

**CAUTION: Read the [ICD-9 Policy Holding Library](#) page about policy in this document.**

## Blood and Blood Derivatives

This section describes the policy and billing instructions for blood and blood derivative products. For additional help, refer to the *Blood and Blood Derivatives Billing Examples* section of this manual.

### **Designated Blood Donation**

Additional payment for the handling of blood designated by the donor for a specific patient is not a Medi-Cal benefit. Claims for this service will be denied.

### **Blood Factors: Billing for Bleeding and Clotting Disorders**

Blood factor billing codes differ depending on the provider type. Pharmacists must bill using National Drug Codes (NDC). All other providers must bill according to physician-administered drug policy, which may be found in the *Physician-Administered Drugs – NDC* section in this manual. For physician claim form completion instructions, refer to the *Physician-Administered Drugs – NDC: CMS-1500 Billing Instructions*, or *Physician-Administered Drugs – NDC: UB-04 Billing Instructions* section in the appropriate Part 2 manual.

Blood factor reimbursement is based on the lesser of the manufacturer's reported Average Sales Price (ASP), which is updated quarterly, plus 20 percent or the provider's usual and customary charges. Providers should submit claims with their usual and customary charges.

Coagulation factors for bleeding disorders, such as hemophilia, represent the first class of specialty drugs to utilize provider contracts. These products are identified in *Welfare and Institutions Code* (W&I Code) 14105.86(a)(2)(A). The Department of Health Care Services (DHCS) will contract with any specialty pharmacy that will sign a contract to meet a list of performance obligations. These include, but are not limited to, delivery time requirements, providing patient education and submitting quarterly and yearly reports to DHCS. A provider who does not sign an agreement to become a provider under these provisions will no longer be allowed to provide the specialized drug to Medi-Cal, California Children's Services (CCS) or Genetically Handicapped Persons Program (GHPP) recipients.

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**Contract Blood Factors**

The following blood factors, covered by Medi-Cal, are listed by product name under their respective HCPCS code.

<u>HCPCS Code</u>	<u>Description</u>
C9133	Factor IX (antihemophilic factor, recombinant), per IU Rixubis *
C9134	Factor XIII (antihemophilic factor, recombinant), Tretten, per 10 IU *
J3590	<del>Unclassified biologics Catridecacog *, Coagulation factor IX (recombinant), Fc fusion protein **</del>
J7180	Factor XIII, anti-hemophilic factor, Corifact® *
<b><u>J7182</u></b>	<b><u>Injection, factor VIII, antihemophilic factor, (recombinant), (novoeight), per IU</u></b>
J7183	Injection, von Willebrand factor complex (human), wilate per IU VWF:RCO. Reimbursable in conjunction with ICD-9-CM code 286.4
J7185	Factor VIII (antihemophilic factor, recombinant), per IU Xyntha™
J7186	Antihemophilic factor VIII/von Willebrand factor complex (human), per factor VIII IU Alphanate® Reimbursable with ICD-9-CM codes 286.0, 286.4 and 286.7
J7187	Von Willebrand Factor Complex, human Humate P®
J7189	Factor VIIa (antihemophilic factor, recombinant), per mcg * NovoSeven® *, NovoSeven® RT *
J7190	Factor VIII (antihemophilic factor, human), per IU Hemofil-M *, Koate® DVI, Monarc-M™ *, Monoclote-P®
J7192	Factor VIII (antihemophilic factor, recombinant), per IU Advate *, Helixate® FS, Kogenate® FS, Recombinate *, ReFacto®
J7193	Factor IX (antihemophilic factor, purified, nonrecombinant), per IU Mononine® , AlphaNine® SD

\* Authorization is required

\*\* Effective October 20, 2014

<u>HCPCS Code</u>	<u>Description</u>
J7194	Factor IX complex per IU Bebulin <sup>®</sup> VH *, Profilnine <sup>®</sup> SD, Proplex T <sup>®</sup> *
J7195	Factor IX (antihemophilic factor, recombinant), per IU BeneFIX <sup>®</sup>
J7197	Antithrombin III (human), per IU * Thrombate III *
J7198	Antiinhibitor, per IU * Feiba VH *
J7199	Hemophilia clotting factor, not otherwise classified * <b><u>Antihemophilic factor (recombinant), porcine sequence, (Obizur<sup>™</sup>)*</u></b>
J7201	Injection, factor IX, Fc fusion protein (recombinant), per IU (Alprolix <sup>™</sup> )
Q9975	Injection, factor VIII, Fc fusion protein (recombinant), per IU

\* Authorization is required

**Blood Factors Billing:  
Non-Pharmacists**

The above listed HCPCS Level II codes are for blood factors billed by physicians, hospital outpatient departments, clinics and blood banks.

Failure to use the above codes when billing for factors VIIa, VIII or IX may result in claim denial. Other codes such as P9010 – P9012, P9016, P9019 – P9023, P9031 – P9040, P9043, P9044, P9048, P9050 – P9058 and Z7610 are not to be used when billing for blood factors.

**NDC Billing Requirement  
Billing Guidelines**

Providers must bill according to the physician-administered drug policy, which may be found in the *Physician-Administered Drugs – NDC* section in this manual. For physician claim form completion instructions, refer to the *Physician-Administered Drugs – NDC: CMS-1500 Billing Instructions*, or *Physician-Administered Drugs – NDC: UB-04 Billing Instructions* sections in the appropriate Part 2 manual. Non-pharmacy providers must use the appropriate HCPCS injection codes and modifiers (when required) to bill for all immunizations and injections listed in the *Injections: Code List* section in the appropriate Part 2 manual.

In addition, providers must include the number of units provided in the *Remarks* field (Box 80)/*Additional Claim Information* (Box 19) of the claim.

Providers may be reimbursed for the outpatient use of Factor VIIa (HCPCS code J7189). Claims billed with code J7189 must contain an approved TAR unless a manufacturer rebate is provided. Examples of medical justification include but are not limited to:

- Treatment of bleeding episodes in hemophilia A or B with inhibitors and in acquired hemophilia
- Prevention of bleeding in surgical interventions or invasive procedures in hemophilia A or B with inhibitors and in acquired hemophilia
- Treatment of bleeding episodes in congenital Factor VII deficiency
- Prevention of bleeding in surgical interventions or invasive procedures in congenital Factor VII deficiency

**Blood Factor Billing:  
Pharmacists**

Pharmacies must bill blood factor products using the National Drug Code (NDC) via a pharmacy claim form. Attachments are not required.

Pharmacy providers who bill for CCS-only, CCS/Healthy Families, GHPP-only eligible beneficiaries, and Medi-Cal/CCS/GHPP eligible beneficiaries who bill with legacy authorizations must bill using the paper *Pharmacy Claim Form* (30-1). Claims must contain required authorization as required by the Children's Medical Services Branch.

Reimbursement under this method is based on the lesser of the manufacturer's Average Selling Price (ASP) plus 20 percent or the provider's usual and customary charges. Providers should submit claims with their usual and customary charges. The ASP price is updated by the manufacturer quarterly.

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Continuing Care

Medi-Cal will provide reimbursement for blood factors marked “authorization required” only with an approved *Treatment Authorization Request (TAR)* or the beneficiary qualifies for continuing care. To be eligible for continuing care and exemption from the authorization requirement, the following conditions must be met:

- The beneficiary must be taking the drug when it is suspended or deleted from the List of Contracted Blood Factors; and
- The DHCS Fiscal Intermediary must have received a claim for the drug, in the same dosage form and strength, within 100 days prior to the drug’s suspension or deletion. Providers may access the Provider Telecommunications Network (PTN) to determine if a beneficiary has been dispensed a continuing care drug that is eligible under continuing care. For complete information on the PTN, see the *Provider Telecommunications Network (PTN)* section in the Part 1 manual.
- To maintain beneficiary eligibility under continuing care, a claim must be submitted for the drug, in the same dosage form and strength, at least every 100 days from the date of service. The beneficiary may switch between brands of the drug in the same dosage form and strength and maintain their continuing care status.

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**Contracted Providers**

To meet the unique specialized care needs of the Medi-Cal population who utilize specialty drugs, only contracted providers are eligible to provide contract blood factors. A list of the contracted specialty providers who are eligible to provide those blood factors included in the contract blood factor list is available on the “Pharmacy Benefits Division and Vision Care Program” page of the DHCS website ([www.dhcs.ca.gov](http://www.dhcs.ca.gov)).

**Blood Products and  
Blood Derivatives Other  
Than Blood Factors**

Use HCPCS codes P9010 – P9012, P9016, P9019 – P9023, P9031 – P9040, P9043, P9044, P9048 and P9050 – P9058 to bill for blood products and blood derivatives (for example, platelets, plasma, granulocytes or red blood cells), with the exception of Blood Factors: Bleeding and Clotting Disorders and other exceptions specified on a following page.

**Fresh Frozen Plasma**

Use HCPCS codes P9017, P9023, P9059 or P9060 for reimbursement of fresh frozen plasma. Billing with any other code may result in claim denial.

Medi-Cal coverage of fresh frozen plasma is restricted to:

- Replacement of isolated coagulation factor deficiencies
- Reversal of warfarin effect
- Massive blood transfusion (although prophylactic administration of fresh frozen plasma does not appear to decrease transfusion requirements in patients who do not have documented coagulation defects)
- Use in antithrombin III deficient conditions
- Treatment of thrombotic thrombocytopenic purpura

**Services Not Covered**

Fresh frozen plasma should not be used as a volume expander or as a nutritional supplement due to risks accompanying its use. These risks include:

- Post-transfusion hepatitis
- AIDS
- Allergic reactions
- Volume overload
- Alloimmunization

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### Pheresis

Pheresis, the separation of plasma from the formed elements of the blood by filtration and centrifugation, requires authorization when billed fee-for-service and performed either on an outpatient or an inpatient basis.

### Plasmapheresis: Primary Treatment

Plasmapheresis may be authorized as the primary treatment in the following diseases:

- Guillian-Barre Syndrome
- Thrombotic thrombocytopenic purpura
- Goodpasture's syndrome
- Rapidly progressive glomerulonephritis
- Anti-glomerular basement membrane disease
- Waldenstrom's macroglobulinemia
- Multiple myeloma
- Protein-bound poisons

### Secondary Treatment

Plasmapheresis also may be authorized when there is documented evidence of far-advanced disease, unresponsive to drug therapy in patients with the following diseases, most of which are thought to be mediated through immune mechanisms:

- Systemic lupus erythematosus
- Rheumatoid vasculitis
- Myasthenia gravis
- Progressive systemic sclerosis
- Hemolytic anemia
- Immune neutropenia
- Immune thrombocytopenia
- Polymyositis
- Idiopathic thrombocytopenic purpura
- Cryoglobulinemia
- Vasculitis, associated with circulating immune complexes, as seen in hypersensitivity disorders and Henoch-Schonlein purpura
- Chronic inflammatory polyneuropathy
- Relapsing polyneuropathy

Cytapheresis	<p>Cytapheresis is covered for the following problems:</p> <ul style="list-style-type: none"> <li>• Acute or chronic leukemia (cell counts more than 100,000)</li> <li>• Thrombocytosis (platelet count more than 1,000,000)</li> <li>• Sickle cell disease in severe crisis, preoperatively or when complicated by pregnancy or priapism</li> </ul>
Therapeutic Apheresis: Billing Procedures	<p>CPT-4 codes 36511 – 36516 must be billed with modifier AG for any type of therapeutic apheresis. Claims for therapeutic apheresis billed with HCPCS codes P9010 – P9012, P9016, P9019 – P9023, P9031 – P9040, P9043 – P9044, P9048 and P9050 – P9058 will be denied. The approved <i>Treatment Authorization Request</i> (TAR) determines the number of pheresis treatments allowed.</p> <p>The HCPCS codes listed above must be used to bill for blood products/blood derivatives (for example: platelets, plasma, granulocytes or red blood cells) collected from donors by apheresis.</p>
Administering Plasmapheresis	<p>All plasmapheresis procedures should be done in a hospital setting, whether on an inpatient or an outpatient basis, with readily available lifesaving equipment. The physician who bills for these procedures should be available to provide help to the plasmapheresis technician or registered nurse at all times during the procedure.</p>
<b>Extracorporeal Photopheresis</b>	<p>Extracorporeal photopheresis (ECP), also called photochemotherapy, involves ex vivo separation of leukocytes from erythrocytes and exposure of the leukocytes to 8-methoxypsoralen and ultraviolet light. 8-MOP is a naturally occurring furocoumarin that is biologically inert, unless exposed to ultraviolet A light, whereupon it becomes photo activated and covalently binds and cross-links DNA. The combination of 8-MOP and UVA radiation causes apoptosis of the treated T cells and may cause preferential apoptosis of activated or abnormal T cells, thus targeting the pathogenic cells of cutaneous T-cell lymphoma (CTCL), chronic graft versus host disease (GVHD), lung transplant rejection or cardiac allograft rejection.</p>
Indications	<p>ECP is indicated for the treatment of any of the following:</p> <ul style="list-style-type: none"> <li>• CTCL Stage IIIA or IV</li> <li>• Cardiac allograft rejection</li> <li>• Chronic GVHD</li> <li>• Lung transplant rejection (bronchiolitis obliterans)</li> </ul> <p>ECP is not to be used for the prophylaxis of any of the indications above.</p>

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Authorization An approved TAR is required for reimbursement.

Billing CPT-4 code 36522 (photopheresis, extracorporeal)

**Albumin** Use the following HCPCS Level II codes for reimbursement of human albumin.

<u>HCPCS Code</u>	<u>Description</u>
P9041	Infusion, albumin (human), 5%, 50 ml
P9045	Infusion, albumin (human), 5%, 250 ml
P9046	Infusion, albumin (human), 25%, 20 ml
P9047	Infusion, albumin (human), 25%, 50 ml

Claims for human albumin billed with either HCPCS codes P9010 – P9012, P9016, P9019 – P9023, P9031 – P9040, P9043 – P9044, P9048 and P9050 – P9058 or CPT-4 code 96372 (therapeutic, prophylactic or diagnostic injection) or 96379 (unlisted therapeutic, prophylactic or diagnostic injection) will be denied.

Medical Necessity Albumin codes P9041 and P9045 – P9047 may be billed up to the following limits:

<u>HCPCS Code</u>	<u>Limit</u>
P9041	300 ml
P9045	250 ml
P9046	60 ml
P9047	50 ml

**Blood Irradiation:  
Blood Banks** CPT-4 code 86945 (irradiation of blood product, each unit) with the appropriate split billing modifier must be used by blood banks billing for whole blood or blood product irradiation.