The View from the Administrative Suite: Living Donation from a Financial Perspective

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Financial Considerations in Living Donor Transplantation

1. Basic Principles – who pays donor expenses?
2. CMS vs. Commercial Payors
3. Standard Acquisition /Departmental Charges
4. Physician Charges
5. Special Cases: PDE, Preemptive
6. Complications
Donor should not incur any hospital or physician costs

All hospital and physician costs follow the recipient

Payors generally follow CMS lead
CMS Reference Documents

- CMS has referred to three documents in response to inquiries:
  - Provider Reimbursement Manual 2771.A
  - Medicare Claim Processing Manual Publication 100-04, Chapter 3, Section 90.1.1
  - Program Memorandum 9-26-2003
Donor Costs Can Be Recorded in 2 ways

- Standard Acquisition Charge (SAC)
  - CMS preferred
- Departmental charges
Standard Acquisition Charge (SAC)

- Not a charge representing the cost of a **specific** kidney but a charge that represents the AVERAGE cost associated with acquiring that type of kidney (in this case, living donor kidney)

- All-inclusive (direct & indirect)

- Includes physician evaluation services up to the admission to the hospital for donation or transplantation

- Usually calculated once per year

- Includes the costs of ALL donors and recipients – not just Medicare recipients
All donor costs (live and deceased) + all recipient evaluation costs

# of kidneys transplanted

SAC for your institution

Medicare reimburses transplant center for the percent of patients who are Medicare
All donor costs (live and deceased) + all recipient evaluation costs = $2,000,000

100 kidney transplants in FY

= $20,000 SAC per recipient

Medicare reimburses transplant center for the percent of patients who are Medicare

Medicare recipients = 75/100 or 75%

Medicare pays Transplant Center

.75 X 2,000,000 = $1,500,000
Standard Acquisition Charge – Commercial Payors

All donor costs (live and deceased) + all recipient evaluation costs

kidney transplants in FY

= FULL COST SAC per recipient

• Mark-up applied
• Standard Acquisition Charge on hospital bill
  – Fee for service: Discount on charges applied
  – Case rate/global rate: Reimbursed as part of case or global payment
All donor costs (live and deceased) + all recipient evaluation costs = $2,000,000

100 kidney transplants in FY = $20,000 per recipient = FULL COST

- Mark-up applied – 75% = $35,000 Standard Acquisition Charge on hospital bill
  - Fee for service: 40% Discount on charges applied = reimbursement = $21,000
  - Case rate/global rate: Reimbursed as part of case or global payment: Case rate = $50,000, event costs= $25,000, portion left for acquisition = $25,000
All live donor costs (donor only NO recipient costs)

# of live kidneys successfully donated

= live donor SAC for your institution
Financial Considerations in Living Donor Transplantation

SAC Considerations

**Advantages of SAC**

- Maximizes CMS reimbursement
- Provides for costs in pre-emptive, not yet on Medicare
- Eliminates questions of when individual donor costs were incurred
- Dilutes issues of multiple donors for a single recipient, etc…
- Can be transparent between centers as soon as match is made (PDE)

**Disadvantages of SAC**

- May reduce reimbursement opportunities from commercial payors
- Differences in overhead could cause difficulties in PDE
- How are “extra” costs treated (i.e. recipient center requests additional tests in PDE)?
- Isolating donor costs may represent new administrative processes for some centers (PDE)
Departmental Charges

- Itemized bill for costs associated with a specific donor for a specific recipient can be billed to the recipient transplant center.

- Transplant centers must bill SAC to Medicare or third-party payors for organs acquired and transplanted.
<table>
<thead>
<tr>
<th>Service</th>
<th>Price</th>
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<tr>
<td>Transplant donor evaluation</td>
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<tr>
<td>Acquisition services</td>
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<tr>
<td>Tissue Typing</td>
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<tr>
<td>Chest X-ray</td>
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<td>Chem 20</td>
<td>$80</td>
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<tr>
<td>CBC</td>
<td>$30</td>
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<tr>
<td>Operating room minutes, etc...</td>
<td>$150</td>
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</tbody>
</table>
Financial Considerations in Living Donor Transplantation

Departmental Charges

Advantages of DC

- Very transparent
- Allows for exact costing of the specific donor in PDE

Disadvantages of DC

- May reduce reimbursement opportunities from Medicare
- Adds complexity – particularly if recipient is MC pending
- Adds complexity in determining when/which donor costs should be included in PDE
- Assigning overhead may represent new administrative processes for some centers (PDE)
Financial Considerations in Living Donor Transplantation

Physician Services

CMS: Eval

CMSEvent

CP: Eval

CP: Event

Standard Acquisition Charge: Part A
Cost Report
Fee for service

Recipient Part B: Fee for service

Standard Acquisition Charge: Fee for service

Recipient Insurance: Fee for service or
global/case rate
Donor Complications

- Donor hospital bills recipient’s part A or B
- Physician bills recipient part B
- Commercial payors are a mixed bag
Financial Considerations in Living Donor Transplantation

Donor Complications in PDE

- This is obviously an area that could lead to controversy

  **Who decides:**
  - What to treat?
  - How to treat?
  - Where to treat?
  - If it’s a donation-related complication?
  - What if recipient is no longer eligible?
  - Contractual agreements between transplant centers should spell this out **BEFORE** transplant occurs
Financial: Recipient Reimbursement to Donor Facility/Physicians – Highlights

Facility Fees:
1. Participating hospitals will develop a Standard Acquisition Charge (SAC)
2. As Medicare also allows invoicing by departmental charges (individual full costs for that particular donor’s evaluation and donation); this billing method will also be accepted. NMH will use the SAC methodology.
3. Transportation costs are billed to the recipient hospital directly or by the donor hospital
4. Donor complications The recipient hospital will remain responsible for the costs of any donor complication that occur six months after the donation in the event the recipient’s insurer denies any claims related to donor complications.
5. The determination of donor complications is solely the judgment of the donor surgeon or his/her designate as documented in the patient medical record.

Physician professional fees

Donation Event:
1. Donor routine follow-up and donor complications (solely by the judgment of donor surgeon documented in the patient's medical record)
   1. Medicare Primary – Donor physician(s) will bill CMS; if denied – donor physicians will write off the expense
   2. Case rate – will be billed to recipient insurance; if denied, paid by recipient hospital at CMS allowable rate
   3. Other insurance/fee for service – will be handled in single letter as referenced above.

Incomplete or failed transplant:
1. In the event that a donation happens but implantation cannot occur into intended recipient due to recipient factors, recipient hospital will use its best effort to find a listed recipient for the kidney consistent with UNOS allocation rules by running a match run list for the recipient hospital’s center and make the donated kidney available for transplantation. Recipient hospital should have run this list as part of a viable back-up plan prior to transplant surgery. If recipient factors that made transplant impossible resolve at a later time, the initial intended recipient should be considered a stranded recipient.
2. If for any reason one transplant occurs but another cannot be completed, and it is not possible to abort the other procedure(s) without risking the donor or kidney, the transplant will proceed to completion and the recipient considered stranded. This provision applies to situations that would also include a transportation failure or other mishap resulting in an unusable kidney. The participating hospitals must notify affected hospital immediately upon discovering an issue that may prevent successful completion of planned transplant.
3. Treatment of stranded recipients: The parties in this agreement agree to prioritize finding a donor for a stranded recipient in any chains or exchanges involving unpaired or anonymous donors (donors who present with no intended recipient).
4. Once a donor kidney enters recipient’s surgical field, the transplant will be considered to be complete, regardless of its outcome beyond that point, and the intended recipient will not be considered to be a stranded recipient.
5. Sample will be here
Preemptive Transplant Donors

- Best way to handle is to record all these donor costs to your donor acquisition cost center, similar to any other donor.
- If patient is Medicare eligible upon transplantation these costs will be recovered via the Medicare Cost Report.
- If patient is commercial or other payor, costs will be recovered via SAC on hospital bill.
- There is NO reason (in most cases) to delay donor evaluation or transplantation until recipient is on dialysis.
Thank You!

Questions?