Title 23: Division of Medicaid

Part 202: Hospital Services

Chapter 4: Solid Organ and Tissue Transplants

Rule 4.1: Transplant Provider Requirements

Providers of transplant services must:

A. Complete the requirements for participation in the Mississippi Medicaid program.

B. Meet the following facility criteria:

1. Solid organ transplant procedures must be performed in a facility which meets the Centers for Medicare and Medicaid Services (CMS) requirements for Conditions of Participation approved as a transplant facility unless otherwise authorized by the Division of Medicaid, and

2. Bone marrow and stem cell transplant procedures must be performed in a facility accredited by a CMS-deemed national accreditation organization.

C. Obtain prior authorization from a Utilization Management/Quality Improvement Organization (UM/QIO), the Division of Medicaid or designated entity for the inpatient hospital admission and for outpatient services, if required, for the transplant procedure as soon as it is determined that the beneficiary may be a potential candidate for the transplant.

1. The prior authorization request must include, but is not limited to the following:

a) A description of the medical condition which necessitates the transplantation,

b) Diagnostic confirmation by clinical laboratory studies of the underlying pathological process,

c) A history of other treatments which have been tried and treatments which have been considered and ruled out, including an explanation as to why the treatment was ruled out,

d) Comprehensive assessments:

1) Examination, evaluation and recommendations completed by a board-certified or board-eligible specialist in a field directly related to the beneficiary's condition which necessitates the transplantation,

2) Psycho-social evaluation including a comprehensive history of substance abuse and compliance with any medical treatment of:

(a) The beneficiary, and

(b) The parents or guardian/legal representative if the beneficiary is less than eighteen (18) years of age,

e) Psychiatric evaluation of the beneficiary if the beneficiary has a history of mental illness,

f) Infectious disease evaluation of a beneficiary with a recent or current suspected infectious episode,

g) Evaluation of a beneficiary diagnosed with cancer that includes staging of the cancer, laboratory tests, and imaging studies, and

h) Any other medical evidence needed to evaluate possible contraindications for the type of transplantation being considered.

2. Prior authorization is not required for transplants when the beneficiary has Medicare coverage.

3. Prior authorization is required for transplants when the beneficiary has third party coverage and the hospital intends to bill Medicaid for any transplant related hospital charges.

D. Ensure that the transplant procedure is performed at the facility requesting prior authorization for the transplant procedure.

E. Submit documentation for a concurrent review for beneficiaries not enrolled in a Coordinated Care Organization (CCO) to a UM/QIO, the Division of Medicaid, or designated entity if a beneficiary's length of stay exceeds nineteen (19) days.

F. Provide the appropriate medical records, progress or outcome reports as requested by a UM/QIO, the Division of Medicaid, or designated entity.

Source: 42 U.S.C. § 1320b-8; 21 C.F.R. Parts 1270 and 1271; 42 C.F.R. Part 121, 42 C.F.R. §§ 441.35, 482.12, 482.68-104; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised eff. 01/01/2017; Revised eff.10/01/2012.

Rule 4.2: Covered Services

A. The Division of Medicaid covers the following solid organ transplant services when medically necessary and prior authorized by a Utilization Management/Quality Improvement Organization (UM/QIO), the Division of Medicaid, or designated entity:

1. Single organs:

a) Heart, according to current criteria of the International Society for Heart and Lung Transplantation,

b) Intestine, according to current criteria of the American Gastroenterological Association and American Society of Transplantation,

c) Liver, according to current criteria of the American Association for the Study of Liver Diseases and the American Society of Transplantation,

d) Single lung, according to current criteria of the Pulmonary Transplantation Council of the International Society for Heart and Lung Transplantation, and

e) Bilateral lung, according to current criteria of the Pulmonary Transplantation Council of the International Society for Heart and Lung Transplantation,

2. Multiple-organs which meet the current criteria according to the respective single organ criteria in Rule 4.2.A.:

a) Heart-lung,

b) Intestines with other organs,

c) Kidney-heart,

d) Kidney-pancreas, which only reimburses for the kidney transplant,

e) Liver-kidney, and

f) Other multi-organs.

B. The Division of Medicaid covers kidney transplants when medically necessary with no prior authorization.

C. The Division of Medicaid covers bone marrow transplantations, peripheral stem cell transplantations and cornea transplantations when medically necessary with no prior authorization, meets Medicare coverage guidelines and are not experimental or investigational.

D. The Division of Medicaid covers all facility and physician charges relating to the procurement of an organ, whether from a cadaver or a living donor.

1. The Division of Medicaid covers donor related charges including, but not limited to, the following:

a) A search for matching tissue, bone marrow, or organ,

b) The donor's transportation,

c) Charges for the removal, withdrawal, and preservation/storage of the organ or tissue, and

d) The donor's hospitalization.

2. The Division of Medicaid covers medically necessary follow-up care outside of the transplant inpatient hospital admission for the living donor only if the donor is a Mississippi Medicaid beneficiary.

Source: 42 C.F.R. §§ 441.35, 482.90-104; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised eff. 01/01/2017; Revised eff.10/01/2012.

Rule 4.3: Non-Covered Services

The Division of Medicaid does not cover the following transplant procedures/services including, but not limited to:

A. Transplant procedures/services not medically necessary,

B. Transplant procedures/services still in clinical trials and/or investigational or experimental in nature,

C. Transplant procedures/services performed in a facility not approved by the Division of Medicaid and/or meeting the criteria in Miss. Admin. Code Part 202, Rule 4.1,

D. Inpatient admissions or outpatient procedures, if required, for transplant procedures/services that have not been prior authorized by a UM/QIO, the Division of Medicaid, or designated entity, or

E. Pancreas transplants.

Source: Miss. Code Ann. § 43-13-121.

History: Revised eff. 01/01/2017.

Rule 4.4: Reimbursement

A. All fee-for-service (FFS) transplants performed in the state of Mississippi are paid under the Mississippi All Patient Refined-Diagnosis Related Group (APR-DRG) payment methodology, including a policy adjustor.

B. All FFS transplants available in Mississippi but performed outside the state of Mississippi are

paid under the Mississippi APR-DRG payment methodology, including a policy adjustor.

C. Payment for transplant services not available in Mississippi is made under the Mississippi APR-DRG payment methodology including a policy adjustor. If the Mississippi APR-DRG payment limits access to care, a case rate may be set.

1. A case rate is set at forty percent (40%) of the sum of billed charges for transplant services as published in the State Plan according to *Milliman's U.S. Organ and Tissue Transplant Cost Estimates and Discussion*.

2. The *Milliman* categories comprising the sum of billed charges include outpatient services received thirty (30) days pre-transplant, procurement, hospital transplant inpatient admission, physician services during transplant and one-hundred eighty (180) days post (transplant) hospital discharge. Outpatient immunosuppressants and other prescriptions are not included in the case rate.

3. If the transplant hospital stay exceeds the hospital length of stay published by *Milliman*, an outlier per-diem payment will be made for each day that exceeds the hospital length of stay.

4. Reimbursement for transplant services cannot exceed one-hundred percent (100%) of the sum of *Milliman's* billed charges for the categories listed in Miss. Admin. Code Part 202, Rule 4.4.C.2.

5. Provisions listed in Miss. Admin. Code Part 202, Rule 4.4 apply to transplant services on or after October 1, 2012.

6. Transplant services not available in Mississippi and not listed in the *Milliman's U.S. Organ and Tissue Transplant Cost Estimates and Discussion* will be reimbursed using the Mississippi APR-DRG payment methodology. If the Mississippi APR-DRG payment limits access to care, the Division of Medicaid will reimburse what the domicile state pays for the service.

D. All conditions of third party liability procedures must be satisfied.

E. All claims must be submitted according to the requirements of the Mississippi Medicaid program.

F. All charges, both facility and physician, relating to procurement/storage must be billed by the transplant facility on the current uniform billing (UB) claim form with the appropriate revenue code(s).

G. The Division of Medicaid reimburses all facility and physician charges relating to the procurement of an organ, whether from a cadaver or a living donor, to the transplant facility using the appropriate revenue codes.

Source: 42 C.F.R. §§ 441.35, 482.90 - 104; Miss. Code Ann. § 43-13-121.

History: Revised to correspond with SPA 15-018 (eff. 12/01/2015) eff. 01/01/2017; Revised eff. 10/01/2012.

Rule 4.5: Fundraising

A. The Division of Medicaid allows fundraisers to obtain funds needed for transplant costs not covered by the Medicaid program.

B. Fundraising criteria includes, but is not limited to, the following:

1. Prior to accepting donations, arrangements must be made with the Division of Medicaid to deposit donations in a trust fund/special account.

2. The trust fund/special account must be established and administered in compliance with all applicable federal and state rules and regulations.

3. The trust fund/special account must be managed and administered by someone other than the beneficiary or the beneficiary's guardian, legal representative or family member. The beneficiary or the beneficiary's guardian, legal representative or family member cannot have direct access to the trust fund/special account.

4. Trust fund/special account must be maintained separately from personal monies belonging to the beneficiary or the beneficiary's guardian, legal representative or family member.

5. Legible and authentic documentation of income and expenditures must be made available to a Utilization Management/Quality Improvement Organization (UM/QIO), the Division of Medicaid, or designated entity upon request.

6. The beneficiary must report all sources of income to the Division of Medicaid. Donated funds for the purpose of payment of medical services are considered a third party source.

7. Transplant facilities/providers cannot participate in fundraising for beneficiaries to raise additional funds to pay for the transplant procedure and/or related services.

Source: 42 U.S.C. § 1396p; Miss. Code Ann. § 43-13-121.

History: Revised to correspond with SPA 15-018 (eff. 12/01/2015) eff. 01/01/2017; Revised eff. 10/01/2012.

Rule 4.6: Documentation Requirements

Providers of transplant services must document and maintain records in accordance with requirements set forth in Miss. Admin. Code Part 200, Rule 1.3 on each beneficiary receiving a

transplant and must include the following:

A. Comprehensive history and physical.

B. Treatments rendered that were unable to prevent progressive disability and/or death.

C. Use of tobacco, alcohol, and/or illegal drugs within the last six (6) months.

D. Absence of severe and irreversible organ dysfunction in organ(s) other than the organ(s) being transplanted.

E. Relevant diagnostic studies and results including, but not limited to:

1. X-rays,

2. Lab reports,

3. EKG reports,

4. Pulmonary function studies,

5. Psychosocial reports,

6. Nutritional evaluation, and

7. Performance status.

F. Reports, consults or other documentation to substantiate the transplant including documentation of transplant approval by the facility's transplant review team.

G. Copy of informed consent form signed by the beneficiary and/or guardian or legal representative.

Source: 42 C.F.R. § 482.90 -104; Miss. Code Ann. §§ 43-13-117; 43-13-118; 43-13-121.

History: Revised to correspond with SPA 15-018 (eff. 12/01/2015) eff. 01/01/2017.

Rule 4.7: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

The Division of Medicaid pays for all medically necessary services for early and periodic screening, diagnosis, and treatment (EPSDT)-eligible beneficiaries in accordance with Miss. Admin. Code Part 223, without regard to service limitations and with prior authorization.

Source: Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Renumbered rule eff. 01/01/2017; Revised eff. 01/01/2013; Revised eff. 10/01/2012.