The ABC's of Transplant Finance

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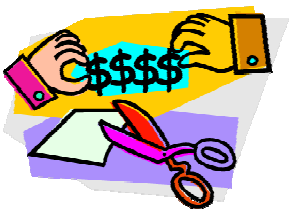
Disclosure

I have no relevant financial relationships to disclose

Topics Covered

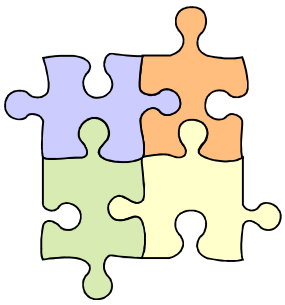
Acquisition (Organ **A**cquisition)
Billing for Transplantation
Cost Reporting (Medicare **C**ost Report)

How Much Does A Transplant Cost?



Answer

The Cost of a Transplant is not a Figure, but a Formula.



Formula for Transplant Cost

- **Pre-Transplant Costs of Recipient & Donor**
- **In-Patient Costs**
- **Cost of Organ**
- **Post-Transplant Care for Managed Care Contracts**

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Formula for Transplant Costs

Deceased Donor Transplants

+ Pre-Transplant Costs of Recipient
+ Cost of Organ
+ In-Patient Costs
+ Post-Transplant Care for Managed Care Contracts

= Cost of Transplant

Living Donor Transplants

✓ Pre-Transplant Costs of Recipient & Live Donor Work-Up
✓ In-Patient Costs- for Recipient & Donor
✓ Post-Transplant Care for Managed Care Contracts

= Cost of Transplant

Acquisition

How Are Costs Captured?

The Organ Acquisition Cost (OAC)

- The costs included in the OAC are related to determining the suitability of a candidate or donor for transplantation. They do not include costs associated with patient care or treatment pre, during, or post-transplant. (Exception to this is donor care in certain situations).

OAC

Conceptually, the OAC may be viewed as having four (4) distinct components:

1. Normal Operating Costs (associated with program operations)
2. Costs Associated with Medical Consultation or Evaluation of Potential Recipients/Donors
3. Costs Associated with Maintenance on the Waiting List (incl. Monitoring of patient for ongoing suitability)
4. Costs Associated with Acquiring the Organs for Transplant (cadaveric or living donor)

OAC

1. Normal Operating Costs

- Space related costs
- Personnel costs incl. clerical & professional
- Cost of program administration
- Cost of registering potential recipients with UNOS

2. Medical Consultation/Evaluation

- Tissue typing lab costs
- Other lab service costs
- MD fees for evaluation of potential recipients/donors
- Social Services, dietary, pharmacist & other support
- Other clinical evaluation costs (i.e. dental, psychiatry)
- Costs of applicable inpatient & outpatient services for evaluation

OAC

3. Costs Associated with Maintenance on Waiting List

- Periodic antibody screening
- Required re-evaluation for transplant suitability

4. Costs of Acquiring Organs for Transplant

- Charges from OPO for cadaveric organs
- Hospital costs for living donors at the time of donation
- Lab costs for final crossmatch & organ acquisition
- Perfusion & preservation costs
- Surgeon's fee for excision
- Transportation

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Costs Directly Reimbursable through OAC

- Medical/Clinical Director (portion of salary)
- Hospital Administration
- Transplant Coordinators
- Social & Dietary Services
- Financial Coordinator
- Secretarial/Clerical/Data Coordinator
- Pre-transplant Patient Records
- Storage
- Telephone, Answering Service, Pagers, Cells, etc.
- Equipment & Supplies (assoc. with evaluation)
- Patient Education Materials
- Utilities
- Maintenance
- Computers
- Insurance
- Travel Reimbursement (UNOS,NATCO)
- Continuing Education Mtgs & Seminars
- Memberships, Dues, Subscriptions
- Indirect costs (i.e. hospital overhead - a portion of non-revenue producing cost centers that support pre-transplant - housekeeping, finance, contracting, etc.

OAC Billing Summary

1. All inpatient or outpatient services from the hospital as part of the pre-transplant evaluation process for both potential recipients and donors are billed to OAC.
2. When a living donor is admitted to the hospital for organ donation, the OAC is billed for all hospital services.
3. Similarly, when a living donor uses any in or outpatient hospital services post donation, for donation specific problems, the OAC is billed.

OAC Billing Summary

4. Physician services, beginning when the donor is admitted for donation, and continuing through the post donation period, are no longer considered 'acquisition services' and thus do not get billed under Medicare Part A.
5. Instead, expenses for physicians' services to the donor are treated as though they had been incurred by the recipient under Medicare Part B. They are billed in the normal manner directly to Medicare under the recipient's account and are reimbursed at 100% of the reasonable charge.

OAC Billing Summary

6. When a recipient is admitted for a cadaveric or living donor transplant, Medicare Part A or the appropriate primary payer is billed.

Billing

Evaluation Services

Medicare Primary –

Hospital Services – The Transplant Center is financially responsible.

Physician Services – Bill Transplant Center

Other Third Party Payers or Self Pay – Bill the patient or the payer for the patient for Transplant Center services and bill the Transplant Center for Physician Services

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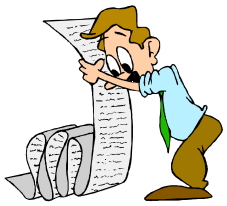
Recipient's Insurance pays for costs of donor evaluation and donation.

- Follows Medicare guidelines
- Most payors follow this as well



However, some commercial payors do try to require donor insurance assumes responsibility….

- transplant center needs to assess and address before case can proceed.

Potential Living Donor Evaluation

The potential Living Donor for a Medicare Entitled ESRD recipient is NEVER to be billed for pre-transplant evaluation services.

Potential Recipient Patient Care

If a Medical Condition is discovered that needs to be taken care of during the Recipient Evaluation process, taking care of the condition is the responsibility of the Recipient and not the Transplant Center.

Potential Living Donor Patient Care

If a Medical Condition is discovered that needs to be taken care of during the Donor Evaluation process, taking care of the condition is the responsibility of the Donor.

Insurance Carriers

- Many different providers:
  - BCBS, Aetna, United, Cigna, Oxford, etc.
- Many different policies:
  - PPO, POS, Indemnity, HMO, EPO
  - Some require case management
- Out of pocket costs:
  - Patient responsibility
    - Co-pays
    - Deductible
    - % coverage
    - Transplant Case Rate

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Medicare Coverage

If patient meets Social Security requirements, such as having 40 work quarter history, **Medicare will begin**:

- after three (3) full months of hemodialysis
  - First month if patient is on peritoneal dialysis
- the day the patient receives a transplant
- the month you are admitted to approved hospital
  - For transplant or procedures preliminary to transplant
- two (2) months before month of transplant
  - If transplant is delayed more than 2 months

Medicare Coverage

Medicare coverage will end:

- If End Stage Renal Disease (ESRD is the ONLY reason you were entitled:
  - 12 months after month you no longer require maintenance dialysis OR
  - 36 months after month of kidney transplant

Medicare Coverage

Patients will not lose their Medicare if within 36 months after a kidney transplant:

- Patient restarts dialysis starts OR
- Patient has another kidney transplant

Medicare 30-Month Coordination Period

If a patient has Medicare and other health coverage, each type of coverage is called a "payer."

When there's more than one payer, "coordination of benefits" rules decide who pays first.

The "primary payer" pays what it owes on your bills first, and then your provider sends the rest to the "secondary payer" to pay.

In some cases, there may also be a "third payer."

If you	Situation	Pays first	Pays second
Are covered by Medicare and Medicaid	Entitled to Medicare and Medicaid	Medicare	Medicaid, but only after other coverage (like employer group health plans) has paid
Are 65 or older and covered by a group health plan because you or your spouse is still working	Entitled to Medicare	Group health plan	Medicare
	The employer has 20 or more employees		
	The employer has less than 20 employees*	Medicare	Group health plan
Have an employer group health plan through your own former employer after you retire and are 65 or older	Entitled to Medicare	Medicare	Retiree coverage
Are disabled and covered by a large group health plan from your work, or from a family member (like spouse, domestic partner, son, daughter or grandchild) who is working	Entitled to Medicare	Large group health plan	Medicare
	The employer has 100 or more employees		
	The employer has less than 100 employees	Medicare	Group health plan
Have End-Stage Renal Disease (ESRD) (permanent kidney failure requiring dialysis or a kidney transplant) and group health plan coverage (including a retirement plan)	First 30 months of eligibility or entitlement to Medicare	Group health plan	Medicare
	After 30 months of eligibility or entitlement to Medicare	Medicare	Group health plan
Have ESRD and COBRA coverage	First 30 months of eligibility or entitlement to Medicare on the basis of ESRD	COBRA	Medicare
	After 30 months	Medicare	COBRA

Medicare 30-Month Coordination Period

The 30 month coordination period starts when patient is first eligible for Medicare, even if patient is not enrolled in Medicare.

- During coordination period:
  - Commercial health insurance pays first
  - Medicare pays second

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Contracting

- Negotiated Case Rates
  - Fee for Service
  - Global Rate
- Contractual Agreements
  - Donor Travel
  - Follow-up/Complications
- Reimbursement Reconciliation
  - Timely and accurate payment
  - Provider reimbursement
- Education of Recipient and Donor of Coverage
  - Will there be out of pocket costs or potential liability?

Living Donor

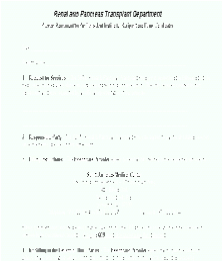
The Transplant Center is financially responsible for the Inpatient stay of the Living Donor.

The bill for the inpatient stay is NOT to be billed to any payer (Donor or Recipient).

The transplant center should be the guarantor or the "insurance company" and the accounts receivable should be written off to a Medicare Contractual Allowance.

- Who Pays for What?
  - What is covered?
    - Tests to determine suitability for donation
    - Treatment is not covered
    - Pre-donation work-up is not a "blank check"
- Education of Process
  - Donors
  - Providers
    - Internal
    - External

Billing for Living Donation



- Billing for donor work-up
  - How will bills be paid?
  - How and when is the facility reimbursed?
  - How are the providers reimbursed?
  - Does your facility use a billing letter/agreement?

Transplant

Bill the appropriate payer at the time of Transplant Admission.

Inpatient Transplant Billing

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Inpatient Transplant Billing

- Facility charges for both recipient and donor handled through Acquisition Cost
- Provider charges for both recipient and donor billed directly to recipient's insurance

Special Considerations in Transplant Billing

Plasmapheresis and IVIG

- Can be used for desensitization or treatment for rejection

Facility billing:

Pretransplant outpatient:

- requires pre-certification and approval from commercial insurance
- not routinely covered by Medicare for desensitization. This varies by local intermediary. Centers should check coverage of this prior to providing services
  - Also subject to Medicare's 72 hour rule – if performed outpatient within 72 hours of admission, payment included in inpatient Medicare DRG payment…not additional funds received
- current ICD9 for coverage depending on indication– 99.71/V58.83
- ICD10-
  - 2014 ICD-10-PCS 6A550Z3 Pheresis of Plasma, Single
  - 2014 ICD-10-CM T86.10 Unspecified complication of kidney transplant
    or:
  - 2014 ICD-10-CM T86.11 Kidney transplant rejection
    or:
  - 2014 ICD-10-CM T86.12 Kidney transplant failure
- J code for IVIG – J1459

Special Considerations in Transplant Billing

Plasmapheresis and IVIG

Facility billing:

Initial inpatient transplant admission or post transplant inp admission:

- included in inpatient DRG payment from Medicare or commercial insurance payment for admission

Post transplant outpatient:

- requires pre-certification and approval from commercial insurance
- covered by Medicare for post transplant complications
- current ICD9 for coverage depending on indication– 99.71/V58.83/996.81
- ICD10 –
  - 2014 ICD-10-PCS 6A550Z3 Pheresis of Plasma, Single
  - 2014 ICD-10-CM T86.10 Unspecified complication of kidney transplant
    or:
  - 2014 ICD-10-CM T86.11 Kidney transplant rejection
    or:
  - 2014 ICD-10-CM T86.12 Kidney transplant failure
- J code for IVIG – J1459

Special Considerations in Transplant Billing

Plasmapheresis and IVIG

Providers:

- Plasmapheresis CPT code-36514
- IVIG drug code J1459
- may also require pre-certification pre, peri and post transplant for commercial insurers of both procedure and drug code
- also, per above, Medicare does not routinely cover for pre-transplant desensitization
- if performed on the same day as a visit or another procedure/test, may require modifier 25 (separate procedure)

Special Considerations in Transplant Billing

Aranesp

- Used to improve hemoglobin levels in transplant

Facility billing:

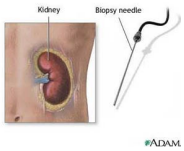
- cpt for injection 90772
- current ICD9 for coverage requires appropriate anemia code 285.21 as well as current ESRD code 585.1-585.5 (for kidney patients)
- ICD10-
  - 2014 ICD-10-CM D63.1 Anemia in chronic kidney disease
    - Chronic kidney disease N18.1-N18.5
- also requires appropriate H&H levels (documented to warrant treatment)
- J code for IVIG – J0881
- if performed on the same day as a visit or another procedure/test, may require modifier 25 (separate procedure)
- may also require pre-certification pre, peri and post transplant for commercial insurers of both procedure and drug code

Special Considerations in Transplant Billing

Biopsy

Initial inpatient transplant admission or post transplant inpatient admission:

- included in inpatient DRG payment from Medicare or commercial insurance payment for admission



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Special Considerations in Transplant Billing

Biopsy

Post transplant outpatient:

- requires pre-certification and approval from commercial insurance
- covered by Medicare for post transplant complications
- current ICD9 for coverage depending on indication– 996.81
- ICD10:
  - 2014 ICD-10-CM T86.18 Unspecified complication of kidney transplant
    or:
  - 2014 ICD-10-CM T86.11 Kidney transplant rejection
    or:
  - 2014 ICD-10-CM T86.12 Kidney transplant failure
- cpt code varies per organ – i.e. kidney biopsy cpt code–50200
- if performed on the same day as a visit or another procedure/test, may require modifier 25 (separate procedure)
- may also require pre-certification pre, peri and post transplant for commercial insurers of both procedure and drug code

Post-Transplant Care

The post-transplant care of the Recipient is to be billed to the patient's appropriate primary payer.

Post-Donation Complications

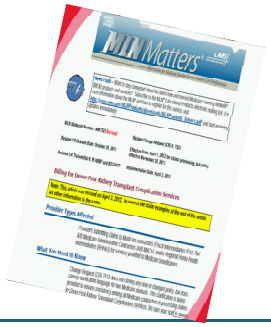
The Transplant Center is financially responsible for hospital services related to donation-related complications of the Living Donor.

The bill(s) for related in or outpatient services is NOT to be billed to any payer (Donor or Recipient). Physician Services are to be billed to the Recipients Payer.

The transplant center should be the guarantor or the "insurance company" and the accounts receivable should be written off to a Medicare Contractual Allowance.

Post-Transplant Donor Care

- Post-Transplant Care is billed to the appropriate payer.
- **Donor Complications**
  - Local donors
  - Out-of-State donors



Cost Report

Organ acquisition is one of the very few services left that are reimbursed at cost on the Medicare cost report.

- All Medical Services were originally paid at cost but over the years, one by one, they have been moving to a prospective or fee rate payment system.
- The only service left paid at straight cost is organ acquisition cost and therefore subject to great scrutiny at time of cost report audit.
- Rural Health Clinic services and Sole Community Hospitals are still paid at cost but have an imposed cost limit/ceiling creating a maximum that will be paid for the service.

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- Medicare Certified Solid Organs
  Kidney
  Pancreas
  Liver
  Heart
  Lung
  Intestinal and Multi-Visceral

  Reimbursed: Cost Reimbursed

- ***Non Solid Organ Transplant Services***
  Cornea
  Bone Marrow
  Stem Cell

  Reimbursed: Prospective Payment Services

CMS' Expectations of Hospital Accounting

- Must follow G.A.A.P. (Generally Accepted Accounting Principles)
- General ledger and Financial Statements that are reported on a CMS cost report must be certified (for chain organization, entire organization certification is expected)
- Proper analysis of any amounts reported in the cost report as being pertinent to the providers operations and allowed under the Medicare program as a service related to the care of patients.
- Any information included in a Medicare cost report is subject to audit including non-ledger items such as statistics and the financials/ledger of anyone providing/ selling services to a Medicare Provider.

Main sections of a cost report

- Overhead and support expenses (Administration, Dietary, Housekeeping, etc.)
- Routine Areas – Inpatient Rooms such as Med/Surg, ICU, Nursery, etc.
- Ancillary Departments – Operating Room, Radiology, Emergency Room, etc.
- Non-Reimbursable Cost Centers – Medical Office Building, Marketing, non-certified programs, etc.

Review all pre-transplant evaluation charges done outside facility (by other providers) for adequacy and expense to organ acquisition cost center

Maintain a patient transplant log listing:

- Patient
- Organ transplanted
- Transplant date
- Status (living related, living unrelated, cadaver)
- Excision physician (if physician paid directly, organs other than kidney)
- Excision payment to physician or OPO if invoiced separately.
- Cadaver organ identifier if organ was harvested at facility or came from outside.
- OPO invoice number
- OPO invoice amount
- Other transport, special charges
- Patient I-Plan / Financial class

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Work with the Business Office in the management of patient insurance information and billings for transplant patients.

Work with logging to ensure accurate reporting of transplant patient charges, billing, payments, secondary billing, etc.

- Maintain updated records of personnel job descriptions and other required record keeping functions. Whenever possible, try to separate positions by pre-transplant/evaluation and post-transplant.
- Ensure that when staff is completing time studies, job functions match job descriptions.

- Monitor square footage usage (if transplant clinic is in the same area/cost center as organ acquisition department) for pre and post transplant usage.
- Work with Medical Directors to ensure their completion of time studies.
- Maintain operations according to Government and accrediting agencies.
- Maintain a transplant log (as listed in slide 15).

Provide statistics:

- Organs transplanted
- Live and cadaver counts
- Excisions
- Organs harvested at facility
- Evaluation and other patient processing information

Medicare Ratio Determinants

Medicare Primary Transplants
+
Medicare 2nd Payor Transplants
(only if Medicare is paid as secondary)
+
Cadaveric Organs Procured at Your Hospital
=
Total Medicare Organs
divided by
Total Transplants + Cadaveric Organs
=
Medicare Ratio

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Medicare Ratio Method: Basic

Total Organ Acquisition costs

X

$$\left\{ \frac{\text{Medicare Organs}}{\text{Total Organs}} \right\} = \text{Medicare Ratio}$$

–

Revenue for Organs Sold

=

Net Medicare Organ Acquisition Cost

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