

Additional Q&A from AST Business of Transplantation Webinar 12/12/12 Transplant Cost Report 101...Understanding the Basics

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Question: If organs are procured at your institution, must they be transplanted in order to be counted?

A. Aussi: All organs procured at your hospital system and "sold" to an OPO or transferred a Federal military hospital in case the donor is military are to be counted, regardless of whether the organs end up being transplanted or not.

Question: Are tests during the evaluation that are done because they "evidenced based" guidelines such as colonoscopy at age 50 expensed to Medicare or the insurer?

A. Aussi: If the patient is insured by other than Medicare as a primary insurance, then the charge is billed to insurer for pre-transplant diagnostic services as evidence based guidelines as in example provided, AND the hospital costs for service rendered are also accounted for on the transplant cost report. If the patient has a Medicare Primary insurance, then the acquisition cost center is responsible. The hospital costs for service rendered and professional fees are accounted for on the transplant cost report.

Question: If a pap smear is required for pre-transplant evaluation and a patient did not routinely get it done, should it be charged to organ acquisition?

A. Aussi: It certainly is an allowable cost for a diagnostic evaluation, if required as part of pre-transplant evaluation protocol and the patient's insurance does provide as a covered benefit.

Question: You mention direct costs of transplant personnel, can you explain which personnel (RN, coordinators, physicians?) what about membership to transplant societies for transplant personnel?

A. Aussi: All Transplant personnel other than physicians who earn a salary through an acquisition cost center are direct costs. As presented only pre-transplant related acquisition services which are supported by time studies are reimbursed. Membership to transplant societies for transplant personnel is allowable if supported by a policy outlining requirements to maintain annual staff competencies.

Question: Alexander, Is it possible to do the evaluation/diagnostic testing with the patient in an observation or inpatient bed and have this reimbursed on the cost report?

A. Aussi: Absolutely - The orders for observation should be clear (e.g. Place patient on the 3rd floor for observation post cardiac cath procedure). This is always a challenge given the many departments our transplant patients get evaluated in. An observation status could last for up to 48 hours and still be considered as an outpatient visit and billed as such, again with special conditions as pertains to documentation and the way the orders are written...

Question: What about conferences for Medical Directors? Can they be included?

Question: If the MD is employed by the hospital, can the hospital claim more than the transplant non-billable activity ? e.g. treat them like a staff person

A. Aussi: payment for Conferences attended by Medical Directors should be factored in as part of their medical directorship payments. MDs could document time spent as administrative non-billable time to manage the program. If the MD is employed by the hospital, they cannot treat them as a staff person. All MDs payments are subject to a Reasonable Compensation Equivalent (RCE) limit which is considered a fair market value for physician's administrative time.

Question: For a live donor transplant, who gets the SAC charge?

A. Aussi: The Medical center should establish a live donor SAC fee similar to the Deceased-donor SAC fee although with a lower \$ amount due to no payment made to the OPO. This charge is then placed on the account of the transplant recipient at time of admission for transplantation regardless of the recipient's insurance (Medicare and other).

Question: Would you consider a Medicare Advantage plan as Medicare Primary?

A. Aussi: Not any more if the Medicare Advantage plan is a Medicare replacement policy. Essentially, a patient sign off the policy to a private insurer and the insurer accepts the 80% Medicare coverage and provides all or part of the remaining 20 percent. We used to count those organs as Medicare organs, when the Advantage plans were treated as Demonstration projects. We now negotiate the SAC fee in addition to the payment received for the Phase III event.

Question: The contact information for the question about the resources/ seminars for Organ Procurement Organization's completion of the cost report

A. Aussi: Bill Vaughan built his reputation on review of OPO cost reports. I would recommend you give him a call or drop him an email at vaughan@guidryeast.com

Question: Under phase 4 for living donors, is the general follow up post-op care billed to the acquisition fund or to the recipient's insurance?

A. Aussi: All phase 4 routine follow-up for living donors AFTER the first 6 months period from the transplant procedure should be billed on the account of the recipient per recent CMS instructions.

Question: How can one bill for polyp removal when original intent was for scope? The scope is being billed to the Transplant program, but treatment is against insurance. Will physician be paid for polyp removal only without the scope being billed?

A. Aussi: I would bill the entire procedure as therapeutic management to insurance.

Question: what is CMS allowable reimbursement for a medical directorship? Multi-organ transplant abdominal transplantation

A. Aussi: All MD payments are subject to a Reasonable Compensation Equivalent (RCE) limit which is considered a fair market value for physician's administrative time. At this time it is limited to around \$100 per hour. It is allowable for a program to have multiple medical directorships per organ. MD Colleagues could cover some medical directorship hours as long as the medical director (contract owner) cosigns time spent.

Question: Does a physician need to supply documentation of their specific administrative duties or is a time study that includes only hours worked with no supporting documentation OK?

A. Aussi: they must provide documentation to support time spent as administrative non-billable to manage program needs. These could be strategic planning, protocol development, Attendance to selection meetings, meeting with leadership, education of staff, outreach and education to community MDs or other.