

CPT Code	Description
36430	Transfusion, blood, or blood components
36440	Push transfusion, blood, 2 years or under
36450	Exchange transfusion, blood, newborn
36455	Exchange transfusion, blood, other than newborn
36456	Partial exchange transfusion, blood, plasma, or crystalloid necessitating the skill of a physician or other qualified health-care professional, newborn
36460	Transfusion, intrauterine, fetal

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**Note**

CPT code 36430 is the mostly commonly used code for transfusion procedures.

CPT codes also are used to report many other types of blood-related services discussed later in this guide, including molecular pathology tests, therapeutic apheresis, and blood bank physician services. In addition, codes for many patient-specific laboratory services performed on blood units (such as crossmatching) can be found in the Transfusion Medicine code series of the Pathology and Laboratory section of the CPT manual, which consists of CPT codes 86850-86999.

CPT and HCPCS codes may be subject to various types of coding edits, such as National Correct Coding Initiative (NCCI) Procedure-to-Procedure (PTP) edits and Medically Unlikely Edits (MUEs), which are intended to prevent inappropriate utilization of services. More information on coding edits can be found in Appendix D.

The above CPT codes do not represent an exhaustive list of all possible procedures. Providers should consult a current CPT manual to determine which CPT code(s), if any, appropriately describe the service(s) rendered to the patient, as the above codes may not be appropriate for all patients. The American Medical Association (AMA)—the organization that updates and maintains CPT codes—instructs providers to select a CPT code with a descriptor “that accurately identifies the service performed,” rather than a code “that merely approximates the service provided.” In the absence of a specific code that accurately identifies a service, providers should “report the service using the appropriate unlisted procedure or service code.”<sup>7</sup> All codes must be supported with adequate documentation in the medical record.

## VI. MEDICARE REIMBURSEMENT FOR BLOOD PRODUCTS AND RELATED SERVICES: HOSPITAL INPATIENT SETTING

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### Overview

Medicare reimburses for inpatient admissions using the hospital inpatient prospective payment system (IPPS), which is based on Medicare severity diagnosis-related groups (MS-DRGs). Under IPPS, each hospital inpatient case is assigned to one of more than 700 MS-DRGs based on the patient's diagnosis(es) and the procedure(s) performed. The MS-DRG provides a fixed, hospital-specific payment that is intended to cover nearly all costs incurred during the hospital inpatient stay. MS-DRG payment rates are adjusted for each hospital to reflect geographic differences in hospital labor costs, disproportionate share burden, and teaching status.

#### Note

MS-DRG payments do not cover the costs of physician services, as physicians are reimbursed separately for their professional services under the Medicare physician fee schedule.

### Payment for Blood Products and Related Services

As with most other biologicals, drugs, and supplies, Medicare does not provide separate payment for blood products when used in the hospital inpatient setting; rather, reimbursement for blood products is bundled into the MS-DRG payment rate for the inpatient stay.

Additionally, transfusion procedures usually do not affect MS-DRG assignment; instead, a case involving a transfusion generally will be assigned to an MS-DRG based on the other procedures or diagnoses on the claim. For this reason, MS-DRG assignments and payment rates for inpatient stays involving blood transfusions can vary greatly depending on the specifics of a particular case.

### Coding and Billing for Blood Products and Related Services

Medicare hospital inpatient claims for blood products, transfusions, and related services should include the following types of codes:

Type of Code	Billing Guidance
ICD-10-CM Diagnosis Code	<ul style="list-style-type: none"> <li>Report appropriate ICD-10-CM code(s) to describe the patient's condition</li> <li>Diagnosis coding will vary by patient</li> </ul>
ICD-10-PCS Procedure Code	<ul style="list-style-type: none"> <li>Report appropriate ICD-10-PCS code for the transfusion procedure (see previous section for a discussion of transfusion ICD-10-PCS codes)</li> <li>Report ICD-10-PCS code(s) for other procedure(s) as appropriate</li> <li>ICD-10-PCS codes may not be available for all services (for example, many laboratory services do not have ICD-10-PCS codes)</li> </ul>
Revenue Code	<ul style="list-style-type: none"> <li>Report appropriate revenue code for each charge line item</li> <li>Use revenue code 0390 to report processing charges for <i>transfused</i> blood units (remember: hospitals are never allowed to bill for unused blood)</li> <li>Use revenue code 0391 to report charges for transfusion procedure (if reported as a separate line item)*</li> <li>Revenue code series 030X can be used to report charges for patient-specific laboratory services performed on blood units (if applicable)</li> </ul>

\*According to CMS, whether an inpatient transfusion procedure should be reported as a separate charge line item depends on the type of cost center in which the transfusion is performed. If an inpatient transfusion is performed in an *ancillary* cost center, such as the operating room or emergency room, the charge for the transfusion procedure should be reported as a separate line item under revenue code 0391. For inpatient transfusions performed in a *routine* cost center, such as room and board, CMS provides the following guidance: "The provider must consider the established practice of the same class of providers in the same State as to whether to include blood transfusion in the routine service charge (for both Medicare and non-Medicare patients)."<sup>8</sup>

#### Note

Regardless of whether the transfusion procedure is billed as a separate line item, hospitals should separately report processing charges for transfused blood units using revenue code 0390.

Hospitals generally do not use CPT and HCPCS codes when billing inpatient charges to Medicare. Although many facilities may use CPT and HCPCS codes in the inpatient setting for their own internal purposes, these codes are not included on hospital inpatient claims submitted to Medicare. (An exception is hemophilia clotting factors; Medicare accepts HCPCS codes on inpatient claims in certain circumstances. More detail appears in Appendix C.) Instead, hospitals report inpatient charges on Medicare claims using only revenue codes. CPT and HCPCS codes play an important role in hospital outpatient billing, which is discussed in the next section.