

Division of Medicaid State of Mississippi Provider Policy Manual	New: Revised: X Current:	Date: Date: 07/01/04 07/01/08
Section: Hospital Inpatient	Section: 25.11	
Subject: Transplants	Pages: 2	
	Cross Reference: Transplants 28.01-28.18	

Mississippi Medicaid benefits are provided for the following transplants if the transplant facility obtains prior approval (PA), when required, and satisfies all criteria:

PROCEDURE	COVERED	PA REQUIRED
Cornea	Yes	No
Heart	Yes	Yes
Heart/Lung	Yes	Yes
Kidney	Yes	No
Liver	Yes	Yes
Lung – Single	Yes	Yes
Lung – Bilateral	Yes	Yes
Marrow or Peripheral Hematopoietic Stem Cell: Autologous, Syngeneic, or Allogeneic	Yes	Yes <u>No</u>
Pancreas	No	No
Small Bowel	Yes	Yes

~~*A kidney transplant done in conjunction with pancreas will be reimbursed as a kidney transplant only.~~

Note: Pancreas transplants are not covered by the DOM. When a pancreas transplant is done in conjunction with another covered transplant procedure (example: pancreas transplant in conjunction with the kidney), DOM will only consider reimbursement for those charges related to the covered transplant procedure.

Requests for prior approval should be sent to ~~DOM's Peer Review Organization (PRO)~~ the Division of Medicaid's Utilization Management/Quality Improvement Organization (UM/QIO). Physicians are urged to submit their requests as soon as it is determined that the patient may be a potential candidate for transplant.

All transplant benefits are contingent upon:

1. The beneficiary's continued eligibility for Mississippi Medicaid;
2. The beneficiary's application for the transplant being approved by DOM's ~~PRO~~ UM/QIO;
3. All inpatient days being certified by DOM's ~~PRO~~ UM/QIO;

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4. All conditions of third party liability procedures being satisfied;
 5. All providers of services completing requirements for participation in the Mississippi Medicaid program; all claims being completed according to the requirements of the Mississippi Medicaid program;
 6. All charges, both facility and physician, relating to procurement/storage must be billed by the transplant facility on the ~~UB92~~ appropriate UB claim form under the appropriate revenue code;
 7. The transplant facility providing appropriate medical records, progress or outcome reports as requested by DOM, the ~~PRO~~ UM/QIO or the fiscal agent; and
 8. The transplant procedure being performed at the requesting facility.

All terms of the Mississippi Medicaid program, including timely filing requirements, are applicable.

Approval will not be given for:

- Transplant procedures for which medical necessity has not been proven;
- Transplant procedures which are still investigative, experimental, or still in clinical trial;
- Transplant procedures performed in a facility not approved by DOM;
- Inpatient or outpatient admissions for transplant ~~procedures on which certification or re-certification is not obtained from the PRO~~ procedures/services not certified/re-certified by the UM/QIO.

Division of Medicaid	New:	Date:
State of Mississippi	Revised: X	Date: 08/01/07
Provider Policy Manual	Current:	07/01/08
Section: Transplants	Section: 28.01	
	Pages: 1	
Subject: Introduction	Cross Reference:	

Medicaid, as authorized by Title XIX of the Social Security Act, is a federal and state program of medical assistance to qualified individuals. Each state designates a state agency as the single state agency for the administration of Medicaid. State law has designated the Division of Medicaid, Office of the Governor, as the single state agency to administer the Medicaid program in Mississippi.

DOM will pay routine Mississippi Medicaid benefits for all covered, medically necessary, and reasonable charges for solid organ and bone marrow/peripheral stem cell transplants ~~that are prior approved~~. All ~~solid organ and bone marrow/peripheral stem cell~~ transplants, with the exception of kidney, and cornea, and bone marrow/peripheral stem cell transplants, must be prior authorized regardless of the age of the beneficiary or the diagnosis. All policies in this section are applicable to solid organ transplants and to all inpatient/outpatient bone marrow/peripheral stem cell transplants. **Transplant services not covered by DOM include pancreas transplants and bone marrow/peripheral stem cell transplants for breast cancer.**

A transplant provider's participation in the Mississippi Medicaid program is entirely voluntary. However, if a provider does choose to participate in Medicaid, the provider must accept the Medicaid payment as payment in full for those services covered by Medicaid. The provider cannot charge the beneficiary the difference between the usual and customary charge and Medicaid's payment. The provider cannot accept payment from the beneficiary, bill Medicaid, and then refund Medicaid's payment to the beneficiary. Services not covered under the Medicaid program can be billed directly to the Medicaid beneficiary.

The Mississippi Medicaid program purchases needed health care services for beneficiaries as determined under the provision of the Mississippi Medical Assistance Act. DOM is responsible for formulating program policy. DOM staff is directly responsible for the administration of the program. Under the direction of DOM, the fiscal agent is responsible for processing claims, issuing payments to providers, and for notifications regarding billing. Medicaid Policy as it relates to these factors is initiated by DOM.

Division of Medicaid State of Mississippi Provider Policy Manual	New: Revised: X Current:	Date: Date: 08/01/07 07/01/08
Section: Transplants	Section: 28.02	
Subject: Covered Transplant Procedures	Pages: 2	
	Cross Reference:	

Mississippi Medicaid benefits are provided for the following transplants if the transplant facility obtains prior approval (PA), when required, and satisfies all criteria:

Transplant Procedure	Covered	PA Required
Cornea	Yes	No
Heart	Yes	Yes
Heart/Lung	Yes	Yes
Kidney*	Yes	No
Liver	Yes	Yes
Lung - Single	Yes	Yes
Lung - Bilateral	Yes	Yes
Bone Marrow (BMT) or Peripheral Hematopoietic Stem Cell (PSCT): Autologous, Syngeneic, or Allogeneic	Yes	Yes No (Inpatient and outpatient)
Pancreas	No	No
Small Bowel	Yes	Yes

~~*A kidney transplant done in conjunction with a pancreas transplant will be reimbursed as a kidney transplant only.~~

Note: Pancreas transplants are not covered by the DOM. When a pancreas transplant is done in conjunction with another covered transplant procedure (example: pancreas transplant in conjunction with the kidney), DOM will only consider reimbursement for those charges related to the covered transplant procedure.

Requests for prior approval must be sent to the Division of Medicaid's Utilization Management/Quality Improvement Organization (UM/QIO). Providers should submit requests as soon as it is determined that the beneficiary may be a potential candidate for transplant.

Transplant benefits are contingent upon all of the following:

- The beneficiary's continued eligibility for Mississippi Medicaid
- The beneficiary's application for the transplant being approved by the UM/QIO
- All inpatient days being certified by the UM/QIO
- All conditions of third party liability procedures being satisfied
- All providers completing requirements for participation in the Mississippi Medicaid program
- All claims being completed according to the requirements of the Mississippi Medicaid program
- All charges, both facility and physician, relating to procurement/storage being billed by the transplant facility on the current UB claim form with the appropriate revenue code(s)

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- The transplant facility providing appropriate medical records, progress or outcome reports as requested by DOM, the UM/QIO or the fiscal agent
 - The transplant procedure being performed at the requesting transplant facility

All terms of the Mississippi Medicaid program, including timely claims filing requirements, are applicable.

Transplant procedures/services subject to denial include, but are not limited to the following:

- Transplant procedures/services when medical necessity has not been proven
- Transplant procedures/services still in clinical trials and/or investigative or experimental in nature
- Transplant procedures/services performed in a facility not approved by DOM,
- Inpatient or outpatient admissions for transplant procedures/services not certified/re-certified by the UM/QIO
- ~~Outpatient admissions for BMT/PSCT procedures/services not certified/re-certified by the UM/QIO~~

Division of Medicaid State of Mississippi Provider Policy Manual	New:	Date:
	Revised: X	Date: 08/01/07
	Current:	07/01/08
Section: Transplants	Section: 28.04	
	Pages: 3	
Subject: Bone Marrow Transplant/Peripheral Stem Cell Transplant Coverage Criteria	Cross Reference: Facility Criteria 28.10	

Age

Less than 56 years of age for allogeneic (<66 if fully matched sibling donor)
Less than 66 70 years of age for autologous

Performance Status

Karnofsky >70 or ECOG <3

Compatibility

Allogeneic HLA-MLC match (1 antigen mismatch accepted)

Infections

Controlled for 48 hours prior to transplant

Cardiac

Left ventricular ejection fraction >40%

Pulmonary

FEV1 of >50% of predicted
Dlco >60% of predicted

Psychosocial Evaluation

A psychosocial evaluation has been performed for the adult candidate or, if the candidate is a child, for the family, with the following results:

- Candidate's psychiatric disorders, if present, are being treated
- Candidate's social support system has been evaluated and found to be adequate
- Candidate has no previous history of significant non-compliance to medical treatment

Other

- All other treatments have been attempted or considered and none will prevent progressive

disability and/or death

- The candidate and/or legal representative understands the transplant risks and benefits, gives informed consent, and has the capacity and is willing to comply with needed care, including immunosuppressive therapy
- The candidate has been approved by the transplant review team
- The candidate's immunization history and HIV status has been obtained

Specific Diagnostic Inclusion Criteria (Allogeneic BMT or PSCT)

- Severe aplastic anemia
- Pure erythrocyte aplasia
- Myelodysplasia
- Severe hemoglobinopathy (ex: sickle cell, thalassemia)
- Selected immunodeficiency syndrome (ex: SCID, Wiskott-Aldrich, Chediak-Higashi)
- Genetic storage disease (ex: Hurler's, Morquio's)
- Primary amyloidosis
- Paroxysmal nocturnal hemoglobinuria
- Severe platelet dysplasia
- Acute lymphocytic leukemia (in first remission if high risk, at early relapse, or in second remission)
- Acute myelogenous leukemia (in same clinical states as listed for acute lymphocytic leukemia)
- Chronic lymphocytic leukemia
- Chronic myelogenous leukemia
- Hodgkin's lymphoma (failed first line therapy or failed at least one standard chemotherapy regimen)
- Non-Hodgkin's lymphoma (failed or responsive to first line therapy or high risk during first remission)
- Familial hemophagocytic lymphohistiocytosis (FHL) also known as familial erythrophagocytic
- Lymphohistiocytosis (FEL)

Specific Diagnostic Inclusion Criteria (Autologous BMT or PSCT)

- Acute lymphocytic leukemia (in first remission if high risk, at early relapse, or in second remission)
- Acute myelogenous leukemia (in same clinical states as listed for acute lymphocytic leukemia)
- Chronic lymphocytic leukemia
- Chronic myelogenous leukemia
- Hodgkin's lymphoma (for failed first line therapy or if failed at least one standard chemotherapy regimen)
- Multiple Myeloma-a single autologous BMT/SCT transplant will be considered for beneficiaries with Durie-Salmon stage II or stage III disease if the following criteria is met:
 - Newly diagnosed disease or responsive multiple myeloma. This includes beneficiaries with previously untreated disease, those with at least a partial response to prior chemotherapy (defined as 50% decrease in either measurable serum and/or urine paraprotein or in bone marrow infiltration, sustained for at least one (1) month), and those in responsive relapse with adequate renal, pulmonary, and hepatic function.

Note: Tandem BMT/SCT for multiple myeloma is specifically excluded from coverage. (Bold type)

- Non-Hodgkin's lymphoma (either failed or responsive to first line therapy or, if high risk, during first remission)
- Neuroblastoma
- Nephroblastoma

Exclusion Criteria

- Active chemical dependency (drugs or alcohol) within the preceding six (6) months
- HIV
- ~~Multiple myeloma (Note: a single autologous transplant may be considered for a beneficiary with newly diagnosed or significantly responsive Durie-Salmon Stage II or III disease)~~
- Breast cancer
- Uncorrectable absence of an essential psychosocial support system
- Unmanageable psychiatric disorder felt to significantly compromise the candidate's compliance with the post-transplant regimen

Facility

Facility is approved for bone marrow or peripheral Hematopoietic stem cell transplants by the Division of Medicaid. Transplant facilities performing bone marrow/peripheral stem cell transplant procedures must meet DOM facility criteria. Refer to Provider Policy Manual Section 28.10 for Facility Criteria policy.

Division of Medicaid State of Mississippi Provider Policy Manual	New: Revised: X Current:	Date: Date: 08/01/07 07/01/08
Section: Transplants	Section: 28.09	
Subject: Prior Approval	Pages: 1	
	Cross Reference: <u>Third Party Recovery 6.0 Billing Procedures 6.03</u>	

All solid organ and bone marrow/peripheral stem cell transplants, with the exception of kidney, and cornea, and bone marrow/peripheral stem cell transplants, must be prior authorized regardless of the age of the beneficiary or the diagnosis. ~~All policies in this section are applicable to all solid organ transplants and to all inpatient/outpatient bone marrow/peripheral stem cell transplants.~~

The Utilization Management and Quality Improvement Organization (UM/QIO) for the Division of Medicaid is responsible for the evaluation of transplant facilities in accordance with DOM policy. In addition, the UM/QIO verifies beneficiary eligibility and performs a pre-transplant review, including a determination of medical necessity. The transplant facility must contact the UM/QIO **after** the evaluation process has been completed and it has been determined that the beneficiary is a transplant candidate, but **before** the transplant admission.

When the UM/QIO has completed the review process, the case will be forwarded to DOM. DOM will determine final approval or denial and issue a letter of agreement or denial to the transplant facility.

Additional information on the prior approval process for transplant may be obtained by accessing the UM/QIO web site <http://www.hsom.org>. Transplant information is covered in the Acute Care Provider Manual. All procedures and criteria set forth by the UM/QIO are applicable and are approved by the Division of Medicaid. General information needed prior to accepting a beneficiary for transplant evaluation may be obtained by contacting DOM, Bureau of Medical Services.

Third Party Coverage

Transplants on beneficiaries with Medicare coverage do not require prior approval. Claims will be processed as cross-over claims. Refer to Provider Policy Manual Section 6.03 for Billing Procedures policy. ~~in this manual.~~

If the beneficiary has private insurance and the transplant facility will be billing Medicaid for any of the transplant related hospital charges, prior authorization from the UM/QIO is required.

A copy of the approval/denial by the private insurer must be submitted to the UM/QIO.

- If the procedure has been denied, the UM/QIO will proceed with the certification process.
- If the procedure has been approved and the beneficiary has **not** exhausted benefits, the UM/QIO will not review the case but a file will be established and held.
- If the procedure has been approved but the beneficiary has or is in danger of exhausting benefits, the UM/QIO will review the case.

Division of Medicaid State of Mississippi Provider Policy Manual	New: Revised: X Current:	Date: Date: 08/01/07 07/01/08
Section: Transplants	Section: 28.10	
Subject: Facility Criteria	Pages: 2	
	Cross Reference:	

The Utilization Management and Quality Improvement Organization (UM/QIO) for the Division of Medicaid is responsible for the evaluation of transplant facilities in accordance with DOM policy.

Adult Organ Transplant Facilities

~~Adult transplant procedures, except Bone Marrow/peripheral Stem Cell must be performed in a Medicare approved transplant facility. The criteria listed below are applicable to adult Bone Marrow/Peripheral Stem Cell facilities will be evaluated using the criteria listed below. Organ transplant procedures must be performed in a Medicare approved transplant facility.~~

Pediatric Transplant Facilities and Adult Bone Marrow/Peripheral Stem Cell Transplant Facilities

~~DOM criteria for evaluating pediatric transplant facilities and adult bone marrow/peripheral stem cell transplant facilities are as follows:~~

Transplant Certification, Credentialing, and Information Sources

- Centers for Medicare and Medicaid Services (CMS) and other regulations
- United Network for Organ Sharing (UNOS) requirements and by-laws
- Organ Procurement and Transplant Network (OPTN) regulations
- National Marrow Donor Program (NMDP)
- The Foundation for the Accreditation of Cellular Therapy (FACT) standards
- Organ Procurement Organizations (OPO)
- Organizations of transplant physicians and surgeons
- Peer-reviewed transplant articles and journals

Medical Criteria

- The facility must have written criteria for transplant candidate selection and a written implementation plan.
- The facility must have a written transplant candidate management plan/protocol that includes both evaluative and therapeutic procedures for the waiting period, in-hospital period, and post-transplant phases of treatment.
- The facility must make a sufficient commitment of resources and planning to the transplant program to demonstrate the importance of the program at all levels. Indications of this commitment must be broadly evident throughout the facility. The facility must use a

multidisciplinary team that includes representatives with expertise in the appropriate organ specialty (ex: hepatology, cardiology, or pulmonology) and the following general areas: transplant surgery, vascular surgery, anesthesiology, immunology, infectious diseases, pathology, radiology, nursing, blood banking, and social services.

Experience Criteria

- The facility's volume of transplants and survival rates must demonstrate both experience and success with ~~clinical solid organ and bone marrow (including peripheral stem cell)~~ bone marrow and/or peripheral stem cell transplantation. The facility staff must have performed a reasonable number of successful transplants for each ~~organ~~ transplant type for which DOM approval is sought. ~~For example, according to the useful benchmarks enumerated in CMS' revised "Criteria for Medicare Approval of Transplant Centers" of July 26, 2000 the transplant center may generally be expected to have performed:~~
 - ~~Twelve (12) or more heart transplants per year with actuarial survival rates of 73% at one (1) year and 65% at two (2) years~~
 - ~~Twelve (12) or more liver transplants per year with actuarial survival rates of 77% at one (1) year and 60% at two (2) years~~
 - ~~Ten (10) or more lung transplants per year with actuarial survival rates of 69% at one (1) year and 62% at two (2) years~~
 - ~~Small bowel transplant facilities (which are not included in the July 26, 2000 publication noted above) should generally have performed ten (10) intestinal transplants, whether or not transplanted in conjunction with another organ, with a demonstrated one year actuarial survival of at least 65% using the Kaplan-Meier technique.~~
- The facility must provide documentation to support the current competence of its transplant physicians and transplant surgeons, and, if requested, its ~~organ-specific~~ transplant-specific and general clinical staff. The qualifications and transplant experience of transplant physicians and surgeons specified by UNOS (UNOS bylaws Appendix B – III (2): Liver; (4): Heart; and (5): Lung and Heart-Lung) will be considered appropriate for each specified ~~organ~~ transplant program.

Administrative Criteria

- The facility must be an active member of the OPTN and abide by its approved rules. The facility must also have an agreement with an OPO.
- The facility must make available, either directly or by specified arrangements, all laboratory services needed to meet the needs of transplant candidates/recipients.
- The facility must agree to maintain and, when requested, periodically submit clinical data, including pre-certification, concurrent review, and other requested information to DOM or to its UM/QIO.

Division of Medicaid	New:	Date:
State of Mississippi	Revised: X	Date: 08/01/06
Provider Policy Manual	Current:	07/01/08
Section: Transplants	Section: 28.15	
	Pages: 1	
Subject: Reimbursement	Cross Reference:	

The Division of Medicaid will pay routine benefits for all covered medically necessary solid organ and hematopoietic stem cell transplants. These include, but are not limited to: autologous, syngeneic, or allogeneic hematopoietic stem cells (whether derived from marrow or peripheral blood), cornea, heart, heart/lung, kidney, liver, and lung. Transplant services will be reimbursed only when provided in a DOM approved facility. All transplants require prior approval with the exception of kidney, ~~and~~ cornea, and bone marrow/peripheral stem cell transplants. Benefits are provided in accordance with the Mississippi Medicaid program. A kidney transplant done in conjunction with a pancreas transplant will be reimbursed as a kidney transplant only. Pancreas transplants are not covered.

For services not available in Mississippi, the Division of Medicaid may pay a reasonable enhanced reimbursement for the transplant services to ensure access to care for adults and children. The transplant reimbursement rate may be inclusive of all charges for covered hospital and physician services provided during the transplant admission (inpatient or outpatient).

Effective July 1, 2008, the days included in the transplant case rate will not count against the thirty (30) day limit for inpatient hospital care.