

**Policy terminated because Medicaid covers codes in the same manner as
Health Choice.**

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1.0 Description of the Procedure, Product, or Service

- a. Whole blood and blood components (e.g., red cells, plasma, platelets and leukocytes) are used in the treatment of a wide variety of conditions.
- b. Blood derivatives (e.g., albumin, gamma globulin and prothrombin), likewise, are used in the treatment of several conditions and are often processed similarly to drugs.

2.0 Eligible Recipients

2.1 General Provisions

To be eligible, NCHC recipients must be enrolled on the date of service.

3.0 When the Procedure, Product, or Service Is Covered

3.1 General Criteria

NCHC covers procedures, products, and services related to this policy when they are medically necessary and

- a. the procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the recipient's needs;
- b. the procedure, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available; **AND**
- c. the procedure, product, or service is furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

3.2 Specific Criteria

- a. Benefits are available for the collection, storage and transfusion of either blood or any one or more of its components in conjunction with a covered surgical procedure or a covered medical service.
- b. Transfusion services are those services which are necessary to test blood and administer transfusions (e.g., blood, equipment, supplies, storage, administration, processing, typing and cross-matching) that are ordered by the physician.
- c. Blood derivatives classified as formulary drugs are eligible for coverage as prescription drugs.
- d. Charges for transfusion services that obtain and deliver blood derivatives are eligible for coverage as supplies or laboratory services

4.0 When the Procedure, Product, or Service Is Not Covered

4.1 General Criteria

Procedures, products, and services related to this policy are not covered when

- a. the recipient does not meet the eligibility requirements listed in **Section 2.0**;
- b. the recipient does not meet the medical necessity criteria listed in **Section 3.0**;
- c. the procedure, product, or service unnecessarily duplicates another provider's procedure, product, or service; **OR**
- d. the procedure, product, or service is experimental or investigational.

4.2 Specific Criteria

- a. Transfusion services for autologous blood and blood components in the absence of a covered medical or surgical procedure are not medically necessary and are ineligible for benefits.
- b. Testing of autologous blood is not medically necessary if the blood is used by the donor.
- c. Services associated with autologous blood that is not used by the donor but becomes part of an allogeneic transfusion are not covered. All costs associated with collection and subsequent transfusion should be passed on to the recipient.
- d. No benefits are available for any services related to the collection of blood when its use in any manner is associated with an experimental/investigational medical or surgical procedure as determined by DMA's vendor.

5.0 Requirements for and Limitations on Coverage

5.1 Prior Approval

Prior approval is not required.

6.0 Providers Eligible to Bill for the Procedure, Product, or Service

To be eligible to bill for procedures, products, and services related to this policy, providers shall

- a. meet NCHC qualifications for participation;
- b. be currently enrolled with NHCH; and
- c. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

7.0 Additional Requirements

7.1 Compliance

Providers must comply with all applicable federal, state, and local laws and regulations, including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements.

8.0 Policy Implementation/Revision Information

Original Effective Date: July 1, 2010

Revision Information:

Date	Section Revised	Change
July 1, 2010	Throughout	Policy Conversion: Implementation of Session Law 2009-451, Section 10.32 "NC HEALTH CHOICE/PROCEDURES FOR CHANGING MEDICAL POLICY."
February 29, 2012	Throughout	Policy Termination

Attachment A: Claims-Related Information

Reimbursement requires compliance with all Medicaid guidelines.

A. Claim Type

Professional (CMS-1500/837P transaction)

Institutional (UB-04/837I transaction)

B. Diagnosis Codes

Providers must bill the ICD-9-CM diagnosis codes(s) to the highest level of specificity that supports medical necessity.

C. Procedure Code(s)

Revenue codes				
		380	381	382
383	384	385	386	387
389	390	391	399	
CPT codes				
		36430	36440	36450
36455	36460	86890*	86891	86927*
86930*	86931*	86932*		
HCPCS codes				
		P9010	P9011	P9012
P9016	P9017	P9019	P9020	P9021
P9022	P9023	P9031	P9032	P9033
P9034	P9035	P9036	P9037	P9038
P9039	P9040	P9041	P9043	P9044
P9045*	P9046	P9048	P9051	P9052
P9053	P9054	P9055	P9056	P9057
P9058	P9059	P9603	P9604	S9538
ICD-9-CM procedure codes				
			99.0	99.00
99.01	99.02	99.03	99.04	99.05
99.06	99.07	99.08	99.09	

*HCPCS code P9045 will deny incidental if on the same day as revenue codes 381, 383, 384, 385 & 386.

*CPT codes 86890, 86927, 86930 86931 & 86932 will deny as incidental if done by a pathologist.

D. Modifiers

Providers are required to follow applicable modifier guidelines.

E. Billing Units

The appropriate procedure code(s) used determines the billing unit(s).

F. Place of Service

Inpatient and Outpatient setting

G. Co-payments

Co-payment(s) may apply to covered prescription drugs and services.

H. Reimbursement

Providers must bill their usual and customary charges.

Date of Termination: 02.29.2012