Program Memorandum Intermediaries/Carriers

Department of Health and Human Services (DHHS)
HEALTH CARE FINANCING ADMINISTRATION (HCFA)

Transmittal AB-01-73 **Date: MAY 3, 2001**

CHANGE REQUEST 1564

SUBJECT: Payment Instructions for Intestinal Transplants Furnished to Beneficiaries Enrolled in Medicare+Choice (M+C) Plans With Dates of Service on or After April 1, 2001, but Before January 1, 2002.

The purpose of this Program Memorandum (PM) is to advise you of the actions you must take if you receive a claim for an intestinal transplant service on or after April 1, 2001, but before January 1, 2002, when those services were furnished to a Medicare beneficiary who is enrolled in a Medicare+Choice plan.

Review PM AB-01-58 for specific Medicare guidelines regarding coverage of intestinal transplants and payment for intestinal transplants furnished to beneficiaries enrolled in Medicare fee for service plans.

Medicare regulation 42 CFR, §422.109(a) requires that when the Secretary makes a national coverage determination (NCD) that meets the regulation's test for being a "significant cost", Medicare must pay for the services outside of the payment made to the M+C plan until rates announced in a regular March rate announcement come into effect.

HCFA has determined that the payment for intestinal transplants meets the significant cost test of the NCD. Thus, Medicare must pay for these services outside of the 2001 M+C payment rate. Therefore, if you receive a claim for physician services and immunosuppressive drugs required as a result of the transplant, hospital, and other services related to intestinal transplants that were furnished on or after April 1, 2001, but before January 1, 2002, and these services meet the Medicare coverage criteria specified in PM AB-01-58, you must pay the claims for these services as though the beneficiary was not an M+C enrollee. Hospital services would be paid based on the applicable DRG (refer to PM AB-01-58 for specific instructions); physician services would be paid based on the physician fee schedule. No payment will be made to the managed care organization (MCO) unless it is an enrolled provider or supplier.

These payments will be made outside of the Common Working File (CWF), as specified in §3863 of the Medicare Intermediary Manual, Part 3 and §6009 of the Medicare Carriers Manual, Part 3. CWF edits will not be modified to permit payment of these services through CWF. HCFA has determined that such changes are not practical due to the short time period in which these payments should be made by intermediaries and carriers for M+C beneficiaries. Furthermore, the frequency of these services is exceedingly small and they are mostly provided for non-Medicare pediatric patients. Therefore, it is highly likely that you may not see such claims for covered services to M+C beneficiaries with dates of service between April 1, 2001, and January 1, 2002. However, if you do see such claims for covered services to M+C beneficiaries you must pay them if they meet the coverage criteria, notwithstanding the refusal of CWF to accept the claim.

The *effective date* for this PM is April 1, 2001.

The *implementation date* for this PM is July 1, 2001.

These instructions should be implemented within your current operating budget.

This PM may be discarded after January 1, 2002.

If you have any questions, contact Yvette Cousar at (410) 786-2160.