HIGHMARK WESTERN NEW YORK

Medicaid Managed Care
Child Health Plus

Centers of Medical Excellence Transplant Operations Manual

A supplemental document to the
Highmark Blue Cross Blue Shield of Western New York *Provider Manual*

https://providerpublic.mybcbswny.com

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TABLE OF CONTENTS

Highmark Blue Cross Blue Shield of Western New York (Highmark BCBSWNY) partners with Amerigroup companies to administer certain services to Medicaid Managed Care (MMC) and Child Health Plus (CHPlus) members. Please note, this information is specific to the MMC and CHPlus programs only.

SECTION I: Scope

Unless otherwise expressly indicated in this operations manual, all terms used shall have the meaning in the *Centers of Medical Excellence Transplant Stand Alone Agreement* or *Centers of Medical Excellence Transplant Attachment to the Highmark BCBSWNY Agreement*.

The Highmark BCBSWNY Centers of Medical Excellence (CME) for transplant consists of a network of approved providers and facilities for the following transplant procedures: autologous/allogeneic bone marrow/stem cell, heart, lung, combination heart/lung, liver, liver/kidney, kidney, simultaneous kidney/pancreas and pancreas. Individual transplant procedures (for example, heart, lung or combination heart/lung) are referred to in this manual as a "program."

The following list of Highmark BCBSWNY products will have access to the Network:

- Government programs: Medicaid, Medicare Advantage
- Children's Health Insurance Program (CHIP)

All covered individuals, including local, national and affiliates, have network access under the terms of the CME *Stand Alone Transplant Agreement* or CME *Transplant Attachment to the Hospital Agreement* between you and Highmark BCBSWNY attached hereto and incorporated herein.

Please refer to your contract for specific information to product type and exceptions.

SECTION II: Quality Oversight of the Highmark BCBSWNY CME Network

The Highmark BCBSWNY CME transplant certification procedures are designed to ensure covered individuals that all network transplant centers meet company established clinical criteria and levels of service. Participating transplant centers are selected based on their ability to meet defined clinical criteria that are unique for each transplant type.

To begin the certification process

To initiate the transplant certification process for programs not currently in the network, prospective applicants should contact their respective Highmark BCBSWNY Contract Manager to express interest. The Highmark BCBSWNY Contract Manager will notify the Highmark BCBSWNY CME Quality Oversight Department to begin the certification process.

Initial application and recertification

Each prospective transplant center is evaluated independently against established criteria via a Request for Information (RFI) survey. Upon written request, prospective solid organ transplant centers, will submit data using the current online version of the United Network for Organ Sharing (UNOS) Standardized RFI forms. Access to the secure data entry site can be obtained by contacting UNOS. Prospective bone marrow/stem cell centers will submit data using the current American Society for Transplantation and Cellular Therapy (ASTCT) Standardized RFI forms, which can be accessed at **www.astct.org**.

Quality review process

The Highmark BCBSWNY CME quality review process for participation in the transplant network will include evaluation of selection criteria that encompass, but are not limited to, the following:

Solid organ transplant programs	Bone and marrow transplant programs
1. Volume (by transplant type)	1. Volume (by transplant type)
2. 1-month, 1-year and 3-year patient and graft survival	2. 100-day and 1-year patient survival
3. Transplant rate	3. Percent follow up
4. Mortality rate while on the waitlist rate	4. Transplant team composition, stability
5. Percent follow up	5. FACT accreditation
6. UNOS certification	6. CIBMTR data submission

Each program is reviewed by Highmark BCBSWNY's National Transplant Quality Review Committee (NTQRC). The NTQRC is comprised of transplant experts from across the country. There are two committees: one for solid organ transplants and one for blood and marrow transplants. No less than annually, the certification criteria and benchmarks are reviewed and approved by each committee.

Annual recertification and ongoing monitoring of outcomes data assures transplant programs continue to meet applicable network participation requirements.

Appeal process

Health care facilities or programs that are not accepted for participation in the network or which are terminated from the Network will be provided the reconsideration or appeal process described in the Highmark BCBSWNY Provider Manual.

Health care facilities or programs that are terminated from the Network will be provided the reconsideration or appeal process described below:

Highmark BCBSWNY CME will provide a one-level reconsideration process for currently designated health care facilities or programs that are terminated from the Highmark BCBSWNY CME transplant network if an appeal is submitted in writing to the Highmark BCBSWNY CME Quality Program Manager at the address listed below within thirty days of the date of receipt of the termination letter. The program's written appeal must include the reason why the facility or program should be reconsidered and any corrected/completed data or supporting documentation related to the reason for the appeal. The written appeal information will be reviewed by the National Transplant Quality Review Committee (NTQRC) at its first scheduled meeting following receipt of the appeal and the program will be notified of the appeal review determination via electronic mail and/or UPS mail delivery. The appeal determination is final.

Send Appeal Letter to:
CME Program Manager
3350 Peachtree Rd. NE
GAG006-0005
Atlanta, GA. 30326

Provider responsibility

As a participating provider in the Highmark BCBSWNY CME transplant network, each center agrees to immediately report major changes in its team or program structures, its federal rating status (such as loss of Medicare certifications) or any event that could result in failure to satisfy the criteria for participation in the network. All health care professionals are required to refer patients to a Highmark BCBSWNY approved facility, unless there is a medical reason for referring the patient to a non-approved transplant facility.

SECTION III: Transplant Care Management Program

The procedures outlined below must be followed for each transplant in order to determine medical necessity:

To initiate the member's transplant pre - authorization review:

- Phone number: **757-473-2737** ext. **106-103-5138**
- Fax: **1-844-430-6801**

To contact the member's Case Manager:

- Phone number: **866-231-0847**
- Fax: **800-964-3627**

Identification

Cases are identified to the Case Management Program primarily through referrals from our other medical management programs, the preservice certification/concurrent review process or from other referral sources such as family, physician, hospital personnel and company representatives. Cases that meet certain criteria are referred to a transplant case manager for proactive intervention when appropriate.

Nontransplant precertification

Please refer to the Highmark BCBSWNY Provider Manual. Please call Customer Service using the phone number listed on the back of the covered individual's insurance card for precertification requirements for nontransplant services.

Transplant review process

Pre-transplant or pre-admission prior authorization review process for transplant. The transplant provider must submit to Highmark BCBSWNY a request for transplant authorization and the covered individual's clinical records to support this request. Highmark BCBSWNY will conduct a review to determine whether a scheduled admission, transplant or transplant services are medically necessary. Such review is required for all nonemergent admissions and transplants.

Pre-service review. For all specific transplant information for covered individuals, please call the number above and ask for the Transplant Case Manager. Pre-service review determines whether the scheduled outpatient and/or ambulatory procedures are medically necessary. Services that may be subject to pre-service review include, but are not limited to, the following:

- Pre-transplant evaluation and work-ups
- Donor search and HLA testing (when applicable)
- Marrow/stem cell harvesting collection, modification and/or storage (when applicable)
- Other pre-transplant and post-transplant services provided to the covered individual outside of the global case rate period and/or rendered on an outpatient

Medical necessity review process

The Transplant Case Manager reviews and determines the appropriateness of the diagnosis, the type of transplant requested, the referral for transplant and the covered individual's eligibility. After the initial review of the submitted medical records, which include the transplant evaluation results, the Transplant Case Manager contacts the CME facility if additional information is required to authorize the requested procedure. Once medical necessity is established, authorization letters are sent to the transplant physician, CME facility and the

member. When admission for transplant occurs, the CME facility contacts the member's Transplant Pre-authorization Review for ongoing case management.

Re-certification

For covered individuals on a transplant waitlist, regular and ongoing updates and reviews are performed on a case-by-case basis with the CME facility and will take place no less than once a year. Benefits and eligibility will be checked and verified at these intervals. A written confirmation of the updated authorization will be sent via the U.S. mail.

Concurrent review

Determines whether a continued inpatient stay is medically necessary. Such reviews are required for all covered individuals during a hospital stay for the actual transplant procedure

Retrospective review

When pre-certification was not performed prior to the transplant evaluation or the transplant procedure, a thorough review will be done by the Transplant Case Manager to determine if services were medically necessary. (Some penalties may apply. Call customer service for more information regarding penalties.)

Member appeal process

Please refer to the appeal process described in the Highmark BCBSWNY Provider Manual.

SECTION IV: Highmark BCBSWNY CME Transplant Cell Descriptions

Cell 1 includes evaluation and all transplant services that are covered transplant services required to assess and evaluate the covered Individual for acceptance to the transplant program. Cell 1 ends with the acceptance and listing on UNOS for solid organ recipient or the non-acceptance of a covered Individual into the transplant program. For bone marrow/stem cell transplants, Cell 1 ends with the acceptance or non-acceptance of the covered individual into the transplant program.

Cell 2 includes pre-transplant care and all transplant services that are covered transplant services provided to a covered Individual following acceptance into a Hospital transplant program or covered individual's listing with UNOS, until one day prior to the covered transplant procedure. Cell 2 charges related to pre-transplant care end one day prior to the covered transplant procedure. For solid organ transplants this means the end date is two days prior to the covered transplant procedure, and for bone marrow/stem cell transplants, the end date is two days prior to initiation of the preparative regimen for autologous and for allogeneic transplants that are covered transplant procedures.

Cell 3 includes the covered transplant procedure provided to a covered individual. For solid organs the covered transplant procedure begins the day prior to the transplant or for bone marrow begins the day prior to high dose chemotherapy or preparative regimen and ends at the end of the global case rate period or if the covered individual is still inpatient at the end of the global case rate period on the date of discharge from the inpatient stay. If days for inpatient admission for the solid organ or bone marrow transplant exceed the global case rate period for transplant, the reimbursement will revert to the outlier per diem rate for transplant for all days outside of the global case rate period, until the date of discharge from inpatient stay.

Cell 4 follow up care includes all covered transplant services provided to a covered individual during the six months following the end of Cell 3 for solid organ transplants and 50 days following the end of Cell 3 for a bone marrow/stem cell transplant.

Covered transplant services inclusions for the four transplant cells (use only if this information does not appear in the attachment to your contract)

For the purposes of this agreement, only Cell 3 is applicable. Cells 1, 2 and 4 will be covered under the terms of the Highmark BCBSWNY local agreement.

Cell 1: All covered transplant services, including but not limited to the items listed below, that are provided to a covered individual are included in the Cell 1 case rate and will not be unbundled and billed to a covered individual. Covered transplant services include the transplant-related health care services and supplies that are provided by hospital, group and its physicians, or other health care professionals who are either employees of hospital or are subcontracted by hospital to provide certain services to covered individuals; and are provided under the supervision of hospital and/or the medical group and physicians.

1. Diagnostic testing, including without limitation, evaluation services, HLA typing, and diagnostic testing to determine eligibility or disease stage (if applicable).
2. Donor services, including donor identification, living donor health care services and supplies relating to donation, bone marrow registry charges, Billed Charges, donor search and identification (if applicable).

Cell 2: All covered transplant services, including but not limited to the items listed below, that are provided to a covered individual are included in the Cell 2 case rate and will not be unbundled and billed to a covered individual.

1. Cell 2 includes pre-transplant care and all transplant services that are covered transplant services provided to a covered individual following acceptance into a hospital transplant program or covered individual's listing with UNOS, until one day prior to the covered transplant procedure.
2. Cell 2 charges related to pre-transplant care end one day prior to the covered transplant procedure. For solid organ transplants this means the end date is two days prior to the covered transplant procedure and for bone marrow/stem cell transplants, the end date is two days prior to initiation of the preparative regimen for autologous and for allogeneic transplants that are covered transplant procedures.

Cell 3 Inclusions

All covered transplant procedures, including but not limited to the items listed below, that are provided to a covered individual are included in the Cell 3 global case rate for transplant and will not be unbundled and billed to a covered individual.

1. Anesthesiology services and supplies.
2. Bone marrow/peripheral blood stem cell (or cord blood) mobilization and harvesting related services (including preparation, transportation, storage and administration) and complications, regardless of when these services occur before transplant (if applicable)
3. Living donor is considered to be a person who donates an organ, part of a solid organ, kidney, liver, lung or bone marrow/stem cells while alive to another person. Covered services for living donor donation would include Health Services and Medical Services for the donor for up to 30 days after the date of donation.
4. Inpatient rehabilitation services and supplies when Covered Individual is transferred to an inpatient rehabilitation unit post-transplant. Days do not count toward the Global Case Rate Period for Transplant.
5. Inpatient services provided during Cell 3 – all medically necessary services are included in the Transplant Rate, including dialysis (if applicable), room, board and supplies, and pharmaceutical agents and supplies. Nothing is excluded.
6. Organ procurement and transport, including procurement and transport that occurs outside of Facility's service area for all solid organ transplants.
7. Outpatient drugs, supplies and biological agents that are pre-transplant, treatment specific for preparing Covered Individual or Donor for transplant procedure.
8. Outpatient drugs, supplies and biological agents that are given to covered individual during the transplant process.
9. Outpatient services provided in Cell 3 — all services are included, including rehabilitation services and supplies, biopsies and laboratory.
10. Preparative regimen for bone marrow, cord blood or stem cell transplant, including chemotherapy, radiotherapy or chemo-radiotherapy (if applicable).
11. Donor leukocyte/lymphocyte infusion post-transplant for boosting engraftment of bone marrow/stem cells if provided while covered individual is in Cell 3.

Cell 4

Covered Transplant Services, including but not limited to the items listed below, that are provided to a Covered Individual are included in the Cell 4 Global Case Rate Period.

1. Includes all outpatient transplant-related follow-up care for the recipient.
2. Medically necessary inpatient services.
3. Ancillary services (i.e. home health care services and supplies) provided by Hospital Medical Group or subcontracted providers.
4. Outpatient pharmacy and laboratory are excluded.

Covered Transplant Services Exclusion

The services below delivered during the global case rate period for transplant are excluded from the global case rate for transplant. Excluded covered transplant services will be reimbursed according to the terms of the Highmark BCBSWNY facility, professional or ancillary agreements with providers.

SECTION V: Highmark BCBSWNY CME Transplant Claim Billing Guidelines

General Global Billing Guidelines for the Four Transplant Cells

Cell 1 Processing Guidelines (if applicable)

These services will be reimbursed according to the terms of the current Highmark BCBSWNY facility agreement and the current Highmark BCBSWNY professional agreement.

Cell 2 Processing Guidelines (if applicable)

These services will be reimbursed according to the terms of the current Highmark BCBSWNY facility agreement and the current Highmark BCBSWNY professional agreement.

Cell 3 Processing Guidelines

At the end of the global case rate period for transplant or outlier period for transplant (if applicable) the hospital (provider) will collect all itemized bills (*UB 04* and *CMS 1500* claim forms) for all inpatient and outpatient-hospital, professional, and ancillary charges included in the global case rate, and outlier rate (if applicable).

All eligible transplant services and applicable rates are listed on the compensation schedule (see *Appendix B*).

A bundled claim packet should not include claims from the following:

- Charges for specifically excluded services noted on the compensation schedule of the Highmark BCBSWNY CME transplant agreement
- Charges before the global case rate period for transplant begins
- Charges after the global case rate period for transplant and/or after any applicable outlier period for transplant

Mail the bundled Cell 3 global case rate period claim packet with the proper billing summary form (see Appendix A) in one envelope to the claim address listed above. Failure to include the billing summary form may result in delayed correct payment. *Form C* should be included with solid organ transplant bundled claims. *Form D* should be included with bone marrow transplant bundled claims.

Cell 4 Processing Guidelines (if applicable)

These services will be reimbursed according to the terms of the current Highmark BCBSWNY Facility Agreement and the current Highmark BCBSWNY Professional Agreement.

Special billing instructions

Claim processing:

All claims are processed according to the benefit level in effect at the time the services are rendered.

Living donor charges (if applicable)

Claims for living donor charges should be filed with the correct procedure codes and donor diagnosis codes based on the type of service that was rendered to the covered individual. Claims should be filed with the recipient's insurance.

Non-Highmark BCBSWNY membership Cell 3 Transplant Services

Cell 3 transplant services for non-Highmark BCBSWNY Covered Individuals should be bundled and submitted to the address for your state located in section V of this document.

Coordination of benefits

Coordination of Benefits for the transplant recipient is the responsibility of the provider on initial contact. Claims will be denied for payment if Highmark BCBSWNY is not the primary insurance coverage and there is not an Explanation of Benefits attached from the primary insurance carrier.

Compensation schedule

The compensation schedule provides information specific to each individual transplant type. The information includes Cell 3 global case rates and the transplant services included and excluded during the global case rate period, which may also include applicable outlier period or pre-transplant period timeframes.

Please contact your Contract Manager for your current provider compensation schedule.

Common issues identified by operations that slow payment

- Illegible coversheet
- Missing coversheet
- Coversheet totals do not match the bundled claim totals
- Required fields are missing
- Billing contact name and phone number are missing
- Global claims should not be submitted electronically
- Previous global payments need to be deducted from the global case rate on the coversheet
- Autologous bone marrow transplants require the mobilization date(s) and harvesting date(s) be included on the coversheet
- Itemized bills should be submitted
- Bundled claims must all have the correct member ID

Donor services

Services rendered to transplant recipients and donor(s) are reimbursable only if the transplant recipient is enrolled and eligible for Highmark BCBSWNY coverage on the date the services are performed.

When billing for services rendered to the transplant donor, providers enter the **donor's** name on the claim but the **recipient's** date of birth, sex and Highmark BCBSWNY ID number.

Donor ICD-10 and Revenue Codes for bone marrow/stem cell/cord blood and solid organs

Code	Definition	Submission note
Solid Organ		
0811	Living donor	Line Item on UB on Recipient Transplant Admission Claim
0812	Deceased donor	Line Item on UB on Recipient Admission Claim
0813	Unknown donor	Kidney Paired Exchange programs

Z52.000 is the code for whole blood; be sure to reflect the correct modifier when infusion represents BM/stem cell or cord blood products.

Key fields
UB box 8b — Donor's name
UB box 58 — Insured's name
UB box 59 — Relationship code of 39 or 40
UB box 80 —Remarks noting this is a donor claim submission
HCFA box 19 — Insured's name

SECTION VI: Highmark BCBSWNY CME Transplant Claim Billing Contacts

Highmark BCBSWNY CME transplant claim billing guidelines and claim submission requirements

Please refer to the Provider Manual for billing instructions for non-transplant related claims.

To process your transplant case, please send your CME covered bundled hard copy transplant claims and a copy of *Form C* or *D* to:

CME program

Claims
P.O. Box 61010
Virginia Beach, VA 23466-1010

Appendix A: Covered Transplant Services Covered by the Agreement

For: _____

Effective:_____

Transplant type	Adult	Pediatric
Autologous bone marrow/stem cell (single)		
Tandem autologous bone marrow stem cell transplant (2 autologous transplants)		
Sequential autologous bone marrow stem cell transplants (3 or 4 autologous transplants)		
Allogeneic bone marrow/stem cell related		
Allogeneic bone marrow/stem cell unrelated		
Cord blood (single or multiple units)		
Tandem allogeneic first procedure (allo/allo)		
Tandem allogeneic (auto/allo/cord [single or multiple units]) (allo/allo/cord [single or multiple units])		
Heart		
Lung (single)		
Lung (double)		
Heart lung		
Liver — deceased donor		
Liver — living donor		
Liver kidney		
Kidney — deceased donor		
Kidney — living donor		
Kidney — pancreas (SPK)		
Pancreas after Kidney (PAK)		
Pancreas (PTA)		

C = covered by this agreement
NC = not covered by this agreement
ND = not designated: reimbursement terms included in this agreement but program not designated as CME

National Provider Identifier (NPI): _____

Hospital Tax Identification Number (TIN): _____

CMS Identification Number: _____

APPENDIX B: Compensation Schedule

Providers should refer to their *Contract Reimbursement Schedule*.

APPENDIX C: Related Forms

Attachment Form A1: Transplant Services Notification Form

Attachment Form A2: Hospital Notification of Transplant Admission Form

Attachment Form B: Patient Discharge Care Notification Form

Form C: Billing Summary Solid Organ Transplant

Form D: Billing Summary Form Bone Marrow/Stem Cell Transplant