CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 13508	**Date: December 23, 2025**
	Change Request 14262

SUBJECT: Implementation CR - Send Transplant Program Hospital Type and the New Organ Types to the Fiscal Intermediary Shared System (FISS) on Provider Enrollment Chain & Ownership System (PECOS) Extract Files and for FISS to Process so PECOS is the system of Record for the Transplant Program Hospital Type and for the Organs Type Transplanted at the Hospital

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to update the PECOS to FISS extract process to send Transplant Program indicator and/or Organ Type information if needed to process claims.

EFFECTIVE DATE: April 1, 2026
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 6, 2026

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	3/90/90.1/90.1.2/Billing for Kidney Transplant and Acquisition Services
R	3/90/90.2/Heart Transplants
R	3/90/90.4/90.4.2/Billing for Liver Transplant and Acquisition Services
R	3/90/90.5/Pancreas Transplants Kidney Transplants
R	3/90/90.5/90.5.1/Pancreas Transplants Alone (PA)
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: 13508	Date: December 23, 2025	Change Request: 14262

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I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to update the PECOS to FISS extract process to send Transplant Program indicator and/or Organ Type information if needed to process claims.

II. GENERAL INFORMATION

A. Background: As part of the last CMS-855A form update, the Transplant Program Subgroup/unit indicator is collected in PECOS for hospital provider types, when applicable. An organ type field is required if Transplant Program is selected as the hospital subgroup/unit. PECOS currently collects the Transplant Program indicator and Organ Type information for hospital provider types that identify having a Transplant Program. PECOS currently sends other hospital provider type Subgroup/units on Child Record 01. CMS is established an analysis CR to evaluate the need to send the Transplant Program indicator on Child Record 01 and Organ Type information on a new child record 22 to FISS.

Implementing this CR will facilitate data integrity between the two systems by ensuring that the Transplant Program Organ Type information in both systems matches and by ensuring that the FISS always has all Organ Type information as specified by the Provider in their enrollment record. In addition, it will improve efficiency by reducing the time and effort that the MACs spend researching transplant claims.

B. Policy: There are no regulatory, legislative, or statutory requirements related to this CR.

III. 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	
14262.1	The Shared System Maintainer (SSM) shall accept a new child record 22 from PECOS and create a load process for retrieval of the child record 22 record data					X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	using the existing processes. Note: Child 22 records received can be added or updated (current and/or history records) See Attachment 4.									
14262.2	The SSM shall be prepared to receive a test file containing 01, 02 and 22 child records no later than January 5, 2026.					X				
14262.3	The SSM shall create a new menu option MAP/screen to house the following transplant information when a Child Record 22 is received from PECOS: • From the 02 record, the billing provider CMS Certification Number (CCN), • From the 22 record: Create date, Organ Type, Organ Type Effective Date, Organ Type End date, Other Organ Type Description. Note: See Attachment 5 for the Organ Type Codes. Note: If Other Organ Type is selected, the SSM shall only display the information on the daily 'Transplant Record' report as described in					X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	Business Requirement (BR) 14262.4									
14262.4	The SSM shall create a daily 'Transplant Record' report that will include the Transplant records added or updated containing the data from BR 14262.3. The report shall be sorted by CCN					X				
14262.5	The SSM shall create an updatable Parameter Screen (PARM) to house the ICD-10 procedure codes in Attachment 6.					X				
14262.5.1	The SSM shall populate the PARM data by listing the ICD-10 procedure code and their associated transplant type(s). See Attachment 6.					X				
14262.5.2	The MACs shall be responsible for maintaining the PARM by updating new procedure codes and/or transplant types as directed by CMS.	X								
14262.6	The SSM shall modify the process for assignment of the Medicare Code Editor (MCE) reason codes W1505 through W1510 and W1867 through W1885 by analyzing the PARM and new Transplant Screen to determine if the MCE edit should continue to be assigned or bypassed (not assigned).					X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
14262.6.1	The SSM shall create a new reason codes (set to RTP)to be applied if any of the following ICD-10-CM PCS procedure codes: 02HA0QZ 02HA3QZ 02HA4QZ 02HA0RS 02HA0RZ 02HA3RS 02HA4RS 02HA4RZ 02WA0QZ 02WA0RZ 02WA3QZ 02WA3RZ 02WA4QZ 02WA4RZ If any of the above codes are found in any ICD-10-CM PCS procedure code position on the claim and analyzing the PARM and new Transplant Screen to determine if the new edit should continue to be assigned or bypassed (not assigned).	X				X				
14262.6.2	The SSM shall create a new reason codes (set to	X				X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	RTP) to be applied if any of the following ICD-10-CM PCS procedure codes: 02RK0JZ If any of the above codes are found in any ICD-10-CM PCS procedure code position on the claim and analyzing the PARM and new Transplant Screen to determine if the new edit should continue to be assigned or bypassed (not assigned).									
14262.7	The SSM shall remove system logic for claim level reason codes 32917 and 32918 from the system and set the reason code status/location to SMDLTD.					X				
14262.8	The SSM shall remove the LIVER IND and LIVER DT fields from the provider file, MAP1101.					X				
14262.9	The SSM shall remove the HEART TRANSPLANT CERT DT field from the provider file MAP1101.					X				
14262.10	The SSM shall remove the TRANSPLANT date field for kidney transplants from the provider file MAP1104.					X				
14262.11	The SSM shall modify the Pricer interface process by no longer sending the Liver, Heart and Kidney					X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	values from the provider file to the Pricer (data will be initialized if the fields are not removed by the Pricer team).									
14262.12	The SSM shall modify the 01 child record copybook to include new fields present on the record, however, the data shall not be displayed or used in the system.					X				
14262.13	Contractors shall attend a single call with PECOS and SSM to determine any file issues early in the Software Development Life Cycle near the end of week of January 5, 2026.					X				Hybrid Cloud Data Center (HCDC), MIST, PECOS
14262.14	PECOS shall add the following organ type to the organ type list. 16 - Heart Assist registry					X				PECOS
14262.15	The CMS shall provide an approval for transplant hospital data sheet with accurate hospital CCN/National Provider Identifier (NPI) combinations. • Each hospital CCN/NPI combination should have only one occurrence for an organ type. • Hospitals that have multiple									CMS, PECOS

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	transplant centers for the organ type will list the earliest effective date for the organ type on the data sheet.									
14262.15.1	MACs shall verify the transplant program information provided by CMS in BR 14262.15 and identify any discrepancies with the spreadsheet.	X								CMS, PECOS
14262.15.2	PECOS shall load MAC and CMS Approved and Verified Transplant Program information from the spreadsheet, which originated from the Survey and Certification's Quality, Certification and Oversight Reports site into PECOS. PECOS will load the CMS/MAC approved and verified organ types. Any organ type not approved and verified will have to be entered manually into PECOS by MAC after go-live. CMS/MAC Approved Transplant Data are matched to PECOS finalized enrollments using the following enrollment criteria: • Approved • Entity CCN • NPI • Hospital Provider Type	X								PECOS

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	Approved Finalized Hospital Enrollments that match CCN/NPI combinations shall be updated as follows: • If the organ type does not exist on the matching enrollment, the following data will be added to the enrollment: o Transplant Program indicator shall be set to Y. o Organ Type Code o Effective Date If the organ type does exist on the matching enrollment, no changes shall be made to the organ type record since the information was submitted by the provider.									
14262.16	PECOS shall trigger and send the enrollments with transplant program organ types in the first Daily FISS Extract file after go-live. All current and historical organ type information for these enrollments shall be sent on this first file to populate the FISS system with the enrollments organ type information.					X				PECOS

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
14262.17	PECOS shall send the Specialty Hospital and Transplant Program subunit/subgroup indicator to FISS via updated FISS Child Record 01. • Transplant Program: o Field Name: Transplant Program o Length: 1 o Position: 120 o Value: Y or N Note: Logic for existing fields in the extract file shall remain unchanged.					X				PECOS
14262.17.1	PECOS shall send the current and historic organ types on the new Child Record 22 – Organ Types. When enrollment is triggered to FISS. The Organ Type code shall be sent for the following Organ Type Descriptions: HOSP_ORGN_TYPE_CD HOSP_ORGN_TYPE_DESC 01 ADULT HEART/LUNG 02 ADULT HEART-ONLY					X				PECOS

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	03 ADULT INTESTINE/MULTIVISCERAL 04 ADULT KIDNEY-ONLY 05 ADULT LIVER 06 ADULT LUNG-ONLY 07 ADULT PANCREAS 08 PEDIATRIC HEART/LUNG 09 PEDIATRIC HEART-ONLY 10 PEDIATRIC INTESTINE/MULTIVISCERAL 11 PEDIATRIC KIDNEY ONLY 12 PEDIATRIC LIVER 13 PEDIATRIC LUNG-ONLY 14 PEDIATRIC PANCREAS 15 OTHER ORGAN TYPE 16 HEART ASSIST REGISTRY If HOSP_ORGN_TYPE_CD = ‘15’ the									

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	HOSP_ORGN_TYPE_OTHR_TXT shall be populated. Child Record 22 will contain all current and/or historic organ type information for the enrollment.									
14262.18	PECOS Provider Interface and Administrative Interface (AI) shall display instructions to: • use the earliest Organ Type effective date when a hospital enrollment has multiple transplant centers transplanting the same organ type, and • end date an Organ Type when all of the transplant centers can no longer transplant that organ type.									PECOS
14262.18.1	PECOS AI shall allow an Organ Type End Date = Effective Date to signify deleted Organ Type information.									PECOS
14262.18.2	PECOS AI shall disable the delete option for previously finalized									PECOS

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	current Organ Types.									
14262.19	Contractors shall educate providers regarding the use of the "Other Organ Type" and free form text field. Existing Organ Type options should not be listed in the Other Organ Type free form text field.	X								
14262.20	Contractors shall set the Organ Type End Date = Organ Type Effective date when an Organ Type data or an Organ Type Effective Date was entered in error.	X								
14262.21	PECOS shall send the sample test file created in BR 14262.16 to SSM by January 5, 2026 for alpha testing and send a sample test file to the MIST by February 5, 2026 and send a complete test file to Virtual Data Centers (VDCs) for User Acceptance Testing (UAT) by March 9, 2026. VDCs shall allow for A/B MAC (A) testing of the Daily FISS Extract file process in UAT during the normal release testing process. Note: The test file sent on March 9, 2026, shall contain data for BR 14262.17 and BR 14262.17.1.	X				X				Hybrid Cloud Data Center (HCDC), MIST, PECOS
14262.22	Contractors shall not process any 855A Hospital Enrollment records into PECOS from	X								

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
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	April 3, 2026 – April 5, 2026 (dark days) as the changes are made to the production PECOS files.									
14262.23	PECOS shall ensure that A/B MAC (A) contractor site specific data will be captured for each A/B MAC (A) FISS region and not one large file that contains every A/B MAC (A) contractor's information.									Hybrid Cloud Data Center (HCDC), PECOS
14262.24	SSM shall provide the team working on this issue by day one of the Program Increment planning. Medicare contractors which includes the claims processing experts at the MACs and the provider enrollment experts shall send participant names and email addresses within three (3) business days of final issuance of this CR to kusum.jha2@cms.hhs.gov and dionna.fair-latta@cms.hhs.gov for the UAT calls.	X				X				PECOS
14262.25	SSM and other maintainers shall take meeting minutes for impacts to their systems for the UAT calls.					X				PECOS
14262.26	Provider Enrollment experts at the MACs and claims processing experts at the MACs shall participate in four weeks of UAT testing.	X								PECOS

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	1. Provider Enrollment experts at the MACs shall test UI and create data to send to FISS. 2. Claims processing experts at the MACs shall verify that the claims are being processed properly.									
14262.26.1	MACs shall verify Organ Type information for accuracy during UAT: • Organ type(s) and Original Participation Date(s) is accurate for the hospital enrollment • All applicable organ types are listed on the enrollment	X								
14262.27	SSM shall support MACs/ PECOS during UAT testing.	X				X				PECOS
14262.28	SSM and MACs shall participate in UAT kick off call and twice per week UAT status calls as well as a go/no go call, which will be held at the end of UAT to determine if there will be major impacts to the hospital community prior to implementation. Claims processing experts at the MACs and provider enrollment experts at the	X				X				Hybrid Cloud Data Center (HCDC), PECOS

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	MACs shall also attend these calls and participate in UAT testing.									
14262.29	Contractors shall participate in additional calls as needed to address questions that arise during implementation or UAT. The SSM, PECOS, Claims processing experts at the MACs, provider enrollment experts at the MACs, and CMS shall attend these calls during the implementation and UAT timeframe as required.	X				X				PECOS
14262.30	Contractors shall provide sign off for April release for Send Transplant Program and Organ Type end-to-end testing at the end of the UAT testing. Claims processing experts at the MACs and provider enrollment experts at the MACs shall also participate in UAT testing.	X								PECOS

IV. PROVIDER EDUCATION

Medicare Learning Network® (MLN): CMS will develop and release national provider education content and market it through the MLN Connects® newsletter shortly after we issue the CR. MACs shall link to relevant information on your website and follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1 for distributing the newsletter to providers. When you follow this manual section, you don't need to separately track and report MLN content releases. You may supplement with your local educational content after we release the newsletter.

Impacted Contractors: A/B MAC Part A

V. 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

VI. CONTACTS

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

VII. 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: 1

Medicare Claims Processing Manual

Chapter 3 - Inpatient Hospital Billing

(Rev.13508; Issued: 12-23-25)

Transmittals for Chapter 3

90.1.2 - Billing for Kidney Transplant and Acquisition Services

(Rev. 13508; Issued: 12-23-25; Effective: 04-01-26; Implementation:04-06-26)

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 *shared system* checks the provider number to determine if the provider is an approved transplant center, and checks the effective approval date. The *shared system* shall also determine if the facility is certified for adults and/or pediatric transplants dependent upon the patient's age. 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. 13508; Issued: 12-23-25; Effective: 04-01-26; Implementation:04-06-26)

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 *shared system* 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 *shared system* checks the provider number to determine if the provider is an approved transplant center, and checks the effective approval date. The *shared system* shall also determine if the facility is certified for adults and/or pediatric transplants dependent upon the patient's age. 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.

90.4.2 - Billing for Liver Transplant and Acquisition Services

(Rev. 13508; Issued: 12-23-25; Effective: 04-01-26; Implementation:04-06-26)

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 below ICD-10-CM codes if ICD-10-CM is applicable.

Nationally Covered Diagnosis Codes

Diagnosis Code	Description
B16.0	Acute hepatitis B with delta-agent with hepatic coma
B16.1	Acute hepatitis B with delta-agent without hepatic coma
B16.2	Acute hepatitis B without delta-agent with hepatic coma
B16.9	Acute hepatitis B without delta-agent and without hepatic coma
B17.0	Acute delta-(super) infection of hepatitis B carrier
B17.10	Acute hepatitis C without hepatic coma
B17.11	Acute hepatitis C with hepatic coma
B17.2	Acute hepatitis E
B17.8	Other specified acute viral hepatitis
B17.9	Acute viral hepatitis, unspecified
B18.0	Chronic viral hepatitis B with delta-agent
B18.1	Chronic viral hepatitis B without delta-agent
B18.2	Chronic viral hepatitis C
B18.8	Other chronic viral hepatitis
B18.9	Chronic viral hepatitis, unspecified
B19.0	Unspecified viral hepatitis with hepatic coma
B16.0	Acute hepatitis B with delta-agent with hepatic coma
B16.1	Acute hepatitis B with delta-agent without hepatic coma
B16.2	Acute hepatitis B without delta-agent with hepatic coma
B19.10	Unspecified viral hepatitis B without hepatic coma
B19.11	Unspecified viral hepatitis B with hepatic coma
B19.20	Unspecified viral hepatitis C without hepatic coma
B19.21	Unspecified viral hepatitis C with hepatic coma
B19.9	Unspecified viral hepatitis without hepatic coma
C22.0	Liver cell carcinoma
E70.1	Other hyperphenylalaninemias
E70.20	Disorder of tyrosine metabolism, unspecified
E70.21	Tyrosinemia
E70.29	Other disorders of tyrosine metabolism

Diagnosis Code	Description
E70.30	Albinism, unspecified
E70.310	X-linked ocular albinism
E70.311	Autosomal recessive ocular albinism
E70.318	Other ocular albinism
E70.319	Ocular albinism, unspecified
E70.320	Tyrosinase negative oculocutaneous albinism
E70.321	Tyrosinase positive oculocutaneous albinism
E70.328	Other oculocutaneous albinism
E70.329	Oculocutaneous albinism, unspecified
E70.330	Chediak-Higashi syndrome
E70.331	Hermansky-Pudlak syndrome
E70.338	Other albinism with hematologic abnormality
E70.339	Albinism with hematologic abnormality, unspecified
E70.39	Other specified albinism
E70.40	Disorders of histidine metabolism, unspecified
E70.41	Histidinemia
E70.49	Other disorders of histidine metabolism
E70.5	Disorders of tryptophan metabolism
E70.81	Aromatic L-amino acid decarboxylase deficien
E70.89	Other disorders of aromatic amino-acid metabolism
E70.9	Disorder of aromatic amino-acid metabolism, unspecified
E71.0	Maple-syrup-urine disease
E71.110	Isovaleric acidemia
E71.111	3-methylglutaconic aciduria
E71.118	Other branched-chain organic acidurias
E71.120	Methylmalonic acidemia
E71.121	Propionic acidemia
E71.19	Other disorders of branched-chain amino-acid metabolism
E71.2	Disorder of branched-chain amino-acid metabolism, unspecified
E71.30	Disorder of fatty-acid metabolism, unspecified
E71.310	Long chain/very long chain acyl CoA dehydrogenase deficiency
E71.311	Medium chain acyl CoA dehydrogenase deficiency
E71.312	Short chain acyl CoA dehydrogenase deficiency
E71.313	Glutaric aciduria type II
E71.314	Muscle carnitine palmitoyltransferase deficiency
E71.318	Other disorders of fatty-acid oxidation
E71.32	Disorders of ketone metabolism
E71.39	Other disorders of fatty-acid metabolism
E71.40	Disorder of carnitine metabolism, unspecified
E71.41	Primary carnitine deficiency
E71.42	Carnitine deficiency due to inborn errors of metabolism
E71.43	Iatrogenic carnitine deficiency
E71.440	Ruvalcaba-Myhre-Smith syndrome
E71.448	Other secondary carnitine deficiency
E71.50	Peroxisomal disorder, unspecified
E71.510	Zellweger syndrome
E71.511	Neonatal adrenoleukodystrophy
E71.518	Other disorders of peroxisome biogenesis
E71.520	Childhood cerebral X-linked adrenoleukodystrophy
E71.521	Adolescent X-linked adrenoleukodystrophy

Diagnosis Code	Description
E71.522	Adrenomyeloneuropathy
E71.528	Other X-linked adrenoleukodystrophy
E71.529	X-linked adrenoleukodystrophy, unspecified type
E71.53	Other group 2 peroxisomal disorders
E71.540	Rhizomelic chondrodysplasia punctata
E71.541	Zellweger-like syndrome
E71.542	Other group 3 peroxisomal disorders
E71.548	Other peroxisomal disorders
E72.00	Disorders of amino-acid transport, unspecified
E72.01	Cystinuria
E72.02	Hartnup's disease
E72.03	Lowe's syndrome
E72.04	Cystinosis
E72.09	Other disorders of amino-acid transport
E72.10	Disorders of sulfur-bearing amino-acid metabolism, unspecified
E72.11	Homocystinuria
E72.12	Methylenetetrahydrofolate reductase deficiency
E72.19	Other disorders of sulfur-bearing amino-acid metabolism
E72.20	Disorder of urea cycle metabolism, unspecified
E72.21	Argininemia
E72.22	Arginosuccinic aciduria
E72.23	Citrullinemia
E72.29	Other disorders of urea cycle metabolism
E72.3	Disorders of lysine and hydroxylysine metabolism
E72.4	Disorders of ornithine metabolism
E72.50	Disorder of glycine metabolism, unspecified
E72.51	Non-ketotic hyperglycinemia
E72.52	Trimethylaminuria
E72.53	Primary hyperoxaluria
E72.59	Other disorders of glycine metabolism
E72.81	Disorders of gamma aminobutyric acid
E72.89	Other specified disorders of amino-acid metabolism
E72.9	Disorder of amino-acid metabolism, unspecified
E80.0	Hereditary erythropoietic porphyria
E80.29	Other porphyria
E83.00	Disorder of copper metabolism, unspecified
E83.01	Wilson's disease
E83.09	Other disorders of copper metabolism
E83.110	Hereditary hemochromatosis
E83.111	Hemochromatosis due to repeated red blood cell transfusions
E83.118	Other hemochromatosis
E83.119	Hemochromatosis, unspecified
E85.0	Non-neuropathic heredofamilial amyloidosis
E85.1	Neuropathic heredofamilial amyloidosis
E85.2	Heredofamilial amyloidosis, unspecified
E85.3	Secondary systemic amyloidosis
E85.4	Organ-limited amyloidosis
E85.89	Other amyloidosis
E88.01	Alpha-1-antitrypsin deficiency
E88.02	Plasminogen deficiency

Diagnosis Code	Description
I82.0	Budd-Chiari syndrome
K70.0	Alcoholic fatty liver
K70.10	Alcoholic hepatitis without ascites
K70.11	Alcoholic hepatitis with ascites
K70.2	Alcoholic fibrosis and sclerosis of liver
K70.30	Alcoholic cirrhosis of liver without ascites
K70.31	Alcoholic cirrhosis of liver with ascites
K70.40	Alcoholic hepatic failure without coma
K70.41	Alcoholic hepatic failure with coma
K70.9	Alcoholic liver disease, unspecified
K71.0	Toxic liver disease with cholestasis
K71.10	Toxic liver disease with hepatic necrosis, without coma
K71.11	Toxic liver disease with hepatic necrosis, with coma
K71.2	Toxic liver disease with acute hepatitis
K71.3	Toxic liver disease with chronic persistent hepatitis
K71.4	Toxic liver disease with chronic lobular hepatitis
K71.50	Toxic liver disease with chronic active hepatitis without ascites
K71.51	Toxic liver disease with chronic active hepatitis with ascites
K71.6	Toxic liver disease with hepatitis, not elsewhere classified
K71.7	Toxic liver disease with fibrosis and cirrhosis of liver
K71.8	Toxic liver disease with other disorders of liver
K72.00	Acute and subacute hepatic failure without coma
K72.01	Acute and subacute hepatic failure with coma
K72.10	Chronic hepatic failure without coma
K72.11	Chronic hepatic failure with coma
K72.90	Hepatic failure, unspecified without coma
K72.91	Hepatic failure, unspecified with coma
K73.1	Chronic lobular hepatitis, not elsewhere classified
K73.2	Chronic active hepatitis, not elsewhere classified
K73.8	Other chronic hepatitis, not elsewhere classified
K73.9	Chronic hepatitis, unspecified
K74.01	Hepatic fibrosis, early fibrosis
K74.02	Hepatic fibrosis, advanced fibrosis
K74.1	Hepatic sclerosis
K74.2	Hepatic fibrosis with hepatic sclerosis
K74.3	Primary biliary cirrhosis
K74.4	Secondary biliary cirrhosis
K74.5	Biliary cirrhosis, unspecified
K74.60	Unspecified cirrhosis of liver
K74.69	Other cirrhosis of liver
K75.0	Abscess of liver
K75.1	Phlebitis of portal vein
K75.2	Nonspecific reactive hepatitis
K75.3	Granulomatous hepatitis, not elsewhere classified
K75.4	Autoimmune hepatitis
K75.81	Nonalcoholic steatohepatitis (NASH)
K75.89	Other specified inflammatory liver diseases
K75.9	Inflammatory liver disease, unspecified
K76.0	Fatty (change of) liver, not elsewhere classified
K76.1	Chronic passive congestion of liver

Diagnosis Code	Description
K76.2	Central hemorrhagic necrosis of liver
K76.3	Infarction of liver
K76.4	Peliosis hepatis
K76.5	Hepatic veno-occlusive disease
K76.6	Portal hypertension
K76.7	Hepatorenal syndrome
K76.81	Hepatopulmonary syndrome
K76.89	Other specified diseases of liver
K77	Liver disorders in diseases classified elsewhere
K83.01	Primary sclerosing cholangitis
K83.09	Other cholangitis
K83.1	Obstruction of bile duct
K83.5	Biliary cyst
K83.8	Other specified diseases of biliary tract
K83.9	Disease of biliary tract, unspecified
K91.82	Postprocedural hepatic failure
Q44.1	Other congenital malformations of gallbladder
Q44.2	Atresia of bile ducts
Q44.3	Congenital stenosis and stricture of bile ducts
Q44.4	Choledochal cyst
Q44.6	Cystic disease of liver
T86.40	Unspecified complication of liver transplant
T86.41	Liver transplant rejection
T86.42	Liver transplant failure

Local Discretion Covered Diagnosis Codes

Diagnosis Code	Description
C24.0	Malignant neoplasm of extrahepatic bile duct
C7B.02	Secondary carcinoid tumors of liver
D37.6	Neoplasm of uncertain behavior of liver, gallbladder and bile ducts

Nationally NON-Covered Diagnosis Codes

Diagnosis Code	Description
C22.1	Intrahepatic bile duct carcinoma
C22.3	Angiosarcoma of liver
C22.7	Other specified carcinomas of liver
C78.7	Secondary malignant neoplasm of liver and intrahepatic bile duct
C7A.1	Malignant poorly differentiated neuroendocrine tumors
C7A.8	Other malignant neuroendocrine tumors
C7B.8	Other secondary neuroendocrine tumors
D01.5	Carcinoma in situ of liver, gallbladder and bile ducts
D18.00	Hemangioma unspecified site
D18.01	Hemangioma of skin and subcutaneous tissue
D18.02	Hemangioma of intracranial structures
D18.03	Hemangioma of intra-abdominal structures

D18.09	Hemangioma of other sites
D3A.8	Other benign neuroendocrine tumors

The MCE contains a limited coverage edit for liver transplant procedures using ICD- 10-PCS codes, if ICD-10-PCS code is applicable.

0FY00Z0- Transplantation of Liver, Allogeneic, Open Approach 0FY00Z1-Transplantation of Liver, Syngeneic, Open Approach

Where a liver transplant procedure code is identified by the MCE, the shared system 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. 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 diagnosis's codes are for a covered condition, 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

90.5 - Pancreas Transplants Kidney Transplants

(Rev. 13508; Issued: 12-23-25; Effective: 04-01-26; Implementation:04-06-26)

A. - Background

Effective July 1, 1999, Medicare covered pancreas transplantation when performed simultaneously with or following a kidney transplant if ICD-9 is applicable, ICD-9-CM procedure code 55.69. If ICD-10 is applicable, the following ICD-10-PCS codes will be used:

0TY00Z0,
0TY00Z1,
0TY00Z2,
0TY10Z0.
0TY10Z1, and
0TY10Z2.

Pancreas transplantation is performed to induce an insulin independent, euglycemic state in diabetic patients. The procedure is generally limited to those patients with severe secondary complications of diabetes including kidney failure. However, pancreas transplantation is sometimes performed on patients with labile diabetes and hypoglycemic unawareness.

Medicare has had a policy of not covering pancreas transplantation. The Office of Health Technology Assessment performed an assessment on pancreas-kidney transplantation in 1994. They found reasonable graft survival outcomes for patients receiving either simultaneous pancreas-kidney (SPK) transplantation or pancreas after kidney (PAK) transplantation. For a list of facilities approved to perform SPK or PAK, refer to the following Web site: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/downloads/ApprovedTransplantPrograms.pdf

B. - Billing for Pancreas Transplants

There are no special provisions related to managed care participants. Managed care plans are required to provide all Medicare covered services. Medicare does not restrict which hospitals or physicians may perform pancreas transplantation.

The transplant procedure and revenue code 0360 for the operating room are paid under these codes. Procedures must be reported using the current ICD procedure codes for pancreas and kidney transplants. Providers must place at least one of the following transplant procedure codes on the claim:

If ICD-9 Is Applicable

52.80 Transplant of pancreas
52.82 Homotransplant of pancreas

The Medicare Code Editor (MCE) has been updated to include 52.80 and 52.82 as limited coverage procedures. The *shared system shall* determine if the facility is approved for the transplant and certified for either pediatric or adult transplants dependent upon the age of the patient.

Effective October 1, 2000, ICD-9-CM code 52.83 was moved in the MCE to non-covered. The contractor must override any deny edit on claims that came in with 52.82 prior to October 1, 2000 and adjust, as 52.82 is the correct code.

If the discharge date is July 1, 1999, or later: the contractor processes the bill through Grouper and Pricer.

If ICD-10 is applicable, the following procedure codes (ICD-10-PCS) are:

- 0FYG0Z0 Transplantation of Pancreas, Allogeneic, Open Approach
- 0FYG0Z1 Transplantation of Pancreas, Syngeneic, Open Approach

Pancreas transplantation is reasonable and necessary for the following diagnosis codes. However, since this is not an all-inclusive list, the contractor is permitted to determine if any additional diagnosis codes will be covered for this procedure.

If ICD-9-CM is applicable, Diabetes Diagnosis Codes and Descriptions

ICD-9-CM Code	Description
250.00	Diabetes mellitus without mention of complication, type II (non-insulin dependent) (NIDDM) (adult onset) or unspecified type, not stated as uncontrolled.
250.01	Diabetes mellitus without mention of complication, type I (insulin dependent) (IDDM) (juvenile), not stated as uncontrolled.
250.02	Diabetes mellitus without mention of complication, type II (non-insulin dependent) (NIDDM) (adult onset) or unspecified type, uncontrolled.
250.03	Diabetes mellitus without mention of complication, type I (insulin dependent) (IDDM) (juvenile), uncontrolled.
250.1X	Diabetes with ketoacidosis
250.2X	Diabetes with hyperosmolarity
250.3X	Diabetes with coma
250.4X	Diabetes with renal manifestations
250.5X	Diabetes with ophthalmic manifestations
250.6X	Diabetes with neurological manifestations
250.7X	Diabetes with peripheral circulatory disorders
250.8X	Diabetes with other specified manifestations
250.9X	Diabetes with unspecified complication

NOTE: X=0-3

If ICD-10-CM is applicable, the diagnosis codes are: E10.10 - E10.9

Hypertensive Renal Diagnosis Codes and Descriptions if ICD-9-CM is applicable :

ICD-9-CM Code	Description
403.01	Malignant hypertensive renal disease, with renal failure
403.11	Benign hypertensive renal disease, with renal failure
403.91	Unspecified hypertensive renal disease, with renal failure
404.02	Malignant hypertensive heart and renal disease, with renal failure
404.03	Malignant hypertensive heart and renal disease, with congestive heart failure or renal failure
404.12	Benign hypertensive heart and renal disease, with renal failure
404.13	Benign hypertensive heart and renal disease, with congestive heart failure or renal failure
404.92	Unspecified hypertensive heart and renal disease, with renal failure
404.93	Unspecified hypertensive heart and renal disease, with congestive heart failure or renal failure

ICD-9-CM Code	Description
585.1 - 585.6, 585.9	Chronic Renal Failure Code

If ICD-10-CM is applicable, diagnosis codes and descriptions are:

ICD-10-CM code	Description
I12.0	Hypertensive chronic kidney disease with stage 5 chronic kidney disease or end stage renal disease
I13.11	Hypertensive heart and chronic kidney disease without heart failure, with stage 5 chronic kidney disease, or end stage renal disease
I13.2	Hypertensive heart and chronic kidney disease with heart failure and with stage 5 chronic kidney disease, or end stage renal disease
N18.1	Chronic kidney disease, stage 1
N18.2	Chronic kidney disease, stage 2 (mild)
N18.3	Chronic kidney disease, stage 3 (moderate)
N18.4	Chronic kidney disease, stage 4 (severe)
N18.5	Chronic kidney disease, stage 5
N18.6	End stage renal disease
N18.9	Chronic kidney disease, unspecified

NOTE: If a patient had a kidney transplant that was successful, the patient no longer has chronic kidney failure, therefore it would be inappropriate for the provider to bill ICD-9-CM codes 585.1 - 585.6, 585.9 or, if ICD-10-CM is applicable, the diagnosis codes N18.1 - N18.9 on such a patient. In these cases one of the following codes should be present on the claim or in the beneficiary's history.

The provider uses the following ICD-9-CM status codes only when a kidney transplant was performed before the pancreas transplant and ICD-9 is applicable:

ICD-9-CM code	Description
V42.0	Organ or tissue replaced by transplant kidney
V43.89	Organ tissue replaced by other means, kidney or pancreas

If ICD-10-CM is applicable, the following ICD-10-CM status codes will be used:

ICD-10-CM code	Description
Z48.22	Encounter for aftercare following kidney transplant
Z94.0	Kidney transplant status

NOTE: If a kidney and pancreas transplants are performed simultaneously, the claim should contain a diabetes diagnosis code and a renal failure code or one of the hypertensive renal failure diagnosis codes. The claim should also contain two transplant procedure codes. If the

claim is for a pancreas transplant only, the claim should contain a diabetes diagnosis code and a status code to indicate a previous kidney transplant. If the status code is not on the claim for the pancreas transplant, the contractor will search the beneficiary's claim history for a status code indicating a prior kidney transplant.

C. – Drugs
If the pancreas transplant occurs after the kidney transplant, immunosuppressive therapy will begin with the date of discharge from the inpatient stay for the pancreas transplant.

D. - Charges for Pancreas Acquisition Services
A separate organ acquisition cost center has been established for pancreas transplantation. The Medicare cost report will include a separate line to account for pancreas transplantation costs. The 42 CFR 412.2(e)(4) was changed to include pancreas in the list of organ acquisition costs that are paid on a reasonable cost basis.

Acquisition costs for pancreas transplantation as well as kidney transplants will occur in Revenue Center 081X. The contractor overrides any claims that suspend due to repetition of revenue code 081X on the same claim if the patient had a simultaneous kidney/pancreas transplant. It pays for acquisition costs for both kidney and pancreas organs if transplants are performed simultaneously. It will not pay for more than two organ acquisitions on the same claim. In addition, the contractor remove acquisition charges prior to sending the claims to Pricer so such charges are not included in the outlier calculation.

E. - Medicare Summary Notices (MSN) and Remittance Advice Messages

If the provider submits a claim for simultaneous pancreas kidney transplantation or pancreas transplantation following a kidney transplant, and omits one of the appropriate diagnosis/procedure codes, the contractor shall reject 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: B15
RARC: N/A
MSN: 16.32

If no evidence of a prior kidney transplant is presented, then 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: 50
RARC: MA126
MSN: 15.4

90.5.1 - Pancreas Transplants Alone (PA)
(Rev. 13508; Issued: 12-23-25; Effective: 04-01-26; Implementation:04-06-26)

A. - General

Pancreas transplantation is performed to induce an insulin-independent, euglycemic state in diabetic patients. The procedure is generally limited to those patients with severe secondary complications of diabetes, including kidney failure. However, pancreas transplantation is sometimes performed on patients with labile diabetes and hypoglycemic unawareness. Medicare has had a long-standing policy of not covering pancreas transplantation, as the safety and effectiveness of the procedure had not been demonstrated. The Office of Health Technology Assessment performed an assessment of pancreas-kidney transplantation in 1994. It found reasonable graft survival outcomes for patients receiving either simultaneous pancreas-kidney transplantation or pancreas-after-kidney transplantation.

B. - Nationally Covered Indications

CMS determines that whole organ pancreas transplantation will be nationally covered by Medicare when performed simultaneous with or after a kidney transplant. If the pancreas transplant occurs after the kidney transplant, immunosuppressive therapy will begin with the date of discharge from the inpatient stay for the pancreas transplant.

C. - Billing and Claims Processing

Contractors shall pay for Pancreas Transplantation Alone (PA) effective for services on or after April 26, 2006 when performed in those facilities that are Medicare-approved for kidney transplantation. Approved facilities are located at the following address: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/downloads/ApprovedTransplantPrograms.pdf

The shared system shall reject claims for PA services that were performed in an unapproved facility.

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: 58
RARC: N/A
MSN: 16.2

Payment will be made for a PA service performed in an approved facility, and which meets the coverage guidelines mentioned above for beneficiaries with type I diabetes.

All-Inclusive List of Covered Diagnosis Codes for PA if ICD-9-CM is applicable

(**NOTE: "**X" = 1 and 3 only)

ICD-9-CM code	**Description**
250.0X	Diabetes mellitus without mention of complication, type I (insulin dependent) (IDDM) (juvenile), not stated as uncontrolled.
250.1X	Diabetes with ketoacidosis
250.2X	Diabetes with hyperosmolarity
250.3X	Diabetes with coma
250.4X	Diabetes with renal manifestations

ICD-9-CM code	Description
250.5X	Diabetes with ophthalmic manifestations
250.6X	Diabetes with neurological manifestations
250.7X	Diabetes with peripheral circulatory disorders
250.8X	Diabetes with other specified manifestations
250.9X	Diabetes with unspecified complication

If ICD-10-CM is applicable, , the provider uses the following range of ICD-10-CM codes:

E10.10 – E10.9.

Procedure Codes

If ICD-9 CM is applicable

52.80 - Transplant of pancreas
52.82 - Homotransplant of pancreas

If ICD-10 is applicable, the provider uses the following ICD-10-PCS codes:

0FYG0Z0 Transplantation of Pancreas, Allogeneic, Open Approach
0FYG0Z1 Transplantation of Pancreas, Syngeneic, Open Approach

Contractors who receive claims for PA that are not billed using the covered diagnosis/procedure codes listed above shall reject such claims. The MCE edits to ensure that the transplant is covered based on the diagnosis. The MCE also considers ICD-9-CM codes 52.80 and 52.82 and ICD-10-PCS codes 0FYG0Z0 and 0FYG0Z1 as limited coverage dependent upon whether the facility is approved to perform the transplant and is certified for the age of the patient.

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: 50
RARC: N/A
MSN: 15.4

Contractors shall hold the provider liable for denied\rejected claims unless the hospital issues a Hospital Issued Notice of Non-coverage (HINN) or a physician issues an Advanced Beneficiary Notice (ABN) for Part-B for physician services.

D. - Charges for Pancreas Alone Acquisition Services

A separate organ acquisition cost center has been established for pancreas transplantation. The Medicare cost report will include a separate line to account for pancreas transplantation costs. The 42 CFR 412.2(e)(4) was changed to include PA in the list of organ acquisition costs that are paid on a reasonable cost basis.

Acquisition costs for PA transplantation are billed in Revenue Code 081X. The contractor removes acquisition charges prior to sending the claims to Pricer so such charges are not included in the outlier calculation.

90.6 - Intestinal and Multi-Visceral Transplants

(Rev. 13508; Issued: 12-23-25; Effective: 04-01-26; Implementation:04-06-26)

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 *shared system* shall override the MCE when this procedure code is listed and *services are provided* in an approved transplant facility, and also determine if the facility is certified for adults and/or pediatric transplants dependent upon the patient's age.

For these procedures where the provider is approved as a transplant facility and certified for the adult and/or pediatric population, and the service is performed on or after the transplant approval date dependent on patient's age, 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

TOTAL ATTACHMENTS: 6

Attachment 1. QCOR Transplant Code to PECOS Organ Type Crosswalk

Transplant Program Type Code	Transplant Program Type	HOSP_ORGN_TYPE_CD	HOSP_ORGN_TYPE_DESC
AHL	Adult Heart Lung	01	ADULT HEART/LUNG
AHO	Adult Heart Only	02	ADULT HEART-ONLY
AIM	Adult Intestine/Multivisceral	03	ADULT INTESTINE/MULTIVISCERAL
AKO	Adult Kidney Only	04	ADULT KIDNEY-ONLY
ALI	Adult Liver Only	05	ADULT LIVER
ALO	Adult Lung Only	06	ADULT LUNG-ONLY
APA	Adult Pancreas	07	ADULT PANCREAS
PHL	Pediatric Heart Lung	08	PEDIATRIC HEART LUNG
PHO	Pediatric Heart Only	09	PEDIATRIC HEART-ONLY
PIM	Pediatric Intestine/Multivisceral	10	PEDIATRIC INTESTINE/MULTIVISCERAL
PKO	Pediatric Kidney Only	11	PEDIATRIC KIDNEY ONLY
PLI	Pediatric Liver	12	PEDIATRIC LIVER
PLO	Pediatric Lung Only	13	PEDIATRIC LUNG-ONLY
PPA	Pediatric Pancreas	14	PEDIATRIC PANCREAS
		15	OTHER

Attachment 2. PECOS Daily FISS Extract Child Records

FISS Extract Child Record Types

* Record Type Values
"01" – HOSPITAL-TYPE
"02" – MEDICARE-IDENTIFICATION
"03" – ENROLLMENT STATUS
"04" – PRACTICE-LOCATION
"05" – SPECIAL PAYMENT
"06" – L&T SUBMITTAL REASON
"07" – CHOW/ACQUISITION/MERGER/CONSOLIDATION
"08" - MEDICARE ID-NPI COMBINATION ASSOCIATION TO PRACTICE LOCATION
"09" – ADMINISTRATIVE FLAGS (PEND only)
"17" – ADMINISTRATIVE FLAGS
"18" – OWNERSHIP CONTROL
"19" – Electronic Funds Transfer Information
"20" - FISS Reassign Members Info Child Record
"21" - MEDICAL RECORD CORRESPONDENCE ADDRESS (not yet implemented)
"22" – ORGAN-TYPE

Attachment 3. PECOS Daily FISS Extract Child Record 01 Hospital Type

Description	Field Name	Length	Default Value	Start Position	
Record Type	BSE-REC-TYPE	2	01	1	
FI Contractor ID	BSE-FI-ID	5	N/A	3	
Create Date	BSE-CREAT-DT	8	N/A	8	
PAC ID	BSE-PAC-ID	10	N/A	16	
Enrollment ID	BSE-ENR-ID	15	N/A	26	
General	HSP-GENERAL	1	N/A	41	
Acute Care	HSP-ACUTE	1	N/A	42	
Children's Hospital (excluded from PPS)	HSP-CHILDREN	1	N/A	43	
Long-Term (excluded from PPS)	HSP-LONG	1	N/A	44	
Psychiatric (excluded from PPS)	HSP-PSYCHIATRIC-EXPPS	1	N/A	45	
Rehabilitation Unit (excluded from PPS)	HSP_TYP_REHAB	1	N/A	46	
Short-Term (General and Specialty)	HSP-SHORT	1	N/A	47	
Swing-Bed Approved	HSP-SWING	1	N/A	48	
Psychiatric Unit	HSP-PSYCHIATRIC	1	N/A	49	
Other Hospital	HSP-OTHER	1	N/A	50	
Other Specify	HSP-OTHER-SP	60	N/A	51	
End Date	HSP-END-DT	8	N/A	111	
Specialty Hospital	HSP-TYP-SPCLTY	1	N/A	119	Possible Values: Y or N
Transplant Program	HSP-TYP-TRNSPLNT	1	N/A	120	Possible Values: Y or N
Filler	FILLER	701	N/A	121	
Total Length	N/A	**821**	N/A	N/A	

Attachment 4. PECOS Daily FISS Extract Child Record 22 Organ Type

Description	Field Name	Length	Default Value	Start Position	
Record Type	BSE-REC-TYPE	2	22	1	
FI Contractor ID	BSE-FI-ID	5	N/A	3	
Create Date	BSE-CREAT-DT	8	N/A	8	
PAC ID	BSE-PAC-ID	10	N/A	16	
Enrollment ID	BSE-ENR-ID	15	N/A	26	
Organ Type	HOSP_ORGN_TYPE_CD	2	N/A	41	Required Possible Values: 01 - 16

Description	Field Name	Length	Default Value	Start Position	
Organ Type Effective Date	HOSP_ORGN_TYPE_EFCTV_DT	8	N/A	43	Required Format: YYYYMMDD
Organ Type End Date	HOSP_ORGN_TYPE_END_DT	8	N/A	51	Optional Format: YYYYMMDD
Other Organ Type Description	HOSP_ORGN_TYPE_OTHR_TXT	60	N/A	59	Provided if HOSP_ORGN_TYPE_CD = '15'
Filler	FILLER	703	N/A	119	
Total Length	N/A	**821**	N/A	N/A	

Attachment 5. PECOS Daily FISS Extract Child Record 22 ORGAN-TYPE: Organ Type Codes

HOSP_ORGN_TYPE_CD	HOSP_ORGN_TYPE_DESC
01	ADULT HEART/LUNG
02	ADULT HEART-ONLY
03	ADULT INTESTINE/MULTIVISCERAL
04	ADULT KIDNEY-ONLY
05	ADULT LIVER
06	ADULT LUNG-ONLY
07	ADULT PANCREAS
08	PEDIATRIC HEART/LUNG
09	PEDIATRIC HEART-ONLY
10	PEDIATRIC INTESTINE/MULTIVISCERAL
11	PEDIATRIC KIDNEY ONLY
12	PEDIATRIC LIVER
13	PEDIATRIC LUNG-ONLY
14	PEDIATRIC PANCREAS
15	OTHER ORGAN TYPE
16	HEART ASSIST REGISTRY

Attachment 6. ICD-10 Procedure Codes

Procedure	HOSP_ORGN_TYPE_CD
02YA0Z0	**1, 2, 8, or 9**
02YA0Z1	**1, 2, 8, or 9**
02YA0Z2	**1, 2, 8, or 9**
02RK0JZ	**1, 2, 8, or 9**
0BYC0Z0	**1, 6, 8, or 13**
0BYC0Z1	**1, 6, 8, or 13**
0BYC0Z2	**1, 6, 8, or 13**
0BYD0Z0	**1, 6, 8, or 13**
0BYD0Z1	**1, 6, 8, or 13**
0BYD0Z2	**1, 6, 8, or 13**
0BYF0Z0	**1, 6, 8, or 13**
0BYF0Z1	**1, 6, 8, or 13**
0BYF0Z2	**1, 6, 8, or 13**

0BYG0Z0	**1, 6, 8, or 13**
0BYG0Z1	**1, 6, 8, or 13**
0BYG0Z2	**1, 6, 8, or 13**
0BYH0Z0	**1, 6, 8, or 13**
0BYH0Z1	**1, 6, 8, or 13**
0BYH0Z2	**1, 6, 8, or 13**
0BYJ0Z0	**1, 6, 8, or 13**
0BYJ0Z1	**1, 6, 8, or 13**
0BYJ0Z2	**1, 6, 8, or 13**
0BYK0Z0	**1, 6, 8, or 13**
0BYK0Z1	**1, 6, 8, or 13**
0BYK0Z2	**1, 6, 8, or 13**
0BYL0Z0	**1, 6, 8, or 13**
0BYL0Z1	**1, 6, 8, or 13**
0BYL0Z2	**1, 6, 8, or 13**
0BYM0Z0	**1, 6, 8, or 13**
0BYM0Z1	**1, 6, 8, or 13**
0BYM0Z2	**1, 6, 8, or 13**
0DY80Z0	**3 or 10**
0DY80Z1	**3 or 10**
0DY80Z2	**3 or 10**
0DYE0Z0	**3 or 10**
0DYE0Z1	**3 or 10**
0DYE0Z2	**3 or 10**
0FY00Z0	**5 or 12**
0FY00Z1	**5 or 12**
0FY00Z2	**5 or 12**
0FYG0Z0	**7 or 14**
0FYG0Z1	**7 or 14**
0TY00Z0	**4 or 11**
0TY00Z1	**4 or 11**
0TY00Z2	**4 or 11**
0TY10Z0	**4 or 11**
0TY10Z1	**4 or 11**
0TY10Z2	**4 or 11**
02HA0QZ	**16**
02HA3QZ	**16**
02HA4QZ	**16**
02HA0RS	**16**
02HA0RZ	**16**
02HA3RS	**16**
02HA4RS	**16**
02HA4RZ	**16**
02WA0QZ	**16**
02WA0RZ	**16**
02WA3QZ	**16**
02WA3RZ	**16**
02WA4QZ	**16**
02WA4RZ	**16**