Blood and blood components
Applies to:

Blue Cross Blue Shield of Michigan

A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

☐ Medicare Plus Blue PPO℠ ☐ Medicare Plus Blue Group PPO℠ ☒ Both

Blood and blood components

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. The three unit limit is applied even if one or more providers administer the units during the calendar year. In addition, a deductible is applied to these first three pints of whole blood or equivalent units of packed RBCs. Other components of blood 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.

Medicare Plus Blue℠ PPO Enhanced Benefit

Medicare Plus Blue is a Medicare Advantage Plan, which provides 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 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 cells furnished in either an inpatient or outpatient setting provides coverage (including storage 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 coverage for whole blood and packed RBCs furnished in either an inpatient or outpatient setting is provided under both Medicare Plus Blue Group and Individual plans. The scope of the benefit, reimbursement methodology, maximum payment amounts, and the member's cost sharing are determined by Blue Cross for the individual coverage and by the group for those with group-based coverage.

Conditions for payment

The table below specifies conditions for blood products, 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
HCPCS codes	P9010 - P9011, P9016, P9021 - P9022, P9038 - P9040, P9051, P9054, P9056 - P9058
Diagnosis restrictions	No restrictions apply
Age restrictions	No restrictions

Reimbursement

Medicare Plus Blue plan's maximum payment amount for the delivery of 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 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

- Medicare Plus Blue PPO 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 Medicare Plus Blue 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 utilize our provider portal or call 1-866-309-1719.

Billing instructions for providers

1. Bill services on the CMS 1500 (02/12) claim form, UB-04 or the 837 equivalent claim form.
2. Use the Medicare Advantage PPO 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. Submit claims to your local BCBS plan.
6. Use electronic billing:
   a. Michigan providers
      Copies of the ANSI ASC X 12N 837 and 835 Institutional Health Care Claim and Health Care Claim Payment/Advice (Blue Cross Electronic Data Interchange Institutional 837/835 Companion Documents) are available on the Blue Cross website under the reference library section at: ***bcbsm.com/providers/help/edi***.
   b. Providers outside of Michigan should contact their local Blue Cross plan.

Revision history

Policy number: MAPPO 1005

Reviewed: 08/30/2023, 08/31/2022, 08/25/2021, 11/20/2020, 08/27/2019, 08/31/2017, 10/19/2016

Revised: 11/08/2017, 08/31/2017, 01/01/2016, 01/01/2014

11/08/2017: Changed the language in the policy paper to clarify that the intent of the enhanced policy benefit is to cover whole blood and packed red blood cells. Removed language/HCPCS codes referencing blood components, because they are not part of the enhanced benefit.

08/31/17: Changed policy number from MAPPO 1030 to MAPPO 1031, Under the Original Medicare Section 'Deductibles are applied differently depending on whether the blood and/or blood components are delivered in an inpatient (Part A) or outpatient setting (Part B).' changed to 'Deductibles and other co-insurance amounts for services related to the provision of who blood, packed RBCs and other blood components are applied differently depending whether the blood or blood components...'; deleted 'The three unit limit is applied', deleted 'In addition,' revised sentence adding 'A deductible, in the form of a requirement to replace the three pints and/ or units, is also applied...' clarified 'Other components of blood that are covered as biologicals...'; clarified that in addition to requiring the replacement of the units, under Original Medicare the provider may also add the customary charge for the unit(s) as part of the deductible.

01/01/2016: Coverage expanded to apply to other blood components beginning with the first unit used, added HCPCS codes for additional blood components.

01/01/2014: Policy established, covered the cost of the first three pints of blood administered (P9010, P9016) and the applicable deductible when administered in an outpatient facility setting including storage and administration charges.

Created: 10/19/2016

Effective: 01/01/2014