

<b>CMS Manual System</b>	<b>Department of Health &amp; Human Services (DHHS)</b>
<b>Pub 100-04 Medicare Claims Processing</b>	<b>Centers for Medicare &amp; Medicaid Services (CMS)</b>
<b>Transmittal 2008</b>	<b>Date: July 30, 2010</b>
	<b>Change Request 6978</b>

This CR is being re-issued to correct a date in 6978.1 and to include RHHIs for 6978.4. The transmittal number, date issued and all other information remains the same.

**SUBJECT: Common Working File (CWF) Override Edit for Kidney Transplant Donor Claims When the Kidney Recipient is Deceased**

**I. SUMMARY OF CHANGES:** Currently CMS instructions, Publication 100-02, Section 80.4 allow donor expenses incurred after the death of the recipient to be treated as incurred before the death of the recipient. However, when these claims are received in CWF, they are rejecting. This CR is needed to ensure consistency among contractors in allowing the error code 5211 to be overridden when a donor kidney transplant claim is received for a kidney transplant recipient that has died.

**EFFECTIVE DATE: January 1, 2011**

**IMPLEMENTATION DATE: January 3, 2011**

*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.*

**II. CHANGES IN MANUAL INSTRUCTIONS:** (N/A if manual is not updated)

R=REVISED, N=NEW, D=DELETED-Only One Per Row.

<b>R/N/D</b>	<b>CHAPTER / SECTION / SUBSECTION / TITLE</b>
R	3/90.1.1/The Standard Kidney Acquisition Charge

**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: 2008	Date: July 30, 2010	Change Request: 6978
-------------	-------------------	---------------------	----------------------

This CR is being re-issued to correct a date in 6978.1 and to include RHHIs for 6978.4. The transmittal number, date issued and all other information remains the same.

**SUBJECT: Common Working File (CWF) Override Edit for Kidney Transplant Donor Claims When the Kidney Recipient is Deceased**

**Effective Date:** January 1, 2011

**Implementation Date:** January 3, 2011

## I. GENERAL INFORMATION

**A. Background:** The CMS instructions allow donor expenses incurred after the death of the recipient to be treated as incurred before the death of the recipient. However, when these claims are received in CWF, they are rejecting. This CR is to ensure consistency among contractors in allowing the CWF error code 5211 to be overridden when a donor is receiving services related to the procedure and the kidney transplant recipient has died.

**B. Policy:** Publication 100-02, Chapter 11, Section 80.4 allows donor expenses incurred after the death of the recipient to be treated as incurred before the death of the recipient.

## II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility								
		A / B M A C	D M M A C	F I I E R	C A R I E R	R H H I	Shared-System Maintainers			
					F I S S	M I C S	V M S	C M W F		
6978.1	For services performed on or after January 1, 2011, CWF shall allow Edit 5211 to be overridden at the header level by the contractor.									X
6978.2	For services performed on or after January 1, 2011, contractors shall override Edit 5211 when Q3 is present on the claim for physician and institutional bills which utilize modifiers.	X		X	X	X				
6978.2.1	Contractors shall note change in Publication 100-04, Chapter 3, Section 90.1.1 that references requirement and use of <b>Q3 – Live Kidney Donor and Related Services</b>	X		X	X	X				
6978.2.2	For institutional claims where modifiers are not used, contractors shall override 5211 when the donor is receiving institutional services related to donation of the kidney.	X		X						
6978.3	Contractors shall not reprocess previously submitted claims unless brought to their attention.	X		X	X	X				

### III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility									
		A / B  M A C	D M E  M A C	F I  I E R	C A R I E R	R H H I  S S	Shared-System Maintainers				Other
						F I S S	M C S	V M S	C W F		
6978.4	<p>A provider education article related to this instruction will be available at <a href="http://www.cms.hhs.gov/MLNMattersArticles">http://www.cms.hhs.gov/MLNMattersArticles</a> 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.</p> <p>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.</p>	X		X	X	X					

### IV. SUPPORTING INFORMATION

#### Section A: Recommendations and supporting information associated with listed requirements:

X-Ref Requirement Number	Recommendations or other supporting information:
	N/A

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

### V. CONTACTS

**Pre-Implementation Contact(s):** For Institutional claim issues, Sarah Shirey-Losso at (410) 786-0187 or [sarah.shirey-losso@cms.hhs.gov](mailto:sarah.shirey-losso@cms.hhs.gov) or For Physician (professional) claim issues, Yvette Cousar at (410) 786-2160 or [yvette.cousar@cms.hhs.gov](mailto:yvette.cousar@cms.hhs.gov)

**Post-Implementation Contact(s):** Regional Office or Appropriate MAC PO

## **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)*:**

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.

### **90.1.1 - The Standard Kidney Acquisition Charge**

*(Rev. 2008, Issued: 07-30-10, Effective: 01-01-11, Implementation: 01-03-11)*

There are two basic standard charges that must be developed by transplant hospitals from costs expected to be incurred in the acquisition of kidneys:

- The standard charge for acquiring a live donor kidney; and
- The standard charge for acquiring a cadaver kidney.

The standard charge is not a charge representing the acquisition cost of a specific kidney; rather, it is a charge that reflects the average cost associated with each type of kidney acquisition.

When the transplant hospital bills the program for the transplant, it shows its standard kidney acquisition charge on revenue code 081X. Such charges are not considered for the IPPS outlier calculation when a procedure code beginning with 556 is reported.

Acquisition services are billed from the excising hospital to the transplant hospital. A billing form is not submitted from the excising hospital to the FI. The transplant hospital keeps an itemized statement that identifies the services furnished, the charges, the person receiving the service (donor/recipient), and whether this is a potential transplant donor or recipient. These charges are reflected in the transplant hospital's kidney acquisition cost center and are used in determining the hospital's standard charge for acquiring a live donor's kidney or a cadaver's kidney. The standard charge is not a charge representing the acquisition cost of a specific kidney. Rather, it is a charge that reflects the average cost associated with each type of kidney acquisition. Also, it is an all-inclusive charge for all services required in acquisition of a kidney, i.e., tissue typing, post-operative evaluation.

#### **A. Billing For Blood And Tissue Typing of the Transplant Recipient Whether or Not Medicare Entitlement Is Established**

Tissue typing and pre-transplant evaluation can be reflected only through the kidney acquisition charge of the hospital where the transplant will take place. The transplant hospital includes in its kidney acquisition cost center the reasonable charges it pays to the independent laboratory or other hospital which typed the potential transplant recipient, either before or after his entitlement. It also includes reasonable charges paid for physician tissue typing services, applicable to live donors and recipients (during the pre-entitlement period and after entitlement, but prior to hospital admission for transplantation).

#### **B. Billing for Blood and Tissue Typing and Other Pre-Transplant Evaluation of Live Donors**

The entitlement date of the beneficiary who will receive the transplant is not a consideration in reimbursing for the services to donors, since no bill is submitted directly to Medicare. All charges for services to donors prior to admission into the hospital for excision are "billed" indirectly to Medicare through the live donor acquisition charge of transplanting hospitals.

### **C. Billing Donor And Recipient Pre-Transplant Services (Performed by Transplant Hospitals or Other Providers) to the Kidney Acquisition Cost Center**

The transplant hospital prepares an itemized statement of the services rendered for submittal to its cost accounting department. Regular Medicare billing forms are not necessary for this purpose, since no bills are submitted to the FI at this point.

The itemized statement should contain information that identifies the person receiving the service (donor/recipient), the health care insurance number, the service rendered and the charge for the service, as well as a statement as to whether this is a potential transplant donor or recipient. If it is a potential donor, the provider must identify the prospective recipient.

#### **EXAMPLE:**

Mary Jones  
Health care insurance number  
200 Adams St.  
Anywhere, MS

Transplant donor evaluation services for recipient:

John Jones  
Health care insurance number  
200 Adams St.  
Anywhere, MS

Services performed in a hospital other than the potential transplant hospital or by an independent laboratory are billed by that facility to the potential transplant hospital. This holds true regardless of where in the United States the service is performed. For example, if the donor services are performed in a Florida hospital and the transplant is to take place in a California hospital, the Florida hospital bills the California hospital (as described in above). The Florida hospital is paid by the California hospital, which recoups the monies through the kidney acquisition cost center.

### **D. Billing for Cadaveric Donor Services**

Normally, various tests are performed to determine the type and suitability of a cadaver kidney. Such tests may be performed by the excising hospital (which may also be a transplant hospital) or an independent laboratory. When the excising-only hospital performs the tests, it includes the related charges on its bill to the transplant hospital or to the organ procurement agency.

When the tests are performed by the transplant hospital, it uses the related costs in establishing the standard charge for acquiring the cadaver kidney. The transplant hospital includes the costs and charges in the appropriate departments for final cost settlement purposes.

When the tests are performed by an independent laboratory for the excising-only hospital or the transplant hospital, the laboratory bills the hospital that engages its services or the organ procurement agency. The excising-only hospital includes such charges in its charges to the transplant hospital, which then includes the charges in developing its standard charge for acquiring the cadaver kidney. It is the transplant hospitals' responsibility to assure that the independent laboratory does not bill both hospitals.

The cost of these services cannot be billed directly to the program, since such tests and other procedures performed on a cadaver are not identifiable to a specific patient.

#### **E. Billing For Physicians' Services Prior to Transplantation**

Physicians' services applicable to kidney excisions involving live donors and recipients (during the pre-entitlement period and after entitlement, but prior to entrance into the hospital for transplantation) as well as all physicians' services applicable to cadavers are considered Part A hospital services (kidney acquisition costs).

#### **F. Billing for Physicians' Services After Transplantation**

All physicians' services rendered to the living donor and all physicians' services rendered to the transplant recipient are billed to the Medicare program in the same manner as all Medicare Part B services are billed. All donor physicians' 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 the claim. For services performed on or after January 1, 2011 CWF shall allow Edit 5211 to be overridden at the contractor level. Also, contractors shall override Edit 5211 when this modifier appears on claims for donor services it receives when the recipient is deceased (See Publication 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.*

#### **G. Billing For Physicians' Renal Transplantation Services**

To ensure proper payment when submitting a Part B bill for the renal surgeon's services to the recipient, the appropriate HCPCS codes must be submitted, including HCPCS codes for concurrent surgery, as applicable.

The bill must include all living donor physicians' services, e.g., Revenue Center code 081X.