Blood and Blood Components

Applies to Iowa and South Dakota:

Blue Medicare Advantage PPO℠, Blue Medicare Advantage Enhanced PPO℠, Blue Medicare Advantage Classic PPO℠, and Blue Medicare Advantage℠ Valor PPO

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 even if one or more provider administers 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. When the provider refuses to accept an offered replacement unit, unless for 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.

Wellmark Advantage Health Plan PPO Enhanced Benefits

Wellmark Advantage Health Plans (WMAHPs) are Medicare Advantage Plans, which provide at least the samelevel 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 WMAHP to offer enriched plans by using Original Medicare as the base program and adding desired benefit options.

The benefit for blood and blood components 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, the first unit of packed RBCs or the first unit of other blood components 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.

Coverage for blood and blood components furnished in either an inpatient or outpatient setting is provided under Wellmark Advantage Health Plan (WMAHP). The scope of benefit reimbursement methodology, maximum payment amounts, and the member's cost sharing are determined by WMAHP.

Conditions for Payment

The table below specifies conditions for blood and or blood components 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
CPT/HCPCS codes	P9010-P9012, P9016-P9017, P9019-P9023, P9031-P9044, P9045-P9048, P9050-P9060, P9070-P9071, P9073, P9099-P9100, P9603-P9604, P9612 36430-36460, 86890, 86927, 86930-86932
Diagnosis restrictions	No restrictions apply
Age restrictions	No restrictions

Reimbursement

WMAHP PPO 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 (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

WMAHP providers should collect the applicable if any 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 WMAHP cost sharing amount from the member.

Please reference the plans Evidence of Coverage (EOC) or Summary of Benefits (SB) for specific cost share amounts.

If the member elects to receive a non-covered service, he or she is responsible for the entire charge associated with that non-covered service.

To verify member eligibility, benefits, and cost share, go to the Wellmark Advantage Health Plans secure website at www.WellmarkAdvantageHealthPlan.com or call Provider Inquiry **1-855-716-2556 (TTY:711).**

Billing Instructions for Providers

- Bill services on the CMS 1500 (02/12) claim form, UB-04 or the 837 equivalent claim form
- Report CPT/HCPCS codes and diagnosis codes to the highest level of specificity
- Report your National Provider Identifier number on all claims
- Use electronic billing.
- Submit claims to:

Wellmark Advantage Health Plan
Station 1E238
PO Box 9291
Des Moines, IA 50306

Revision History

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