CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 10002	**Date: March 20, 2020**
	Change Request 11687

SUBJECT: Update to the Internet Only Manual (IOM) Publication (Pub.) 100-04, Chapter 3, Section 90.4.2

I. SUMMARY OF CHANGES: This Change request makes updates to chapter 3 of the Medicare Claims Processing Manual Pub. 100-04.

EFFECTIVE DATE: April 20, 2020
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 20, 2020

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-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	3/90/90.4.2 - Billing for Liver Transplant and Acquisition Services

III. FUNDING:

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

Attachment - Business Requirements

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I. GENERAL INFORMATION

A. Background: This Change Request (CR) is updating Pub. 100-04, Chapter 3 Inpatient Hospital Billing, Section 90.4.2, of the Medicare Claims Processing manual.

B. Policy: No policy changes.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
11687.1	The Medicare contractors shall be aware of the manual updates in Pub 100-04, Chapter 3, Section 90.4.2.	X								
11687.2	The Medicare contractors shall use claims data to determine that the coverage criteria specified in Publication 100-03, Section 260.1 have been met.	X								

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	None					

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Cindy Pitts, Cindy.Pitts@cms.hhs.gov , Cami DiGiacomo, Cami.DiGiacomo@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: 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.

ATTACHMENTS: 0

90.4.2 - Billing for Liver Transplant and Acquisition Services

(Rev. 10002, Issued: 03-20-2020, Effective: 04-20-2020, Implementation: 04-20-2020)

The inpatient claim is completed in accordance with instructions in chapter 25 for the beneficiary who receives a covered liver transplant. Applicable standard liver acquisition charges are identified separately by revenue code 081X. Where interim bills are submitted, the standard acquisition charge appears on the billing form for the period during which the transplant took place. This charge is in addition to the hospital's charge for services furnished directly to the Medicare recipient.

The contractor deducts liver acquisition charges for IPPS hospitals prior to processing through Pricer. Costs of liver acquisition incurred by approved liver transplant facilities are **not** included in the liver transplant prospective payment. They are paid on a reasonable cost basis. This item is a "pass-through" cost for which interim payments are made. (See the Provider Reimbursement Manual, Part 1, §2802 B.8.) The contractor includes liver acquisition charges under revenue code 081X in the HUIP record that it sends to CWF and the QIO.

MCE Interface

The MCE contains a limited coverage edit for liver transplant procedures using ICD-9-CM code 50.59 if ICD-9 is applicable, and, if ICD-10 is applicable, using ICD-10-PCS codes 0FY00Z0, 0FY00Z1, and 0FY00Z2.

Where a liver transplant procedure code is identified by the MCE, the contractor shall check the provider number and effective date to determine if the provider is an approved liver transplant facility at the time of the transplant, and determine if the facility is certified for adults and/or pediatric transplants dependent upon the patient's age. *Contractors shall use claims data to determine that the coverage criteria specified in Publication 100-03, Section 260.1 have been met.* If payment is appropriate (i.e., the facility is approved, the service is furnished on or after the approval date, and the beneficiary has a covered condition), the contractor sends the claim to Grouper and Pricer.

If none of the diagnoses codes are for a covered condition, or if the provider is not an approved liver transplant facility, the contractor denies the claim.

NOTE: Some noncovered conditions are included in the covered diagnostic codes. (The diagnostic codes are broader than the covered conditions. Do not pay for noncovered conditions.

Grouper

If the bill shows a discharge date before March 8, 1990, the liver transplant procedure is not covered. If the discharge date is March 8, 1990 or later, the contractor processes the bill through Grouper and Pricer. If the discharge date is after March 7, 1990, and before October 1, 1990, Grouper assigned CMS DRG 191 or 192. The contractor sent the bill to Pricer with review code 08. Pricer would then overlay CMS DRG 191 or 192 with CMS DRG 480 and the weights and thresholds for CMS DRG 480 to price the bill. If the discharge date is after September 30, 1990, Grouper assigns CMS DRG 480 and Pricer is able to price without using review code 08. If the discharge date is after September 30, 2007, Grouper assigns MS-DRG 005 or 006 (Liver transplant with MCC or Intestinal Transplant or Liver transplant without MCC, respectively) and Pricer is able to price without using review code 08.

Liver Transplant Billing From Non-approved Hospitals

Where a liver transplant and covered services are provided by a non-approved hospital, the bill data processed through Grouper and Pricer must exclude transplant procedure codes and related charges.

When CMS approves a hospital to furnish liver transplant services, it informs the hospital of the effective date in the approval letter. The contractor will receive a copy of the letter.