Subject: Billing Blood and Blood Products

I. SUMMARY OF CHANGES: It has come to CMS’s attention that inconsistencies exist among billing/claim processing requirements for blood services. This CR instructs Medicare system maintainers to modify blood edits to align with existing Part A and hospital Part B policies for paying blood services and assigning blood deductible, as well as with current revenue code standards set by the National Uniform Billing Committee (NUBC).

New / Revised Material
Effective Date: October 1, 2008
Implementation Date: October 6, 2008

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-Only One Per Row.

<table>
<thead>
<tr>
<th>R/N/D</th>
<th>Chapter / Section / Subsection / Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>R</td>
<td>3/40.2.2/Charges to Beneficiaries for Part A Services</td>
</tr>
</tbody>
</table>

III. FUNDING:
SECTION A: For Fiscal Intermediaries and Carriers:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

SECTION B: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

*Unless otherwise specified, the effective date is the date of service.*
SUBJECT: Billing Blood and Blood Products

Effective Date: October 1, 2008
Implementation Date: October 6, 2008

I. GENERAL INFORMATION
A. Background:
It has come to CMS’ attention that inconsistencies exist among billing/claim processing requirements for blood services. This CR instructs Medicare system maintainers to modify blood edits to align with existing Part A and hospital Part B policies for paying blood services and assigning blood deductible, as well as with current revenue code standards set by the National Uniform Billing Committee (NUBC).

B. Policy:
According to CFR §410.161, Medicare does not pay for the first three units of whole blood or packed red cells that are furnished under Part A or Part B in a calendar year. The Part B blood deductible is reduced to the extent that it has been met under Part A, and vice versa. The blood deductible does not apply to the costs of processing, storing, and administering blood.

To meet the blood deductible, beneficiaries have the option of paying the hospital's charges for the blood or packed red cells or arranging for it to be replaced. Beneficiaries are not responsible for the blood deductible if the provider obtained the whole blood or packed red cells at no charge other than the processing charge.

In order to ensure correct application of the Medicare blood deductible, providers should report charges for whole units of packed red cells using Revenue Code 381 (Packed red cells), and should report charges for whole units of whole blood using Revenue Code 382 (Whole blood), as instructed in the Medicare Claims Processing Manual, Chapter 4, Section 231.2. Revenue Codes 381 and 382 should be used only to report charges for packed red cells and whole blood, respectively.

Per the Medicare Claims Processing Manual, Chapter 4, Section 231.4, providers also should bill split units of packed red cells and whole blood using revenue code 389 (Other blood), and should not use revenue codes 381 (Packed red cells) or 382 (Whole blood). Providers should bill split units of other blood products using the applicable revenue codes for the blood product type, such as 383 (Plasma) or 384 (Platelets), rather than 389.

II. BUSINESS REQUIREMENTS TABLE

“Shall” denotes a mandatory requirement

<table>
<thead>
<tr>
<th>Number</th>
<th>Requirement</th>
<th>Responsibility (place an “X” in each applicable column)</th>
</tr>
</thead>
<tbody>
<tr>
<td>5867.1</td>
<td>Contractors shall modify all existing edits relating to blood and/or blood deductible to no longer allow revenue code 380 to be billed (since a 380 revenue code is not a valid revenue code for Medicare).</td>
<td>A / B / M / C</td>
</tr>
</tbody>
</table>

Note: This requirement applies to Part A and Part B edits.
### III. PROVIDER EDUCATION TABLE

<table>
<thead>
<tr>
<th>Number</th>
<th>Requirement</th>
<th>Responsibility (place an “X” in each applicable column)</th>
</tr>
</thead>
<tbody>
<tr>
<td>5867.7</td>
<td>A provider education article related to this instruction will be available at shortly <a href="http://www.cms.hhs.gov/MLNMattersArticles/">http://www.cms.hhs.gov/MLNMattersArticles/</a> after the CR is released. You will receive notification of the article release via the established &quot;MLN Matters&quot; listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of</td>
<td>X</td>
</tr>
<tr>
<td>Number</td>
<td>Requirement</td>
<td>Responsibility (place an “X” in each applicable column)</td>
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<td>A / B D M E F I C A R R I E R R H I F I S S M C V M S C W F</td>
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<td></td>
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<td>Shared-System MaintainersOTHER</td>
</tr>
</tbody>
</table>

the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.

IV. SUPPORTING INFORMATION

A. Recommendations and supporting information associated with listed requirements: N/A
"Should" denotes a recommendation.

<table>
<thead>
<tr>
<th>X-Ref Requirement Number</th>
<th>Recommendations or other supporting information:</th>
</tr>
</thead>
</table>

B. All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Joe Bryson at 410-78-2986 or joseph.bryson@cms.hhs.gov

Post-Implementation Contact(s): Regional Office

VI. FUNDING

A. For Fiscal Intermediaries and Carriers:
No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

B. For Medicare Administrative Contractors (MAC):
The Medicare Administrative Contractor (MAC) is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as changes to the MAC Statement of Work (SOW). The contractor is not obligated to incur costs in excess of the amounts specified in your contract unless and until specifically authorized by the contracting officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the contracting officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.
40.2.2 - Charges to Beneficiaries for Part A Services

(Rev. 1495; Issued: 05-02-08; Effective Date: 10-01-08; Implementation Date: 10-06-08)

The hospital submits a bill even where the patient is responsible for a deductible which covers the entire amount of the charges for non-PPS hospitals, or in PPS hospitals, where the DRG payment amount will be less than the deductible.

A hospital receiving payment for a covered hospital stay (or PPS hospital that includes at least one covered day, or one treated as covered under guarantee of payment or limitation on liability) may charge the beneficiary, or other person, for items and services furnished during the stay only as described in subsections A through H. If limitation of liability applies, a beneficiary's liability for payment is governed by the limitation on liability notification rules in Chapter 30 of this manual. For related notices for inpatient hospitals, see CMS Transmittal 594, Change Request3903, dated June 24, 2005.

A. Deductible and Coinsurance

The hospital may charge the beneficiary or other person for applicable deductible and coinsurance amounts. The deductible is satisfied only by charges for covered services. The FI deducts the deductible and coinsurance first from the PPS payment. Where the deductible exceeds the PPS amount, the excess will be applied to a subsequent payment to the hospital. (See Chapter 3 of the Medicare General Information, Eligibility, and Entitlement Manual for specific policies.)

B. Blood Deductible

The Part A blood deductible provision applies to whole blood and red blood cells, and reporting of the number of pints is applicable to both PPS and non-PPS hospitals. (See Chapter 3 of the Medicare General Information, Eligibility, and Entitlement Manual for specific policies.) Hospitals shall report charges for red blood cells using revenue code 381, and charges for whole blood using revenue code 382.

C. Inpatient Care No Longer Required

The hospital may charge for services that are not reasonable and necessary or that constitute custodial care. Notification may be required under limitation of liability. See CMS Transmittal 594, Change Request3903, dated June 24, 2005, section V. of the attachment, for specific notification requirements. Note this transmittal will be placed in Chapter 30 of this manual at a future point. Chapter 1, section 150 of this manual also contains related billing information in addition to that provided below.
In general, after proper notification has occurred, and assuming an expedited decision is received from a Quality Improvement Organization (QIO), the following entries are required on the bill the hospital prepares:

- Occurrence code 31 (and date) to indicate the date the hospital notified the patient in accordance with the first bullet above;
- Occurrence span code 76 (and dates) to indicate the period of noncovered care for which it is charging the beneficiary;
- Occurrence span code 77 (and dates) to indicate the period of noncovered care for which the provider is liable, when it is aware of this prior to billing; and
- Value code 31 (and amount) to indicate the amount of charges it may bill the beneficiary for days for which inpatient care was no longer required. They are included as noncovered charges on the bill.

D. Change in the Beneficiary's Condition

If the beneficiary remains in the hospital after receiving notice as described in subsection C, and the hospital, the physician who concurred in the hospital's determination, or the QIO, subsequently determines that the beneficiary again requires inpatient hospital care, the hospital may not charge the beneficiary or other person for services furnished after the beneficiary again required inpatient hospital care until proper notification occurs (see subsection C).

If a patient who needs only a SNF level of care remains in the hospital after the SNF bed becomes available, and the bed ceases to be available, the hospital may continue to charge the beneficiary. It need not provide the beneficiary with another notice when the patient chose not to be discharged to the SNF bed.

E. Admission Denied

If the entire hospital admission is determined to be not reasonable or necessary, limitation of liability may apply. See 2005 CMS transmittal 594, section V. of the attachment, for specific notification requirements.

NOTE: This transmittal will be placed in Chapter 30 of this manual at a future point.

In such cases the following entries are required on the bill:

- Occurrence code 31 (and date) to indicate the date the hospital notified the beneficiary.
• Occurrence span code 76 (and dates) to indicate the period of noncovered care for which the hospital is charging the beneficiary.

• Occurrence span code 77 (and dates) to indicate any period of noncovered care for which the provider is liable (e.g., the period between issuing the notice and the time it may charge the beneficiary) when the provider is aware of this prior to billing.

• Value code 31 (and amount) to indicate the amount of charges the hospital may bill the beneficiary for hospitalization that was not necessary or reasonable. They are included as noncovered charges on the bill.

F. Procedures, Studies and Courses of Treatment That Are Not Reasonable or Necessary

If diagnostic procedures, studies, therapeutic studies and courses of treatment are excluded from coverage as not reasonable and necessary (even though the beneficiary requires inpatient hospital care) the hospital may charge the beneficiary or other person for the services or care according the procedures given in CMS Transmittal 594, Change Request3903, dated June 24, 2005.

The following bill entries apply to these circumstances:

• Occurrence code 32 (and date) to indicate the date the hospital provided the notice to the beneficiary.

• Value code 31 (and amount) to indicate the amount of such charges to be billed to the beneficiary. They are included as noncovered charges on the bill.

G. Nonentitlement Days and Days after Benefits Exhausted

If a hospital stay exceeds the day outlier threshold, the hospital may charge for some, or all, of the days on which the patient is not entitled to Medicare Part A, or after the Part A benefits are exhausted (i.e., the hospital may charge its customary charges for services furnished on those days). It may charge the beneficiary for the lesser of:

• The number of days on which the patient was not entitled to benefits or after the benefits were exhausted; or

• The number of outlier days. (Day outliers were discontinued at the end of FY 1997.)

If the number of outlier days exceeds the number of days on which the patient was not entitled to benefits, or after benefits were exhausted, the hospital may charge for all days on which the patient was not entitled to benefits or after benefits were exhausted. If the number of days on which the beneficiary was not entitled to benefits, or after benefits
were exhausted, exceeds the number of outlier days, the hospital determines the days for which it may charge by starting with the last day of the stay (i.e., the day before the day of discharge) and identifying and counting off in reverse order, days on which the patient was not entitled to benefits or after the benefits were exhausted, until the number of days counted off equals the number of outlier days. The days counted off are the days for which the hospital may charge.

H. Contractual Exclusions

In addition to receiving the basic prospective payment, the hospital may charge the beneficiary for any services that are excluded from coverage for reasons other than, or in addition to, absence of medical necessity, provision of custodial care, non-entitlement to Part A, or exhaustion of benefits. For example, it may charge for most cosmetic and dental surgery.

I. Private Room Care

Payment for medically necessary private room care is included in the prospective payment. Where the beneficiary requests private room accommodations, the hospital must inform the beneficiary of the additional charge. (See the Medicare Benefit Policy Manual, Chapter 1.) When the beneficiary accepts the liability, the hospital will supply the service, and bill the beneficiary directly. If the beneficiary believes the private room was medically necessary, the beneficiary has a right to a determination and may initiate a Part A appeal.

J. Deluxe Item or Service

Where a beneficiary requests a deluxe item or service, i.e., an item or service which is more expensive than is medically required for the beneficiary's condition, the hospital may collect the additional charge if it informs the beneficiary of the additional charge. That charge is the difference between the customary charge for the item or service most commonly furnished by the hospital to private pay patients with the beneficiary's condition, and the charge for the more expensive item or service requested. If the beneficiary believes that the more expensive item or service was medically necessary, the beneficiary has a right to a determination and may initiate a Part A appeal.

K – Inpatient Acute Care Hospital Admission Followed By a Death or Discharge Prior To Room Assignment

A patient of an acute care hospital is considered an inpatient upon issuance of written doctor’s orders to that effect. If a patient either dies or is discharged prior to being assigned and/or occupying a room, a hospital may enter an appropriate room and board charge on the claim. If a patient leaves of their own volition prior to being assigned and/or occupying a room, a hospital may enter an appropriate room and board charge on the claim as well as a patient status code 07 which indicates they left against medical
advice. A hospital is not required to enter a room and board charge, but failure to do so may have a minimal impact on future DRG weight calculations.