DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

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MLN Matters® Number: MM7523 Revised | Related Change Request (CR) #: 7523

Related CR Release Date: October 28, 2011 | Effective Date: April 1, 2012 for claims processing, but policy effective November 28, 2011

Related CR Transmittal #: R148BP and R2334CP | Implementation Date: April 2, 2012

Billing for Donor Post-Kidney Transplant Complication Services

Note: This MLN Matters® Article was revised on June 4, 2012, to add a reference to MM7816 at http://www.cms.gov/MLNMattersArticles/downloads/MM7816.pdf which instructs providers to use a temporary work around to enable the payment of claims for organ donor complications. All other information remains the same.

Provider Types Affected

This MLN Matters® Article is intended for providers submitting claims to Medicare contractors (Fiscal Intermediaries (FIs), Part A/B Medicare Administrative Contractors (A/B MACs), and/or Regional Home Health Intermediaries (RHHIs)) for services provided to Medicare beneficiaries.

What You Need to Know

Change Request (CR) 7523 does not convey any new or changed policy, but does convey clarification language for two Medicare manuals. This clarification is being provided to ensure consistency among all Medicare contractors in processing claims

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for Donor Post-Kidney Transplant Complications services. Be sure your staff is aware of the clarifications.

Key Points of CR7523

Section 140.9 of Chapter 11 of the "Medicare Benefit Policy Manual" is being updated to show the following:

The donor of an organ for a Medicare transplant 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.

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 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.

In addition, CR7523 is adding language to Section 90.1.3 of Chapter 3 of the "Medicare Claims Processing Manual" to provide clarifications as follows:

- 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

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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.

- Institutional claims will be required to also include:
  - Occurrence Code 36 (Date of Inpatient Hospital Discharge for covered transplant patients); and
  - Patient Relationship Code 39 (Organ Donor).

Sample claims appear at the end of this article to provide examples of the above coding instructions.

Additional Information

The official instruction, CR7523, was issued to your RHHI, FI or A/B MAC via two transmittals. The first modifies the "Medicare Benefit Policy Manual" and it is at http://www.cms.gov/Transmittals/downloads/R148BP.pdf and the second at http://www.cms.gov/Transmittals/downloads/R2334CP.pdf modifies the "Medicare Claims Processing Manual".

If you have any questions, please contact your RHHI, FI or A/B MAC at their toll-free number, which may be found at http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip on the CMS website.

News Flash - **Vaccination is the Best Protection Against the Flu.** The Centers for Disease Control and Prevention is encouraging everyone 6 months of age and older to get vaccinated against the seasonal flu. The risks for complications, hospitalizations, and deaths from the flu are higher among individuals aged 65 years and older. Medicare pays for the seasonal flu vaccine and its administration for seniors and others with Medicare with no co-pay or deductible. And remember, vaccination is particularly important for healthcare workers, who may spread the flu to high-risk patients; don't forget to immunize yourself and your staff. *Protect your patients. Protect your family. Protect yourself. Get the Flu Vaccination – Not the Flu.*
Remember – The flu vaccine plus its administration are covered Part B benefits. CMS has posted the 2011-2012 seasonal flu vaccine payment limits at http://www.CMS.gov/McrPartBDrugAvgSalesPrice/10_VaccinesPricing.asp. Note that the flu vaccine is NOT a Part D-covered drug. For more information on coverage and billing of the flu vaccine and its administration, as well as related educational provider resources, visit http://www.CMS.gov/MLNProducts/35_PreventiveServices.asp and http://www.cms.gov/immunizations.

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