood or red blood cells, leukocytes reduced, CMV-negative, each unit
 - P9053, Platelets, pheresis, leukocytes reduced, CMV-negative, irradiated, each unit
 - P9055, Platelets, leukocytes reduced, CMV-negative, apheresis/pheresis, each unit
 - P9058, Red blood cells, leukocytes reduced, CMV-negative, irradiated, each unit
- OPSS providers should choose the HCPCS code that most accurately describes the unit of blood they are transfusing, and should incorporate the additional CMV-related cost into their processing charges for the unit.

Is there a billing code available for the directed donor fee?

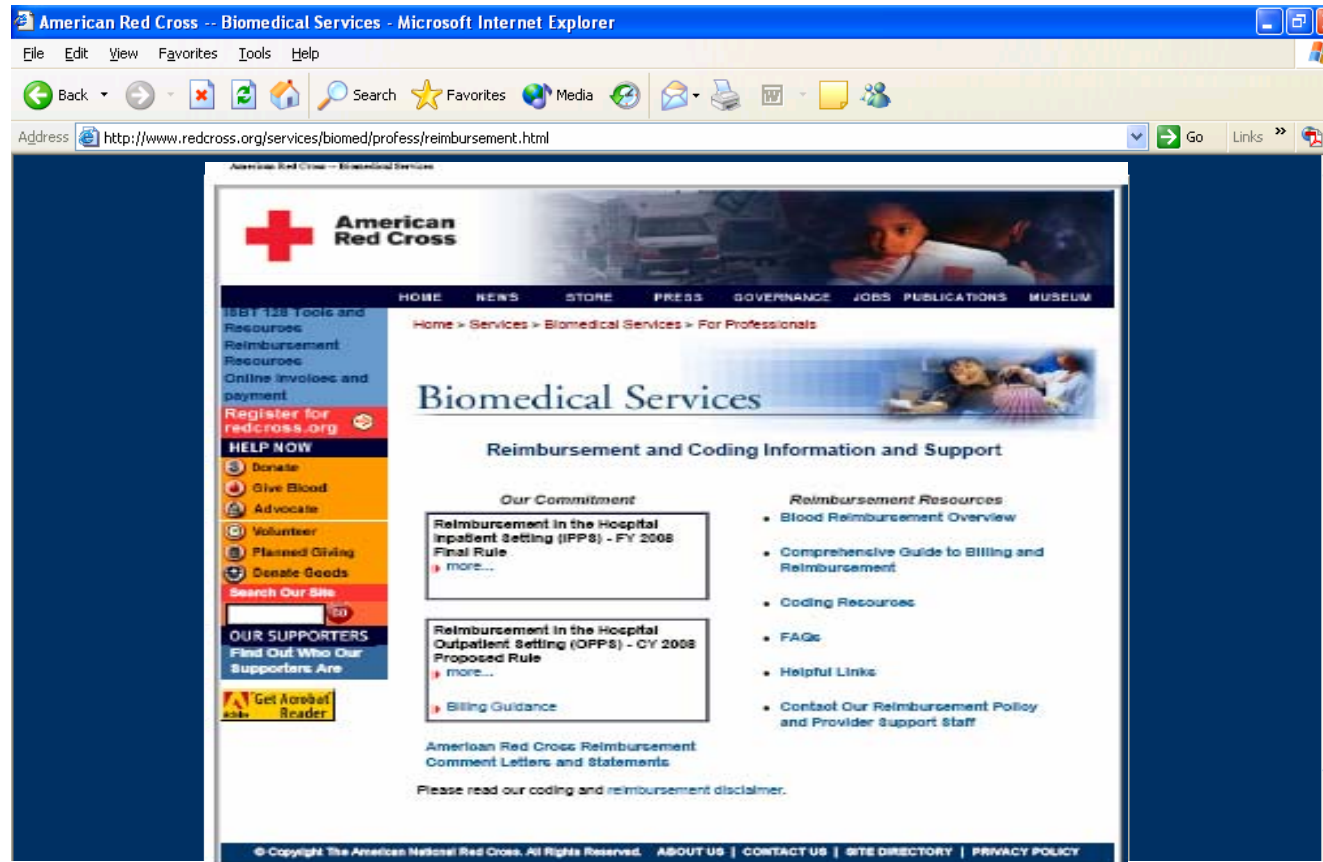
- There is no specific code for directed donation, and the directed donor fee is not separately billable.
 - Hospitals should *not* report this fee with autologous CPT code 86890.
 - Hospitals can incorporate the directed donor fee into their charge for the unit, but this would not result in additional reimbursement.
- The OPPS blood billing guidelines address directed donor blood that is not transfused by referring readers to the section of the guidelines on unused blood.
 - This means that no special billing policies apply to unused directed donor blood.
- When directed donor units *are* transfused, the hospital would use whichever P-code normally would describe the product if it were not directed donor.

Additional Reimbursement Resources

What is the Red Cross doing to help customers with reimbursement?

- The Red Cross is committed to:
 - educating payers regarding the costs associated with providing the safest possible blood supply for the American people;
 - assisting our customers with receiving appropriate reimbursement for the blood products that they use in the care of their patients; and
 - providing timely reimbursement resources—such as educational seminars, reimbursement updates, and coding guides—to our customers.
- ➔ **The Red Cross continuously examines the reimbursement environment for its blood products and services to ensure appropriate payment for its customers.**

The Red Cross's reimbursement Website offers detailed blood product and transfusion coding and billing information.



- The address is: <http://6l3zvr.redcross.org/services/biomed/profess/reimbursement.html>.
- Customers also can email specific questions to: reimburse@usa.redcross.org.

What you can do to make a difference in Medicare reimbursement:

- Stay informed.
 - Visit the Red Cross's reimbursement Website.
 - Take advantage of CMS resources.
- Participate in CMS Open Door Forums.
 - Open Door Forum meetings are open to the public by teleconference.
 - Information on Open Door Forums is available at:
www.cms.hhs.gov/OpenDoorForums/01_Overview.asp#TopOfPage.
- Sign up for CMS Listservs.
 - Hospital Inpatient: <https://list.nih.gov/archives/hospitals-acute-l.html>
 - Hospital Outpatient: <https://list.nih.gov/archives/op-pps-l.html>
 - Rural Health: <https://list.nih.gov/archives/rural-health-l.html>
 - Open Door Forums: http://www.cms.hhs.gov/AboutWebsite/20_EmailUpdates.asp
- Consider contacting Medicare directly to make your voice heard.
 - Email CMS at OutpatientPPS@cms.hhs.gov if you have questions or concerns about the March 4, 2005, OPFS blood billing guidelines or subsequent transmittals.

If you have reimbursement questions, please send an email to reimburse@usa.redcross.org.