CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 12130	**Date: July 21, 2023**
	Change Request 13250

SUBJECT: Internet Only Manual Update, Pub. 100-04, Chapter 3 (Inpatient Hospital Billing), Sections 90.1.2 - Billing for Kidney Transplant and Acquisition Services, 90.2 - Heart Transplants and 90.6- Intestinal and Multi-Visceral Transplants

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to remove reference to contractors determining if the facility is certified for adults and/or pediatric kidney transplants, heart transplants, and intestinal - Multi-Visceral transplants dependent upon the patient's age in Chapter 3 of the Medicare Claims Processing Manual Pub. 100-04.

EFFECTIVE DATE: August 21, 2023
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: August 21, 2023

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	3/90/90.1.2/Billing for Kidney Transplant and Acquisition Services
R	3/90/90.2/Heart Transplants
R	3/90/90.6/Intestinal and Multi-Visceral Transplants

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

Pub. 100-04	Transmittal: 12130	Date: July 21, 2023	Change Request: 13250

SUBJECT: Internet Only Manual Update, Pub. 100-04, Chapter 3 (Inpatient Hospital Billing), Sections 90.1.2 - Billing for Kidney Transplant and Acquisition Services, 90.2 - Heart Transplants and 90.6- Intestinal and Multi-Visceral Transplants

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I. GENERAL INFORMATION

A. Background: The purpose of this Change Request (CR) is to remove references to contractors determining if the facility is certified for adults and/or pediatric for kidney, heart and intestinal and multi - visceral transplants dependent upon the patient's age in the Medicare Claims Processing Manual Pub. 100-04, Chapter 3, Section 90.1.2, 90.2 and 90.6 to be consistent with the State Operations Manual Pub. 100-07, Chapter 2, Section 2061A and Appendix X - Guidance to Surveyors: Organ Transplant Programs, X-023.

B. Policy: There is no new policy associated with this instruction.

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	
13250.1	The Medicare contractors shall be aware of the manual updates in Pub 100-04, Chapter 3, Sections 90.1.2, 90.2 and 90.6	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

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

90.1.2 - Billing for Kidney Transplant and Acquisition Services

(Rev. 12130; Issued: 07-21-23; Effective: 08-21-23; Implementation: 08-21-23)

Applicable standard kidney acquisition charges are identified separately by revenue code 0811 (Living Donor Kidney Acquisition) or 0812 (Cadaver Donor Kidney Acquisition). 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 charges for services rendered directly to the Medicare recipient.

The contractor deducts kidney acquisition charges for PPS hospitals for processing through Pricer. These costs, incurred by approved kidney transplant hospitals, are **not** included in the kidney transplant prospective payment. They are paid on a reasonable cost basis. Interim payment is paid as a "pass through" item. (See the Provider Reimbursement Manual, Part 1, §2802 B.8.) The contractor includes kidney acquisition charges under the appropriate revenue code in CWF.

Bill Review Procedures

The Medicare Code Editor (MCE) creates a Limited Coverage edit for kidney transplant procedure codes. Where these procedure codes are identified by MCE, the contractor checks the provider number to determine if the provider is an approved transplant center and checks the effective approval date. If payment is appropriate (i.e., the center is approved, and the service is on or after the approval date) it overrides the limited coverage edit.

90.2 - Heart Transplants

(Rev. 12130; Issued: 07-21-23; Effective: 08-21-23; Implementation: 08-21-23)

Cardiac transplantation is covered under Medicare when performed in a facility which is approved by Medicare as meeting institutional coverage criteria. On April 6, 1987, CMS Ruling 87-1, "Criteria for Medicare Coverage of Heart Transplants" was published in the "Federal Register." For Medicare coverage purposes, heart transplants are medically reasonable and necessary when performed in facilities that meet these criteria. If a hospital wishes to bill Medicare for heart transplants, it must submit an application and documentation, showing its ongoing compliance with each criterion.

If a contractor has any questions concerning the effective or approval dates of its hospitals, it should contact its RO.

For a complete list of approved transplant centers, visit:
https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/downloads/ApprovedTransplantPrograms.pdf

A. - Effective Dates

The effective date of coverage for heart transplants performed at facilities applying after July 6, 1987, is the date the facility receives approval as a heart transplant facility. Coverage is effective for discharges October 17, 1986 for facilities that would have qualified and that applied by July 6, 1987. All transplant hospitals will be recertified under the final rule, Federal Register / Vol. 72, No. 61 / Friday, March 30, 2007, / Rules and Regulations.

The CMS informs each hospital of its effective date in an approval letter.

B. - Drugs

Medicare Part B covers immunosuppressive drugs following a covered transplant in an approved facility.

C. - Noncovered Transplants

Medicare will **not** cover transplants or re-transplants in facilities that have not been approved as meeting the facility criteria. If a beneficiary is admitted for and receives a heart transplant from a hospital that is not approved, physicians' services, and inpatient services associated with the transplantation procedure are not covered.

If a beneficiary received a heart transplant from a hospital while it was not an approved facility and later requires services as a result of the noncovered transplant, the services are covered when they are reasonable and necessary in all other respects.

D. - Charges for Heart Acquisition Services

The excising hospital bills the OPO, who in turn bills the transplant (implant) hospital for applicable services. It should not submit a bill to its contractor. The transplant hospital must keep an itemized statement that identifies the services rendered, the charges, the person receiving the service (donor/recipient), and whether this person is a potential transplant donor or recipient. These charges are reflected in the transplant hospital's heart acquisition cost center and are used in determining its standard charge for acquiring a donor's heart. The standard charge is not a charge representing the acquisition cost of a specific heart; rather, it reflects the average cost associated with each type of heart acquisition. Also, it is an all-inclusive charge for all services required in acquisition of a heart, i.e., tissue typing, post-operative evaluation, etc.

Acquisition charges shall be billed on a 081X revenue code. Such charges are not considered for the IPPS outlier calculation when billed for a heart transplant.

E. - Bill Review Procedures

The contractor takes the following actions to process heart transplant bills. It may accomplish them manually or modify its MCE and Grouper interface programs to handle the processing.

1. MCE Interface

The MCE creates a Limited Coverage edit for heart transplant procedure codes. Where these procedure codes are identified by MCE, the contractor checks the provider number to determine if the provider is an approved transplant center and checks the effective approval date. If payment is appropriate (i.e., the center is approved, and the service is on or after the approval date) it overrides the limited coverage edit.

2. Handling Heart Transplant Billings From Nonapproved Hospitals

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

90.6 – Intestinal and Multi-Visceral Transplants

(Rev. 12130; Issued: 07-21-23; Effective: 08-21-23; Implementation: 08-21-23)

A. - Background

Effective for services on or after April 1, 2001, Medicare covers intestinal and multi-visceral transplantation for the purpose of restoring intestinal function in patients with irreversible intestinal failure. Intestinal failure is defined as the loss of absorptive capacity of the small bowel secondary to severe primary gastrointestinal disease or surgically induced short bowel syndrome. Intestinal failure prevents oral nutrition and may be associated with both mortality and profound morbidity. Multi-Visceral transplantation includes organs in the digestive system (stomach, duodenum, liver, and intestine). See §260.5 of the National Coverage Determinations Manual for further information.

B. - Approved Transplant Facilities

Medicare will cover intestinal transplantation if performed in an approved facility. The approved facilities are located at: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/downloads/ApprovedTransplantPrograms.pdf

C. - Billing

If ICD-9-CM is applicable, ICD-9-CM procedure code 46.97 is effective for discharges on or after April 1, 2001. If ICD-10 is applicable, the ICD-10-PCS procedure codes are 0DY80Z0, 0DY80Z1, 0DYE0Z0, and 0DYE0Z1. The Medicare Code Editor (MCE) lists these codes as limited coverage procedures. The contractor shall override the MCE when this procedure code is listed and the coverage criteria are met in an approved transplant facility.

For these procedures where the provider is approved as a transplant facility, and the service is performed on or after the transplant approval date, contractors shall use claims data to determine that the coverage criteria specified in Publication 100-03, Section §260.5 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 ICD-9-CM is applicable, charges for ICD-9-CM procedure code 46.97, and, if ICD-10 is applicable, the ICD-10-PCS procedure codes 0DY80Z0, 0DY80Z1, 0DYE0Z0, or 0DYE0Z1 should be billed under revenue code 0360, Operating Room Services.

For discharge dates on or after October 1, 2001, acquisition charges are billed under revenue code 081X, Organ Acquisition. For discharge dates between April 1, 2001, and September 30, 2001, hospitals were to report the acquisition charges on the claim, but there was no interim pass-through payment made for these costs.

Bill the procedure used to obtain the donor's organ on the same claim, using appropriate ICD procedure codes.

The 11X bill type should be used when billing for intestinal transplants.

Immunosuppressive therapy for intestinal transplantation is covered and should be billed consistent with other organ transplants under the current rules.

If ICD-9-CM is applicable, there is no specific ICD-9-CM diagnosis code for intestinal failure. Diagnosis codes exist to capture the causes of intestinal failure. Some examples of intestinal failure include but are not limited to the following conditions and their associated ICD-9-CM codes:

- Volvulus 560.2,
- Volvulus gastroschisis 756.79, other [congenital] anomalies of abdominal wall,
- Volvulus gastroschisis 569.89, other specified disorders of intestine,
- Necrotizing enterocolitis 777.5, necrotizing enterocolitis in fetus or newborn,
- Necrotizing enterocolitis 014.8, other tuberculosis of intestines, peritoneum, and mesenteric,
- Necrotizing enterocolitis and splanchnic vascular thrombosis 557.0, acute vascular insufficiency of intestine,

- Inflammatory bowel disease 569.9, unspecified disorder of intestine,
- Radiation enteritis 777.5, necrotizing enterocolitis in fetus or newborn, and
- Radiation enteritis 558.1.

If ICD-10-CM is applicable, some diagnosis codes that may be used for intestinal failure are:

- Volvulus K56.2,
- Enteroptosis K63.4,
- Other specified diseases of intestine K63.89,
- Other specified diseases of the digestive system K92.89,
- Postsurgical malabsorption, not elsewhere classified K91.2,
- Other congenital malformations of abdominal wall Q79.59,
- Necrotizing enterocolitis in newborn, unspecified P77.9,
- Stage 1 necrotizing enterocolitis in newborn P77.1,
- Stage 2 necrotizing enterocolitis in newborn P77.2, and
- Stage 3 necrotizing enterocolitis in newborn P77.3.

D. - Acquisition Costs

A separate organ acquisition cost center was established for acquisition costs incurred on or after October 1, 2001. Therefore, acquisition charges billed on revenue code 081x are removed from the claim's total covered charges so as to not be included in the IPPS outlier calculation. The Medicare Cost Report will include a separate line to account for these transplantation costs.

For intestinal and multi-visceral transplants performed between April 1, 2001, and October 1, 2001, the DRG payment was payment in full for all hospital services related to this procedure.

E. - Medicare Summary Notices (MSN), Remittance Advice Messages, and Notice of Utilization Notices (NOU)

If an intestinal transplant is billed by an unapproved facility after April 1, 2001, the contractor shall deny the claim.

The following reflects the remittance advice messages and associated codes that will appear when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario 3.

Group Code: CO
CARC: 171
RARC: N/A
MSN: 21.6 or 21.18 or 16.2