

Preoperative Autologous Blood Donation Payment Policy

Policy

Autologous blood collection, processing, and storage is not covered for commercial plan members (*unless coverage for autologous blood collection, processing, and storage has been added as a rider to their Member Handbook/Evidence of Coverage*), because it has not been proven that preoperative autologous blood donation is as cost-effective as the established alternatives that achieve similar health outcomes, such as allogeneic blood transfusion, intraoperative blood salvage, postoperative blood salvage, and acute normovolemic hemodilution.

Autologous blood collection, processing, and storage is covered for Fallon Medicare Plus Plan and other Plans with Medicare enrollment (NaviCare, Summit Eldercare, etc.) members because it is a Medicare-covered service, and the Plan is contractually obligated to provide coverage for this service to our Medicare members.

Definitions

This policy applies to payment for preoperative autologous blood donation. "Autologous" blood is a patient's own blood. To reduce the risk of transmission of infectious diseases, autologous blood may be collected, processed, and stored for use during or after a surgery in which the likelihood of transfusion is high, such as hip replacement surgery or cardiovascular surgery. Autologous blood transfusion does not eliminate all of the risk associated with blood transfusions.

A patient may decide to donate autologous blood for transfusion after a discussion between the surgeon and the patient regarding the risks and benefits of blood transfusions. Some patients may not be eligible for autologous blood donation. Eligible patients will generally "donate" one or more units of blood over a period of 4 to 6 weeks prior to surgery. Many patients can donate blood as frequently as once a week.

Autologous blood requires special handling and separate processing and storage, and consequently, autologous blood costs more than donated allogeneic blood. In addition, one-third to one-half of collected autologous blood is not needed. (Collection in excess of transfusion is unavoidable.) Unused autologous blood is stored for a period of time after the operation, typically until the patient's discharge or the blood's expiration date (blood can be stored for up to 42 days), and then the blood is discarded.

Reimbursement

Commercial plan

Autologous blood collection, processing and storage (CPT 86890) is not covered for commercial plan members and claims for autologous blood collection, processing, and storage (CPT 86890) will be denied as member liable (*unless coverage for autologous blood collection, processing, and storage has been added as a rider to their Member Handbook/Evidence of Coverage*).

Medicare Based Plans

Autologous blood collection, processing, and storage (CPT 86890) is covered for Fallon Medicare Plus Plan, NaviCare, and Summit Eldercare members who are scheduled for a covered inpatient or outpatient surgical procedure in which the likelihood of transfusion is high, such as hip replacement surgery or cardiovascular surgery.

MassHealth:

The service is considered non-covered for MassHealth and thus will not be covered by the plan.

The Plan reimburses claims for autologous blood processing and storage in accordance with the American Association of Blood Banks (AABB) Billing Guide, Edition 4.0, October 2007. The AABB Billing Guide complies with Medicare regulations.

The inclusion of services provided to hospital patients by an outside supplier as part of hospital services is referred to as bundling. In the situation where a hospital obtains autologous blood from an independent blood supplier or community blood bank, the supplier collects, processes, and stores the blood, and then typically delivers it to the hospital. *The hospital is responsible for paying the supplier.*

Reimbursement for autologous blood claims for inpatient procedures:

The Plan reimburses most hospitals for inpatient care on a per diem or case rate basis. A per diem is a negotiated payment for each day of care, regardless of the resources used. Case rates are predetermined dollar amounts defined by the diagnosis(es) assigned or the procedure(s) performed. Under the provider contract, the per diem or case rate paid to the inpatient facility includes all covered services, including autologous blood processing and storage expenses, whether or not the blood is eventually used.

No separate payment is made for autologous blood collection, processing, and storage for hospital inpatient procedures, even when autologous blood is collected but not transfused. Claims for the collection, processing, and storage of autologous blood for inpatients will be denied as not separately reimbursed.

Reimbursement for autologous blood claims for outpatient procedures:

- When an autologous blood product is transfused, the outpatient facility should bill for the number of units of the appropriate blood product that is transfused along with the transfusion service provided, on the date that the transfusion took place (not on the date that the autologous blood was collected or supplied). Payment for the blood product is intended to cover all of the costs associated with the collection, processing, storage and transportation (if applicable) of the autologous blood product.
- When autologous blood is collected but not transfused, the facility should bill CPT 86890 (autologous blood or component, collection, processing, and storage; pre-deposited) and the number of units collected but not transfused, on the date that the facility is certain that the blood will not be transfused, rather than on the date of collection or receipt from an independent blood supplier.

Referral/notification/prior authorization requirements

No prior authorization is required for autologous blood storage and processing.

Billing/coding guidelines

Inpatient procedures:

Hospitals should accurately code all resources used, including autologous blood products and transfusion administration services.

For inpatient facilities reimbursed on a per diem or case rate basis, the costs associated with autologous blood are included in the per diem or case rate and no separate payment will be made for autologous blood, including collection, processing, and storage.

For inpatient facilities that are reimbursed on a fee-for-service basis, claims for blood products transfused during inpatient surgery are reimbursed separately:

- Transfused blood products, including autologous blood products should be billed with the number of units of the appropriate HCPCS code for the blood product (payment for the product is intended to cover the costs associated with providing the autologous blood product, i.e., the collection, processing, and storage) and a CPT code for the transfusion administration. Each transfusion administration CPT code will be paid once per day, regardless of the number of units or different types of blood products transfused.
- CPT 86890 (autologous blood or component, collection, processing and storage; pre-deposited) should only be billed when autologous blood is collected but not transfused. The

inpatient facility should bill CPT 86890 on the date that the hospital is certain that the blood will not be transfused.

Outpatient procedures:

Autologous blood products and transfusion administration services provided during outpatient surgery are reimbursed separately. The date of service should reflect the date of the transfusion and not the date of collection or receipt from the supplier. Claims for outpatient services require an ICD diagnosis code, a CPT/HCPCS code and a revenue code. Hospital outpatient revenue codes for autologous blood products and transfusion administration services are the same as hospital inpatient revenue codes. Claims for transfused blood products in the outpatient setting are billed with the number of units of the appropriate HCPCS code for the blood product (payment for the product is intended to cover the costs associated with providing the autologous blood product, i.e., the collection, processing, and storage) and a CPT code for the transfusion administration. Each transfusion administration CPT code will be paid once per day, regardless of the number of units or different types of blood products transfused.

When certain that autologous blood collected for outpatient surgery will not be transfused, the hospital may submit a claim for CPT 86890 (autologous blood or component, collection, processing and storage; pre-deposited). Billing of 86890 is only indicated when autologous blood is collected but not transfused, therefore, the hospital should bill 86890 on the date that the hospital is certain that the blood will not be transfused rather than on the date of the collection or receipt from the supplier.

Policy history

Origination date:	09/13/2006
Previous revision date(s):	10/10/07 05/01/2014 - Updated codes and format. 11/01/2015 - Annual review and moved to new Plan template.
Connection date & details:	September 2016 – Annual review. January 2018 – Clarified this services is not covered for MassHealth January 2019 – Annual Review, no updates January 2020 – Clarified what plan types are covered.

The criteria listed above apply to Fallon Health plan and its subsidiaries. This payment policy has been developed to provide information regarding general billing, coding and documentation guidelines for the Plan. Even though this payment policy may indicate that a particular service or supply is considered covered, specific provider contract terms and/or member individual benefit plans may apply and this policy is not a guarantee of payment. The Plan reserves the right to apply this payment policy to all of the Plan companies and subsidiaries. The Plan routinely verifies that charges billed are in accordance with the guidelines stated in this payment policy and are appropriately documented in the medical records. Payments are subject to post-payment audits and retraction of overpayments.