
Transplants

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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.

Coverage

«Medi-Cal covers bone marrow (stem cell), heart, heart/lung, intestinal, liver, liver/intestinal, liver/kidney, lung and pancreas/kidney (pancreas after kidney [PAK], and simultaneous pancreas/kidney [SPK]) transplants only when performed by Medi-Cal approved Centers of Excellence (COE). Programs that perform corneal, autologous islet cell or kidney transplants are not required to be a Medi-Cal approved COE».

COE Enrollment

Any transplant program that wishes to become a Medi-Cal approved COE may submit a written request with the required documentation via email to DHCSTransplants@dhcs.ca.gov, or U.S. Mail to:

Department of Health Care Services, Benefits Division
MS 4601, P.O. Box 997417
Sacramento, California 95899-7417

Authorization

Authorization is required for major solid organ, autologous islet cell and bone marrow transplants. *Treatment Authorization Requests* (TARs), including those for readmissions related to complications of the transplant, should be submitted for approval. For more information regarding each type of transplant, refer to the *TAR and Non-Benefit List* section of this manual.

Authorization also is required for organ and bone marrow procurement.

<<Information about authorization requirements for services such as home health visits, Durable Medical Equipment (DME), medical transportation and physical and occupational therapy may be found in other sections of the appropriate Part 2 manual.

Autologous Islet Cell Transplantation

Total pancreatectomy with autologous islet cell transplantation (TPIAT) is reimbursable by Medi-Cal when the patient has chronic pancreatitis or relapsing acute pancreatitis and meets all the following criteria:

1. Severe abdominal pain of at least six months duration resulting in at least one of the following:
 - a. Opiate dependence for more than three months, or
 - b. Impaired quality of life with one of the following
 - i. Decreased ability to work, attend school, or participate in usual age-appropriate activities or
 - ii. Frequent hospitalizations
2. A complete evaluation with no reversible cause of chronic pancreatitis or acute relapsing pancreatitis present or untreated
3. Abdominal pain is unresponsive to maximal medical therapy and endoscopic therapy
4. Adequate islet cell function (C-peptide positive non-insulin requiring diabetes or non-diabetic)
5. Does not have intrapancreatic mucinous neoplasm (IPMN)
6. Does not have involvement of a major system (e.g., kidneys, lung, heart, or brain damage) or any co-existing condition that would preclude surgery or indicate a poor potential for rehabilitation
7. The patient's psychological assessment, social arrangement, and family support indicate reasonable expectation that the patient will adhere strictly to the difficult long-term medical regimen, which will be required post-transplant
8. Patients with alcohol abuse or other substance abuse who have documented abstinence for a minimum of six months and documentation of a thorough multidisciplinary assessment (including social and psychiatric evaluation) may be considered for kidney transplantation if they possess appropriate psychosocial support systems so that they can comply with lifelong immunosuppressive therapy and be expected to maintain permanent abstinence from the substance abuse.>>

«Kidney Transplant Criteria

Kidney transplant programs must be approved by the Centers for Medicare & Medicaid (CMS) and must have current membership in the Organ Procurement and Transplantation Network (OPTN).

The patient must meet all of the following criteria:

1. Has end stage renal disease (ESRD) as defined by
 - a. Is already on hemodialysis or continuous ambulatory peritoneal dialysis (CAPD); or
 - b. Glomerular filtration rate (GFR) less than or equal to 20 mL/min;
2. Has no reversible renal disease.
3. Does not have involvement of a major system (e.g., kidneys, lung, heart, or brain damage) or any co-existing condition that would preclude surgery or indicate a poor potential for rehabilitation.
4. The patient's psychological assessment, social arrangement, and family support indicate reasonable expectation that the patient will adhere strictly to the difficult long-term medical regimen which will be required post-transplant.
5. Patients with alcohol abuse or other substance abuse who have documented abstinence for a minimum of six months and documentation of a thorough multidisciplinary assessment (including social and psychiatric evaluation) may be considered for kidney transplantation if they possess appropriate psychosocial support systems so that they can comply with lifelong immunosuppressive therapy and be expected to maintain permanent abstinence from the substance abused.>>

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

«CCS-approved transplant Special Care Centers use the Provider Electronic Data Interchange (PEDI) web portal to submit electronic SARs along with supporting documents that establish medical eligibility for the CCS or GHPP Programs and medical necessity of the requested services. More information about PEDI can be found on the [CMS Net PEDI](#) page of the Department of Health Care Services (DHCS) website.

If needed, SAR forms are available on the [California Children's Services Forms](#) page of the DHCS website.

Once a request has been submitted, providers then notify the county in which the child resides and the State through *the CCSPhysicianReview@dhcs.ca.gov* mailbox as described on the [CCS](#) page of the DHCS website.»

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 *Additional Claim Information* 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 *Additional Claim Information* 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 *Additional Claim Information* 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)

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.

CMS-1500 & UB-04 Claim Form Fields

Claim Field	Enter for Transplant Recipient	Enter for Transplant Donor
Patient Name (Box 2 on <i>CMS-1500</i>) (Box 8B on <i>UB-04</i>)	Recipient's name	Donor's name
Birth date (Box 3 on <i>CMS-1500</i>) (Box 10 on <i>UB-04</i>)	Recipient's date of birth	Recipient's date of birth
Sex (Box 3 on <i>CMS-1500</i>) (Box 11 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>)	N/A	11 (donor)
Documentation *(Box 19 on <i>CMS-1500</i>) (Box 80 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)

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. National revenue codes 201 or 203 should be used for transplant recipient claims, not donor claims. 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).»

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-10-PCS 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® 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.

Description	CPT Code
Chest surgery procedure	32999
Cardiac surgery procedure	33999
Unlisted procedure, small intestine	44799
Liver surgery procedure	47399
Unlisted procedure, pancreas	48999
Urology surgery procedure	53899

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:

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

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.

Donor Services

Donor services are not reimbursed at the transplant rate.

Bone Marrow Transplants

Billing Requirements

Stem Cell Harvesting

Blood-derived peripheral stem cell harvesting for transplantation is billed with CPT codes <<38205 and>> 38206. These services require a TAR.

Transplant Preparation of Hematopoietic Progenitor Cells

CPT codes 38207 thru 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 code 38232; autologous) or donor (CPT 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 codes 38240 (bone marrow or blood derived peripheral stem cell transplantation; allogeneic), 38241 (bone marrow or blood derived peripheral stem cell transplantation; autologous), 38242 (bone marrow or blood derived peripheral stem cell transplantation allogeneic, donor lymphocyte infusions) or 38243 (HPC boost). Codes 38240 thru 38243 require a TAR.

«Autologous Islet Cell Transplants

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

Liver Transplants

Authorization

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

Liver-Lung Transplants

Indications

For combined liver-lung transplantation:

- End-stage liver disease of the recipient must meet Medi-Cal criteria for liver transplantation.
- End-stage lung disease of the recipient must meet Medi-Cal criteria for lung transplantation.
- It must be demonstrated that the recipient would not survive the lung transplant without the liver transplant.
- The institution must be a Medi-Cal approved Center of Excellence for both liver and lung transplantation.

Liver Heart Transplants

Indications

For combined liver-heart transplantation:

- End-stage liver disease of the recipient must meet Medi-Cal criteria for liver transplantation.
- End-stage heart disease of the recipient must meet Medi-Cal criteria for heart transplantation.
- It is demonstrated that the recipient would not survive the heart transplant without the liver transplant.
- The institution must be a Medi-Cal approved Center of Excellence for both liver and heart transplantation.

«Intestine and Simultaneous Liver and Intestine Transplants»

Physician Services

«Providers should bill for intestinal transplants with CPT code 44135 (intestinal allotransplantation; from cadaver donor). Providers should bill for combined liver and intestinal transplants with CPT code 47399 (unlisted procedure, liver).»

Billing

CPT 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.

«Legend»

«Symbols used in the document above are explained in the following table.»

Symbol	Description
«	This is a change mark symbol. It is used to indicate where on the page the most recent change begins.
»	This is a change mark symbol. It is used to indicate where on the page the most recent change ends.
*	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.
‡	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 <i>Special Billing Instructions for Outpatient Services</i> section for information about "from-through" billing