Blood and blood components

Applies to:
Blue Cross and Blue Shield of Nebraska Medicare Advantage Plans

BlueCross BlueShield Nebraska
An independent licensee of the Blue Cross and Blue Shield Association

Overview

A person's need for blood and/or blood components can be due to either an acute or a chronic medical condition. The administration of blood and/or blood components may take place in either an inpatient or outpatient setting.

Original Medicare

Original Medicare covers the provision of whole blood, packed red blood cells (packed RBCs), and other blood components under both Part A and Part B benefits. Deductibles and other co-insurance amounts for services related to the provision of whole blood, packed RBCs and other blood components are applied differently depending on whether the blood and/or blood components are delivered in an inpatient (Part A) or outpatient setting (Part B).

Original Medicare does not provide payment for the first three pints of blood or equivalent units of packed RBCs received under Parts A and B combined in a calendar year even if one or more providers administer the units during the calendar year. A deductible, in the form of a requirement to replace the three pints and/or units, is instead applied to these first three pints of whole blood or equivalent units of packed RBCs. Other components of blood that are covered as biologicals such as platelets, fibrinogen, plasma, gamma globulin and serum albumin are not subject to the blood deductible.

A provider may charge the beneficiary its customary charge for a pint of blood or equivalent unit of packed RBCs for the first three units that are subject to the deductible unless the beneficiary, another person or blood bank replaces and/or arranges for the replacement of the pint and/or unit. Where the provider refuses to accept an offered replacement unit for other than a reasonable basis of concern of a health risk to either a potential recipient or the prospective donor, the provider may not charge the beneficiary for the deductible pint and/or unit. If the provider does not pay to obtain the first three units, then the patient is not responsible for payment or replacement.

BCBSNE Medicare Advantage Enhanced Benefit

The Blue Cross and Blue Shield of Nebraska Medicare Advantage plans provide at least the same level of benefit coverage as Original Medicare (Part A and Part B) and may provide enhanced benefits beyond the scope of Original Medicare within a single health care plan. This flexibility allows Blue Cross Blue Shield of Nebraska to offer enriched plans by using Original Medicare as the base program and adding desired benefit options.

The enhanced benefit for whole blood and packed red blood cells furnished in either an inpatient or outpatient setting provides full coverage (including storing and administration) beginning with the cost of the first pint of whole blood or the first unit of packed RBCs when medically necessary. Coverage of the first three pints of blood or equivalent units of packed RBCs also releases the member from the obligation to replace these units and from any charges from the provider for failing to do so.

Enhanced covered whole blood and packed RBCs furnished in either an inpatient or outpatient setting is provided to all members under the Medicare Advantage plans. The scope of the benefit, reimbursement methodology, maximum payment amounts, and the member's cost sharing are determined by Blue Cross and Blue Shield of Nebraska.

Conditions for payment

The table below specifies conditions for whole blood and packed RBCs in an inpatient or outpatient setting.

Conditions for payment	
Eligible provider	Consistent with Original Medicare
Payable location	Inpatient or Outpatient facility
Frequency	As medically necessary each calendar year
HCPC Codes	P9010 - P9023, P9031 – P9041, P9043, P9044, P9048, P9050 – P9060, P9070 – P9072, 36430-36460, 86890, 86930 - 86932
Diagnosis Restrictions	Restrictions apply
Age Restrictions	No restrictions

Reimbursement

BCBSNE Medicare Advantage plans' maximum payment amount for the delivery of whole blood, packed RBCs and other blood components is consistent with Original Medicare. The provider will be paid based on either the Medicare Inpatient Prospective Payment System (IPPS) or the Outpatient Prospective Payment System
(OPPS) depending on where the service was provided. This represents payment in full and providers are not allowed to balance bill the member for the difference between the allowed amount and the charge.

Member cost-sharing

- BCBSNE Medicare Advantage providers should collect the applicable cost sharing from the member at the time of the service when possible. Cost sharing refers to a flat-dollar copayment, a percentage coinsurance or a deductible. Providers can only collect the appropriate BCBSNE Medicare Advantage cost-sharing amount from the member.
- If the member elects to receive a non-covered service, he or she is responsible for the entire charge associated with that service.

To verify benefits and cost-share, providers may call 888-505-2022.

Billing instructions for providers

1. Bill services on the CMS 1500 (02/12) claim form, UB-04 or the 837 equivalent claim.
2. Use the BCBSNE Medicare Advantage unique billing requirements.
3. Report CPT/HCPCS codes and diagnosis codes to the highest level of specificity.
4. Report your National Provider Identifier number on all claims.
5. Send your claims to your local BCBS plan.

Revision History:

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