The Transplant Revenue Cycle:
A Practical Guide to Maximize Cost, Recovery, and Reimbursement

TODAY'S PANELISTS

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THE Alliance | *Leadership & Engaged Learning in Organ Donation & Transplantation*

Thursday, September 29, 2022, 3:00pm – 4:00pm ET

Continuing Education Information

Evaluations & Certificates

Nursing

The Organ Donation and Transplantation Alliance is offering **1.0 hours of continuing education credit** for this offering, approved by The California Board of Registered Nursing, Provider Number CEP17117. No partial credits will be awarded. CE credit will be issued upon request within 30 days post-webinar.

CEPTC

The Organ Donation and Transplantation Alliance will be offering **1.0 Category I CEPTC credits** from the American Board for Transplant Certification. Certified clinical transplant and procurement coordinators and certified clinical transplant nurses seeking CEPTC credit must complete the evaluation form within 30 days of the event.

Certificate of Attendance

Participants desiring CE's that are not being offered, should complete a certificate of attendance.

- Certificates should be claimed within 30 days of this webinar.
- We highly encourage you to provide us with your feedback through completion of the online evaluation tool.
- Detailed instructions will be emailed to you within the next 24 hours.
- You will receive a certificate via email upon completion of a certificate request or an evaluation
- Group leaders, please share the follow-up email with all group participants who attended the webinar.

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THE Alliance

Need Assistance?

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Meet Our Moderator

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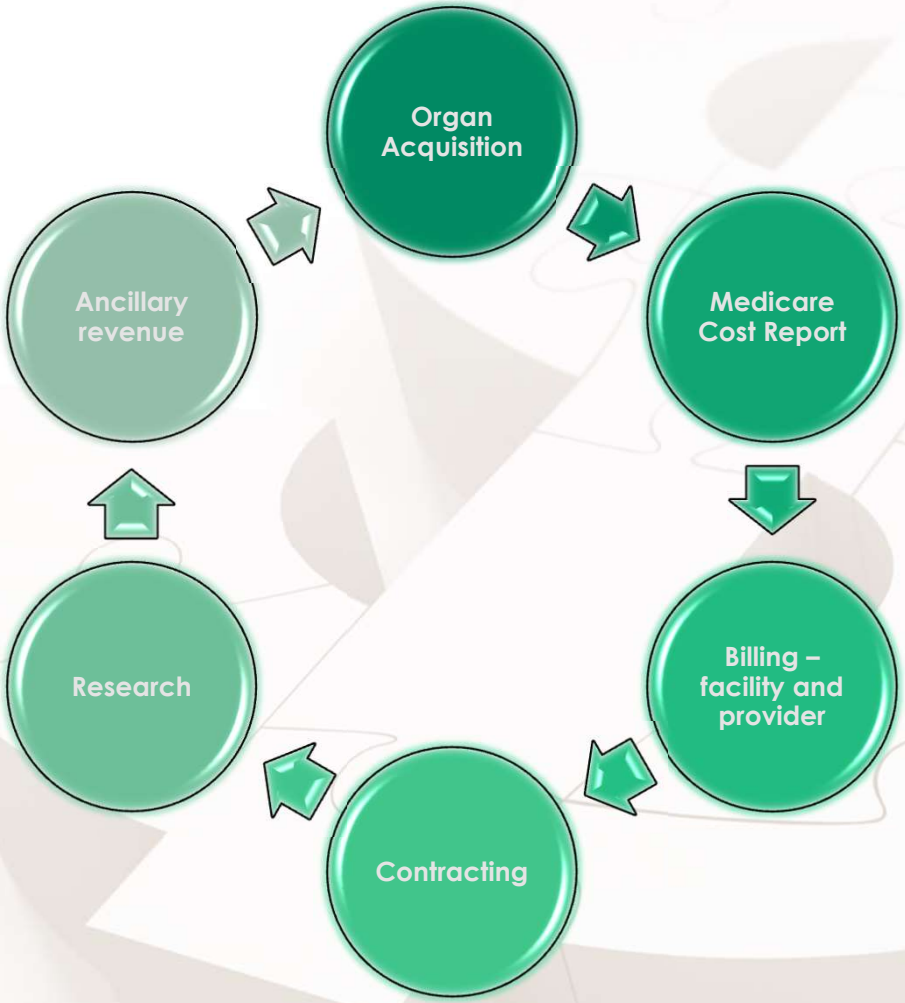
The Transplant Revenue Cycle

A practical guide to maximize cost recovery and reimbursement

Objectives



1. Describe elements of the Transplant Revenue Cycle
2. Review where to find this information
3. Share examples of how these concepts translate to your daily operations

The Transplant Revenue Cycle

do not need

to be

to obtain this information for your program

Why is the Transplant Revenue Cycle important to your program?

- Programs need resources
- Resources require funds
- Transplant revenue can provide funds for resources

The Transplant Revenue Cycle

The Transplant Revenue Cycle

Organ Acquisition

- **Medicare reimburses hospitals** that are certified transplant programs **for costs associated with the acquisition of organs for Medicare beneficiaries.**

Organ Acquisition

- Allowable organ acquisition costs include **organ donor and recipient costs before hospital admission for the transplant** operation (i.e., pre-transplant services) and **hospital inpatient costs associated with the donor**.

cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021929

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Back to Paper-Based Manuals

The Provider Reimbursement Manual - Part 1

Publication # 15-1

Title The Provider Reimbursement Manual - Part 1

Downloads

Chapter 28 -- Prospective Payments (ZIP)

Chapter 29 -- Provider Payment Determination And Appeals (ZIP)

Chapter 30 -- NON-PPS Hospitals and Distinct Part Units (ZIP)

Chapter 31 – Organ Donation and Transplant Reimbursement (ZIP)

B. Cadaveric Donor Standard Acquisition Charge.--The cadaveric donor SAC is established by the CTC/HOPO for each type of organ. This charge is an average charge developed for each type of organ by estimating the reasonable and necessary costs expected to be incurred in procuring cadaveric organs, combined with the expected costs of acquiring cadaveric organs from other sources. This estimated amount is divided by the projected number of usable cadaveric organs to be transplanted within the hospital's cost reporting period. Where the CTC/HOPO provides the organ to an OPO, the CTC/HOPO uses its cadaveric donor SAC or its standard departmental charges, reduced to cost, to bill the OPO.

Expenses that may be used to develop the cadaveric donor SAC include, but are not limited to the following:

- costs of organs acquired from other providers;
- costs of transportation of the organs;
- surgeons' fees for excising cadaveric organs (currently limited to $1,250 for kidneys);
- costs of tissue typing services, including those services furnished by independent laboratories;
- preservation and perfusion costs;
- general routine and special care service costs; and
- operating room other inpatient ancillary service costs.

Machine perfusion is allowable

The Transplant Revenue Cycle

Organ Acquisition

Expenses allowable in Organ Acquisition

The costs included in the OAC are related to determining the suitability of a candidate or donor for transplantation.

They do not include costs associated with patient care or treatment pre, during, or post-transplant.

(Exception to this is donor care in certain situations).

Pre-transplant costs captured by the OAC…

- Pre-transplant testing
- Medical/Clinical Director (portion of salary)
- Administration
- Transplant Coordinators
- Social & Dietary Services
- Financial Coordinator
- Secretarial/Clerical/ Data Coordinator
- Storage
- Telephone, Answering Service, Cells, etc.
- Equipment & Supplies
- (assoc. with evaluation)

- Patient Education Materials
- Utilities
- Maintenance
- Computers
- Insurance
- Travel Reimbursement (UNOS,NATCO, AST)
- Continuing Education Mtgs & Seminars
- Memberships, Dues, Subscriptions
- Indirect costs (i.e. hospital overhead - a portion of non-revenue producing cost centers that support pre-transplant - housekeeping, finance, contracting, etc.

Case study – Space allocation FAKE numbers for case

- Kidney Transplant program was moved to a larger space for pre Transplant service to be consolidate in an area to facilitate the through put.

- This change was not communicated to the cost report team.

- This finding allowed a the program to identify 800 additional Sq. feet. The MCR overhead reimbursement was $2,145/ 100 Sq feet.

Case study – Space allocation FAKE numbers for case

- Best Practice
- Convene Quartey meeting with the hospital Cost report team. Examples for discussion:

- 1. Update any change in space or personnel.
- 2. Update on current volume and Donor activity.
- 3. Update on insurance contracts with Medicare secondary options.

Time studies capture staff time spent pre-transplant

Time study must include one (1) full work week per month.

- The weeks selected must be equally distributed among the months in the cost reporting period
  - for a 12 month period, 3 of the 12 weeks in the study must be the 1st week beginning in the month, 3 weeks the 2nd week beginning in the month, 3 weeks the 3rd, and 3 weeks the 4th.
- No two consecutive months may use the same week for the study
  - if the 2nd week in April is the study week for April, the weeks selected for March and May cannot be the 2nd week in those months.

Case study Capturing all Pre Transplant Evaluation Testing

- The program has Epic as the Hospital EMR.
- In order to capture the Pre Transplant evaluation testing the team is using the research flag that is currently available to route the changes to the work que for review for proper billing.

Case study Capturing all Pre Transplant Evaluation Testing

- *PI issues identified*:
- 1. Who has authority to add this designation as well as remove this designation?
- 2. Research flag needs to note Donor and Recipient.
- 3. The Work Que report did not readily display the secondary insurance.
- 4. Physician providers did not have accurate information for pre transplant billing.

Case study Capturing all Pre Transplant Evaluation Testing

- *Solutions identified*:
- 1. Transplant business office organized with reporting structure to Transplant Director.
- 2. Transplant business office policy and procedure manual created with collaboration of the patient access team and the hospital billing department. This included notification to physician providers.
- 3. The Work Que reports were redesigned to facilitate rapid review and sorting for proper billing as well as proper accounting for cost report team.

What costs are excluded from organ acquisition?

Medicare Cost Report

- Post-transplant activity for transplant recipients
- Travel/Lodging for families of recipient/living donor
- Services to treat the patient's condition
- Services related to the transplant surgery for the recipient
- Co-pays/deductibles for patients
- Activity for patients receiving Ventricular Assist Devices (VAD)

The Transplant Revenue Cycle

Question

- Can you only charge costs to Organ Acquisition for Medicare patients?

Answer

- No – you can charge costs for all patients to Organ Acquisition but you will only be reimbursed based on the % of Medicare patients you transplanted during the period

The Transplant Revenue Cycle

So how does this reimbursement work for costs charged to Organ Acquisition?

The Transplant Revenue Cycle

Medicare Cost Report

- Organ acquisition costs are reimbursed through submission of their Medicare Cost Report.

Medicare Cost Report

- Expenses will be reimbursed at the Medicare %

How the Medicare Cost Report reimburses OAC

Effective January 2021 Medicare Advantage Plans are included as Medicare organs ☺

Medicare Primary Transplants — 140
+
Medicare 2nd Payor Transplants (only if Medicare paid as secondary) — 20
+
Cadaveric Organs Procured at Hospital
=
Total Medicare Organs — 160

divided by

Total Transplants + Cad Organs
=
Medicare Ratio

$\frac{160}{200} = 80\%$

How the Medicare Cost Report reimburses OAC

Medicare Advantage Usable Organs (Line 63.01):

Include:

- Kidneys transplanted into MA beneficiaries
- Medicare Secondary Payer (MSP) for MA
- Effective for kidney transplants on or after January 1, 2021

Additional Statistical Categories (Part IV)

- Line 75.01 – Transplanted into Medicare beneficiaries
- Line 75.02 – Transplanted into MA beneficiaries
- Line 75.03 – Transplanted into MSP beneficiaries
- Line 75.04 – Transplanted into non-Medicare beneficiaries

How the Medicare Cost Report reimburses OAC

Total Organ Acquisition costs

X

$\left\{ \frac{\text{Medicare Organs}}{\text{Total Organs}} \right\}$ = Medicare Ratio

–

Revenue for Organs Sold

=

Net Organ Acquisition Cost

($ back to your facility)

Where can I find this information?

Financial Coordinator/ Business Office/Admitting

- Who are the primary payers of your patients?
- What is your Medicare %

Finance/Senior Leadership

- Who prepares your cost report?
- Are you capturing all of your costs?

How can this information help my program?

- When you can demonstrate that costs are covered through the hospital's Medicare Cost Report, you can request budget funding for staff, space, etc. to support your transplant program

- Expenses will be reimbursed at your Medicare Cost Ratio – the # of Medicare transplants performed during the calendar year

- 100 transplants performed
- 80 of 100 transplants performed were paid by Medicare
- Medicare Ratio is 80/100 = 80%

- Request for two new pre-transplant staff totals $100,000
- 80% of the $100,000 or $80,000 is reimbursed by Medicare
  - *Two new staff only costs program* $20,000 *(not $100,000)*

The Transplant Revenue Cycle

F. Organ Payment Policy - Request for Information on Counting Organs for Medicare's Share of Organ Acquisition Costs, IOPO Kidney SACs, and Reconciliation of All Organs for IOPOs

In this proposed rule, we are requesting information on an alternative methodology for counting organs for purposes of calculating Medicare's share of organ acquisition costs; IOPOs' kidney SACs; and Medicare's reconciliation of all organs for IOPOs. While we will not be responding to specific comments submitted in response to this RFI in the CY 2023 OPPS final rule, we intend to use this input to inform future policy development.

1. Counting Organs for Medicare's Share of Organ Acquisition Costs

Medicare calculates its share of organ acquisition costs for THs/HOPOs by multiplying the allowable organ acquisition costs by the ratio of Medicare usable organs (the numerator) to total usable organs (the denominator) reported on the Medicare hospital cost report.[294] Currently, THs/HOPOs must include the following as Medicare usable organs in the numerator of the Medicare share fraction:[295] (1) organs transplanted into Medicare beneficiaries; (2) organs transplanted into Medicare beneficiaries that were partially paid by a primary insurance payor in addition to Medicare; (3) organs sent to other THs or OPOs; (4) kidneys transplanted into Medicare Advantage beneficiaries for dates of service on or after January 1, 2021;[296] (5) l sent to United States military renal transplant centers (MRTCs) with a reciprocal sharing agreement with the HOPO in effect prior to March 3, 1988, and approved by the contract (6) pancreata procured for the purpose of acquiring pancreatic islet cells for transplantatio Medicare beneficiaries participating in a National Institute of Diabetes and Digestive and Kidney

Medicare Cost Report

Proposed changes to OAC by CMS….

The Transplant Revenue Cycle

Medicare Cost Report

and Modernization Act of 2003 (Pub. L. 108–173); 42 U.S.C 1395l (MMA).[297] However, "(3) organs sent to other THs or OPOs" and "(5) kidneys sent to United States MRTCs with a reciprocal sharing agreement with the HOPO in effect prior to March 3, 1988, and approved by the contractor," may include organs that are not actually transplanted into Medicare beneficiaries. Including organs that are not transplanted into Medicare beneficiaries in Medicare usable organs inflates Medicare's share of organ acquisition costs.

Proposed changes may also affect donor care units.
RFI recently completed as well as proposal comments.
CMS response pending Q4 2022

The Transplant Revenue Cycle

Additional pending updates recently clarified as per 2021-27523.pdf (federalregister.gov)

https://public-inspection.federalregister.gov/2021-27523.pdf?utm_source=federalregister.gov&utm_medium=email&utm_campaign=pi+subscription+mailing+list

1) Organ Procurement and Transplantation Network registration fees, and the reasonable and necessary cost of other fees, such as the registration fees for a kidney paired exchange, to register candidates organ transplants. These allowable registry fees must support or promote organ transplantation and must not be duplicative in nature

(2) *Living non-renal donor complications.* Hospital costs incurred for living non-renal donor complications directly related to the non-renal organ donation, which occur after the date of the donor's discharge are not paid through the claims processing system but are reported as organ acquisition costs on the hospital's Medicare cost report.

(A) Medicare covers reasonable hospital costs incurred for living non-renal organ donor complications only if they are directly related to a non-renal organ donation for a covered transplant into a Medicare beneficiary (*meaning patient must be enrolled in Medicare*)

(B) Hospital costs incurred for living non-renal organ donor complications are reported as organ acquisition costs on the Medicare cost report, and paid through the cost report on a reasonable cost basis

The Transplant Revenue Cycle

Billing – facility and provider

Well-defined procedures capture accurate data for billing

Accurate billing maximizes revenue

The Transplant Revenue Cycle

Billing – facility and provider

Pre

- Provider billing for evaluation
- Facility billing for evaluation and listing

Peri

- Provider billing for transplant/donation
- Facility billing for transplant/donation

Post

- Provider billing for post care
- Facility billing for post care – labs, tests, etc.

The Transplant Revenue Cycle

Billing – facility and provider

Pre

- Provider billing for evaluation
- Facility billing for evaluation and listing

The Transplant Revenue Cycle

Billing – facility and provider

Peri

- Provider billing for transplant/donation
- Facility billing for transplant/donation

The Transplant Revenue Cycle

Billing – facility and provider

Post

- Provider billing for post care
- Facility billing for post care – labs, tests, etc.

Case Study

The Transplant division had completed the revisions to monitor the Pre Transplant portion of the revenue cycle.

The transplant event and post billing cycle review noted opportunities for improvement.

PI team formed to improve payment for transplant events.

Issues identified:

1. 1. Pre-certification was not obtained on an acutely ill Liver Transplant case.
2. 2. Physician coding does not always identify the patient acuity.
3. 3. Living donor billed for inpatient care at the time of donation

Solutions:

1. Decision support created a spread sheet for each case that identified current coding, date of billing, insurance provider primary and secondary, when collection completed.
2. TFC designated to monitor all living donor billing at the time of discharge.

Where can I find this information?

Business Office/Provider Billers

- Who bills for your providers?

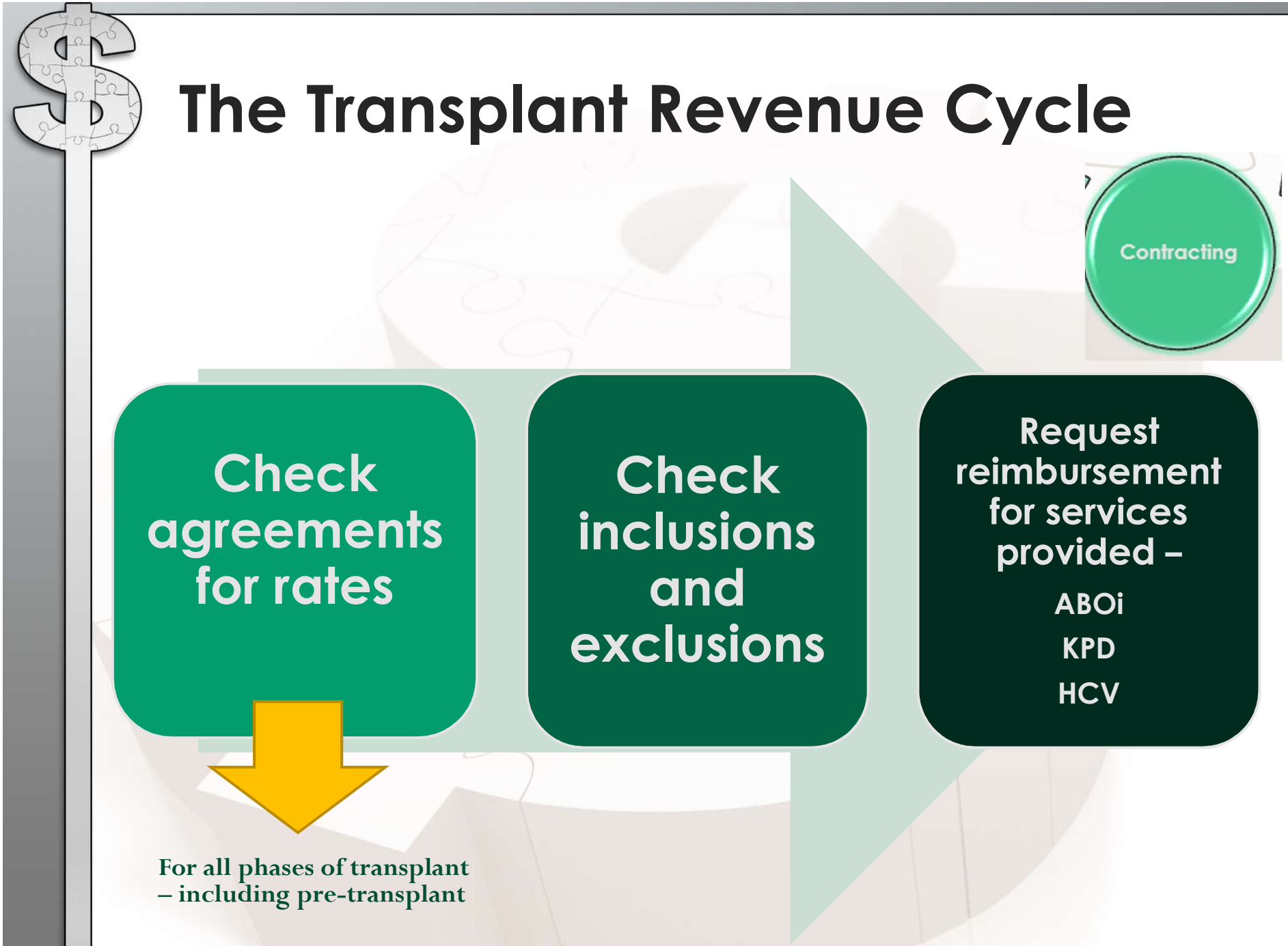
Finance/Senior Leadership

- Request to review…
  - Total revenue
  - Reimbursement (collections; write-offs, etc.)
  - Denials (reasons; workflows to fix issues)
  - Provider stats

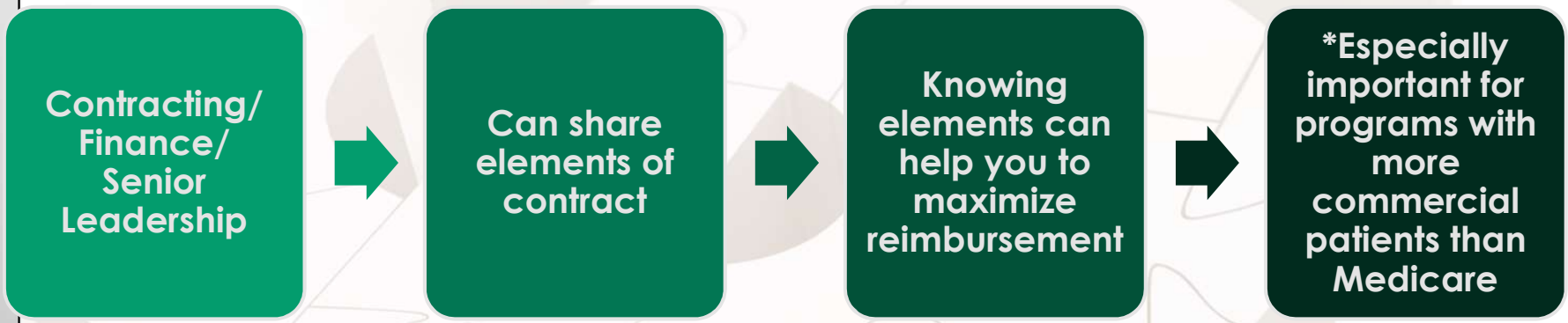
How can this information help my program?

- Efficient and effective billing workflows
- Maximize collections and minimize denials and write-offs
- Increasing revenue to your program

The Transplant Revenue Cycle



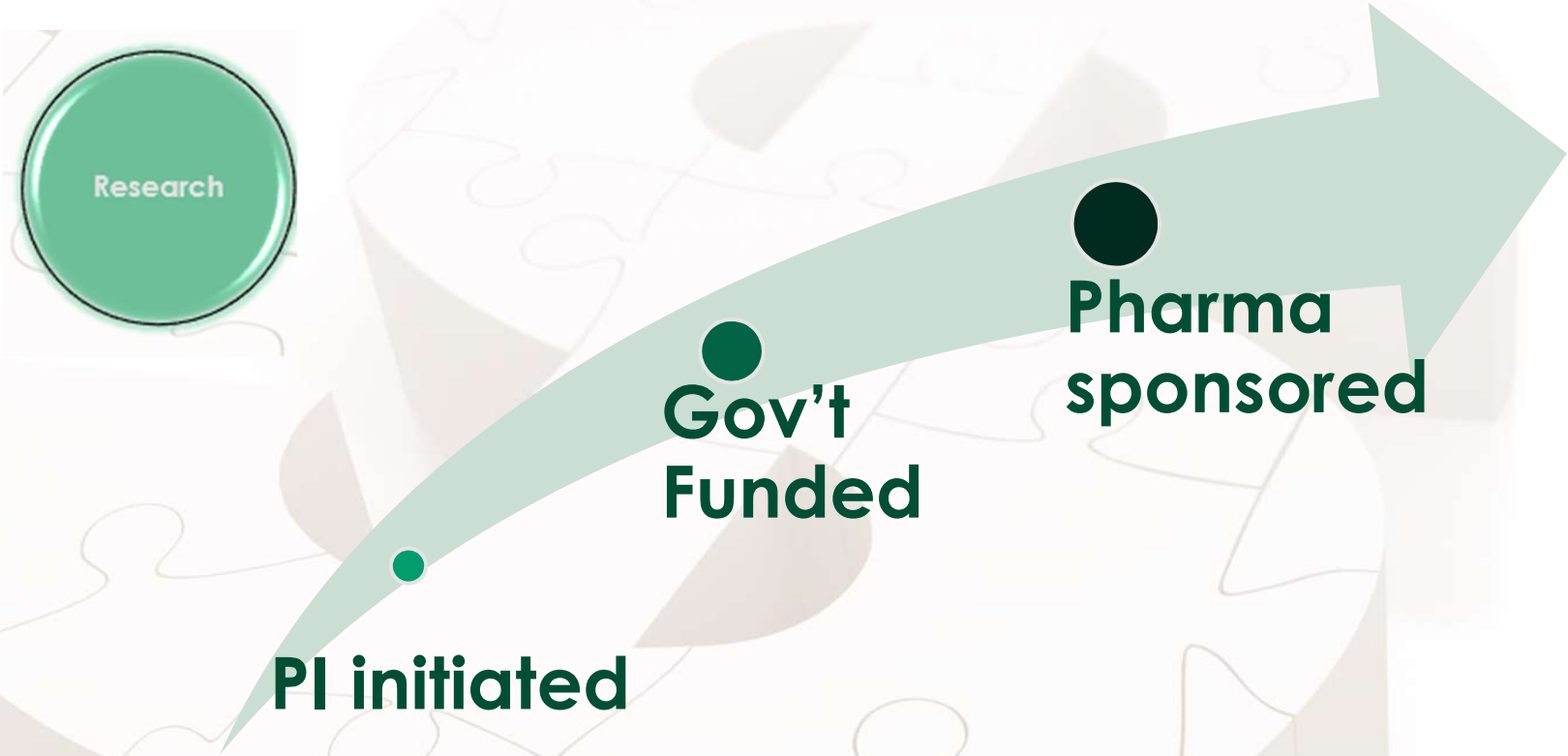
Where can I find this information?



How can this information help my program?

- Good contracts that are being administered correctly
- Maximizes collections and ensures costs are being covered
- Increasing revenue to your program

The Transplant Revenue Cycle



- Opportunity to provide novel therapies
- Can decrease costs
- Can increase revenue

The Transplant Revenue Cycle

Effective Budgeting

- Study tests
- Labor
- Admin costs
- Overhead
- Screen failures

Revenue Collection

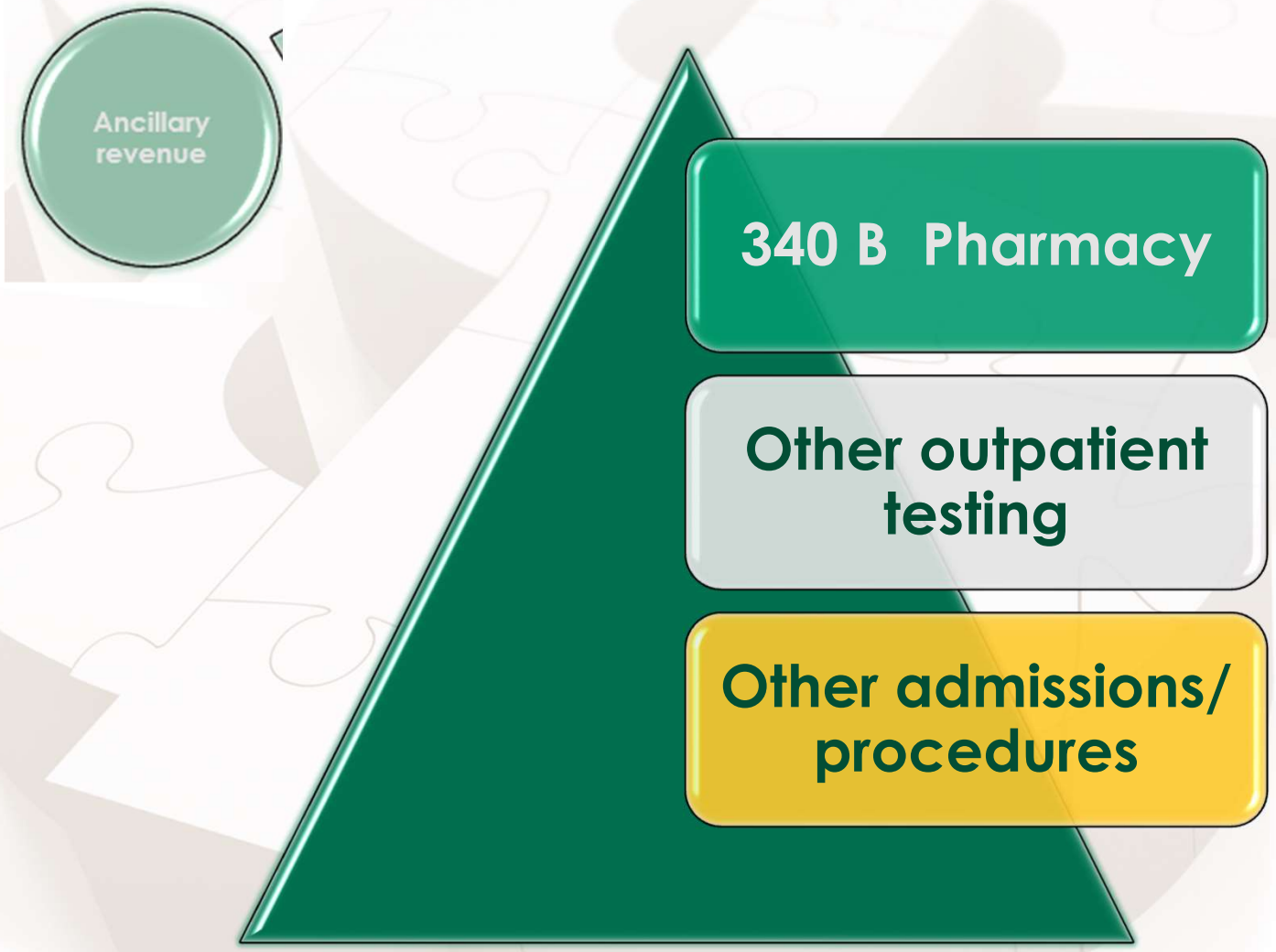
- Invoicing
- Team meetings
- Reports

Indirect Benefits

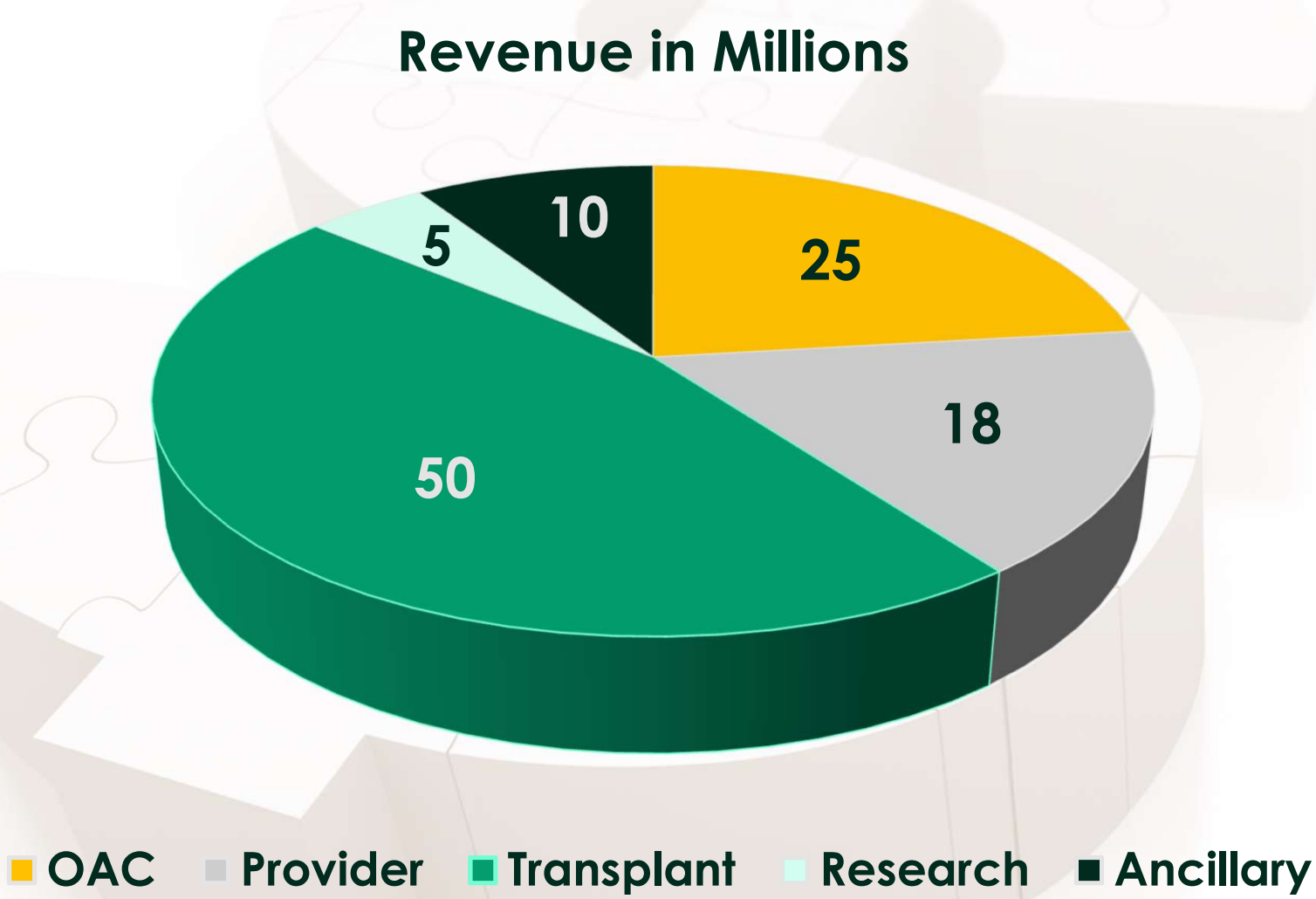
- Drug savings
- Patient referral/recruitment
- Publication/notoriety

Research

The Transplant Revenue Cycle

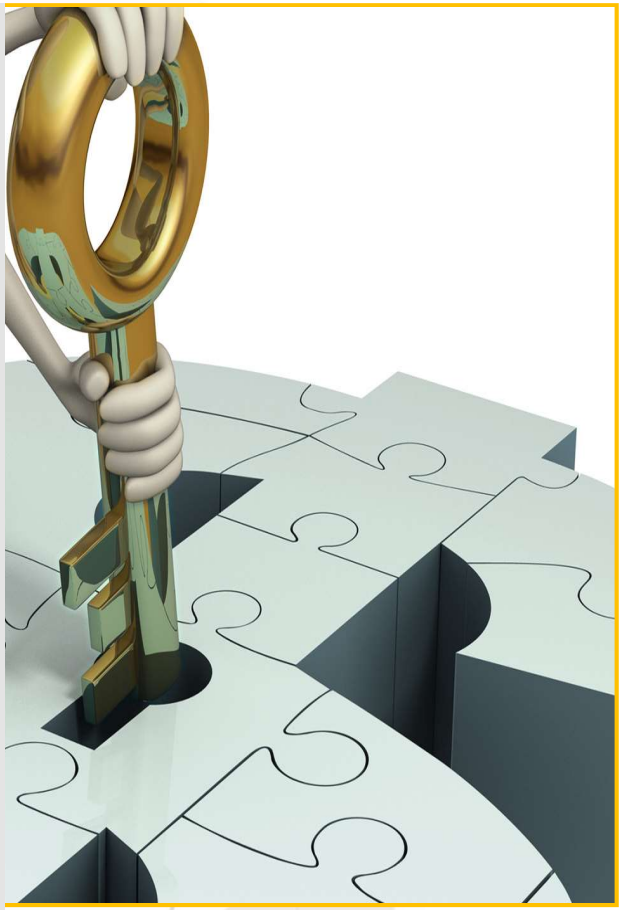


The Transplant Revenue Cycle



Additional tools and information obtained from Finance/Business Office or Senior Leadership…

- Budgets
- Profit and Loss
- Medicare Index
- Hospital Acuity



More resources means more volume

More volume translates to a higher case mix index (CMI)

A higher CMI means more reimbursement dollars for providing care because it indicates that a hospital is treating a sicker patient population

Higher volume also translates to more ancillary business for your organization

The bottom line…

This collectively evidences the profitability of your transplant program within your organization

The Transplant Revenue Cycle

Use tools and resources to assess revenue

Demonstrate your revenue to senior leadership

Use this leverage to gain resources your program requires

Maximize use of resources for patient care delivery

Increase opportunities for transplantation and donation

The Transplant Revenue Cycle

Questions?

The Transplant Revenue Cycle

Thank you

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Q&A
QUESTIONS & ANSWERS