Chapter 11:

Transplant Services

Review/Revised: 01/18, 01/19, 01/20, 09/20, 01/21, 01/22, 2/23

Under certain conditions, Medicare covers services for heart, lung, kidney, pancreas, intestine, and liver organ transplants, bone marrow and cornea transplants. Refer to Chapter 7: Inpatient and Outpatient Hospital Care for more information about Inpatient Services.

11.0 ORGAN TRANSPLANTS

Organ transplants must be done in a Medicare-approved facility. Cornea transplants aren't limited to Medicare-approved transplant centers. The Plan arranges review of the case by the transplant center who determines if the member is eligible.

The following transplant and transplant-related services are not covered when the transplant procedure itself is not covered by Health Choice Pathway:

- Artificial or mechanical hearts or xenografts
- Workups to evaluate the patient as a possible transplant candidate
- Hospitalization for the above procedures
- Organ procurement

All other medically necessary, non-experimental services are covered for the above referenced situations.

11.1 CMS APPROVED TRANSPLANT CENTERS

At the link below you will find a list of facilities certified for Medicare payment of transplants for non-renal organs, along with the effective date of such certification.

http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/Transplant.html.

This information is used by Medicare beneficiaries and their families, to locate facilities that are eligible for Medicare payment for transplants and associated care. The information is also used by other individuals and organizations critical to the effective operation of the Medicare transplant programs.

Such individuals and organizations include, but are not limited to, prospective donors, CMS Regional Offices, the Health Resources and Service Administration (HRSA), the United

Network for Organ Sharing (UNOS), organ procurement organizations (OPOs), medical schools and other academic institutions, and researchers.

11.2 AUTHORIZATION REQUIREMENTS

The most important requirements are to submit appropriate medical documentation with the AHCCCS Transplant Request form found in the Provider Manual Appendix and on the website under the Provider Tab. (i.e., labs, diagnostic test results, History and Physical, Consultation notes, and last office visits). There isn't a Medicare/DSNP Transplant Request Form.

11.3 BILLING REQUIREMENTS

Health Choice Pathway contracts with providers to offer covered transplant services to eligible recipients.

When billing for the acute care hospitalization in which the transplant occurred:

- The contract specifies the inpatient, outpatient, and ancillary services that are included and the payment amount to be received for the services provided.
- The contract may include the following services:
    - Hospitals
    - Inpatient and outpatient services before, during, and after the transplant
    - Physicians, surgeons, anesthesiologist, etc.
    - Laboratory
    - Pharmacy
    - Temporary housing
    - Clinics
    - Pre and postoperative office visits
- The provider must enter the proper ICD-10-PCS procedure code identifying the transplant procedure in the primary procedure field (Field 67) on the claim form.
- Providers must notify Health Choice Pathway when a recipient requires a transplant procedure, by submitting the AHCCCS Transplant Request form.
- The Plan will ensure contract terms are verified with the provider prior to services being rendered. The services included in the terms of the contract shall be submitted as separate case stages or as a package.
- A transplant stage type is assigned to each transplant case
- Each stage has a set dollar value that determines the payment amount for specific dates of service
- Services will be reimbursed based on the terms of the contract
- Health Choice Pathway will provide the Claims Department with the payment requirements, including the provider's name and NPI number under which claims are to be submitted

- Health Choice Pathway will review the case stage, or the package submitted, and the services will be paid according to the terms of the contract
- All medically necessary services provided to the transplant recipient related to the transplant should be billed using the appropriate diagnosis codes, CPT and HCPCS procedure codes, and revenue codes to meet clean claim status
- The claim will automatically pend for medical review for compliance with federal regulations, Plan rules and policies
- Physician and other medical services billed on the CMS 1500 claim form are part of the contracted components and will pend for medical review

Health Choice Pathway partners with providers throughout the transplant course of treatment. We encourage you to contact the transplant care manager by calling Member Services at **1-800-656-8991** or by sending a care management referral to **HCHHCACaseManagement@azblue.com.** The transplant care manager also works closely with the beneficiary providing care management and care coordination.