Principles of Organ Acquisition

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BESLER

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Agenda

- Defining Organ Acquisition and its allowable costs
- CMS Reimbursement for Organ Acquisition
- The four phases of the Transplant Process and how they are reimbursed
- Direct and Indirect Costs of Operating a Transplant Program
- How to accurately report the Organ Acquisition Charges and Days on Worksheet D-4
- Why Medicare Managed Care kidneys are counted toward the Medicare Ratio
- Understanding the requirements associated with Medicare Liability and Medicare Secondary Payer

Defining Organ Acquisition

What are Organ Acquisition Costs?

- Generally speaking, Organ Acquisition Costs represent the necessary costs attributable to acquiring an organ and preparing the potential donor and transplant recipient for organ transplantation.
- Applicable to Medicare and Non-Medicare patients
- Organ Acquisition Costs are reimbursable costs by Medicare under 42 C.F.R. Section 412.100(b).

Organ Acquisition Costs include:

- All Tissue typing and Crossmatch services including services furnished by independent labs (provided they are UNOS approved to provide the service).
- Living Donor and Recipient Evaluations.
- Operating room and other inpatient ancillary services applicable to the donor.
- Other costs associated with excising organs, such as donor routine and special care services.
- Charges to register the patient with UNOS .
- Medical Directorship costs.

Organ Acquisition Costs include:

- Preservation and Perfusion costs.
- Surgeon fees to excise the Deceased Donor organ.
- Transportation of Organ from and to the transplant hospital.
- Costs for organs acquired from other OPOs.
- All Diagnostic interpretations of Pre-transplant physician professional services, including lab, pathology and X-Ray.

Costs that are considered non-allowable:

- Travel, room, and board expenses incurred by a live donor.
- Travel, room, and board incurred by a recipient.
- Transportation of the potential deceased donor to the transplant hospital.
- Burial expenses of the deceased donor.
- Physician on-call time not actually called into hospital.

CMS Reimbursement for Organ Acquisition

CMS Reimbursement for Organ Acquisition

- Hospital Transplant Centers must be certified by CMS to be eligible for organ acquisition. reimbursement. In addition, they must be members of the Organ Procurement & Transplantation Network (OPTN) – a division of the US Dept. of Health & Human Services.
- CMS Relies partially on UNOS (United Network for Organ Sharing) for notification of Program non-compliance with volume and quality outcomes.
- UNOS is the contractor for the OPTN.

CMS Reimbursement for Organ Acquisition

- The United Network for Organ Sharing (UNOS) is a non-profit, scientific and educational organization that administers the only Organ Procurement and Transplantation Network (OPTN) in the United States, established by the U.S. Congress in 1984 (42 U.S.C.§ 274.).

CMS Reimbursement for Organ Acquisition

- UNOS is involved in many aspects of the organ transplant and donation process to include:
  - Managing the national transplant waiting list, matching donors to recipients.
  - Maintaining the database that contains all organ transplant data for every transplant event that occurs in the U.S.
  - Monitoring every organ match to ensure organ allocation policies are followed.

Organ Procurement Organizations

- 58 non-profit organizations.
- Responsible for the evaluation and procurement of deceased donor organs for organ transplantation.
- Each is responsible for organ procurement in a specific region.
- Each must also be a member of the OPTN.

Medicare Reimbursement

- Hospitals with Certified Transplant Centers are eligible to receive “Pass Through” reimbursement (cost based) from Medicare for organ acquisition costs for Medicare’s share of the costs.
  - This is a payment solely determined via the Medicare Cost Report and is a payment outside of the Prospective Payment System (PPS).
  - There are approximately 250 hospitals in the U.S certified to transplant one or more organ types.
  - They are typically your larger hospitals particularly those affiliated with academic institutions.
  - Most common transplanted organs -- Kidney, Heart, Liver, Lungs, and pancreas.

Provider Reimbursement Manual

Medicare
Provider Reimbursement Manual
Part 1 - Chapter 31, Organ Acquisition Payment Policy

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

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HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
Table of Contents, Chapter 31	31-1 - 31-2	
3100 - 3117	31-3 - 31-24 (24 pp).	

CLARIFIED/UPDATED MATERIAL--*EFFECTIVE DATE: NOT APPLICABLE*

Chapter 31 has been created to update, reorganize and clarify Medicare's payment policy regarding organ acquisition costs, formerly found in Chapter 27 – ESRD Services and Supplies, sections 2770 through 2775.4. Sections 2770 through 2775.4 have been removed and reserved. This chapter also incorporates corrections to terminology to reflect current usage; revisions of text to clarify meaning; additions, deletions or corrections to cross references; and revisions of section titles.

Transplant Process

The Transplant Process Four Phases

- **Evaluation**– Pre-transplant Initial referral and evaluation.
- **Maintenance (Waitlist)** – Patient is accepted and listed with UNOS and is now in the maintenance phase.
- **Transplant Event** – Patient is admitted to hospital for organ transplant procedure and subsequent IP stay until first discharge.
- **Post Transplant** – Patient is discharged from hospital and post-transplant follow up care begins.

How are the various phases reimbursed?

- **Evaluation** – Pre-transplant (Organ Acquisition – determined on Medicare cost report).
- **Maintenance (Waitlist)** – Pre-transplant (Organ Acquisition – determined on Medicare cost report).
- **Transplant Event (Recipient)** – Inpatient Stay > MS- DRG.
- **Transplant Event (Donor)** - Organ Acquisition – determined on Medicare cost report.
- **Post Transplant** – Post Transplant > APCs.

Transplant Participants

- **Recipients**
  - Pre-transplant costs = Organ Acquisition costs.
- **Donors**
  - Live donor – Pre-transplant, transplant event = Organ Acquisition costs.
  - Deceased donor – Cost of procuring the organs = Organ Acquisition costs.

Key Worksheets of the Transplant Cost Report

- **Medicare Cost Report Pertinent Worksheets**
  - WS A, Organ Acquisition Direct Costs
  - WS A-6, Reclassification of Expenses
  - WS A-8, Adjustments to Expenses
  - WS A-8-1 Related Party expenses
  - WS A-8-2, Physician Compensation
  - WS B-1, Overhead Statistics
  - WS D-4, Organ Acquisition Settlement

Worksheet A
Cost Centers

- Line 105.00, Kidney Acquisition
- Line 106.00, Heart Acquisition
- Line 107.00, Liver Acquisition
- Line 108.00, Lung Acquisition
- Line 109.00, Pancreas Acquisition
- Line 110.00, Intestinal Acquisition

Operating a Transplant Program includes:

- **Direct Costs** - Transplant Department personnel, outreach/education, travel and meeting expenses, professional education, office rent, office supplies, equipment maintenance, professional subscriptions, etc.
- **Indirect Costs** - from non-revenue producing departments- Depreciation and interest, Plant operations, Housekeeping, Social Service, Employee Benefits, Cafeteria, Nursing Administration, General Administration, IT etc… Basically the cost centers on Worksheet B-1 of the cost report.

The Transplant Cost Report

Direct Costs

Major component of direct costs - Salaries:

- *Note: Post-transplant costs is not organ acquisition.*
- Pre-Transplant versus Post-Transplant – Salaries.
- Must utilize time studies to formulate pre vs. post time (and possibly non-transplant time).
- A payroll system that allows for the tracking of pre versus post time is acceptable.

The Transplant Cost Report

Direct Costs

The most common WS A-6 reclassifications are:

- Reclassify salaries to post-transplant cost center for Transplant Department employees.
- Reclassify salaries between the organ acquisition cost centers for Transplant Department employees.
- Reclassify salaries to other departments for Transplant Department employees.
- Reclassify salaries from other departments to the Organ Acquisition cost centers (example: Pharmacists, Dietician, and Social Workers).
- Reclassify general other costs to Post-Transplant cost center (ex. supplies, rent).

The Transplant Cost Report

Direct Costs

The most common WS A-6 reclassifications are (cont.):

- Other salary related reclassifications that impact all areas of the hospital (bonuses, employee benefits, etc.).
- Medical supplies and drugs related reclassifications that impact numerous cost centers of the hospital.

The Transplant Cost Report

Time Studies

Minimum Time Study Requirements:

- A minimally acceptable time study must encompass at least one full week per month of the cost report period.
- Each week selected must be a full workweek.
- The weeks selected must be equally distributed among the months in the cost reporting period, e.g., for a 12-month period, 3 of the 12 weeks in the study must be the first week beginning in the month, 3 weeks the second week beginning in the month, 3 weeks the third, and 3 weeks the fourth.

The Transplant Cost Report

Time Studies

Minimum Time Study Requirements (cont.):

- No two consecutive months may use the same week for the study, e.g., if the second week beginning in April is the study week for April, the weeks selected for March and May shall not be the second week beginning in those months.
- The time study must be contemporaneous with the costs to be allocated. Thus, a time study conducted in the current cost reporting year may not be used to allocate costs of the prior or subsequent years.

The Transplant Cost Report

Time Studies

Minimum Time Study Requirements (cont.):

- The time records to be maintained must be specified in a written plan submitted to the intermediary (MAC) no later than 90 days prior to the end of the cost reporting period to which the plan is to apply.
- The intermediary must respond in writing to the plan within 60 days from the date of receipt of the request, whether approving, modifying, or denying the plan.

The Transplant Cost Report

Other Costs

How to identify post-transplant “Other” Costs:

- The most common method used is the aggregate percentages established by the time studies.
- It is best to establish accounts that are for the purpose of booking 100% organ acquisition related costs only such as the costs of acquiring the organs themselves, so as to refrain from applying the time study aggregate percentages to these costs.
- If expense can be identified as being 100% post-transplant related it should be classified initially as such and not applied to the Time Study aggregate percentages.

The Transplant Cost Report

Adjustments to Expenses

- Certain expense adjustments are required under the Medicare principles of reimbursement and are made on the basis of cost incurred or revenue received.
- Types of adjustments entered on this worksheet include (1) adjustments to reflect actual expenses incurred (Related Party), (2) adjustments that reduce expenses by revenue received, and (3) adjustments to reflect Medicare regulations.
- A common adjustment is to adjust or remove expense for Advertising, Patient Gifts, or Alcohol which are non-allowable Medicare expenses.

Physician Compensation

- Worksheet A-8-2 provides for the computation of allowable provider-based physician costs.
- CMS requires that physician compensation be allocated between services to individual patients (Part B) and services that benefit patients generally, i.e. provider services (Part A). Only provider services are reimbursable through the cost report.
- This worksheet also provides for the computation of the reasonable compensation equivalent (RCE) limits required by CMS. The methodology used in this worksheet applies the RCE limits to the total provider-based compensation attributable to provider services on a reasonable cost basis.

Physician Compensation

Medical Directors

- Medicare will reimburse that portion of the expense that is related to pre-transplant activities, limiting payment to the RCE hourly rate.
- For this reason, you must have documentation that supports the hours of effort for each Medical Director for time spent pre-transplant. The documentation can be time reports or time studies.

Physician Compensation

- Latest RCE Limits effective with cost reporting periods beginning on or after January 1, 2015:
  - $118 per hour for a surgeon and $102 per hour for a non-surgeon working in an organ acquisition department.
  - All remuneration costs on an organ acquisition line should be “pre-transplant” related. The same for the related hours.

The Transplant Cost Report

Indirect Costs

- The indirect costs are costs booked to overhead departments of the hospital that benefit the organ acquisition cost centers as well as other hospital cost centers that ultimately are allocated to patient treatment cost centers. Examples of overhead costs include Housekeeping, Cafeteria, Maintenance, and Capital Related costs.
- Worksheet B pt. 1 displays the dollars allocated to the Organ Acquisition Cost Centers.
- Worksheet B-1 displays the allocation bases utilized to distribute the overhead dollars to the Organ Acquisition Cost Centers.

Organ Acquisition Charges and Days

Organ Acquisition Charges and Days

- When a hospital provides services to the transplant center's patients (both recipients and donors) in their hospital, the days and charges can be captured and placed on the cost for the organ acquisition related services.
- There are three groups of patients who have their days and charges captured.
- These are reported on Worksheet D-4.

Organ Acquisition Charges and Days

First Group

- Potential live donors and transplant recipients who had pre-transplant services provided in the evaluation and maintenance phases of the transplant process.
- The charges from the first group that should be captured are those associated with evaluations and diagnoses, not treatment.
- The charges should be reviewed by someone with the clinical knowledge to determine the appropriate charges to be captured for reporting on Worksheet D-4 Part 1.
- Pre-transplant charges should not be billed to Medicare.

Organ Acquisition Charges and Days

Second Group

- Live Donors for services provided when donating an organ.
- A listing of all live patients that donated an organ should be compiled.
- All the charges and days associated with the donation should then be accumulated for these individuals and placed on Worksheet D-4 Part 1.

Organ Acquisition Charges and Days

Third Group

- Deceased Donors who had organs excised at the hospital that were procured by the Organ Procurement Organization.
- The charges and days related to keeping the organs viable and excising and procuring the organs should be captured and reported on Worksheet D-4 Pt. 1.
- The charges and days should be pro-rated over all organ types.

Medicare Ratio

The Medicare Ratio

- Once direct costs, indirect costs, and the costs derived from the Organ Acquisition charges and days are combined to formulate the total Organ Acquisition costs, Medicare determines its share of the costs.
- The Medicare Ratio = Medicare usable organs / Total usable organs.

The Medicare Ratio

Medicare Usable Organs

- The number of organs transplanted where Medicare was the primary payer.
- The number of usable organs excised at the hospital and procured by the OPO or sent to another certified transplant center (paired exchanges).
- If certain criteria are met, certain usable organs where Medicare was secondarily liable.

The Medicare Ratio

Total Usable Organs

- The number of organs that were transplanted during the year.
- Plus, the number of organs excised at the hospital and procured by the OPO or sent to other certified transplant centers (paired exchanges).

The Medicare Ratio

Medicare Managed Care

- Beginning on January 1, 2021 Medicare Managed Care kidneys can be counted as a Medicare organ for the purposes of establishing the Medicare Ratio.

  Note: This only applies to kidneys.

Medicare Secondary Payer

Medicare Secondary Payer

- Requirement #1 The primary payer payment amount must be insufficient to cover the Medicare liability.
- Requirement #2 The hospital must submit a bill to Medicare for the MSP claims.
- Requirement #3 There must not be any “payment in full” language in commercial payer agreement.
  - “When the primary insurance requires acceptance of their payment as payment in full … under the contractual arrangement, Medicare has no payment responsibility because the primary payer has made payment in full”

Medicare Secondary Payer

The Medicare Liability is defined as the sum of the following:

- The MS-DRG inclusive of all adjustments (DSH, IME, etc).
- The “cost per organ” calculated from the current cost report. This is derived by dividing the total organ acquisition costs (line 61 of Worksheet D-4 Pt. 3 - total organ acquisition costs) by line 62 of Worksheet D-4 Pt. 3 (total organs).

Medicare Secondary Payer

The following are the MS-DRGs for organ transplants:

- 1 – Heart Transplant with MCC
- 2 – Heart Transplant without MCC
- 5 – Liver Transplant with MCC or Intestinal Transplant
- 6 – Liver Transplant without MCC
- 7 – Lung Transplant
- 8 – Simultaneous Pancreas / Kidney Transplant
- 10 – Pancreas Transplant
- 652 – Kidney Transplant

Medicare Secondary Payer

Potentially two calculations are needed:

- The fully loaded MS-DRG and the cost per organ should be combined and compared to the primary insurance's payment. If the payment is less, than the organ can be counted as a Medicare organ.
- If the first test is passed, then a revenue offset must be determined by dividing the cost per organ by the total Medicare liability and applying the % to the primary payer's payment. This revenue should be included on WS D-4 Part 3 line 66.

Revenue Offsets

Revenue Offsets

The following revenue should be offset against Medicare organ acquisition costs:

- Revenue from selling organs to the OPO (prorate over all organ types).
- Revenue from selling organs to other certified transplant centers in kidney paired exchanges.

Revenue Offsets

The following revenue should be offset against Medicare organ acquisition costs (cont.):

- The primary insurers payment in MSP situations related to the organ acquisition portion of the Medicare liability.
- Include on Worksheet D-4 Part 3 line 66. (note: for cost reports beginning on or after 10/1/20 the primary insurance payment offset should also be reported on line 66.01).

Organ Acquisition Reimbursement Example Calculation

Organ Acquisition Reimbursement Example Calculation

• Organ Acquisition costs:	
• Direct Costs (WS A col. 7)	$5,000,000
• Indirect Costs (WS B col. 27 less WS A col. 7)	$2,000,000
• Cost derived From Organ Acquisition Charges and Days (WS D-4)	$1,300,000
• Total Organ Acquisition Costs (WSD-4 Pt. 3)	$8,300,000
• Medicare Ratio (60 Medicare usable organs / 80 Total usable organs)	75.00%
• Total Medicare reimbursement for organ acquisition	$6,225,000
• Offset Revenues from organs sold to OPOs or other transplant centers	(425,000)
• **Net Medicare reimbursement for organ acquisition**	**$5,800,000**

Question & Answers

Organ Acquisition Reviews are a thorough review to improve accuracy and compliance can help hospitals capture every dollar of potential reimbursement.

Cost Report Preparation is an end-to-end service that includes completion and submission of the cost report to a hospital's specific Medicare Administrative Contractor.

Cost Report Reviews can fix common errors allowing hospitals to receive corrected payments without having to wait for final settlement of the Medicare Cost Report.

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Medicare Cost Report Reviews and Preparation	Disproportionate Share Reviews (DSH)
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