Hospital Transformation Consortium

WEBINAR ETIQUETTE

• All attendees are in “Listen Only” mode
• Questions or comments?
  - Open “Questions” pane in dashboard.
  - Type in comments or questions.
  - Comments will be monitored throughout webinar.
  - Questions will be addressed at end of the webinar.

A PORTION OF THESE MATERIALS WERE PRODUCED PURSUANT TO THE Iowa Small Hospital Improvement Program (SHIP) Grant FY 17, IA Contract #8888SH01 and the Georgia Small Hospital Improvement Grant FY 17.
This webinar will be recorded and emailed to you to share with others on your team.

Handouts are available for download in the Handouts pane and will be emailed out to attendees after the webinar.

Are you on this webinar with a group?

If so, please enter: first/last names and email addresses of those in attendance with you in the Questions Pane.
### AGENDA

<table>
<thead>
<tr>
<th>Welcome &amp; Introductions</th>
<th>Desi Barrett, HomeTown Health, LLC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lab &amp; Supply Presentation</td>
<td>Sandy Sage RN, HomeTown Health, LLC</td>
</tr>
<tr>
<td>Upcoming Events &amp; Resources</td>
<td>Jennie Price, HomeTown Health, LLC</td>
</tr>
</tbody>
</table>

### Speaker Biography: Sandy Sage, RN

- Registered Nurse for 25+ years
- Has worked in rural hospital revenue cycles 17 years
- HTHU Instructor
- Currently a Revenue Analyst for HomeTown Health

- Passionate about saving rural hospitals
- Love my kids and my cats!
Disclosure of Proprietary Interest

HomeTown Health does not have any proprietary interest in any product, instrument, device, service, or material discussed during this learning event.

The education offered by HomeTown Health in this program is compensated by the HRSA Small Hospital Improvement Program (SHIP) grant.

Program Goals

“The goal of the Hospital Transformation Consortium is to build a group of hospitals and other stakeholders that work together to support hospital collaboration and a community of shared best practices in transforming areas of Quality & Data Reporting, Financial Processes, & Technology in order to improve the value for the patient.”

The Objective of the “Pricing Transparency/Chargemaster Series” is to ensure that all revenue producing departments will:

• 1 Understand the Chargemaster and it’s importance
• 2 Be able to self-audit their department’s Chargemaster
• 3 Keep the Chargemaster compliant and Up-to-date
• 4 Develop tools for Pricing Transparency in your hospital
Q and A

What revenue code should a sleep study be billed under?
A: Revenue Code 920

What is the CPT code for HCPCS code G0283?
A: For Medicare and United use G0283 for unattended electrical stimulation other than wound care, and use CPT code 97014 for other payers.

Q and A

Should we use the G codes for mammograms this year?
A: No, the mammography G codes have been deleted. You will use the 7XXXX series for them in 2018.

Should we charge for Gastrograffin?
A: Yes, use HCPCS code Q9963 in revenue code 636. It is not separately payable under OPPS, but should be reported.
Barium is always considered a supply with no HCPCS code.
Q and A

- How should we charge for bilateral procedures in Radiology?
  
  A: Payment is usually 100% first procedure and 50% for the second. I recommend 1.5 times the unilateral charge.

- How do we know what price to charge for new procedures?
  
  A: Use the APC rates and multiply them to cover your costs. Some hospitals multiply reimbursement times 3 or 4 to determine the charge. Remember that with normal price increases this multiplier will not hold static.

Catch Up!

Where we’ve been so far...

- You should understand revenue codes and CPT/HCPCS codes
- You should know what is included in your Chargemaster
- ALL managers should be familiar with their Chargemaster
- You should know what procedures can be charged in outpatient and when a treatment room can and cannot be charged.
- You should know and understand the Respiratory guidelines for 2017 and the manager should have completed the RT CDM review
- If this is Greek to you, go back and listen to the second CDM webinar for a refresher!
Catch Up!

Where we’ve been so far...

► Your Radiology department should have reviewed their charges and deleted any old codes and added the 2018 new codes.
► Radiology should have reviewed all of the modifiers assigned in CDM and added or subtracted as needed.
► ER/OR - Should have reviewed charging for procedures and determining if any are being missed
► Therapy should be reviewing their CDM for accuracy.

► If this is Greek to you, go back and listen to the second and third CDM webinars for a refresher!

Poll Question
Learning Outcomes

- List the supply revenue codes that require a HCPCS code
- Identify a routine vs. non-routine supply
- Identify the three modifiers that may be used for lab codes
- Describe when it is appropriate to bill as a reference lab

Always Therapy

- **MM10176 - Effective 1/1/18**
- Therapy caps are applied to Physical and Speech combined and to Occupational Therapy alone.
- Using the GN, GO, GP modifiers allow CMS to keep up with the caps.
- Medicare recognizes services furnished in Outpatient Therapy as either “always” or “sometimes” therapy.
- CMS publishes a list every year at:
  - [https://www.cms.gov/Medicare/Billing/TherapyServices/AnnualTherapyUpdate.html](https://www.cms.gov/Medicare/Billing/TherapyServices/AnnualTherapyUpdate.html)
Always Therapy

- Services that must always be furnished under a plan of care regardless of who furnishes them;
- And must always be accompanied by the modifiers GN, GP or GO
- In addition, there are several “always” therapy codes that are discipline-specific requiring the GN for 6 codes, GO for 4 codes and GP for 4 codes.
- Those can be found here:

MACs will return/reject claims which contain an “always therapy” procedure code, but do not also contain the appropriate discipline-specific therapy modifier of GN, GO, or GP.

MACs will also return/reject claims if any service line on the claim contains more than one occurrence of a GN, GO, or GP therapy modifier.

MACs who are returning/rejecting such claims will use Group Code CO and Claim Adjustment Reason Code (CARC) 4 on the related remittance advice.
2018 Therapy Update

- Orthotic and prosthetic management services have been revised.
- *Initial Encounter* has been added to 97760 and 97761
- Created 97763 to describe all subsequent encounters for O and P services. It is an always therapy service and must be reported with a therapy modifier.
- 97762 is deleted
- CPT code 97127 is replacing 97532 but CMS will be replacing it with G0515

CAH Therapy

CAHs should make sure to bill therapy codes that have time increments with the correct number of units, i.e. 15 minute timed codes.

If you have covered and non-covered units, bill them on separate lines even if on the same day and claim.

Use one line for all covered units and one line for all non-covered units.
Therapy Caps

- The 2018 therapy caps are $2010 for PT/ST and $2010 for OT
- The exceptions for going above the cap using modifier KX expired on 12/31/17.
- Until Congress can either extend the exceptions or repeal the caps, Medicare patients will be responsible for anything above the cap.
- An ABN will not be necessary because the services are considered statutorily non-covered.

Supply
Centralize or Not?

You can have a centralized CDM which means each department has only their items listed even if items are sometimes used in other departments.

Example: Supplies are used in multiple departments - Are they all in the supply CDM or are they in every department’s CDM?

Centralize or Not?

If you have a centralized Chargemaster make sure that your system has a method for assigning the correct department.

If it is decentralized make sure that pricing for items is consistent.
Supply Revenue Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>270</td>
<td>General supplies</td>
</tr>
<tr>
<td>271</td>
<td>Non-sterile supplies</td>
</tr>
<tr>
<td>272</td>
<td>Sterile supplies</td>
</tr>
<tr>
<td>273</td>
<td>Take home supplies</td>
</tr>
<tr>
<td>274</td>
<td>Prosthetic/Orthotic devices*</td>
</tr>
<tr>
<td>275</td>
<td>Pacemaker*</td>
</tr>
<tr>
<td>276</td>
<td>Intra-ocular lens*</td>
</tr>
<tr>
<td>277</td>
<td>Take home Oxygen</td>
</tr>
<tr>
<td>278</td>
<td>Implants</td>
</tr>
<tr>
<td>279</td>
<td>Other supplies/devices</td>
</tr>
</tbody>
</table>

Commonly Used Revenue Codes

- **270** - is used for supplies that are not sterile and will make up the bulk of your supply CDM.
- **272** - is used for sterile supplies. Anything sterile that is not an implant should be in this revenue code.
- **278** - is used for implants and must be billed with a HCPCS code.
HCPCS Codes

- Revenue codes in this department that require CPT/HCPCS codes are:
  - 274 - Orthotics and Prosthetics
  - 276 - Intraocular lens
  - 278 - Implants

Equipment

- Equipment commonly available to all patients or ordinarily used during the course of a procedure is not separately billable.
- Example: Critical Care patients will always have life-saving equipment nearby. Respiratory and cardiac monitoring equipment, ventilators, defibrillators, and wall oxygen units are not separately billable since these are available to all patients.
- Rental equipment does not change the rule.
Poll Question

Routine Supplies

- The UB editor uses questions to determine separately billable items. Answer yes and it is separately billable:
  - Is the supply medically necessary and ordered by the physician? (not personal convenience items)
  - Is the supply used only for a specific patient? (excludes gowns, gloves, masks)
  - Is the supply not ordinarily used on most patients? (excludes blood pressure cuffs, bed pans, bed linen and gauze)
  - Is the supply not basically a stock or bulk item? (excludes drapes, pads, cotton balls, urinals)
Not Separately Billable

Any supplies, items or services necessary or integral to the provision of a service and/or delivery of a service in a specific location are considered routine and not separately billable.

All items and supplies that can be purchased over the counter.

All reusable items, supplies, equipment that are provided to all patients.

Not Separately Billable

All reusable items such as pulse oximeter, blood pressure cuffs, bedside table that are given to all patients in a specific treatment area or unit.

All reusable items, supplies and equipment that are provided to all patients receiving the same service.

Set Up charges (O2 tent, Croup tent, etc)

No Callback, standby, STAT, Portable charges are billable.
Not Separately Billable-OR

- Monitors (cardiac, anesthesia, BP)
- Reusable instruments
- Crash Carts
- Fracture tables
- Grounding pads
- Nursing services
- Lights, light handles, light covers
- Microscopes
- Bovie or cautery equipment
- Room set-ups
- Solution warmer
- Slush machine
- Laparoscopes, bronchoscopes, endoscopes and accessories
- Video cameras and tape
- Wall suction equipment
- Obtaining specimens
- Surgeon’s visual devices
- X-ray film

Q and A

Q - Can I charge separately for polyp snares used during a colonoscopy or do I need to add them to the price of the procedure?

A - If the supply (snare) is re-useable and used on all patients during the same procedure it is not separately billable. (add to the cost of the procedure)
Supply

- Your supply Chargemaster should not be the same as it was 10 years ago!
- Remember as you take routine supplies out of the CDM, increase your room rates or procedure charges to keep it revenue neutral.
- **Revenue Neutral** - Making sure the revenue stays the same, when taking away charges, by increasing other charges.

What does CMS say?

- Medicare’s information for routine supplies is not all-inclusive. They do **NOT** have a list of routine supplies.
- Medicare states that they do not use routine supply cost to determine reimbursement.
- Just because there is a HCPCS code that can be assigned does not mean you need to use it. For instance, If you are not a DME provider, you should not be billing HCPCS codes for supplies like splints or crutches. You need to bill in 270 or build the cost into the procedure charges.
Billable Devices

- Implants - device or tissue that is used and left in the patient’s body.
- Revenue code 278 requires a HCPCS code
- Some HCPCS codes are broad and will apply to multiple items
- Example - C1713 Anchor/Screw for bone to bone or soft tissue to bone (implantable)

Pass-Through Devices

- Effective 1/1/18 there are no device categories eligible for pass-through payment.
- Transitional devices will now be assigned to an APC for OPPS hospitals based on reasonable cost.
- The device costs are being bundled into the procedure APC, so if a new device is used, the amount bundled will be subtracted from the new device amount for payment.
- Continue to charge all devices in the correct revenue code with the correct HCPCS codes.
Supply

- Skin substitutes should continue to be billed with the correct C codes but for OPPS hospitals they will be assigned a status indicator “N” for no separate payment.
- They will now be bundled into the payment for the procedure.
- You need to consider this when looking at how you charge for those procedures.

Supply Managers

<table>
<thead>
<tr>
<th>Identify</th>
<th>Remove</th>
<th>Add</th>
<th>Check</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identify any codes that are in your CDM that are no longer active (Not in the code book)</td>
<td>Remove or delete any inactive codes</td>
<td>Add any HCPCS codes that are required for Medicare billing. Notify your BOM</td>
<td>Check that your department assignments are correct if you have centralized supply billing</td>
</tr>
</tbody>
</table>
Supply Managers

Increase
Increase charges for procedures and room rates as you remove supplies from the CDM

Discuss
Discuss any major changes with your CFO to ensure revenue neutrality

Make
Make sure you aren’t using any set-up, STAT or other non-billable charges

LABORATORY
AND PATHOLOGY, BLOOD BANK, MICROBIOLOGY AND MORE
Chargemaster Driven

Lab is one of the departments that is completely driven by the Chargemaster.

Important to keep it up-to-date!

Revenue Codes

- **Laboratory**
  - 300 - General
  - 301 - Chemistry
  - 302 - Immunology
  - 304 - Non-routine dialysis
  - 305 - Hematology
  - 306 - Bacteriology & Microbiology
  - 307 - Urology
  - 311 - Cytology
  - 312 - Histology
  - 314 - Biopsy

- **Blood**
  - 381 - Packed Red Blood Cells
  - 382 - Whole blood
  - 383 - Plasma
  - 384 - Platelets
  - 385 - Leucocytes
  - 386 - Other components
  - 390 - General blood storage
  - 391 - Blood Administration
Revenue Codes

- 300 is a general lab revenue code
- For accuracy in billing using 301-314 allows you to communicate more specific information to your payers.
- It also allows you to track the different revenue streams by area.
- Creates better reporting for your CFO

Laboratory Chargemaster

- The Lab Manager **MUST** be involved with every addition to the Lab CDM
- There are complicated testing methods that need to be assigned accurate CPT codes for compliance and correct billing.
- Many tests are sent to outside labs and the manager is the best source for cost information.
There are usually multiple line items with the same CPT codes that help differentiate specific subtests.

This can be a challenge for your cost to charge ratio if the pricing is different on each line.

Lab managers and Chargemaster staff need to ensure prices are above fee schedule and contracted rates.

**Lab Modifiers**

- There are three modifiers used in the lab.
- 91 - Repeat laboratory test.
  - Used when the same test is repeated on the same date of service
- 59 - Procedure was distinct and different from other testing
  - Used when a test with the same CPT but different testing method is used on the same date of service. Usually microbiology or pathology tests.
- QW- Waived tests
Lab Modifiers

- Modifiers should not be in the CDM for lab.
- It would balloon your CDM and become unmanageable.
- You should have a process in place to notify HIM when a test is repeated.
- If the bill hits edits for lab in the billing department the biller should notify lab prior to applying any modifiers.
- There are certain reasons that a test is repeated that it should not be billed twice and the charge may be in error. (clotted specimen, machine malfunction etc.)

Lab Modifiers

- If a panel is done on a patient, then later in the day a part of that panel is ordered, you can use modifier 91.

  - Example: Electrolytes are done in the morning, later in the afternoon the doctor orders a Sodium to be done.
  - You would charge for the electrolyte panel and then for the Sodium with a modifier 91.

  - Allows Medicare to see that the repeat was ordered and intentional.
Lab Modifiers

- Since you do not put lab modifiers in the Chargemaster, you need to have a process in place to let HIM know when a modifier is appropriate.

- The modifier should be applied prior to the claim going to the billing department.

- Billers should not be applying modifiers!

Poll Question
Drug Testing

- There are drug testing codes that can only be reported once per day. Lab managers should know and train their staff!
- 80305, 80306 and 80307
- Each of these has a description that starts: **Drug test(s), presumptive, any number of drug classes, any number of devices or procedures....**
- Do not combine and change the unit to one! The charges do not require a modifier. The additional charges should be removed from the claim!

Outside Lab Testing

- Unavailable charge codes for non-routine labs.
- This can be an exception to your normal Chargemaster addition process.
- Use a miscellaneous charge code that has the option for price and description manipulation.
- If the test is unusual don’t put a completely new charge code in the CDM.
CLIA Waived Tests

- Simple Laboratory tests and procedures
- Cleared by the FDA for home use
- Methods are simple and accurate and incorrect results bring no harm
- Not likely have erroneous results
- Should be billed with **modifier QW**

CLIA Waived Tests

- These tests do NOT require the QW modifier
  - 81002, 81025 Urinalysis
  - 82270, 82272 Stool Sample testing
  - 82962 fingerstick glucose
  - 83026, 85013 hemoglobin, hematocrit
  - 84830 ovulation test
  - 85651 sedimentation rate

No Longer Subject to CLIA Edits in 2018

- 83499 - Hydroxyprogesterone, 20 (synthetic hormone) level
- 84061 - Phosphatase (enzyme) level for forensic examination
- 86185 - Immunologic analysis for detection of antigen
- 86243 - Measurement of Fc receptor
- 86378 - Migration inhibitory factor
- 86729 - Lympho venereum antibody
- 86822 - Lymphocyte culture primed
- 87277 - Legionella micdadei ag if
- 87470 - Bartonella dna dir probe
- 87477 - Lyme dis dna quant
- 87515 - Hepatitis b dna dir probe
- 88154 - Cytopath c/v select


Poll Question
Reference Lab Testing

- If you are doing any reference lab testing it is important to remember that if the lab is not done in your hospital, you should not be billing for the test.
- If you are doing the testing, you should be doing the billing and not allowing another reference lab to bill for you.
- Every test MUST have a signed order and a diagnosis.
- If your contracts do not say that you are an approved reference lab for that payer, do not be surprised if they recover money paid to you.

Blood Products
Revenue Codes

- 380 - General
- 381 - Packed Red Cells
- 382 - Whole Blood
- 383 - Plasma
- 384 - Platelets
- 385 - Leukocytes
- 386 - Other components
- 387 - Cryoprecipitate
- 389 - Other blood
- 39X - Blood storage and Processing
- 390 - General
- 391 - Blood Administration
- 399 - other storage and processing

38X vs. 39X

- Revenue code series 38X is used for blood and blood supply products that have a charge to the hospital associated with them.
- Revenue code series 39X is used for blood products from a supplier that only assesses a processing charge, like the Red Cross.
- Medicare exempts whole blood and packed cells from Red Cross, from the Medicare blood deductible.
Blood Products

- Purchased blood products should be billed as:
  - Revenue code 381 (PRBCs) or 382 (whole blood) with value code 37 and the number of pints received, with the appropriate P code and BL modifier
  - Revenue 390, 392 or 399 (processing and storage) with the same P code, BL modifier, number and dates of service as the RC 38X codes.
  - Revenue code 391 (transfusion) with 36430 CPT code, one unit.

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>HCPCS / Modifier</th>
<th>Units</th>
<th>Value Code</th>
<th>Line Item Date of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>038X</td>
<td>PKX00BL</td>
<td>3</td>
<td>37 3.00</td>
<td>100114</td>
</tr>
<tr>
<td>0390, 0392 or 0399</td>
<td>PKX00BL</td>
<td>3</td>
<td></td>
<td>100114</td>
</tr>
<tr>
<td>0391</td>
<td>CPT code</td>
<td>1</td>
<td></td>
<td>100114</td>
</tr>
</tbody>
</table>

Blood Products

- Non- Purchased blood products should be billed as:
  - Revenue 390, 392 or 399 (processing and storage) with the correct P code, number of units and date of service.
  - Revenue code 391 (transfusion) with 36430 CPT code, one unit.

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>HCPCS / Modifier</th>
<th>Units</th>
<th>Line Item Date of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>0390, 0392 or 0399</td>
<td>PXXXX</td>
<td>2</td>
<td>100114</td>
</tr>
<tr>
<td>0391</td>
<td>CPT code</td>
<td>1</td>
<td>100114</td>
</tr>
</tbody>
</table>
Transfusion

The actual process of transfusing the blood
CPT 36430
Can only be charged once per day
**Do not charge for each unit**

Most hospitals allow lab to bill for this CPT

Types of Blood Products

Lab Managers should be involved in CDM

Multiple CPT codes may be billed for one transfusion

- Irradiated blood
- Autologous Blood
- Split Units
- Whole Blood
- Packed cells and more

Good source for blood billing:
http://www.aabb.org/advocacy/reimbursementinitiatives/Pages/billingfaq082907.aspx
2018 Blood Updates

- Effective 1/1/2018
- **P9073 Platelets Pheresis pathogen reduced**, replaces Q9988
  - Report with revenue code 390
  - The 2018 APC payment for OPPS is $624.61
- **P9100 Pathogen Test for platelets** replaces Q9987
  - Revenue code 305
  - Should be billed in addition to the blood P code
  - One unit for each unit tested
  - Bill if the test is done, even of transfusion is cancelled
  - The 2018 APC payment for OPPS is $25.50

2018 Blood Updates

- Effective 1/1/2018

- **P9072** is being deleted and has not been recognized by Medicare since July 1, 2017

- CMS continues to base rates on hospital charging practices. This methodology is causing a decrease in payment rates in 2018 for several blood products.

- Your rates should reflect the cost of processing and a mark-up so that rates do not continue to decrease!
<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Description</th>
<th>Final CY 2018 APC Payment</th>
<th>Final CY 2017 APC Payment</th>
<th>% Change 2018 vs. 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>P9010</td>
<td>Whole blood for transfusion</td>
<td>$156.91</td>
<td>$155.51</td>
<td>0.9%</td>
</tr>
<tr>
<td>P9011</td>
<td>Blood split unit</td>
<td>$102.67</td>
<td>$131.68</td>
<td>-22.2%</td>
</tr>
<tr>
<td>P9012</td>
<td>Cryoprecipitate each unit</td>
<td>$44.00</td>
<td>$63.03</td>
<td>-17.0%</td>
</tr>
<tr>
<td>P9016</td>
<td>Rbc leukocytes reduced</td>
<td>$183.76</td>
<td>$185.62</td>
<td>-1.1%</td>
</tr>
<tr>
<td>P9017</td>
<td>Plasma 1 donor frz w/in 8 hr</td>
<td>$72.41</td>
<td>$73.73</td>
<td>-1.8%</td>
</tr>
<tr>
<td>P9019</td>
<td>Platelets, each unit</td>
<td>$114.94</td>
<td>$96.49</td>
<td>19.1%</td>
</tr>
<tr>
<td>P9020</td>
<td>Platelet rich plasma unit</td>
<td>$123.50</td>
<td>$131.58</td>
<td>-6.2%</td>
</tr>
<tr>
<td>P9021</td>
<td>Red blood cells unit</td>
<td>$142.76</td>
<td>$142.36</td>
<td>0.3%</td>
</tr>
<tr>
<td>P9022</td>
<td>Washed red blood cells unit</td>
<td>$384.25</td>
<td>$344.37</td>
<td>11.6%</td>
</tr>
<tr>
<td>P9023</td>
<td>Frozen plasma, pooled, sd</td>
<td>$60.57</td>
<td>$66.82</td>
<td>-9.4%</td>
</tr>
<tr>
<td>P9031</td>
<td>Platelets leukocytes reduced</td>
<td>$116.70</td>
<td>$125.73</td>
<td>-7.2%</td>
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<tr>
<td>P9032</td>
<td>Platelets, irradiated</td>
<td>$179.13</td>
<td>$167.42</td>
<td>7.0%</td>
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<tr>
<td>P9033</td>
<td>Platelets leukoreduced irrad</td>
<td>$167.84</td>
<td>$162.09</td>
<td>3.4%</td>
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<tr>
<td>P9034</td>
<td>Platelets, pheresis</td>
<td>$421.17</td>
<td>$412.10</td>
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<td>P9035</td>
<td>Platelet pheresis leukoreduced</td>
<td>$476.96</td>
<td>$499.95</td>
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<td>P9036</td>
<td>Platelet pheresis irradiated</td>
<td>$554.42</td>
<td>$566.58</td>
<td>-2.4%</td>
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<tr>
<td>P9037</td>
<td>Plate pheresis leukoredu irrad</td>
<td>$624.61</td>
<td>$647.40</td>
<td>-3.5%</td>
</tr>
<tr>
<td>P9038</td>
<td>Rbc irradiated</td>
<td>$213.77</td>
<td>$218.95</td>
<td>-2.4%</td>
</tr>
<tr>
<td>P9039</td>
<td>Rbc deglycerolized</td>
<td>$420.80</td>
<td>$383.58</td>
<td>9.7%</td>
</tr>
<tr>
<td>P9040</td>
<td>Rbc leukoreduced irradiated</td>
<td>$260.18</td>
<td>$266.28</td>
<td>-2.3%</td>
</tr>
<tr>
<td>P9043</td>
<td>Plasma protein fract,5%,50ml</td>
<td>$15.39</td>
<td>$19.76</td>
<td>-22.1%</td>
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<tr>
<td>P9044</td>
<td>Cryoprecipitated reduced plasma</td>
<td>$106.53</td>
<td>$63.29</td>
<td>66.7%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Description</th>
<th>Final CY 2018 APC Payment</th>
<th>Final CY 2017 APC Payment</th>
<th>% Change 2018 vs. 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>P9048</td>
<td>Plasma protein fract,5%,250ml</td>
<td>$46.90</td>
<td>$92.67</td>
<td>-49.4%</td>
</tr>
<tr>
<td>P9050</td>
<td>Granulocytes, pheresis unit</td>
<td>Not paid by Medicare</td>
<td></td>
<td></td>
</tr>
<tr>
<td>P9051</td>
<td>Blood, lr, cmv-neg</td>
<td>$192.66</td>
<td>$206.48</td>
<td>-6.7%</td>
</tr>
<tr>
<td>P9052</td>
<td>Platelets, tba-m, lr. unit</td>
<td>$769.26</td>
<td>$738.14</td>
<td>4.2%</td>
</tr>
<tr>
<td>P9053</td>
<td>Plt. pht, lr, cmv-neg, irr</td>
<td>$539.80</td>
<td>$618.89</td>
<td>-12.8%</td>
</tr>
<tr>
<td>P9054</td>
<td>Blood, lr, froz/dgly/wash</td>
<td>$283.48</td>
<td>$275.58</td>
<td>2.9%</td>
</tr>
<tr>
<td>P9055</td>
<td>Plt. sph/plt, lr, cmv-neg</td>
<td>$339.93</td>
<td>$422.00</td>
<td>-19.4%</td>
</tr>
<tr>
<td>P9056</td>
<td>Blood, lr. irradiated</td>
<td>$155.24</td>
<td>$124.37</td>
<td>24.8%</td>
</tr>
<tr>
<td>P9057</td>
<td>Rbc, froz/dgly/white, lr, irad</td>
<td>$281.73</td>
<td>$207.45</td>
<td>35.8%</td>
</tr>
<tr>
<td>P9058</td>
<td>Rbc, lr, cmv-neg, irad</td>
<td>$238.03</td>
<td>$250.10</td>
<td>-4.8%</td>
</tr>
<tr>
<td>P9059</td>
<td>Plasma, frz between 8-24hour</td>
<td>$74.23</td>
<td>$74.00</td>
<td>0.3%</td>
</tr>
<tr>
<td>P9060</td>
<td>Fr frz plasma donor retested</td>
<td>$46.95</td>
<td>$67.19</td>
<td>-28.0%</td>
</tr>
<tr>
<td>P9070</td>
<td>Pathogen reduced plasma pool</td>
<td>$74.23</td>
<td>$74.00</td>
<td>0.3%</td>
</tr>
<tr>
<td>P9071</td>
<td>Pathogen reduced plasma sing</td>
<td>$72.41</td>
<td>$73.73</td>
<td>-1.8%</td>
</tr>
<tr>
<td>P9072*</td>
<td>Plate path red/nad bac tes</td>
<td>N/A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>P9073**</td>
<td>Platelets, pathogen reduced</td>
<td>$624.61</td>
<td>$647.40</td>
<td>-3.5%</td>
</tr>
<tr>
<td>P9100***</td>
<td>Pathogen test for platelets</td>
<td>$25.50</td>
<td>$25.50</td>
<td>0.0%</td>
</tr>
</tbody>
</table>
36515 - therapeutic apheresis with extracorporeal immunoadsorption and plasma reinfusion has been deleted for 2018.

Use 36516

### Learning Outcomes

- List the supply revenue codes that require a HCPCS code
- Identify a routine vs. non-routine supply
- Identify the three modifiers that may be used for lab codes
- Describe when it is appropriate to bill as a reference lab
QUESTIONS?

Contact:
Sandy Sage
Sandy.sage@hometownhealthonline.com

References
- https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/FAQ-Mammography-Services-Coding-Direct-Digital-Imaging.pdf
- https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Downloads/Completer-list-DeviceCats-OPPS.pdf

UPCOMING EVENTS & RESOURCES
Hospital Transformation Consortium

CONSORTIUM SUPPORT:

WEBSITE DASHBOARD
IOWA
www.hthu.net/iahtc
GA/FL
www.hthu.net/htc17
Contact us for password

PROGRAM CALENDAR
“Cheat Sheet”
CONSORTIUM TRAINING

Pricing Transparency: Focus on Chargemaster Series
There is a greater push for increasing price transparency by government and patients. It is important that hospitals have a complete, accurate and compliant chargemaster in order to develop a consistent pricing transparency program. This 5-part series led by Sandy Sage, RN, Revenue Analyst with HomeTown Health, is designed to provide an overview of Pricing Transparency, and to teach hospitals how to complete self-assessments on their own chargemasters so that it remains current and up-to-date. This program is the foundation for accurate and transparent charging and billing.

Webinars held at 1 pm CST/ 2 pm EST on dates below.

<table>
<thead>
<tr>
<th>Date</th>
<th>Title</th>
<th>Type</th>
<th>CEUs</th>
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</thead>
<tbody>
<tr>
<td>August 10, 2017</td>
<td>Program Intro: Pricing Transparency in Healthcare</td>
<td>Webinar</td>
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<tr>
<td>October 12, 2017</td>
<td>Chargemaster 101: Key Elements and How CMD and Coding Data translates to claims</td>
<td>Webinar</td>
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<tr>
<td>December 14, 2017</td>
<td>Breaking it down: Department Specific Chargemaster guidelines</td>
<td>Webinar</td>
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<tr>
<td>February 1, 2018</td>
<td>Chargemaster: The Tough Stuff, Pharmacy and Supply</td>
<td>Webinar</td>
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<tr>
<td>April 12, 2018</td>
<td>Pharmacy, Charge Capture, Q &amp; A</td>
<td>Webinar</td>
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<tr>
<td>May 17, 2018</td>
<td>Becoming Transparent: Putting it all Together</td>
<td>Webinar</td>
<td>0.1</td>
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18th Annual HOMETOWN HEALTH Spring Conference

The Heart of Community
Rural Health Artistry

Savannah Marriott Riverfront
April 25-27, 2018

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SHIP GRANT 2018-2019

Mark your Calendar: Kickoff Webinar Dates
Georgia/Florida Hospitals: June 1, 2018 at 11am Eastern
Iowa Hospitals: May 30th at 1:30pm Central
Questions?
Questions about these resources or Upcoming Events?

Contact:
Sandy Sage, Financial Program Lead
Sandy.Sage@hometownhealthonline.com
or
Jennie Price, SHIP Program Manager
jennie.price@hometownhealthonline.com

TELL US HOW WE DID!
A survey will launch after this webinar closes: please take a moment to give us your feedback on the training, speaker, content, webinar format, and anything else you can share!

If there’s something we can help your hospital with, please let us know!