Blood transfusions, platelets, blood components and blood clotting factors and blood related services are covered when Medicare coverage criteria are met.

Note: Medicare’s Part A 3-pint blood deductible does not apply to UnitedHealthcare Medicare Advantage members. For additional information refer to the member’s Evidence of Coverage (EOC).

Blood and Blood Components

Whole blood is a biological, which cannot be self-administered and is covered when furnished incident to a physician’s services. Payment may also be made for blood fractions if all coverage requirements are satisfied.

Refer to the Medicare Benefit Policy Manual, Chapter 15, Section 50.3 Incident to Requirement.

(Accessed September 30, 2021)

Hemophilia Blood Clotting Factors

Hemophilia, a blood disorder characterized by prolonged coagulation time, is caused by deficiency of a factor in plasma necessary for blood to clot. Blood clotting factors for hemophilia patients are covered when coverage criteria are met.
Refer to the:

- Medicare Benefit Policy Manual, Chapter 15, §50.5.5 – Hemophilia Clotting Factors
- NCD for Anti-Inhibitor Coagulant Complex (AICC) (110.3)

(Accessed September 30, 2021)

**Utilization Guidelines**

The Medicare Benefit Policy Manual and NCD addressing hemophilia clotting factors do not provide utilization guidelines. Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) with utilization guidelines for hemophilia clotting factors exist and compliance with these policies is required where applicable. For the state-specific LCDs/LCAs, refer to the table for Hemophilia Clotting Factors.

For states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled Clotting Factors, Coagulant Blood Products and Other Hemostatics.

Note: After checking the Hemophilia Clotting Factors table and searching the Medicare Coverage Database, if no LCD/LCA is found, then use the policy referenced above for coverage guidelines.

**Blood Transfusion**

Medically necessary transfusion of blood, regardless of the type, may generally be a covered service. Coverage does not make a distinction between the transfusion of homologous, autologous, or donor-directed blood. Refer to the NCD for Blood Transfusions (110.7). (Accessed September 30, 2021)

**Blood Platelet Transfusion**

Blood platelet transfusion is when reasonable and necessary for the individual patient; refer to the NCD for Blood Platelet Transfusions (110.8). (Accessed September 30, 2021)

**Granulocyte Transfusions**

Granulocyte transfusions to patients suffering from severe infection and granulocytopenia are covered for specific indications. Refer to the NCD for Granulocyte Transfusions (110.5). (Accessed September 30, 2021)

**Nonselective (Random) Transfusions and Living Related Donor Specific Transfusions (DST) in Kidney Transplantation**

Pre-transplant nonselective (random) transfusions and living related donor specific transfusions (DST) in kidney transplantation are covered, without a specific limitation on the number of transfusions. Refer to the NCD for Nonselective (Random) Transfusions and Living Related Donor Specific Transfusions (DST) in Kidney Transplantation (110.16). (Accessed September 30, 2021)

**Lymphocyte Immune Globulin, Anti-Thymocyte Globulin (Equine)**

Lymphocyte immune globulin, anti-thymocyte globulin (equine) for the management of allograft rejection episodes in renal transplantation. Note: Other forms of lymphocyte globulin preparation which the FDA approves for this indication in the future may be covered under Medicare.

Refer to the NCD for Lymphocyte Immune Globulin, Anti-Thymocyte Globulin (Equine) (260.7). (Accessed September 30, 2021)

**Intravenous Immune Globulin (IVIG)**

Refer to the Coverage Summary titled Medications/Drugs (Outpatient/Part B).

**Apheresis (Therapeutic Pheresis)**

Apheresis (therapeutic pheresis) is covered for specific indications. Refer to the NCD for Apheresis (Therapeutic Pheresis) (110.14). (Accessed September 30, 2021)
Blood Derived Products for Chronic Non-Healing Wounds
Refer to the Coverage Summary titled Wound Treatments.

Blood Brain Barrier (BBB) Osmotic Disruption for Treatment of Brain Tumors
The use of osmotic BBB is not reasonable and necessary when it is used as part of a treatment regimen for brain tumors. Refer to the NCD for Blood Brain Barrier Osmotic Disruption for Treatment of Brain Tumors (110.20). (Accessed September 30, 2021)

Transfer Factor for the Treatment of Multiple Sclerosis
Transfer factor for the treatment of multiple sclerosis as it is considered experimental for this purpose. Refer to the NCD for Transfer Factor for Treatment of Multiple Sclerosis (160.20). (Accessed September 30, 2021)

Erythropoietin Stimulating Factors
Refer to the Coverage Summary titled Medications/Drugs (Outpatient/Part B).

Supporting Information

Important Note: When searching the Medicare Coverage Database, if no LCD/LCA is found, then use the applicable referenced default policy below for coverage guidelines.

### Hemophilia Clotting Factors
Accessed September 30, 2021

<table>
<thead>
<tr>
<th>LCD/LCA ID</th>
<th>LCD/LCA Title</th>
<th>Contractor Type</th>
<th>Contractor Name</th>
<th>Applicable States/Territories</th>
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<tr>
<td>L33684</td>
<td>Hemophilia Clotting Factors</td>
<td>Part A and B MAC</td>
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<td>L35111</td>
<td>Hemophilia Factor Products</td>
<td>Part A and B MAC</td>
<td>Novitas Solutions, Inc</td>
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<td>Billing and Coding Guidance for Anti-Inhibitor Coagulant Complex (AICC) National Coverage Determination (NCD) 110.3</td>
<td>Part A and B MAC</td>
<td>Palmetto GBA</td>
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Policy History/Revision Information

<table>
<thead>
<tr>
<th>Date</th>
<th>Coverage Guidelines</th>
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<tbody>
<tr>
<td>10/19/2021</td>
<td>Coverage Guidelines</td>
</tr>
<tr>
<td></td>
<td><strong>Hemophilia Blood Clotting Factors</strong></td>
</tr>
<tr>
<td></td>
<td>● Replaced language indicating “blood clotting factors for hemophilia patients with the [listed] diagnoses may be covered if the patient is competent to use such factors without medical supervision” with “blood clotting factors for hemophilia patients are covered when coverage criteria are met”</td>
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<tr>
<td></td>
<td>● Removed list of covered diagnoses</td>
</tr>
<tr>
<td></td>
<td>● Removed reference ink to the Medicare Learning Network (MLN) Matters #4229 – Payment for Blood Clotting Factors Administered to Hemophilia Inpatients</td>
</tr>
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Supporting Information

● Archived previous policy version MCS008.01
Instructions for Use

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The benefit information in this Coverage Summary is based on existing national coverage policy; however, Local Coverage Determinations (LCDs) may exist and compliance with these policies are required where applicable.

There are instances where this document may direct readers to a UnitedHealthcare Commercial Medical Policy, Medical Benefit Drug Policy, and/or Coverage Determination Guideline (CDG). In the absence of a Medicare National Coverage Determination (NCD), Local Coverage Determination (LCD), or other Medicare coverage guidance, CMS allows a Medicare Advantage Organization (MAO) to create its own coverage determinations, using objective evidence-based rationale relying on authoritative evidence (Medicare IOM Pub. No. 100-16, Ch. 4, §90.5).

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