# Table of Contents

1.0 Description of the Procedure, Product, or Service ................................................................. 1
   1.1 Definitions .................................................................................................................................. 2

2.0 Eligibility Requirements ........................................................................................................... 3
   2.1 Provisions ................................................................................................................................. 3
      2.1.1 General ............................................................................................................................... 3
      2.1.2 Specific ............................................................................................................................... 3
   2.2 Special Provisions .................................................................................................................... 3
      2.2.1 EPSDT Special Provision: Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age .......................................................................................... 3
      2.2.2 EPSDT does not apply to NCHC beneficiaries .................................................................. 4
      2.2.3 Health Choice Special Provision for a Health Choice Beneficiary age 6 through 18 years of age ..................................................................................................................... 4

3.0 When the Procedure, Product, or Service Is Covered ............................................................. 5
   3.1 General Criteria Covered ......................................................................................................... 5
   3.2 Specific Criteria Covered ........................................................................................................ 5
      3.2.1 Specific criteria covered by both Medicaid and NCHC ..................................................... 5
      3.2.2 Medicaid Additional Criteria Covered ............................................................................ 5
      3.2.3 NCHC Additional Criteria Covered ................................................................................ 5
      3.2.4 Policy Guidelines ............................................................................................................. 5

4.0 When the Procedure, Product, or Service Is Not Covered ...................................................... 6
   4.1 General Criteria Not Covered .................................................................................................. 6
   4.2 Specific Criteria Not Covered .................................................................................................. 7
      4.2.1 Specific Criteria Not Covered by both Medicaid and NCHC ........................................... 7
      4.2.2 Medicaid Additional Criteria Not Covered .................................................................... 7
      4.2.3 NCHC Additional Criteria Not Covered ........................................................................ 7

5.0 Requirements for and Limitations on Coverage ................................................................... 7
   5.1 Prior Approval ........................................................................................................................ 7
   5.2 Prior Approval Requirements ................................................................................................ 7
      5.2.1 General ............................................................................................................................. 7
      5.2.2 Specific ............................................................................................................................. 8
   5.3 Transplant Prior Approval Requirements ............................................................................. 8

6.0 Provider(s) Eligible to Bill for the Procedure, Product, or Service ....................................... 9
   6.1 Provider Qualifications and Occupational Licensing Entity Regulations .......................... 9
   6.2 Provider Certifications .......................................................................................................... 9

7.0 Additional Requirements ........................................................................................................ 9
   7.1 Compliance .......................................................................................................................... 9

8.0 Policy Implementation/Revision Information .......................................................................... 10
Attachment A: Claims-Related Information

A. Claim Type ....................................................................................................................... 11
B. International Classification of Diseases, Tenth Revisions, Clinical Modification (ICD-10-CM) and Procedural Coding System (PCS) ................................................................. 11
C. Code(s) .............................................................................................................................. 11
D. Modifiers ........................................................................................................................... 12
E. Billing Units ...................................................................................................................... 12
F. Place of Service ................................................................................................................ 12
G. Co-payments .................................................................................................................... 12
H. Reimbursement ............................................................................................................... 12
I. Billing for Donor Expenses .............................................................................................. 12
1.0 Description of the Procedure, Product, or Service

Hematopoietic Stem-Cell Transplantation

Hematopoietic stem-cell transplantation (HSCT) refers to a procedure in which hematopoietic stem cells are infused to restore bone marrow function in cancer patients who receive bone-marrow-toxic doses of cytotoxic drugs with or without whole-body radiation therapy. Hematopoietic stem cells may be obtained from the transplant recipient (autologous HSCT) or from a donor (allogeneic HSCT). They can be harvested from bone marrow, peripheral blood, or umbilical cord blood shortly after delivery of neonates. Although cord blood is an allogeneic source, the stem cells in it are antigenically “naïve” and thus are associated with a lower incidence of rejection or graft-versus-host disease (GVHD). Cord blood is discussed in greater detail in the “Placental and Umbilical Cord Blood as a Source of Stem Cells” 11A-14 (http://www.ncdhhs.gov/dma/mp/11A14.pdf)

Immunologic compatibility between infused hematopoietic stem cells and the recipient is not an issue in autologous HSCT. However, immunologic compatibility between donor and patient is a critical factor for achieving a good outcome of allogeneic HSCT. Compatibility is established by typing human leukocyte antigens (HLA) using cellular, serologic, or molecular techniques. HLA refers to the tissue type expressed at the HLA A, B, and DR loci on each arm of chromosome 6. Depending on the disease being treated, an acceptable donor will match the patient at all or most of the HLA loci.

Conventional Preparative Conditioning for HSCT

The conventional (“classical”) practice of allogeneic HSCT involves administration of cytotoxic agents (e.g., cyclophosphamide, busulfan) with or without total body irradiation at doses sufficient to destroy endogenous hematopoietic capability in the recipient. The beneficial treatment effect in this procedure is due to a combination of initial eradication of malignant cells and subsequent graft-versus-malignancy (GVM) effect that develops after engraftment of allogeneic stem cells within the patient’s bone marrow space. While the slower GVM effect is considered to be the potentially curative component, it may be overwhelmed by extant disease without the use of pretransplant conditioning. However, intense conditioning regimens are limited to patients who are sufficiently fit medically to tolerate substantial adverse effects that include pre-engraftment opportunistic infections secondary to loss of endogenous bone marrow function and organ damage and failure caused by the cytotoxic drugs. Furthermore, in any allogeneic HSCT, immune suppressant drugs are required to minimize graft rejection and GVHD, which also increases susceptibility of the patient to opportunistic infections.

The success of autologous HSCT is predicated on the ability of cytotoxic chemotherapy with or without radiation to eradicate cancerous cells from the blood and bone marrow. This permits subsequent engraftment and repopulation of bone marrow space with presumably normal hematopoietic stem cells obtained from the patient prior to undergoing bone marrow ablation. As a consequence, autologous HSCT is typically performed as consolidation therapy when the patient’s disease is in complete remission. Patients who undergo autologous HSCT are susceptible to chemotherapy-related toxicities and opportunistic infections prior to engraftment, but not GVHD.
Reduced-Intensity Conditioning for Allogeneic HSCT

Reduced-intensity conditioning (RIC) refers to the pretransplant use of lower doses or less intense regimens of cytotoxic drugs or radiation than are used in conventional full-dose myeloablative conditioning treatments. The goal of RIC is to reduce disease burden, but also to minimize as much as possible associated treatment-related morbidity and non-relapse mortality (NRM) in the period during which the beneficial GVM effect of allogeneic transplantation develops. Although the definition of RIC remains arbitrary, with numerous versions employed, all seek to balance the competing effects of NRM and relapse due to residual disease. RIC regimens can be viewed as a continuum in effects, from nearly total myeloablative to minimally myeloablative with lymphoablation, with intensity tailored to specific diseases and patient condition. Patients who undergo RIC with allogeneic HSCT initially demonstrate donor cell engraftment and bone marrow mixed chimerism. Most will subsequently convert to full-donor chimerism, which may be supplemented with donor lymphocyte infusions to eradicate residual malignant cells. For the purposes of this policy, the term “reduced-intensity conditioning” will refer to all conditioning regimens intended to be nonmyeloablative, as opposed to fully myeloablative (conventional) regimens.

Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL)

Chronic lymphocytic leukemia (CLL) and small lymphocytic lymphoma (SLL) are neoplasms of hematopoietic origin characterized by the accumulation of lymphocytes with a mature, generally well-differentiated morphology. In CLL, these cells accumulate in blood, bone marrow, lymph nodes, and spleen, while in SLL they are generally confined to lymph nodes. The Revised European-American/WHO Classification of Lymphoid Neoplasms considers B-cell CLL and SLL a single disease entity.

CLL and SLL share many common features and are often referred to as blood and tissue counterparts of each other, respectively. Both tend to present as asymptomatic enlargement of the lymph nodes, tend to be indolent in nature, but can undergo transformation to a more aggressive form of disease (e.g., Richter’s transformation). The median age at diagnosis of CLL is approximately 72 years, but it may present in younger individuals, often as poor-risk disease with significantly reduced life expectancy.

Treatment regimens used for CLL are generally the same as those used for SLL, and outcomes of treatment are comparable for the two diseases. Both low- and intermediate-risk CLL and SLL demonstrate relatively good prognoses with median survivals of 6 to 10 years, while the median survival of high-risk CLL or SLL may be only 2 years (refer to Guidelines). Although typically responsive to initial therapy, CLL and SLL are rarely cured by conventional therapy, and nearly all patients ultimately die of their disease. This natural history prompted investigation of hematopoietic stem-cell transplantation as a possible curative regimen.

1.1 Definitions

None Apply.
2.0 Eligibility Requirements

2.1 Provisions

2.1.1 General

(The term “General” found throughout this policy applies to all Medicaid and NCHC policies)

a. An eligible beneficiary shall be enrolled in either:
   1. the NC Medicaid Program (Medicaid is NC Medicaid program, unless context clearly indicates otherwise); or
   2. the NC Health Choice (NCHC is NC Health Choice program, unless context clearly indicates otherwise) Program on the date of service and shall meet the criteria in Section 3.0 of this policy.

b. Provider(s) shall verify each Medicaid or NCHC beneficiary’s eligibility each time a service is rendered.

c. The Medicaid beneficiary may have service restrictions due to their eligibility category that would make them ineligible for this service.

d. Following is only one of the eligibility and other requirements for participation in the NCHC Program under GS 108A-70.21(a): Children must be between the ages of 6 through 18.

2.1.2 Specific

(The term “Specific” found throughout this policy only applies to this policy)

a. Medicaid
   None Apply.

b. NCHC
   None Apply.

2.2 Special Provisions

2.2.1 EPSDT Special Provision: Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age

a. 42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]

   Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid beneficiary under 21 years of age if the service is medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed practitioner).

   This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his or her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

   Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the beneficiary’s physician, therapist, or other licensed...
practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the beneficiary’s right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product or procedure:

1. that is unsafe, ineffective, or experimental or investigational.
2. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider’s documentation shows that the requested service is medically necessary “to correct or ameliorate a defect, physical or mental illness, or a condition” [health problem]; that is, provider documentation shows how the service, product, or procedure meets all EPSDT criteria, including to correct or improve or maintain the beneficiary’s health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

b. EPSDT and Prior Approval Requirements

1. If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does NOT eliminate the requirement for prior approval.

2. IMPORTANT ADDITIONAL INFORMATION about EPSDT and prior approval is found in the NCTracks Provider Claims and Billing Assistance Guide, and on the EPSDT provider page. The Web addresses are specified below.

   NCTracks Provider Claims and Billing Assistance Guide:  https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html

   EPSDT provider page:  https://dma.ncdhhs.gov/

2.2.2 EPSDT does not apply to NCHC beneficiaries

2.2.3 Health Choice Special Provision for a Health Choice Beneficiary age 6 through 18 years of age

The Division of Medical Assistance (DMA) shall deny the claim for coverage for an NCHC beneficiary who does not meet the criteria within Section 3.0 of this policy. Only services included under the NCHC State Plan and the DMA clinical coverage policies, service definitions, or billing codes are covered for an NCHC beneficiary.
3.0 When the Procedure, Product, or Service Is Covered

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

3.1 General Criteria Covered

Medicaid and NCHC shall cover the procedure, product, or service related to this policy when medically necessary, and:

a. the procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the beneficiary’s needs;

b. the procedure, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide; and

c. the procedure, product, or service is furnished in a manner not primarily intended for the convenience of the beneficiary, the beneficiary’s caretaker, or the provider.

3.2 Specific Criteria Covered

3.2.1 Specific criteria covered by both Medicaid and NCHC

Medicaid and NCHC shall cover Allogeneic HSCT for CLL and SLL when it is considered medically necessary to treat CLL or SLL in beneficiaries with markers of poor-risk disease (refer to Guidelines in Subsection 3.2.4).

Use of a myeloablative or reduced-intensity pretransplant conditioning regimen must be individualized based on factors that include beneficiary age, the presence of comorbidities, and disease burden.

3.2.2 Medicaid Additional Criteria Covered

None Apply.

3.2.3 NCHC Additional Criteria Covered

None Apply.

3.2.4 Policy Guidelines

Staging and Prognosis of CLL and SLL

Two scoring systems are used to determine stage and prognosis of patients with CLL or SLL. As outlined in Table 1, the Rai and Binet staging systems classify patients into 3 risk groups with different prognoses, and are used to make therapeutic decisions.

Table 1. Rai and Binet Classification for CLL or SLL

<table>
<thead>
<tr>
<th>Rai State</th>
<th>Risk</th>
<th>Description</th>
<th>Median Survival (yr)</th>
<th>Binet Stage</th>
<th>Description</th>
<th>Median Survival (yr)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Low</td>
<td>Lymphocytosis</td>
<td>greater than 10</td>
<td>A</td>
<td>3 or fewer lymphoid areas, normal hemoglobin and platelets</td>
<td>greater than 10</td>
</tr>
<tr>
<td>1</td>
<td>Intermediate</td>
<td>Lymphocytosis plus</td>
<td>7-9</td>
<td>B</td>
<td>3 or more lymphoid areas, normal</td>
<td>7</td>
</tr>
</tbody>
</table>
Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL) Amended Date: March 1, 2017

Because prognosis of patients varies within the different Rai and Binet classifications, other prognostic markers are used in conjunction with staging to determine clinical management. These are summarized in Table 2, according to availability in clinical centers.

Table 2. Markers of Poor Prognosis in CLL or SLL

<table>
<thead>
<tr>
<th>Community Center</th>
<th>Specialized Center</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advanced Rai or Binet stage</td>
<td>IgVh wild type</td>
</tr>
<tr>
<td>Male sex</td>
<td>Expression of ZAP-70 protein</td>
</tr>
<tr>
<td>Atypical morphology or CLL/PLL</td>
<td>del 11q22-q23 (loss of ATM gene)</td>
</tr>
<tr>
<td>Peripheral lymphocyte doubling time less than 12 mos CD38+</td>
<td>del 17p13 (loss of p53)</td>
</tr>
<tr>
<td>Elevated beta2-microglobulin level</td>
<td>trisomy 12</td>
</tr>
<tr>
<td>Diffuse marrow histology</td>
<td>Elevated serum CD23</td>
</tr>
<tr>
<td>Elevated serum lactate dehydrogenase level</td>
<td>Elevated serum tumor necrosis factor-a</td>
</tr>
<tr>
<td>Fludarabine resistance</td>
<td>Elevated serum thymidine kinase</td>
</tr>
</tbody>
</table>

4.0 When the Procedure, Product, or Service Is Not Covered

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

4.1 General Criteria Not Covered

Medicaid and NCHC shall not cover the procedure, product, or service related to this policy when:

a. the beneficiary does not meet the eligibility requirements listed in Section 2.0;

b. the beneficiary does not meet the criteria listed in Section 3.0;
NC Division of Medical Assistance
Hematopoietic Stem-Cell for
Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL)

Medicaid and Health Choice
Clinical Coverage Policy No: 11A-16
Amended Date: March 1, 2017

4.2 Specific Criteria Not Covered

4.2.1 Specific Criteria Not Covered by both Medicaid and NCHC
Medicaid and NCHC do not cover HSCT for CLL and SLL in the following situations:
   a. Allogeneic HSCT is considered investigational to treat CLL or SLL except as noted in subsection 3.2 of this policy.
   b. Autologous HSCT is considered investigational to treat CLL or SLL.

4.2.2 Medicaid Additional Criteria Not Covered
None Apply.

4.2.3 NCHC Additional Criteria Not Covered
   a. NCGS § 108A-70.21(b) “Except as otherwise provided for eligibility, fees, deductibles, copayments, and other cost sharing charges, health benefits coverage provided to children eligible under the Program shall be equivalent to coverage provided for dependents under North Carolina Medicaid Program except for the following:
      1. No services for long-term care.
      2. No nonemergency medical transportation.
      3. No EPSDT.
      4. Dental services shall be provided on a restricted basis in accordance with criteria adopted by the Department to implement this subsection.”

5.0 Requirements for and Limitations on Coverage

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for Medicaid Beneficiaries under 21 Years of Age.

5.1 Prior Approval
Medicaid and NCHC shall require prior approval for HSCT for CLL and SLL. The provider shall obtain prior approval before rendering HSCT for CLL and SLL.

If prior approval has been given for HSCT, donor transplanted-related medical expenses (procuring, harvesting, short-term storing and all associated laboratory costs) are covered.

5.2 Prior Approval Requirements

5.2.1 General
The provider(s) shall submit to the Department of Health and Human Services (DHHS) Utilization Review Contractor the following:
   a. the prior approval request; and
   b. all health records and any other records that support the beneficiary has met the specific criteria in Subsection 3.2 of this policy.
5.2.2 Specific

None Apply.

5.3 Transplant Prior Approval Requirements

The provider(s) shall submit the following to the DMA transplant nurse consultant:

a. Letter of medical necessity signed by the attending transplant physician, which documents regimens and dates, the social history and the transplant evaluation;

b. All health care records and any other records that support the beneficiary has met the specific criteria in Subsection 3.2 of this policy including:
   1. Lab results (less than three months old) to include Complete Blood Count (CBC), complete electrolytes, liver enzymes, Prothrombin Time (PT), International Normalized Ratio (INR), glucose and A1C (Glycated Hemoglobin if Type I or Type II diabetic), and blood type;
   2. Serologies: to include Human Immunodeficiency Virus (HIV), Hepatitis, Rapid Plasma Reagin (RPR), Epstein-Barr Virus (EBV), Cytomegalovirus (CMV), Varicella, Rubella, Herpes Simplex Virus (HSV) I/II, and toxoplasmosis. (Positive serology results may be reported that are greater than three months old);
   3. Diagnostic studies (less than six months old) required in a complete packet include:
      A. Cardiac: Echocardiogram, Electrocardiogram (ECG), and/or cardiac catheterization as appropriate for beneficiary’s clinical status;
      B. Pulmonary: Pulmonary Function Test if beneficiary has cardiac or pulmonary issues, or a history of smoking; and
      C. Chest x-ray for all transplant candidates;
   4. Other diagnostic tests may be requested as appropriate;
   5. Beneficiary’s height and weight
   6. All diagnostic and procedure results, including bone marrow aspiration (not more than six months old)

c. Complete psychological and social evaluation to include:
   1. beneficiary’s medical compliance;
   2. beneficiary’s support network;
   3. post-transplant care plan, with identification of primary and secondary care providers; and
   4. history of mental health issues/substance use/legal issues

d. Beneficiaries with a psychiatric history are required to have an evaluation by a psychiatrist with expertise in evaluating the specific psychiatric issues that relate to transplant candidates.
6.0 Provider(s) Eligible to Bill for the Procedure, Product, or Service

To be eligible to bill for the procedure, product, or service related to this policy, the provider(s) shall:

a. meet Medicaid or NCHC qualifications for participation;

b. have a current and signed Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement; and

c. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

6.1 Provider Qualifications and Occupational Licensing Entity Regulations

None Apply.

6.2 Provider Certifications

None Apply.

7.0 Additional Requirements

*Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.*

7.1 Compliance

Provider(s) shall comply with the following in effect at the time the service is rendered:

a. All applicable agreements, federal, state and local laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements; and

b. All DMA’s clinical (medical) coverage policies, guidelines, policies, provider manuals, implementation updates, and bulletins published by the Centers for Medicare and Medicaid Services (CMS), DHHS, DHHS division(s) or fiscal contractor(s).

c. FDA approved procedures, products, and devices for implantation must be utilized.

d. A statement signed by the surgeon certifying all FDA requirements for the implants, products, and devices must be retained in the beneficiary’s medical record and made available for review upon request.
8.0 Policy Implementation/Revision Information

Original Effective Date: March 1, 2012

Revision Information:

<table>
<thead>
<tr>
<th>Date</th>
<th>Section Revised</th>
<th>Reason for Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>03/01/2012</td>
<td>Throughout</td>
<td>Initial Promulgation of New Service Coverage</td>
</tr>
<tr>
<td>03/01/2012</td>
<td>Throughout</td>
<td>To be equivalent where applicable to NC DMA’s Clinical Coverage Policy # 11A-16 under Session Law 2011-145 § 10.41.(b)</td>
</tr>
<tr>
<td>03/01/2012</td>
<td>Throughout</td>
<td>Technical changes to merge Medicaid and NCHC current coverage into one policy.</td>
</tr>
<tr>
<td>10/01/2015</td>
<td>All Sections and Attachments</td>
<td>Updated policy template language and added ICD-10 codes to comply with federally mandated 10/1/2015 implementation where applicable.</td>
</tr>
<tr>
<td>03/01/2017</td>
<td>Attachment A, Section B</td>
<td>ICD-10 update codes revised.</td>
</tr>
</tbody>
</table>
Attachment A: Claims-Related Information

Provider(s) shall comply with the, NCTracks Provider Claims and Billing Assistance Guide, Medicaid bulletins, fee schedules, DMA’s clinical coverage policies and any other relevant documents for specific coverage and reimbursement for Medicaid and NCHC:

A. Claim Type

Professional (CMS-1500/837P transaction)

B. International Classification of Diseases, Tenth Revisions, Clinical Modification (ICD-10-CM) and Procedural Coding System (PCS)

Provider(s) shall report the ICD-10-CM and Procedural Coding System (PCS) to the highest level of specificity that supports medical necessity. Provider(s) shall use the current ICD-10 edition and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for code description, as it is no longer documented in the policy.

<table>
<thead>
<tr>
<th>ICD-10-Procedure Code(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>30230AZ</td>
</tr>
<tr>
<td>30230G0</td>
</tr>
<tr>
<td>30230G4</td>
</tr>
<tr>
<td>30230Y0</td>
</tr>
<tr>
<td>30230Y4</td>
</tr>
<tr>
<td>30233AZ</td>
</tr>
<tr>
<td>30233G0</td>
</tr>
<tr>
<td>30233G4</td>
</tr>
<tr>
<td>30233G1</td>
</tr>
<tr>
<td>30233Y0</td>
</tr>
<tr>
<td>30233Y4</td>
</tr>
</tbody>
</table>

C. Code(s)

Provider(s) shall report the most specific billing code that accurately and completely describes the procedure, product or service provided. Provider(s) shall use the Current Procedural Terminology (CPT), Health Care Procedure Coding System (HCPCS), and UB-04 Data Specifications Manual (for a complete listing of valid revenue codes) and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for the code description, as it is no longer documented in the policy.

If no such specific CPT or HCPCS code exists, then the provider(s) shall report the procedure, product or service using the appropriate unlisted procedure or service code.

<table>
<thead>
<tr>
<th>CPT Code(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>38205</td>
</tr>
<tr>
<td>38206</td>
</tr>
<tr>
<td>38230</td>
</tr>
<tr>
<td>38232</td>
</tr>
</tbody>
</table>
Unlisted Procedure or Service

CPT: The provider(s) shall refer to and comply with the Instructions for Use of the CPT Codebook, Unlisted Procedure or Service, and Special Report as documented in the current CPT in effect at the time of service.

HCPCS: The provider(s) shall refer to and comply with the Instructions For Use of HCPCS National Level II codes, Unlisted Procedure or Service and Special Report as documented in the current HCPCS edition in effect at the time of service.

D. Modifiers

Providers shall follow applicable modifier guidelines.

E. Billing Units

Provider(s) shall report the appropriate code(s) used which, determines the billing unit(s).

F. Place of Service

Inpatient hospital, Outpatient hospital

G. Co-payments


H. Reimbursement

Providers shall bill their usual and customary charges.

For a schedule of rates, see: https://dma.ncdhhs.gov/

I. Billing for Donor Expenses

1. Billing for Donor Expenses for Medicaid Beneficiaries

Donor transplant-related medical expenses are billed on the Medicaid beneficiary’s transplant claim using the beneficiary’s Medicaid identification number.

Medicaid reimburses only for the actual donor’s transplant-related medical expenses. Medicaid does not reimburse for unsuccessful donor searches.

2. Billing for Donor Expenses for NCHC Beneficiaries

Donor transplant-related medical expenses donors are billed on the NCHC beneficiary’s transplant claim.

NCHC reimburses only for the actual donor’s transplant-related medical expenses. NCHC does not reimburse for unsuccessful donor searches.