CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 2334	**Date: OCTOBER 28, 2011**
	Change Request 7523

SUBJECT: Billing for Donor Post-Kidney Transplant Complication Services

I. SUMMARY OF CHANGES: As a result of questions received from the organ donor industry due to contractor claims processing system inconsistency, instructions in Pub. 100-04, chapter 3, section 90.1.3 are being added. This CR is needed to ensure consistency among contractors in processing claims for donor post-kidney transplant complications services.

EFFECTIVE DATE: Policy Effective date: November 28, 2011;
Claims Processing Effective date: April 1, 2012
IMPLEMENTATION DATE: April 2, 2012

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	3/Table of Contents
N	3/90.1.3/Billing for Donor Post-Kidney Transplant Complication Services

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

Unless otherwise specified, the effective date is the date of service.

Attachment - Business Requirements

Pub. 100-04	Transmittal: 2334	Date: October 28, 2011	Change Request: 7523

SUBJECT: Billing for Donor Post-Kidney Transplant Complication Services

Effective Date: Policy Effective date: November 28, 2011;
Claims Processing Effective date: April 1, 2012

Implementation Date: April 2, 2012

I. GENERAL INFORMATION

A. Background: As a result of questions received from the organ donor industry due to contractor claims processing system inconsistency, instructions in Pub. 100-04, chapter 3, section 90.1.3 are being added. This CR is needed to ensure consistency among contractors in processing claims for donor post-kidney transplant complications services.

B. Policy: Section 90.1.3 of Pub. 100-04, chapter 3, is being created to clarify that donor post-kidney transplant complication services are covered and separately billable.

II. BUSINESS REQUIREMENTS TABLE

Use of "Shall" denotes a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7523-04.1	Contractors shall be aware of the new instructions in Pub. 100-04, chapter 3, section 90.1.3 that references requirement and use of Modifier **Q3 – Live Kidney Donor and Related Services**, Occurrence Code **36 – Date of Inpatient Hospital Discharge for covered transplant patients** and Patient Relationship code **39 (X12) / 11 (UB-04) – Organ Donor.**	X		X		X					
7523-04.2	FISS shall pass the 2 position Patient Relationship code (X12 version) to CWF and CWF shall accept the 2 position Patient Relationship code for all institutional claim types.						X			X	NCH
7523-04.3	Contractors shall allow receipt of claims with Patient Relationship code **39 (X12) / 11 (UB-04) – Organ Donor**.						X				
7523-04.4	Contractors shall edit for the presence and require Occurrence Code **36** when the Patient Relationship code **39/11** is present on a claim.						X				

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7523-04.5	Contractors shall edit for the presence and require Occurrence Code **36** and Patient Relationship code **39/11** when Modifier **Q3** is present on a claim.						X				
7523-04.6	Contractors shall not apply Deductible or Coinsurance to Lines that have Modifier **Q3**.						X				IOCE
7523-04.7	Contractors shall not apply Deductible or Coinsurance to claims that have Occurrence Code **36** and Patient Relationship code **39/11**.						X				
7523-04.8	CWF shall accept claims with Patient Relationship code **39** and not utilize benefits against the Recipients Day Utilization record and Cash Deductible for Inpatient and Outpatient claim types.									X	
7523-04.9	CWF shall bypass edit 5211 and any similar entitlement edits if the beneficiary is deceased but the donor claim contains a Patient Relationship code of **39** – Organ Donor.									X	
7523-04.10	CWF shall bypass entitlement edits if the beneficiary is no longer entitled to Medicare because of completing the 36 month post transplant period but the donor claim contains a Patient Relationship code of **39** – Organ Donor.									X	
7523-04.11	CWF shall bypass edits for Occurrence Code **36** when submitted on a Donor claim containing a Patient Relationship code of **39** – Organ Donor.									X	
7523-04.12	Contractors shall bypass edits for claim overlap when the same Health Insurance Claim Number (HICN) is received on 2 separate claims and one claim has a Patient Relationship code **39/11** and the separate claim has a Patient Relationship code **18/01**. These are not duplicates or overlaps.						X			X	
7523-04.13	Contractors shall suppress MSNs from printing when processing claims where the Patient Relationship is organ donor.						X				

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7523-04.14	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X		X		X					

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below: N/A

Use of "Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: For all other recommendations and supporting information, use this space: N/A

V. CONTACTS

Pre-Implementation Contact(s): For policy questions contact Mark Horney at Mark.Horney@cms.hhs.gov. For billing questions contact Fred Rooke at Fred.Rooke@cms.hhs.gov, Sarah Shirey-Losso at Sarah.Shirey-Losso@cms.hhs.gov, or Cami DiGiacomo at Cami.DiGiacomo@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Technical Representative (COTR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),* and/or *Carriers*:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: *For Medicare Administrative Contractors (MACs),* include the following statement:

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

Medicare Claims Processing Manual
Chapter 3 - Inpatient Hospital Billing

Table of Contents

(Rev. 2334, 10-28-11)

90.1.3 - Billing for Donor Post-Kidney Transplant Complication Services

90.1.3 - Billing for Donor Post-Kidney Transplant Complication Services

(Rev. 2334, Issued: 10-28-11; Effective: Policy Effective date: November 28, 2011; Claims Processing Effective date: April 1, 2012; Implementation: April 2, 2012)

Expenses incurred for complications that arise with respect to the donor are covered and separately billable only if they are directly attributable to the donation surgery.

All covered services (both institutional and professional) for complications from a Medicare covered transplant that arise after the date of the donor's transplant discharge will be billed under the recipient's health insurance claim number and are billed to the Medicare program in the same manner as all Medicare Part B services are billed.

- *All covered donor post-kidney transplant complication services must be billed to the account of the recipient (i.e., the recipient's Medicare number)*

- *Modifier Q3 (Live Kidney Donor and Related Services) appears on each covered line of the claim that contains a HCPCS code.*

Institutional claims will be required to also include:

- *Occurrence Code 36 (Date of Inpatient Hospital Discharge for covered transplant patients)*

- *Patient Relationship Code 39 (Organ Donor)*

Contractors shall override Edit 5211 when modifier Q3 appears on claims for donor services it receives when the recipient is deceased (See Pub. 100-02, chapter 11, section 80.4).

NOTE: *For institutional claims which do not require modifiers, contractors may manually override the CWF edit as necessary.*