

UCDHS COMPLIANCE OFFICE CODING AND BILLING NOTICE

Topic: **Therapeutic Apheresis Services**

This notice outlines the criteria for billing Apheresis Services provided to patients in the UCDHS Hospital setting. The information provided below is in addition to the billing requirements found in the Current Procedural Terminology (CPT) published by AMA.

I. Therapeutic Apheresis Services

The CPT services included in this guideline are:

- 36511 - Therapeutic apheresis for white blood cells
- 36512 - Therapeutic apheresis for red blood cells
- 36513 - Therapeutic apheresis for platelets
- 36514 - Therapeutic apheresis for plasma pheresis
- 36515 - Therapeutic apheresis with extracorporeal immunoadsorption & plasma reinfusion
- 36516 - Therapeutic apheresis with extracorporeal selective adsorption or selective filtration & plasma reinfusion

II. Coverage

- A. Therapeutic Apheresis is a covered benefit of Medicare and Medi-Cal.
 - 1. Medicare covers Non-physician services as hospital services following UCDHS billing guidelines and requires the direct, personal supervision of a physician. In addition, the physician is present to perform medical services and respond to medical emergencies at all times during patient care hours and each patient is under the care of a physician.
 - 2. Medi-Cal requires CPT codes 36511 – 36516 to be billed with modifier –AG for any type of therapeutic apheresis. Medi-Cal also requires By-Report billing and a prior Treatment Authorization Request (TAR). The TAR will indicate the number of treatments authorized. A description of the process of the product/derivative from the donor and the number of blood units obtained must be indicated in the *Remarks area/Reserved For Local Use* field (Box 19) of the claim or on an attachment.
 - 3. Medi-Cal also requires that HCPCS code Z5204 (blood products/blood derivates) must be used to bill for blood products (i.e., platelets, plasma, granulocytes or red blood cells) collected from donors by apheresis.
- B. Insurance carriers should be contacted for individual coverage verification and authorization. Each payer type covers apheresis services based on the patient’s diagnosis to establish medical necessity.

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III. Medical Record Documentation

- A. The treating physician must complete chart documentation for procedures following the established UCDHS Teaching Physician Guidelines for Professional Fee Billing - Policy and Procedure #1928 and UCDHS Medical Records Content Policy and Procedure #2306.
 - 1. For State and Federal payers the Attending Physician must be present during all critical and key portions of the procedure and be immediately available to furnish services during the entire procedure. This means the Attending Physician must be present at some point during the apheresis procedure.
- B. Presence verification may be satisfied with the completion of the UC Davis Medical Center Apheresis Summary card (Attachment 1), documented within the providers Progress Note or by completing a UCDMC Procedure Presence Form.
 - 1. The Apheresis Summary card is a peel-and-stick card to be completed by the Attending provider and nursing staff and permanently adhered in the patient's medical record. The check box stating "Patient seen and evaluated during procedure" must be completed and signed by the Attending Physician.

IV. Billing

- A. The Medical Services Abstracting Unit (MSA) is responsible for processing Inpatient and Outpatient professional billing of these services. There are no global days associated with these services.
- B. The MSA staff receives notice of apheresis services through the Hospital Daily Census Report. Apheresis outpatient services are listed within the 50 prefix case numbers.
- C. Compliance recommends the MSA Unit obtain record of patients receiving Therapeutic Apheresis services by requesting the patient list from the Apheresis Unit Data Base daily. This will serve as a back-up checklist to verify all procedures were captured for Professional Fee billing.
- D. MSA staff will verify procedure presence for State and Federal payers prior to submitting a charge.
- E. If the required procedure presence documentation is missing, the Abstractor will follow the established MSA Request For Information (RFI) procedure.

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- F. Apheresis/pheresis services are billed on a per visit basis and not on a per unit basis. Evaluation and Management (E/M) services by the same physician on the same day as an apheresis service are included in the payment for the procedure unless a separately identifiable service is performed which extends beyond the E/M portion of a typical apheresis/pheresis service. If billing an E/M service code, a modifier 25 is appended to the appropriate E/M code.
- G. The Apheresis Unit will continue to process the Facility billing following current Hospital guidelines.
- H. These procedures are Status Indicator **S** for APC billing purposes. The Hospital billing system will convert the CPT codes billed to the appropriate Medi-Cal billing codes.

Resources:

1. APC Answer Book, Blood Products, 11201-11204, Feb 2006.
2. Medi-Cal Provider Manual, Blood and Blood Derivates, pg. 7, Oct 2005.
3. Medi-Cal Provider Manual, Surgery: Cardiovascular System, pgs. 6-7, Sept 2002.
4. Medi-Cal Proivder Manual, TAR and Non-Benefit List, pg. 5, Oct 2005.
5. Medicare Claims Processing Manual, Ch. 4, Section 231.9.
6. Medicare National Coverage Determinations Manual, Ch.1, Sections 20.5, 110.4, 110.5, 110.7, 110.8, 110.8.1, 110.14.