CHAPTER 5
SECTION 6.2

TRANSFUSION SERVICES FOR WHOLE BLOOD, BLOOD COMPONENTS AND BLOOD DERIVATIVES

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I. PROCEDURE CODE RANGE

86920 - 86922, 86077, 86900 - 86906, 86890 - 86891, and also related is 36430, 36440, 36450-36460

II. DESCRIPTION

Transfusions are the introductions of either whole blood, and blood components (red cells, platelets, plasma, or leukocytes), or blood derivatives (albumin, gamma globulin, Factors VIII and IX, or Rho (D) immune globulins (RhoGAM), and prothrombin) directly into the bloodstream. Transfusion services are those services necessary to test donor blood and administer transfusions. Transfusion services include equipment, supplies, storage, administration, processing, typing and cross-matching.

III. POLICY

A. Charges for whole blood and blood components are not eligible for coverage unless the whole blood and blood components are actually administered to the patient. Unused whole blood and blood components are not eligible for cost-sharing. Inpatient charges for whole blood and blood components used by the patient are included within the DRG charge. No separate charge is allowed.

B. Charges for transfusion services for whole blood and blood components for medically necessary, physician-ordered transfusions of both allogeneic and autologous blood when the whole blood or blood components are used by the patient are eligible for coverage as supplies or laboratory services and are included within the DRG charge.

C. Transfusion services for autologous blood and blood components in the absence of a scheduled covered surgical procedure are not considered medically necessary and are not eligible for coverage.

D. Charges for blood derivatives, outlined above under Description, which are classified as formulary drugs are eligible for coverage as prescription drugs. However, when Factors VIII and IX are provided on an inpatient basis, reimbursement will follow the procedures contained in Chapter 13, Section 6.1D.

E. Charges for transfusion services for blood derivatives are eligible for coverage as supplies or laboratory services and are included within the DRG charge.

F. Charges for the testing of autologous blood are not eligible for coverage since they are not considered medically necessary if the blood is used by the donor.

G. Charges for the testing of autologous blood not used by the donor are not eligible for coverage, since the unused autologous blood becomes part of the allogeneic blood pool. Charges for such testing should be passed on to the recipient, as they are in other allogeneic transfusions.

H. Charges for the collection and storage of autologous blood are included within the DRG charge; no separate charge is allowed. Charges for collection and storage of autologous blood by other than the inpatient facility, such as a blood bank, should be reimbursed by the inpatient facility since they are included in the DRG charge. If the autologous blood is not used by the beneficiary, the charges for collection and storage of the blood are the responsibility of the beneficiary.

IV. EXCEPTION

Blood typing for paternity testing (CPT codes 86910, 86911) is not covered.

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