

**CAUTION: Read the [ICD-9 Policy Holding Library](#) page about policy in this document.**

## Transplants

This section contains information to help providers bill for Medi-Cal-reimbursable transplant services.

### POLICY AND BILLING OVERVIEW

#### Introduction: Important

Providers billing for any type of transplant should read this “Policy and Billing Overview” section in addition to the specific transplant information included later in this section. The overview contains instructions relevant to all types of transplants.

#### Proof of Eligibility

Services rendered to transplant recipients and donor(s) are reimbursable only if the transplant recipient is eligible for Medi-Cal during the month of service. Providers use the transplant recipient’s proof of eligibility to verify donor eligibility.

#### Authorization

Authorization is required for major solid organ and bone marrow transplants. *Treatment Authorization Requests* (TARs), including those for readmissions related to complications of the transplant, should be submitted to the San Francisco Medi-Cal Field Office (SFFO) for approval. Refer to the authorization guidelines for each type of transplant in the *TAR and Non-Benefit List*.

Authorization also is required for organ and bone marrow procurement.

**Exception:** TARs related to kidney transplant services should be submitted to the local Medi-Cal field office.

Human Immunodeficiency Virus (HIV) seropositivity is not an absolute contraindication to transplantation for Medi-Cal recipients. However, documentation submitted with TARs for transplants and related services must demonstrate that a recipient’s HIV infection is well controlled with medical therapy.

Authorization requests for services such as home health visits, Durable Medical Equipment (DME), medical transportation and physical and occupational therapy should be submitted to the appropriate Medi-Cal field office for approval.

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Recipients Younger Than 21 Years of Age or GHPP Eligible at Any Age

For recipients younger than 21 years of age or recipients who are eligible for the Genetically Handicapped Persons Program (GHPP), providers should submit a Service Authorization Request (SAR).

Any other related service requests for authorization, such as evaluations for transplants, should be submitted to the appropriate independent county California Children's Services (CCS) program or CCS regional office for approval. Requests for authorization of kidney transplants should be submitted to the same offices.

Submission of SARs

SAR forms are available on the Department of Health Care Services (DHCS) website at <http://www.dhcs.ca.gov/formsandpubs/forms/Pages/CCSForms.aspx>. Providers may fax SARs to (916) 440-5318.

**Electronic Claims:  
Donor Using Recipient's  
ID Number**

For electronic claim submissions, a statement indicating "donor using recipient's ID" must be entered in the NTE segment of the 837I v.5010 electronic claim.

**Separate Claims:  
Recipient and Donor**

Donor(s) and transplant recipient services are billed on separate claims. If there is more than one donor, services for each donor must be billed on a separate claim.

**Separate Claims: Other  
Physician Services**

Other services performed by physicians, such as pre-transplant evaluation, post-operative care and laboratory services must be billed separately from the transplant using appropriate billing codes and modifiers.

**Bill Using Recipient's  
ID Number**

Services rendered to both the recipient and donor(s) are billed using the recipient's Medi-Cal ID number.

**Billing for Services to Transplant Recipient**

When billing for services rendered to the transplant recipient, providers enter the recipient's name, date of birth, sex and Medi-Cal ID number on the claim and document "Transplant recipient" in the *Reserved for Local Use* field (Box 19) on the *CMS-1500* claim form and in the *Remarks* field (Box 80) on the *UB-04* claim form. Table A in this section includes information for completing select claim lines on both the *CMS-1500* and *UB-04* claim forms.

**Billing for Services to Transplant Donor**

When billing for services rendered to the transplant donor, providers enter the donor's name on the claim but the recipient's date of birth, sex and Medi-Cal ID number. Table A in this section includes information for completing claim lines on both the *CMS-1500* and *UB-04* claim forms.

On the *CMS-1500* claim form, providers identify that the claim is for services rendered to the donor by documenting "Organ Donor" in the *Reserved for Local Use* field (Box 19). On the *UB-04* claim form an "11" (donor) is entered in the *Patient's Relationship to Insured* field (Box 59) to show that the claim is for services rendered to the donor.

The donor claim also must document both of the following in the *Reserved for Local Use* field (Box 19) on the *CMS-1500* claim form and in the *Remarks* field (Box 80) on the *UB-04* claim form:

- (Name of) transplant donor for (name of transplant recipient)
- Number of donors (for example, 1 of 1 or 1 of 2)

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**Claim Completion  
Fields: Donor  
and Recipient**

The following table includes information for completing select claim fields for services rendered to both transplant recipients and donors on either the *CMS-1500* claim form or *UB-04* claim form.

<b>Claim Field</b>	<b>Enter for Transplant Recipient</b>	<b>Enter for Transplant Donor</b>
Patient Name (Box 2 on <i>CMS-1500</i> ) (Box <b>8B</b> on <i>UB-04</i> )	Recipient's name	Donor's name
Birth date (Box 3 on <i>CMS-1500</i> ) (Box <b>10</b> on <i>UB-04</i> )	Recipient's date of birth	Recipient's date of birth
Sex (Box 3 on <i>CMS-1500</i> ) (Box <b>11</b> on <i>UB-04</i> )	Recipient's sex	Recipient's sex
Medi-Cal Identification Number (Box 1A on <i>CMS-1500</i> ) (Box 60 on <i>UB-04</i> )	Recipient's ID number	Recipient's ID number
Patient's Relationship to Insured field (Box 59 on <i>UB-04 Only</i> )		11 (donor)
Documentation * (Box 19 on <i>CMS-1500</i> ) (Box <b>80</b> on <i>UB-04</i> )	Transplant recipient	(Name of) transplant donor for (name of) transplant recipient. Number of donors (for example, 1 of 1 or 1 of 2)

\* Both donor and recipient claims are submitted with the recipient's ID number. If claims are not submitted with correct documentation, they may be denied as duplicates.

*Table A.* Select Field Completion for Service to Transplant Recipients and Donors (Both *CMS-1500* and *UB-04* claim forms).

**Procedure Codes:  
Inpatient Services  
Claims Completion**

Inpatient transplant services must be billed using national revenue code 201 or 203 in conjunction with the appropriate procedure code listed in the right column below. National revenue codes 201 or 203 should be used for transplant recipient claims, not donor claims. The following table lists the ICD-9-CM Volume 3 procedure codes that identify specific transplants.

<b>Transplant or Related Service</b>	<b>Primary ICD-9-CM, Vol. 3, Procedure Code (UB-04 Box 74)</b>	<b>Secondary ICD-9-CM, Vol. 3, Procedure Code (UB-04 Box 74A)</b>
Bone marrow	41.01, 41.02, 41.03, 41.04, 41.05, <u>41.06</u> , 41.07, 41.08, 41.09	
Heart	37.5, 37.51	
Heart-lung	33.6	
Kidney	55.61, 55.69	
Liver	50.51, 50.59	
Small bowel	46.97	
Combined liver/small bowel	50.59	46.97
Lung	33.50, 33.51, 33.52	
Simultaneous kidney-pancreas	52.80	55.61 or 55.69
Pancreas	52.80	

**Tip:** Inpatient providers may find it helpful to enter patient information in the *Patient Control Number* field (Box 3A) to identify the recipient or donor, especially when there are multiple donors. This field is not required by Medi-Cal, but is intended for provider identification of the claim, and will appear on the *Remittance Advice Details* (RAD).

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### **Transplants from Living Donors**

Presently, only liver, kidney and lung transplants may require the donor(s) and recipient to be hospitalized. Occasionally, when a complication arises, a bone marrow donor may also require hospitalization.

When the living donor and recipient are at different hospitals, both hospitals must be designated as Medi-Cal Centers of Excellence for the specific organ transplant involved. Each hospital must obtain a TAR and bill on separate *UB-04* claim forms for the inpatient days using the recipient's Medi-Cal number for both claims. For hospitals paid according to the DRG-reimbursement method, an admit TAR should be obtained for the days. Document in the *Remarks* field (Box 80) of the donor's claim that the services are for a living transplant donor. Refer to the "Claim Completion Fields: Donor and Recipient" table on a preceding page for select claim field completion instructions.

### **Billing Example: Inpatient Services**

For an example of an inpatient claim illustrating a lung transplant, refer to the *Transplants: Billing Examples for Inpatient Services* section in the appropriate Part 2 manual.

### **Repeat Transplant Surgeries**

Claims submitted for repeat inpatient transplant services that have approved treatment authorization are reimbursable at a transplant rate when billed with the appropriate revenue code and ICD-9-CM Volume 3 procedure code. Providers must document the dates for the initial and each repeat transplant surgery (solid organ or bone marrow) within the last 15 months, or the dates of negotiated exception specified in the hospital contract in the *Remarks* field (Box 80) of the *UB-04* claim form.

**Organ Procurement**

The following CPT-4 organ procurement codes are billed “By Report” and must be entered in the *HCPCS/Rate* field (Box 44). For added requirements, refer to “Revenue Code Required” in this section. Assistant surgeon services are not reimbursable for organ procurement.

<b>Description</b>	<b>CPT-4 Code</b>
<b><u>Chest surgery procedure</u></b>	<b><u>32999</u></b>
<b><u>Cardiac surgery procedure</u></b>	<b><u>33999</u></b>
Bone marrow <ul style="list-style-type: none"> <li>• Management of recipient hematopoietic progenitor cell donor search and cell acquisition</li> <li>• Unrelated bone marrow donor</li> </ul>	38204 *
<b><u>Unlisted procedure intestine</u></b>	<b><u>44799</u></b>
<b><u>Liver surgery procedure</u></b>	<b><u>47399</u></b>
<b><u>Unlisted procedure, pancreas</u></b>	<b><u>48999</u></b>
<b><u>Urology surgery procedure</u></b>	<b><u>53899</u></b>

\* Service is reimbursable once per month and should be billed using the “from-through” format. Code 38204 must be billed with a surgery modifier, for example, modifier AG (primary physician). Refer to the *UB-04 Special Billing Instructions for Outpatient Services* section for information about “from-through” billing.

**Revenue Code Required**

Outpatient services provided by a community outpatient hospital or a county outpatient hospital require a revenue code be submitted when the claim is for organ procurement. One of the following revenue codes is required for reimbursement:

<b>Description</b>	<b>Revenue Code</b>
<b><u>Acquisition of Body Components – General Classification</u></b>	<b><u>810</u></b>
<b><u>Acquisition of Body Components – Living Donor</u></b>	<b><u>811</u></b>
<b><u>Acquisition of Body Components – Cadaver Donor</u></b>	<b><u>812</u></b>
<b><u>Acquisition of Body Components – Unsuccessful Organ Search</u></b>	<b><u>813</u></b>
<b><u>Acquisition of Body Components – General Classification</u></b>	<b><u>814</u></b>
<b><u>Acquisition of Body Components – Other Donor</u></b>	<b><u>819</u></b>

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Inpatient Providers Billing Bone Marrow Search/Acquisition

Hospitals paid according to the diagnosis-related group (DRG) reimbursement methodology may submit a claim for CPT-4 code 38204 using their Outpatient provider number. CPT-4 code 38204 is the only code that may be submitted by DRG-reimbursed hospitals on this basis. Refer to the *Diagnosis-Related Groups (DRG): Inpatient Services* section in the *Inpatient Services Provider Manual* for information about DRG.

**Note:** Refer to the *Transplants: Billing Examples for Inpatient Services* section in the *Inpatient Services* provider manual for a CPT-4 code 38204 billing example.

Invoice with Claim:  
Solid Organ

Claims submitted for solid organ procurement require an invoice from the Organ Procurement Organization (OPO) indicating that the facility paid for each organ acquired for each recipient. The invoice must be from a regional non-profit federally designated OPO that is a member of the United Network for Organ Sharing (UNOS).

Invoice with Claim:  
Bone Marrow

Claims submitted for bone marrow procurement require an invoice from either the National Marrow Donor Program or an equivalent registry (for example, an international registry). The letterhead on the invoice must indicate either "National Marrow Donor Program" or the name of the equivalent registry. Dates on the invoice must fall within the "from-through" billing period on both the TAR and claim.

**Reimbursement Restrictions**

Medi-Cal covers transplants only for approved, select diagnoses and only when performed by approved Centers of Excellence.

**Note:** Facilities that are not currently authorized by Medi-Cal to be reimbursed for transplant services, but are interested in being added as a Medi-Cal approved provider, may direct requests to the Department of Health Care Services (DHCS), Medi-Cal Benefits Branch.

Donor Services

Donor services are not reimbursed at the transplant rate.

**BONE MARROW TRANSPLANTS**

**Billing Requirements**

Bone Marrow Transplant (BMT) billing requirements are as follows.

Stem Cell Harvesting

Blood-derived peripheral stem cell harvesting for transplantation is billed with CPT-4 codes 38204 – 38206. These services require a *Treatment Authorization Request (TAR)*.

Transplant Preparation of Hematopoietic Progenitor Cells

CPT-4 codes 38207 – 38215 is performed at a Medi-Cal approved facility. Claims are billed “By Report.” A Food and Drug Administration report of allowable cost is considered acceptable “By Report” documentation. The United Network for Organ Sharing (UNOS) does not generate an invoice for this service.

Bone Marrow Harvesting

Claims submitted for bone marrow harvesting for transplantation, whether from the recipient (CPT-4 code 38232; autologous) or donor (CPT-4 code 38230; allogeneic), must contain a complete description of the operative procedure. The “By Report” description should include identification of the physician(s) by name, role and duration of the procedure. Also refer to “Authorization” and “Invoice with Claim: Bone Marrow” instructions in this section.

Bone Marrow Transplantation

Bone marrow or blood derived peripheral stem cell transplantation to the recipient is billed using CPT-4 codes 38240 (bone marrow or blood derived peripheral stem cell transplantation; allogeneic), 38241 (...autologous), 38242 (...allogeneic, donor lymphocyte infusions) or 38243 (HPC boost). Codes 38240 – 38243 require a TAR.

## LIVER TRANSPLANTS

### Prior Authorization

The surgical team must obtain prior authorization for the surgical procedure in addition to the separate prior authorization for the hospital admission.

### Maximum Reimbursement

DHCS has established a maximum global reimbursement of all surgical-physician related services (with the exception of the anesthesiologist) for liver transplant surgery.

The maximum global reimbursement for CPT-4 code 47135 (liver allotransplantation; orthotopic, partial or whole, from cadaver or living donor, any age) billed with modifier 66 (surgical team) at a Medi-Cal certified liver transplant center includes the following related physician surgical services:

- Entire surgical team including all surgeon and assistant surgeon fees (excluding anesthesiologist's)
- All surgical team member services related to evaluation of the patient for transplant (for example, office visits, hospital visits)
- All surgical services related to transplantation
- All post-operative surgical follow-up care services including treatment for acute rejection, reharvesting and/or re-transplantation for up to 120 days following the surgical procedure

A report itemizing, in detail, all services provided, personnel services covered and all supplies and equipment used must be attached to the claim to permit appropriate pricing and avoid denial.

## **SMALL BOWEL AND COMBINED LIVER AND SMALL BOWEL TRANSPLANTS**

**Physician Services**                      Providers should bill for small bowel transplants with CPT-4 code 44135 (intestinal allotransplantation; from cadaver donor) and 44136 (intestinal allotransplantation; from living donor). Providers should bill for combined liver and small bowel transplants with CPT-4 code 47399 (unlisted procedure, liver).

**Billing**                                      CPT-4 codes 44135 and 47399 must be billed “By Report.” A copy of the operative report must be attached to the claim.

## **SIMULTANEOUS KIDNEY-PANCREAS TRANSPLANTS**

**Physician Services**                      Physician services for the kidney-pancreas transplant must be billed “By Report” with HCPCS procedure code S2065 (simultaneous pancreas kidney transplantation). A TAR is required, and the operative report must accompany the claim.

## **PANCREAS TRANSPLANTS**

**Physician Services**                      Physician services for the pancreas transplant must be billed “By Report” with CPT-4 code 48554 (transplantation of pancreatic allograft). A TAR is required for the primary surgeon, and the operative report must accompany the claim.