Medicare
Intermediary Manual
Part 3 - Claims Process

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

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HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
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3615.6 (Cont.) – 3615.7 (Cont.)	6-136.12C – 6-136.12E (3 pp.)	6-136.12C (1 p.)

NEW/REVISED MATERIAL--*EFFECTIVE DATE: April 1, 2001*
IMPLEMENTATION DATE: April 28, 2003

Section 3615.7, Intestinal and Multi-Visceral Transplants, provides claims processing instructions for the National Coverage Decision, effective April 1, 2001 on intestinal and multi-visceral transplants. Effective October 1, 2001, a separate organ acquisition cost center was established for acquisition costs incurred on or after October 1, 2001.

Provider Education

This information must be shared with providers through your Web site within 2 weeks of receiving this update and must be published in your next regularly scheduled bulletin.

DISCLAIMER: The revision date and transmittal number only apply to the redlined material. All other material was previously published in the manual and is only being reprinted.

These instructions should be implemented within your current operating budget.

CHAPTER VII
BILL REVIEW

Section

code and a V-code to indicate a previous kidney transplant. If the V-code is not on the claim for the pancreas transplant, search the beneficiary's claim history for a V-code.

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 Code of Federal Regulations (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 81X. Override any claims that suspend due to repetition of revenue code 81X on the same claim if the patient had a simultaneous kidney/pancreas transplant. Pay for acquisition costs for both kidney and pancreas organs if transplants are performed simultaneously. Do not pay for more than two organ acquisitions on the same claim.

E. Medicare Summary Notices (MSN), Explanation of Your Medicare Benefits (EOMB), and Remittance Advice Messages.--If a claim for simultaneous pancreas kidney transplantation or pancreas transplantation following a kidney transplant is submitted to you and is missing one of the appropriate diagnosis/procedure codes, deny the claim and use the following EOMB notice or MSN:

- o EOMB 16.79, "Medicare does not pay separately for this service. You do not have to pay this amount."

- o MSN 16.32, "Medicare does not pay separately for this service."

Use the following Remittance Advice Message:

- o Claim adjustment reason code B15, "Claim/service denied/reduced because this procedure or service is not paid separately."

If a claim is denied because no evidence of a prior kidney transplant is presented, use the following EOMB/MSN message:

- o EOMB 15.9, "The information we have in your case does not support the need for this service."

- o MSN 15.4, "The information provided does not support the need for this service or item."

Use the following Remittance Advice Message:

- o Claim adjustment reason code 50, "These are non-covered services because they are not deemed medically necessary by the payer."

To further clarify the situation, the intermediary should also use new claim level remark code MA 126, "Pancreas transplant not covered unless kidney transplant performed."

3615.7 Intestinal and Multi-Visceral Transplants.--

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 the Coverage Issues Manual §35-103 for further information.

B. Approved Transplant Facilities.--Medicare will cover intestinal transplantation if performed in an approved facility. The approved facilities are located at http://cms.hhs.gov/providers/transplant/default.asp.

C. Billing.--ICD-9-CM procedure code 46.97 is effective for discharges on or after April 1, 2001. The Medicare Code Editor (MCE) lists this code as a non-covered procedure with no exceptions. You are to override the MCE when this procedure code is listed and the coverage criteria are met in an approved transplant facility.

We recommend that you automate the diagnostic review for intestinal transplants and suggest that the MCE interface is the best place to do this. Where the procedure code is identified by the MCE, check the provider number and effective date to determine if the provider is an approved intestinal transplant facility. Check the effective date for Medicare approval. Suspend the claim for clerical review of the operative report to determine that the beneficiary has at least one of the covered conditions listed when the diagnosis code is for a covered condition. This review is not part of your medical review workload. Instead you should complete this review as part of your claims processing workload.

Charges for ICD-9-CM procedure code 46.97 should be billed under revenue code 360, Operating Room Services.

For discharge dates on or after October 1, 2001, acquisition charges are billed under revenue code 81X, 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-9-CM 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.

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:

- 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.

D. Acquisition Costs.--A separate organ acquisition cost center was established for acquisition costs incurred on or after October 1, 2001. 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, deny the claim and use MSN message 21.6, “This item or service is not covered when performed, referred, or ordered by this provider;” 21.18, “This item or service is not covered when performed or ordered by this provider;” or, 16.2, “This service cannot be paid when provided in this location/facility;” or NOU message 16.99, "This service cannot be paid when provided in this location/facility;" and Remittance Advice Message, Claim Adjustment Reason Code 52, “The referring/prescribing/rendering provider is not eligible to refer/prescribe/order/perform the service billed."