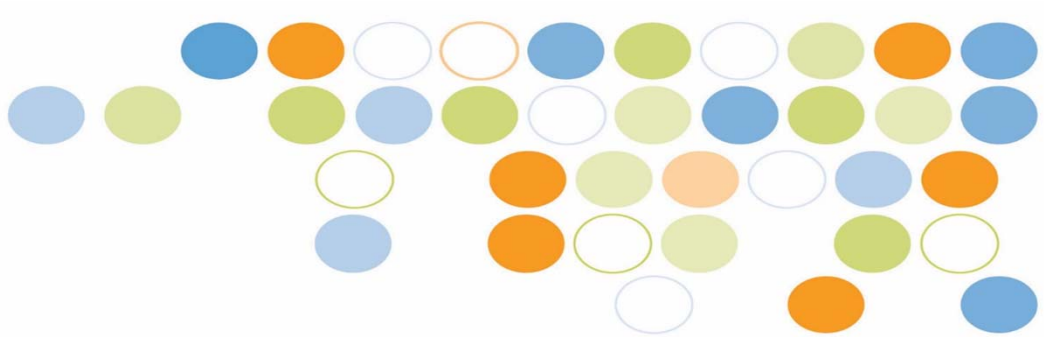


2017 Medicare Coding, Billing, and Reimbursement Updates: Major Changes *Transplant Centers Need to* be Aware Of!

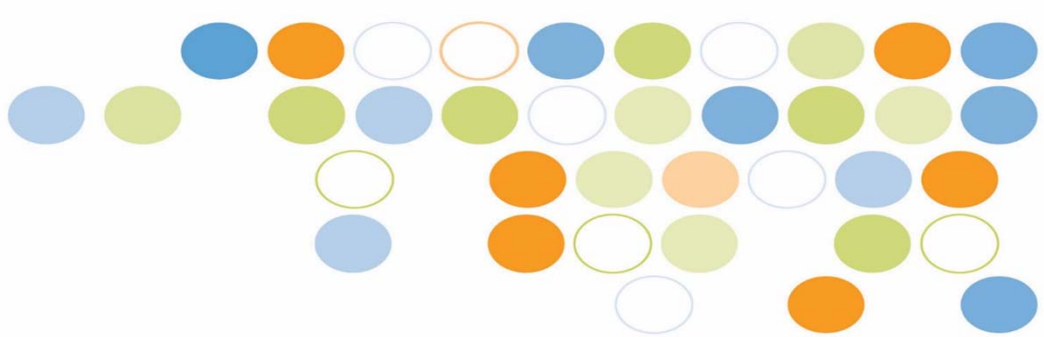
Presented by:
Jugna Shah, MPH, President and Founder of Nimitt Consulting Inc.
Tandem February 23, 2017

Disclosures

- No relevant disclosures to be made.

Review of Centers for Medicare and Medicaid Services (CMS) in Action…

- Advocacy efforts have resulted in a number of changes since 2011 including:
  - In FY 2011: CMS split MS-DRG 009 into two DRGs for allo (014) and auto (015) cases
  - In FY 2012: CMS divided MS-DRG 015 to recognize complications and comorbidities into MS-DRG 016 w/CCs and MS-DRG 017 for no CCs and also requested hospitals report donor source procedure codes
  - In FY 2016: CMS indicated providers should use cost report lines 62 and 63
  - In CY 2017: CMS finalized several changes including creating a comprehensive outpatient "bundled" payment along with other changes
  - Expanded coverage through the Coverage with Evidence Development (CED) process
  - Claims processing manual changes have occurred over the years along with many discussions with CMS and Congressional staff on finding ways to improve reimbursement



Inpatient or Outpatient: Understanding Some Concerning Language…

Department of Health and Human Services

OFFICE OF
INSPECTOR GENERAL

MEDICARE DID NOT PAY SELECTED INPATIENT CLAIMS FOR BONE MARROW AND STEM CELL TRANSPLANT PROCEDURES IN ACCORDANCE WITH MEDICARE REQUIREMENTS

Inquiries about this report may be addressed to the Office of Public Affairs at Public.Affairs@oig.hhs.gov.

Gloria L. Jarmon
Deputy Inspector General
for Audit Services

February 2016
A-09-14-02037

Statements from the OIG report have raised many questions and need to be reviewed carefully

A CMS software program called the Medicare Severity Diagnosis Related Grouper (Grouper) determines the MS-DRG for each claim on the basis of the hospital's reported billing data, which include diagnosis and procedure codes. To detect billing errors, the Grouper's Medicare Code Editor (MCE) has coding, coverage, and clinical edits, such as consistency checks for correct use of diagnosis and procedure codes.

Patients with various kinds of blood-related cancers, such as leukemia and lymphoma, receive transplants of bone marrow and peripheral blood stem cells to restore stem cells that were destroyed by high doses of chemotherapy or radiation therapy or both. After being treated with anticancer drugs or radiation, the patient receives the harvested stem cells, which travel to the bone marrow and begin to produce new blood cells. Stem cell transplantation is not on CMS's list of inpatient-only procedures, and according to an independent medical review contractor, stem cell transplantation is routinely performed as an outpatient procedure. However, with respect to stem cell transplants that are billed as inpatient services under Medicare Part A, the procedure codes for these services primarily fall under one of four MS-DRGs and have geometric mean lengths of stay (GMLOS) from 10 to 21 days, as determined and published by CMS.

WHAT WE FOUND

Medicare paid 10 of the 143 selected inpatient claims for stem cell transplants in accordance with Medicare requirements. However, 133 claims did not comply with those requirements. The lengths of stay for these claims were 1 to 2 days. For 120 of these claims, the hospitals incorrectly billed Medicare Part A for beneficiary stays that should have been billed as outpatient or outpatient with observation services. These claims did not have clinical evidence supporting that an inpatient level of care was required before, during, or after the transplant procedures were performed. For the remaining 13 claims, the hospitals billed incorrect MS-DRGs. As a result of

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

MLN Matters® Number: SE1624 | **Related Change Request (CR) #: N/A**

Article Release Date: November 22, 2016 | **Effective Date: N/A**

Related CR Transmittal #: N/A | **Implementation Date: N/A**

Office of Inspector General Report: Stem Cell Transplantation

Provider Types Affected

This article is intended for providers billing Medicare Administrative Contractors (MACs) for services related to stem cell transplantation.

Provider Action Needed

The Office of the Inspector General (OIG) recently completed a review of Medicare claims related to stem cell transplants. This article is intended to address issues of incorrect billing as a result of the February 2016 OIG report and to clarify coverage of stem cell transplantation. This article does not introduce any new policies. It is intended to clarify the billing for stem cell services.

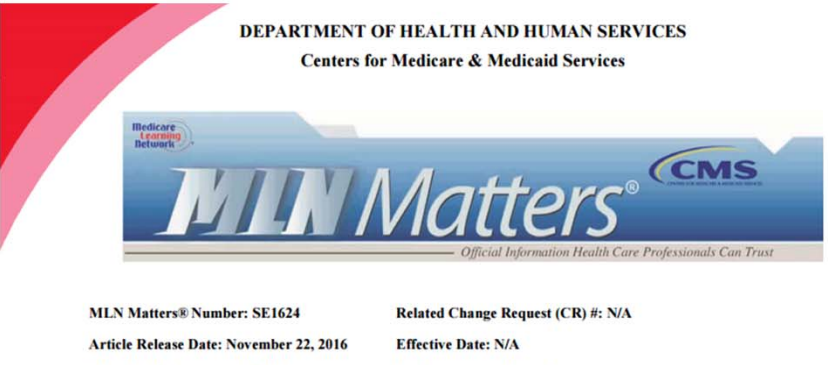
Medicare policy as stated in Transmittal 1805 states that stem cell transplants are typically performed in the outpatient setting. Should complications occur, then the procedure would be performed on an inpatient basis. However, the OIG report suggests that an inpatient stay of just 1 or 2 days is more likely a miscoded claim as opposed to submitting an outpatient claim to cover stem cell transplantation.

In their February 2016 OIG report, the OIG determined that Medicare paid for many stem cell transplant procedures incorrectly. The main finding was that providers billed these procedures as inpatient when they should have been submitted as outpatient or outpatient with observation services. The key points in the report are as follows:

- **Stem cell transplants are typically performed in the outpatient setting.**
- Hospitals may have incorrectly thought that stem cell transplantation was on CMS's list of inpatient-only procedures.
- Hospitals often billed these services using incorrect Medicare Severity Diagnosis Related Groups (MS-DRGs). Of critical importance, the OIG found that many claims contained an MS-DRG suggesting a Geometric Mean Length of Stay (GMLOS) in the hospital that should have been much longer than the claim actually showed. For example, the following table shows the length of stay one might expect for the given MS-DRGs. Yet, the submitted claims reflected a length of stay of just 1 or 2 days. This suggests the claims should have been billed as outpatient, which is what Medicare policy considers to be the norm for stem cell transplants.

- *The information is disturbing and it seems incorrect conclusions being drawn b/c of the two-midnight rule*

(Continued)



DEPARTMENT OF HEALTH AND HUMAN SERVICES

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The Two-Midnight Rule

To assist providers in determining whether inpatient admission is reasonable and payable under Medicare Part A, CMS adopted the Two-Midnight rule for admissions beginning on or after October 1, 2013. This rule established Medicare payment policy regarding the benchmark criteria that should be used when determining whether an inpatient admission is reasonable and payable under Medicare Part A.

In general, the Two-Midnight rule states that:

- Inpatient admissions will generally be payable under Part A if the admitting practitioner expected the patient to require a hospital stay that crossed two midnights and the medical record supports that reasonable expectation.
- Medicare Part A payment is generally not appropriate for hospital stays not expected to span at least two midnights.

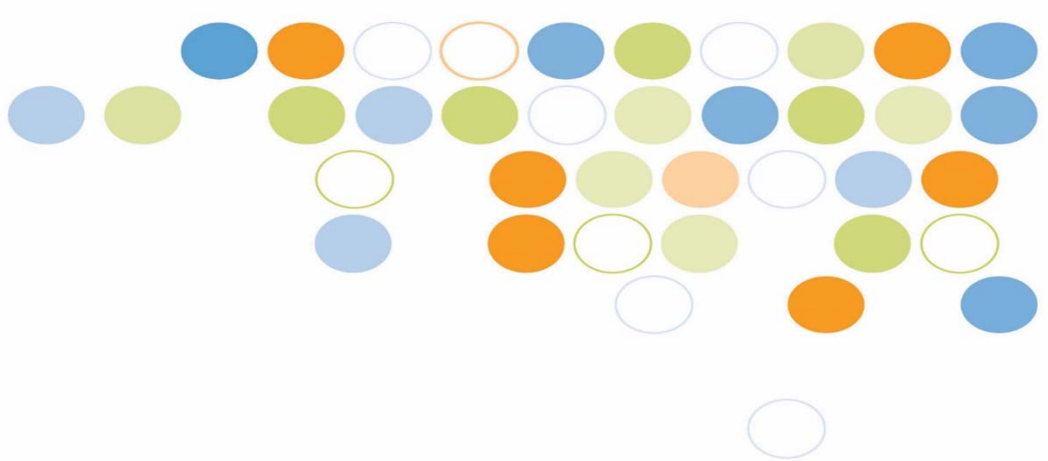
The Two-Midnight rule also specified that all treatment decisions for beneficiaries were based on the medical judgment of physicians and other qualified practitioners. The Two-Midnight rule does not prevent the physician from providing any service at any hospital, regardless of the expected duration of the service.

For stays for which the physician expects the patient to need less than two midnights of hospital care (and the procedure is not on the inpatient-only list or otherwise listed as a national exception), an inpatient admission may be payable under Medicare Part A on a case-by-case basis based on the judgment of the admitting physician. The documentation in the medical record must support that an inpatient admission is necessary, and is subject to medical review.

CMS has been contacted and we are hoping to see revised language

Information Gone Wrong…

- HSCT procedures are NOT outpatient procedures by definition
- Medical necessity is what drives whether a patient requires an inpatient admission; if hospital level care is required for less than two midnights then that must be documented but if more care is needed, then it is more than reasonable that patients receiving stem cell transplants would be inpatients. Physician documentation remains key!
- We don’t know who the Contractor was that’s referenced in the OIG report but it seems clear an incorrect conclusion was drawn about stem cell transplant cases being “outpatient cases” – this was likely drawn from the length of stay being short, the two-midnight rule, and the lack of documentation in the patient’s medical record
- Documented medical necessity for an inpatient stay from the physician is what will protect hospitals from inquiries about short-stay inpatients
- Do not let the OIG and MLN language dictate the care setting in which patients are treated!

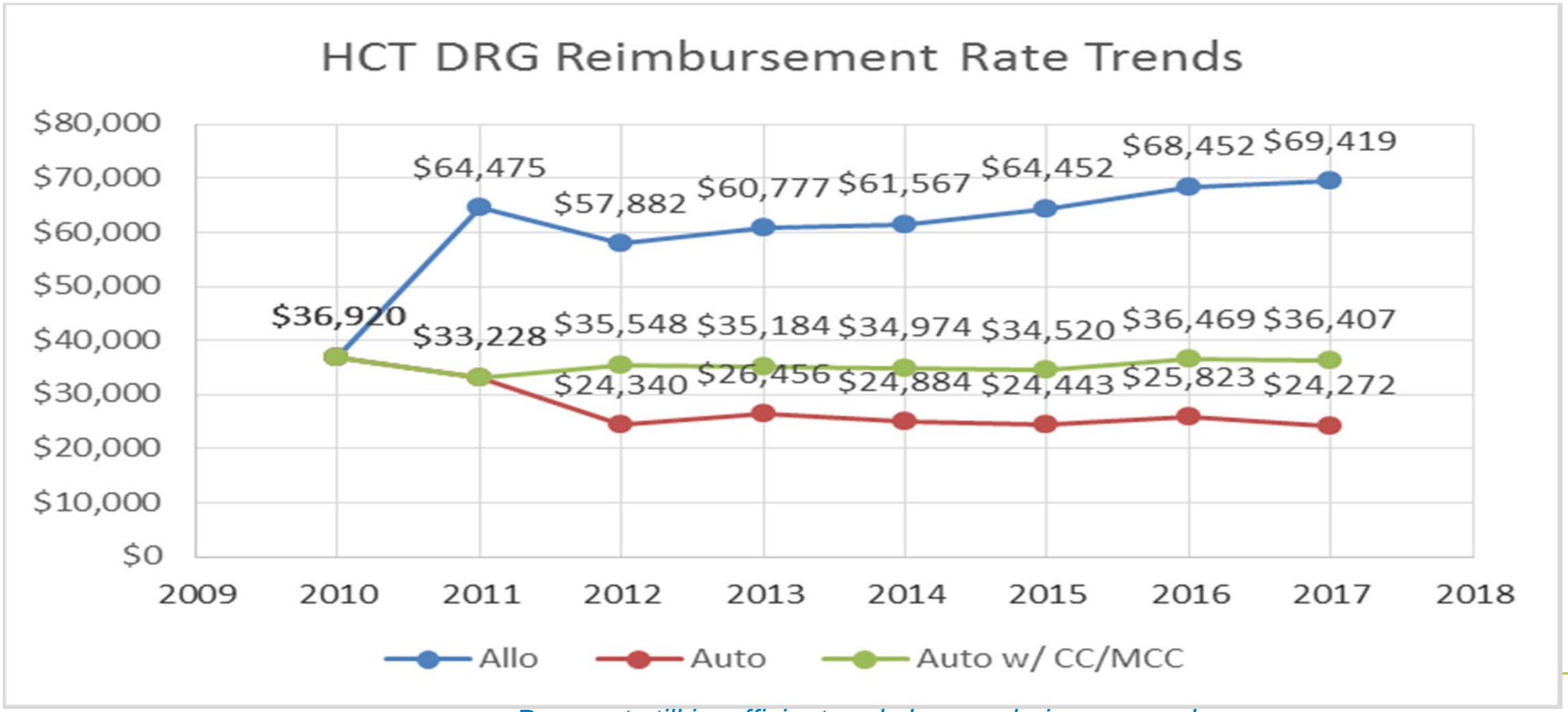


Key Changes for 2017

FY 2017 HCT MS-DRGs

014	016	017
Allogeneic Bone Marrow Transplant	Autologous Bone Marrow Transplant with MCC/CC	Autologous Bone Marrow Transplant without MCC/CC
No breakout for related or unrelated	With CC/MCC (driven by secondary dx codes)	Without CC/MCC (driven by secondary dx codes)
Relative Weight 11.6407	Relative Weight 6.1050	Relative Weight 4.0701

Inpatient MS-DRG Reimbursement Rate Trend



Payment still insufficient and changes being pursued

Trend of Inpatient Data Reporting of Revenue Code 0819 and Donor Source Code for Allogeneic Transplants

Data Year	2007	2009	2011	2012	2013	2014	2015
Total Allogeneic Transplants (MS-DRG 014)	329	495	545	600	702	801	**969**
% reporting 0819	38%	68%	72%	75%	72.80%	75%	**79%**
Median 0819 charges reported (w/o $0 claims)	$8,000	$48,000	$51,800	$50,349	$56,380	$62,019	**$56,223**
% reporting donor source code	N/A	69%	72%	75%	73.10%	76%	**72%**

Source: CMS MedPar Files (FY 2017 payment comes from 2015 data) for non-exempt providers

Reminder 1: CMS has instructed providers to report donor search and cell acquisition charges using a specific revenue code

Reminder 2: CMS has asked providers to report donor source code on inpatient claims

Reminder: Medicare's Definition of Acquisition Charges

- *"Acquisition charges include, but are not limited to, charges for the costs of the following :*
  - National Marrow Donor Program fees, if applicable, for stem cells from an unrelated donor
  - Tissue typing of donor and recipient
  - Donor evaluation
  - Physician pre-procedure donor evaluation services
  - Costs associated with harvesting procedure
    - (e.g., general routine and special care services, procedure/operating room and other ancillary services, apheresis services, etc.)
  - Post-operative/post-procedure evaluation of donor
  - Preparation and processing of stem cells"

Source: CMS Publication 100-04, Chapter 3 Section 90.3.3.A or Ch. 4, Section 231.11

Reminder: Billing Requirement for Reporting Acquisition Charges

- Charges must be held until time of transplant & reported on the recipient's transplant bill. These charges are not paid for separately; but instead are included in the transplant procedure payment (either the MS-DRG or the APC).
- Transplant hospitals should keep an itemized statement that identifies the services furnished, the charges, the associated revenue codes, the person receiving the service (donor/recipient), and whether this is a potential transplant donor or recipient
- Acquisition charges must be reported on the recipient's inpatient or outpatient bill (depending on the setting of the transplant) *using revenue code 0819 (changing to 0815 for 2017)*, at the time of the transplant

Source: CMS Publication 100-04, Chapter 3 Section 90.3.3.B or Ch. 4, Section 231.11

CMS' Inpatient Rate-Setting Process and the Use of Provider Billed Charges

- Remember that Medicare converts the donor search and cell acquisition charges providers report on the recipient's transplant claim to "cost" using a national cost-to-charge ratio
  - If providers do not report donor search and cell acquisition, then Medicare cannot factor that into its MS-DRG 014 rate
  - If providers don't "mark-up" their invoice cost then CMS will under-estimate the cost of donor search and cell acquisition
- Questions for transplant centers to ask:
  - Are we completely and accurately reporting donor search and cell acquisition?
  - Have we conducted an audit?
  - Do we mark up our cost, or just report it "as is"?
  - Do we charge actuals or an average?

Inpatient Claim Example from a Transplant Center

Admit Date	Discharge Date	Primary Diagnosis Code	Diag Code Description	Primary Procedure Code	Proc Code Description
11/22/08	12/25/08	205.01	ACUTE MYELOID LEUKEMIA IN REMISSION	41.05	ALLO HEM STEM CT W/O PUR

Revenue Code	Rev Code Description	Charges
127	ROOM & BOARD - SEMI-PRIVATE 2 BEDS	$42,900
250	PHARMACY	$11,026
272	MEDICAL/SURGICAL SUPPLIES	$206
300	LABORATORY	$15,913
310	LABORATORY PATHOLOGICAL	$732
320	RADIOLOGY-DIAGNOSTIC	$250
331	RADIOLOGY - THERAPEUTIC	$1,740
333	RADIOLOGY - THERAPEUTIC	$2,932
335	RADIOLOGY - THERAPEUTIC	$804
362	OPERATING ROOM SERVICES	$462
390	BLOOD STORAGE AND PROCESSING	$4,463
391	BLOOD STORAGE AND PROCESSING	$2,935
420	PHYSICAL THERAPY	$364
636	DRUGS REQUIRING SPECIFIC IDENTIFICATION	$36,370
730	EKG/ECG (ELECTROCARDIOGRAM)	$134
~~819~~	ORGAN ACQUISITION	~~$28,000~~
Total		**$149,231**

What does this charge amount represent?

What does Medicare see this as?

Medicare Converts Provider Billed Charges to Cost Using National Cost-to-Charge Ratios (CCRs)

Group	CCR
Routine Days	0.457
Intensive Days	0.375
Drugs	0.194
Supplies & Equipment	0.297
Implantable Devices	0.331
Therapy Services	0.321
Laboratory	0.120
Operating Room	0.191
Cardiology	0.112
Cardiac Catheterization	0.118
Radiology	0.153
MRIs	0.079
CT Scans	0.038
Emergency Room	0.171
Blood and Blood Products	0.323
Other Services	0.365
Labor & Delivery	0.410
Inhalation Therapy	0.170
Anesthesia	0.089

FY 2017 CCR applied to billed acquisition charges reported using revenue code 0819

Medicare's Cost Estimation Process Converts Billed Charges to Cost - What This Means…

Ex: Hospital A incurs $28,000 in donor search and cell acquisition cost (i.e., the actual NMDP invoice amount) and reported this using revenue code 0819 on the inpatient transplant claim in CY 2015.

CMS used the national CCR for blood products to reduce this billed "charge" to "cost": $28,000 x 0.323 = **$9,044**

CMS "sees" $9,044 as the cost associated with donor search and cell acquisition and uses this in its MS-DRG rate-setting calculation.

The hospital would have needed to charge a much higher dollar amount to ensure that CMS' reflected the cost the hospital incurred in developing the payment rate for MS-DRG 014.

For example: A charge of $86,687 would reflect the actual invoice cost ($28,000 divided by the national CCR of .323)

The Return of ICD-10 Donor Source Codes

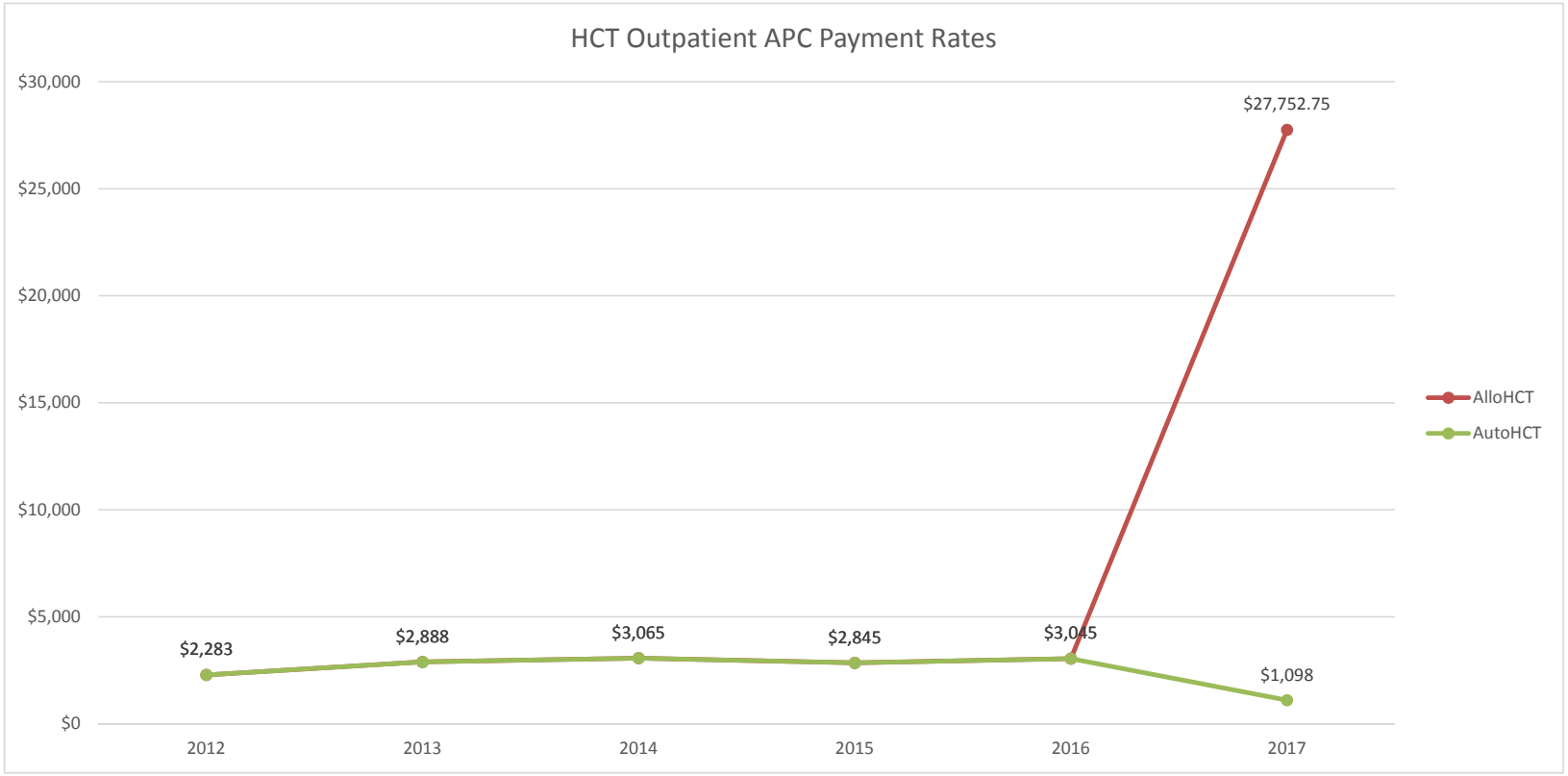
ICD-9	ICD-10 Related	ICD-10 Unrelated
• 00.91(related donor) • 00.92 (unrelated donor)	• 30243G2 – Allo related bone marrow via percutaneous venous central line infusion • 30243X2 – Allo related cord blood via percutaneous venous central line infusion • 30243Y2 – Allo related peripheral stem cells via venous central line infusion	• 30243G3 – Allo unrelated bone marrow via percutaneous venous central line infusion • 30243X3 – Allo unrelated cord blood via percutaneous venous central line infusion • 30243Y3 – Allo unrelated peripheral stem cells via venous percutaneous central line

Other 2017 ICD-10 Coding Updates

ICD-9-CM	2016 ICD-10-PCS	2016 ICD-10-PCS Description	2017 ICD-10-PCS	2017 ICD-10-PCS Description
Transplant				
41.01 Autologous **bone marrow** transplant without purging	30230G0	Peripheral vein, open, bone marrow, autologous	No Change from 2016	
	30233G0	Peripheral vein, percutaneous, bone marrow, autologous		
	30240G0	Central vein, open, bone marrow, autologous		
	30243G0	Central vein, percutaneous, bone marrow, autologous		
	30250G0	Peripheral artery, open, bone marrow, autologous		
	30253G0	Peripheral artery, percutaneous, bone marrow, autologous		
	30260G0	Central artery, open, bone marrow, autologous		
	30263G0	Central artery, percutaneous, bone marrow, autologous		
41.02 Unrelated Allogeneic **bone marrow** transplant with purging	30230G1	Peripheral vein, open, bone marrow, nonautologous	30230G3	Peripheral vein, open, bone marrow, allogeneic, unrelated
	30233G1	Peripheral vein, percutaneous, bone marrow, nonautologous	30233G3	Peripheral vein, percutaneous, bone marrow, allogeneic, unrelated
	30240G1	Central vein, open, bone marrow, nonautologous	30240G3	Central vein, open, bone marrow, allogeneic, unrelated
	30243G1	Central vein, percutaneous, bone marrow, nonautologous	30243G3	Central vein, percutaneous, bone marrow, allogeneic, unrelated
	30250G1	Peripheral artery, open, bone marrow, nonautologous	30250G3	Peripheral artery, open, bone marrow, allogeneic, unrelated
	30253G1	Peripheral artery, percutaneous, bone marrow, nonautologous	30253G3	Peripheral artery, percutaneous, bone marrow, allogeneic, unrelated
	30260G1	Central artery, open, bone marrow, nonautologous	30260G3	Central artery, open, bone marrow, allogeneic, unrelated
	30263G1	Central artery, percutaneous, bone marrow, nonautologous	30263G3	Central artery, percutaneous, bone marrow, allogeneic, unrelated
No equivalent ICD 9 code	No equivalent 2016		30230G2	Peripheral vein, open, bone marrow, allogeneic, related
			30233G2	Peripheral vein, percutaneous, bone marrow, allogeneic, related
			30240G2	Central vein, open, bone marrow, allogeneic, related
			30243G2	Central vein, percutaneous, bone marrow, allogeneic, related
			30250G2	Peripheral artery, open, bone marrow, allogeneic, related
			30253G2	Peripheral artery, percutaneous, bone marrow, allogeneic, related
			30260G2	Central artery, open, bone marrow, allogeneic, related
			30263G2	Central artery, percutaneous, bone marrow, allogeneic, related
No equivalent ICD 9 code	No equivalent 2016		30230G4	Peripheral vein, open, bone marrow, allogeneic, unspecified
			30233G4	Peripheral vein, percutaneous, bone marrow, allogeneic, unspecified
			30240G4	Central vein, open, bone marrow, allogeneic, unspecified
			30243G4	Central vein, percutaneous, bone marrow, allogeneic, unspecified
			30250G4	Peripheral artery, open, bone marrow, allogeneic, unspecified
			30253G4	Peripheral artery, percutaneous, bone marrow, allogeneic, unspecified
			30260G4	Central artery, open, bone marrow, allogeneic, unspecified
			30263G4	Central artery, percutaneous, bone marrow, allogeneic, unspecified
41.03 Allogeneic bone marrow transplant without purging	30230G1	Peripheral vein, open, bone marrow, nonautologous	N	
	30233G1	Peripheral vein, percutaneous, bone marrow, nonautologous		
	30240G1	Central vein, open, bone marrow, nonautologous		
	30243G1	Central vein, percutaneous, bone marrow, nonautologous		
	30250G1	Peripheral artery, open, bone marrow, nonautologous		
	30253G1	Peripheral artery, percutaneous, bone marrow, nonautologous		
	30260G1	Central artery, open, bone marrow, nonautologous		
	30263G1	Central artery, percutaneous, bone marrow, nonautologous		
	30230Y0	Peripheral vein, open, stem cells, hematopoietic, autologous		
	30233Y0	Peripheral vein, percutaneous, stem cells, hematopoietic, autologous		

Coming soon from the NMDP!

Outpatient APC Reimbursement Rate Trends



Summary of Changes Released in the CY 2017 Outpatient Prospective Payment System Rule

Four Key Changes Released

New Comprehensive APC (C-APC) 5244 assigned to CPT code 38240

New revenue code required to report charges for allogeneic donor search and cell acquisition costs

New edit starting January 1, 2017

New dedicated cost center to capture costs for all donor related items and services

New C-APC 5244 for CY17 Outpatient Payment

- C-APCs are like mini-DRGs for the outpatient setting where a single payment is made and its intended to cover the procedure, all donor search and cell acquisition services, other services such as labs, visits, etc. billed on the same claim
  - The CY17 final payment rate of $27,764 is much higher than the rate of $15,267 that CMS had proposed due to CMS listening to comments and using ONLY claims with both CPT code 38240 and revenue code 0819
  - Additionally, the final CY 2017 rate is about 9 times higher than the 2016 payment rate

Revenue Code Reporting Changes

New revenue code required

- Revenue code 0815 released by the National Uniform Billing Committee (NUBC)
- Revenue code 0815 replaces revenue code 0819 beginning January 1, 2017
- Revenue code 0815 requires a CPT/HCPCS code be reported
- CMS issued a MLN Matters brief, about revenue code 0815 that indicates its use is applicable to **both** outpatient and inpatient HSCT claims.
  - https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9674.pdf

Excerpt from NUBC on Revenue Code 081x

081x **Acquisition of Body Components**

The acquisition and storage costs of body tissue, bone marrow, organs and other body components not otherwise identified used for transplantation.

SubC	Subcategory Definition	Standard Abbreviation	Unit	HCPCS
0	General Classification	ORGAN ACQUISIT		Y
1	Living Donor	LIVING DONOR		Y
2	Cadaver Donor	CADAVER DONOR		Y
3	Unknown Donor	UNKNOWN DONOR		Y
4	Unsuccessful Organ Search - Donor Bank Charges	UNSUCCESSFUL SEARCH		Y
5	Stem Cells - Allogeneic (Effective 1/1/17)	STEM CELL		Y
6-8	RESERVED			
9	Other Donor	OTHER DONOR		Y

CPT code needed

Notes:
Living donor is a living person from whom an organ is collected and used for transplantation purposes.

Cadaver is an individual pronounced dead according to medical and legal criteria, and whose organs may be harvested for transplantation.

Unknown is used whenever the status of the individual source cannot be determined. Use the other category whenever the organ is non-human.

Revenue Code 0814 is used only when costs incurred for an organ search do not result in an eventual organ acquisition and transplantation.

New Outpatient Code Edit

New claims reporting requirement

- Starting January 1, 2017, Medicare's Outpatient Code Editor (OCE) will look for the presence of revenue code 0815 each time CPT code 38240 is billed
- If revenue code 0815 is missing on a claim with CPT code 38240, CMS will return the claim to the provider

Cost Report Changes

New Cost Report Elements

- Cost center 77
  - new standard cost center for “Allogeneic Stem Cell Acquisition,” added to Worksheet A (and applicable worksheets) for providers to record allogeneic stem cell acquisition costs
- Cost center line 77
- Cost center code 07700

CDM, Pricing & Billing Considerations

Reminders

- Providers typically incur donor search and cell acquisition costs over a period of time, but must hold these until time of transplant and report them on the recipient's claim
- Starting 1/1/17 donor search and cell acquisition services must be reported using rev code 0815
- Allogeneic donor search and cell acquisition services can either be provided in-house, such as for related donors or can be purchased services such as from the NMDP
  - **In-house:** services are charged out of various departments and already reflect a mark-up, but must be billed under 0815 on the recipient's claim and not under the revenue codes of the respective performing departments
  - **Purchased:** services are acquired from another entity and that entity is paid the invoice it submits to the provider and then the provider in turn must report this in the form of a charge to Medicare; the cost associated with these types of services should be marked-up given CMS' rate-setting methodology.

HCT and the Charge Description Master

- In-house donor search and acquisition services can be set up in the CDM in at least two ways:
  - Option 1 (most common) - Charges post on the donor account reside in each department's GL and are set up under the typical revenue codes (i.e., 30x for lab)
  - Option 2 – Certain CPT codes would be set up twice; once under the typical department revenue code (i.e., 30x for lab) and again under revenue code 0815 representing the hospital's in-house charge for services typically provided to donors but this would require staff knowing which patients are donors when they charge for the services or this is built into the charge triggers from documentation and/or orders

- Purchased services can also be built into the CDM.
  - For allogeneic unrelated donors, set-up one or more line items so you can charge for donor search and cell acquisition (purchased services)
  - You can develop an average charge for each line item based on taking the previous year's average or charge for actual invoice cost plus a mark-up but this requires manually keying in the charge amount.

Proposed New CDM Lines	Revenue Code
Allogeneic Unrelated, International Donor Acquisition	815
Allogeneic Unrelated, Domestic Donor Acquisition	815
Allogeneic Unrelated, Single Cord Donor Acquisition	815
Allogeneic Unrelated, Double Cord Donor Acquisition	815

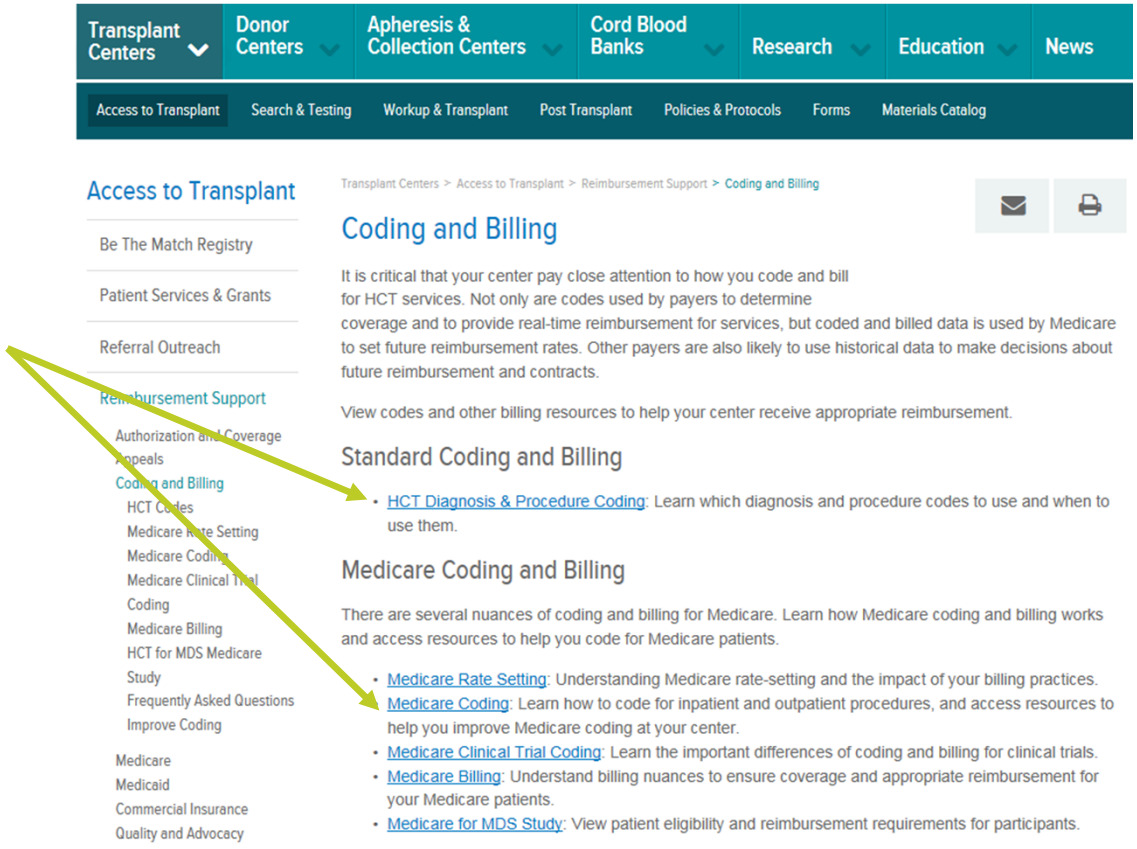
HCT and the Cost Report

- Historically providers have reported stem cell costs in different ways on the cost report
- A best practice is to create a distinct general ledger department and map to the appropriate cost center which enables tracking of both expenses and revenues related to allogeneic donor search and cell acquisition services
  - In the FY 2016 IPPS final rule, CMS stated to use line 62 or 63
  - In the CY 2017 OPPS final rule, CMS stated to use line 77
- Stem cell acquisition charges need to post correctly on the cost report as this impacts the cost-to-charge ratio development used in rate-setting. This requires the revenue and expense associated with purchased services and in-house related donor services to be reclassified so an appropriate match of expenses and revenue occurs in the cost report and results in a correct cost-to-charge (CCR) calculation
- This requires reclassification of in-house donor search and cell acquisition from the performing departments to the Donor Search GL account and to the line 77 in the cost report

Reimbursement Resource Center
Coding & Billing

Look to the NMDP website for updates and important items from Medicare

- Find updated ICD coding crosswalks & donor source coding
- Outpatient billing changes instructions
- Coverage information
- Find answers to frequently asked questions



Summary

Transplant providers and CMS have made improvements, but there is still more to be done by both!

By Providers

- Strive for 100% reporting of revenue code 0815
- Strive for 100% reporting of donor source code
- Make appropriate CDM updates and cost report changes
- Strive for complete reporting of donor search and cell acquisition charges
- Review existing charging practices taking into consideration CMS' rate-setting methodology
- Get involved/stay involved in advocacy efforts

By CMS

- Provide more/clearer guidance to providers
- Recognize the true component costs of transplant, specifically cell acquisition/procurement costs
- Recognize cancelled transplant costs directly
- Continue improving payment methodologies
- Continue expanding coverage

Thank You and Question/Answer

- Presentation by:

Jugna Shah, MPH President Nimitt Consulting Inc.

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