The OPTN Kidney Paired Donation Pilot Program (KPDPP) Operational Guidelines outline all current requirements for the program. Guidelines have been converted into KPD policy, which will go out for public comment Spring 2012, and be voted on by the UNOS Board in November 2012.

The OPTN KPD guidelines/proposed policy currently do not address financial guidelines or concerns with KPD. This document has been created to assist with outlining recommendations for financial clearance and payment with regard to KPD.

There are several elements outlined in the OPTN KPD guidelines/proposed policy that transplant programs must comply with. UNOS has developed several templates to help with compliance. These templates can be used as is, revised, or a center can create their own, as long as the elements outline in the guidelines/proposed policies are covered in the documents used. These documents are referenced below:

Requirements for Participation in the OPTN KPDPP
- OPTN/UNOS Kidney Paired Donation Pilot Program Participation Agreement
- Consent to release PHI to another transplant center (no template available)
  - KPDPP Operational Guidelines, page 31, “Information Sharing between Transplant Centers,” requires that all “participants must sign HIPAA forms to allow centers to share information with other members participating in the KPD Pilot Program.”

Available Templates
- Donor and Candidate Agreement to Participate
- Donor Education Documentation form
- Candidate Education Documentation form

Templates under development
- Checklist for the CMS Living Donor Services Occurring in Transplant Programs Other than that of the Organ Recipient (S&C 11-40-Transplant)
- Business Associate Agreement: allowing transplant centers to share patient clinical and financial information for every match involved in, signed once at entrance into the program. It will include Warranty and Indemnification.

Recommended Financial Model for Kidney Paired Donation

Centers must screen patients, as per their center’s policy, prior to entry into the KPD Pilot Program, to assess their suitability for exchange based on insurance coverage for both the recipient and donor (i.e. recipients with no donor coverage or self-pay recipients)

Recipient:
- Recipient inpatient services: recipient center bills for services and submits claims to the recipient’s insurance company.
- Recipient physician services: physicians to bill the recipient’s insurance for services rendered.

Donor:
- Donor center bills the recipient center for the donor organ recovery
- Per the CMS Provider Reimbursement Manual 15-1, Section 2771, centers may choose to bill using either Standard Acquisition Cost (SAC) or Departmental Charges.
- Centers involved in matches are not required to use the same financial model – the models simply determine how to calculate the cost for the donor nephrectomy.

See the following pages for details on each method.
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Standard Acquisition Cost (SAC) Method

The SAC represents the average cost of acquiring a living donor kidney, regardless of whether the recipient of the kidney is at your center or another center, and does not reflect the cost of any one particular donor. The average cost includes costs for evaluating potential donors who never donate. The SAC is:

- A charge that represents the AVERAGE cost associated to acquire a living donor kidney
- all-inclusive (direct & indirect)
- includes physician services up to the admission to the hospital for donation
- usually calculated once per year by finance department
- calculated as follows:

\[
\text{Living donor SAC for donor's institution} = \frac{\text{All living donor costs}}{\text{# of live kidneys successfully donated}}
\]

How to develop a Living Donor SAC?

1) The best way to manage this process is to establish a dedicated cost center for living donors. You can then determine the SAC once a year from these costs.

2) Costs attributable to all donors over a year can be used to construct a SAC. Remember to include staff salaries and benefits (these should be tracked in your cost report time studies) and D-6 overhead.

Remember to include:
- Evaluation costs
- Donor hospitalization and donor follow-up (facility only)
- Professional fees up to donation admission
- Overhead/indirect costs

Costs to include:* 
- All donor costs associated with evaluation:
  - Tissue typing
  - Labs
  - Imaging
  - Professional fees – up to donation admission
  - All hospital donor cost including costs excluding profession fees
  - Staff salaries:
    - Use time studies for documentation
    - Don’t forget the cost of benefits
  - Overhead should be based on the Medicare Cost Report D-6 overhead and is usually a percentage that is added to all costs

*NOTE: cost should be full cost including indirect costs

Costs not to include:
- Recipient costs
- Disease management of donor (for either pre-existing conditions of the donor, or conditions discovered during evaluation testing.)
- Professional fees starting at donation admission

What donors do I include?
- All potential donors that present to your center over the time period, regardless of their paired candidate OR if they actually donated or not.
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- Using all donor costs, regardless of recipient, does not mean that every donor cost should not have an intended recipient identified - this is a CMS recording-keeping requirement.

**How do I determine the SAC?**
- Aggregate all donor costs including indirect (overhead) over a time period (generally one fiscal year)
- Divide this number by the actual number of living donors who provided a kidney to a recipient to determine your living donor SAC.

**Departmental Charges Method**

In the departmental charges method, the donor center sends an itemized bill for costs associated with a specific donor for a specific recipient to the recipient transplant center. Departmental charges are provided by line item and by revenue code, and are reimbursed at the line item cost-to-charge ratio, as per the transplant center’s most recent Medicare Cost Report.

**NOTE:** This method outlines how to determine cost for facility charges, but does not assist with determining costs for provider pre-donation evaluation.

Transplant centers must treat the billing of these transplants consistently and compliantly, as per the CMS Medicare cost reporting guidelines. Institutions should consider and address the following issues before selecting this method:
- Every donor cost recorded to the cost report must be associated with a named recipient.
- Donor costs that are charged to another transplant center will need to be excluded from the donor center’s acquisition cost center and Medicare Cost Report.
- Staff time, as recorded on time studies, also will need to be billed to the recipient center and excluded from the donor center cost report.
- The donor center will need to consider how to apply overhead/indirect charges to the costs.

Transplant centers must still bill the SAC to third party payers, including Medicare, on the recipient’s claim. Departmental charges cannot be used for this purpose.

**How do I reimburse provider fees for the physician donor nephrectomy?**

Physicians bill the recipient center or recipient’s insurance for services rendered according to the following:
- If Medicare is Primary, physicians shall bill Medicare utilizing the recipients Medicare number.
- If the recipient has commercial insurance, and the Recipient Center does not have a “global” or “case rate” arrangement with a payor that includes reimbursement for both facility and provider charges, the donor’s providers shall direct bill the recipient’s insurance for provider charges.
- If the recipient has commercial insurance, and the Recipient Center has a “global” or “case rate” arrangement with a payor that includes reimbursement for both facility and provider charges, the recipient center will work with the donor center/providers to negotiate a mutually agreeable rate for the donor physicians/providers.

**Organ Transportation Costs**

**Who pays for organ transportation in the KPD?**

Transportation of the donor organ to the recipient center can be coordinated by either the donor center or the appropriate Organ Procurement Organization (OPO), per the KPD Operational Guidelines. Costs related to transporting the donor organ will be billed, via invoice, to the recipient center.
Who pays if there are donor complications?
The donor center will manage the donor and assess and treat any complications that present. The determination of donor-related complications is solely at the discretion of the donor surgeon. The donor hospital must supply the recipient hospital with sufficient documentation to support any claim for payment.

- Donor center bills recipient’s Medicare Part A or B or commercial insurer
- Physician services continue to be billed to the recipient’s insurance
- May require documentation to substantiate that event is donation-related


What if charges for physician services for any donation-related complications are denied, are unpaid by the recipient’s insurer, or are unpaid or denied based on payor rules? (i.e. the payor requires the use of donor insurance)
The Recipient and/or the Recipient Center will be the guarantor, as per the Recipient Center’s policy.

The OPTN is currently reviewing recommendations on donor follow-up guidelines for all living donors, including those taking part in kidney paired donation.

My center was notified of a potential match. What’s next?
Prior to final match acceptance, both the donor and recipient center should obtain and review insurance information for the potentially matched candidates to insure that a transplant would be covered by the recipient’s insurance carrier. This review is time-sensitive and should be done upon notification of the potential match, so that if the match is not viable from an insurance perspective, the match can be cancelled. The following provides additional information on pre-acceptance review:

How do centers communicate recipient and donor financial/demographic information?
Currently, there is no secure site to list recipient insurance. However, centers must ensure that proper HIPAA agreements and patient consents are in place prior to exchanging Protected Health Information (PHI) such as recipient demographics and insurance information with another transplant center.

- Upon receipt of the potential match offer, donor centers need to provide the donor’s name, date of birth and address via secure or encrypted email or facsimile to the recipient center.
- Upon receipt of the matched donor demographic information, recipient centers should complete the OPTN/UNOS KPD Financial Memo, and provide the recipient’s name and insurance coverage information (policy name and number, subscriber, authorization #, and case manager with contact information, if applicable) and send via secure, encrypted email or facsimile, to the donor center so that donor center can determine if their providers will be paid by the recipient’s insurance:

Both the donor center and the recipient center must review the insurance information regarding the potential match.

- Recipient center must confirm that recipient insurance covers donor at donor center— for example, if recipient is receiving a kidney from an out-of-state donor, does recipient have out-of-network coverage for donor’s providers?
- Donor Center must confirm that any providers involved in the case are approved by recipient's insurance (either in-network or authorized) and also how the donor facility’s charges for the nephrectomy will be paid (see section on Financial Models above)
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What do centers need to do at the time of paired donation?

Submit bills for the transplant as follows:

- Bill all recipient charges (facility and provider) to the recipient’s insurer
- Bill donor center claims for the donor nephrectomy to the recipient center. (See financial model information in this document to determine methodology for submitting claims for donor nephrectomy)
- Bill donor provider charges to the recipient’s insurance, or payer or per mutual agreement prior to the donation (see previous section. Some payors have indicated that they would prefer to pay providers directly, outside the global and reduce payment amount to the recipient center.

What happens if my center declines a match based on finances?

There are no consequences if the centers decline for any reason, including finances. We ask that centers enter refusal reasons when they decline a match so that we can work through the more common barriers.