CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-02 Medicare Benefit Policy	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 148	**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. 100-02, chapter 11, section 140.9, are being clarified. 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	11/140.9/Post-transplant Services Provided to Live Donor

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. 100-02	Transmittal: 148	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. 100-02, chapter 11, section 140.9, are being clarified. This CR is needed to ensure consistency among contractors in processing claims for donor post-kidney transplant complications services.

B. Policy: Pub. 100-02, chapter 11, section 140.9 is being clarified to specify 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	
7523-02.1	Contractors shall note changes in Pub. 100-02, chapter 11, section 140.9 for policy on processing claims for donor post-kidney transplant complication services.	X		X		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	
7523-02.2	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.

140.9 – Post-transplant Services Provided to Live Donor

(Rev.148, Issued: 10-28-11; Effective: Policy Effective date: November 28, 2011; Claims Processing Effective date: April 1, 2012; Implementation: April 2, 2012)

The donor *of an organ for a Medicare transplant beneficiary* is covered for an unlimited number of days of care in connection with the *organ* removal operation. Days of inpatient hospital care used by the donor *in connection with the organ removal operation shall* not be charged against either party's utilization record. However, the program's assumption of liability is limited to those donor expenses that are incurred directly in connection with the *organ* donation.

Coverage of *organ* donor services includes postoperative recovery services directly related to the *organ* donation. *For routine follow-up care* the period of postoperative recovery ceases when the donor no longer exhibits symptoms related to the kidney donation. Claims for services rendered more than 3 months after donation surgery will be reviewed. However, follow-up examinations may be covered up to 6 months after the donation to monitor for possible complications. The requirement that additional payment cannot be made for services included in the donor's *organ removal* charge still applies.

Regarding donor follow-up:

Expenses incurred by the transplant center for routine donor follow-up care are included in the transplant center's organ acquisition cost center.

Follow-up services performed by the operating physician are included in the 90-day global payment for the surgery. Beyond the 90-day global payment period, follow-up services are billed using the recipient's health insurance claim number.

Follow-up services billed by a physician other than the operating physician for up to 3 months following donation surgery should be billed under the recipient's health insurance claim number.

Regarding donor complications:

Expenses incurred for complications that arise with respect to the donor are covered only if they are directly attributable to the donation surgery. Complications that arise after the date of the donor's discharge will be billed under the recipient's health insurance claim number. This is true of both facility cost and physician services. Billings for donor complications will be reviewed.

In all of these situations, the donor is not responsible for co-insurance or deductible.