

July 2, 2009

Carol Bazell, MD, MPH
Director
Division of Outpatient Care
Center for Medicare Management
7500 Security Blvd.
Baltimore, MD 21244-1850

Dear Dr. Bazell:

On behalf of AABB, the American Society for Blood and Marrow Transplantation (ASBMT), the American Society of Hematology (ASH), and the National Marrow Donor Program (NMDP), we want to thank you and your colleagues for meeting with us on May 11 to discuss various issues regarding Medicare payment for bone marrow/stem cell transplant services. We appreciate the time given to this topic and the guidance provided, and hope you found the presentation helpful in describing the background, trends and complexities associated with these procedures. There are several issues which we identified in the course of the meeting. By way of summary, those issues included:

Whether to Split DRG 009, Bone Marrow Transplant

Currently, this DRG covers both autologous and allogeneic bone marrow procedures. As discussed at the meeting, there are dramatic differences in the costs of performing a transplant involving the use of a donor, particularly an unrelated donor, and using the patient's own bone marrow. As you know, use of this DRG is dependent upon the procedure code performed. An autologous bone marrow transplant is reported under CPT code 38241, Bone marrow or blood-derived peripheral stem cell transplantation, autologous, while an allogeneic procedure is reported under code 38240, bone marrow or blood-derived peripheral stem cell transplantation, allogeneic. Based on our discussion, we will run the data to confirm our assumption that allogeneic cases are significantly more costly. Following this analysis, we may recommend that CMS consider splitting the DRG into two DRGs – Bone Marrow Transplant, Autologous and Bone Marrow Transplant, Allogeneic.

Recognize Full Costs of Transplants in the Out Patient Department (OPD) Settings

The recently issued manual instruction states at section 90.3.3 that acquisition costs for allogeneic stem cell transplants – including such costs as NMDP fees, tissue typing, donor evaluation, physician donor evaluation services, costs associated with harvesting procedure, post procedure evaluation of donor and preparation and processing of stem cells – are to be included in the MS-DRG payment for the transplant. However, no comparable instruction has been issued for calculating the APC costs for allogeneic transplants in OPD settings. For some of the enumerated services there is a separate APC payment such as preparation and processing of stem cells. However, there is no guidance provided on how, for example, NMDP fees should be treated when the transplant takes place in an OPD. It is not clear whether a separate HCPCS code is needed for this purpose or if there should be instructions directing that hospitals assign a revenue code charge(s) which will be allocated in calculating the APC rate for Code 38240. Similar questions exist with respect to some of the other activities. If there are HCPCS codes and APC rates existing

for the activity, such as harvesting the bone marrow or laboratory services relating to processing the tissue, there would not seem to be a need for these services to be bundled into the APC for the transplant itself. However, where there are no HCPCS codes, such as for NMDP fees or physician donor evaluation, instructions are needed to assure that all of these costs are assigned to the transplant procedure. We believe that there is a need to develop additional policies to cover the transplants occurring in outpatient settings and will bring forth proposals for your consideration.

Bundling of Services from Other Facilities

There is confusion regarding the obligations of the transplant hospitals to bill for transplant-related services rendered by community hospitals. For example, the instruction suggests that harvesting procedures should be included in the acquisition costs of the transplant. As noted above, in a minority of cases, the transplant is performed in a hospital OPD where bundling of a service in another hospital is more problematic. We do not think this policy is well understood and we believe it would be preferable for the hospital and the program for the community hospital to bill for the services directly. Where bone marrow/stem cells are acquired from an international source and billed to the transplant hospital through an NMDP fee the costs can be more easily bundled.

Search and Acquisition Costs Where No Transplant Occurs

Our societies believe that a billable service is performed when a search is ordered and transplant tissue harvested from a donor for a specific patient even if the transplant does not otherwise occur because the patient died or for other reasons. While we appreciate that this is different from most other diagnostic and therapeutic services in that another individual (i.e., the donor) is involved, a different approach in the transplant setting may be justified because a substantial number of patients for whom a search is initiated do not proceed to transplant. This might require the establishment of additional billing codes.

There are obviously a number of complex issues which we have identified. While there is some interrelationship between the issues, we think they can be organized as we have suggested making the process manageable. As indicated, we will run the DRG related data to test our assumption that there are major differences in costs and, if so, consider requesting a change in DRGs for FY 2011. We will also be developing additional information on the other issues raised and bring those data and our recommended solutions to you as we complete our analysis. In the mean time, if you have any questions or additional thoughts guidance regarding these matters please feel free to contact Thomas Joseph, ASBMT, at 847.427.0224 or Michael Boo, NMDP, 612.627.5855.

Sincerely,

AABB
American Society for Blood and Marrow Transplantation
American Society of Hematology
National Marrow Donor Program

Cc: Pat Brooks, RHIA
Kenneth Simon, MD