# Operations Manual

## Centers of Medical Excellence Transplant Network Contract

https://provider.simplyhealthcareplans.com/florida-provider
https://provider.clearhealthalliance.com/florida-provider

Medicaid Managed Care
Medicare Advantage

# *Centers of Medical Excellence Transplant Network Contract Operations Manual*

**A supplemental document to the**
**Simply Healthcare Plans, Inc. and Clear Health Alliance *Provider Manual***

**https://provider.simplyhealthcareplans.com/florida-provider**
**https://provider.clearhealthalliance.com/florida-provider**

Simply Healthcare Plans, Inc. is a Managed Care Plan with a Florida Medicaid contract. Simply Healthcare Plans, Inc. dba Clear Health Alliance is a Managed Care Plan with a Florida Medicaid contract.
Simply Healthcare Plans, Inc. is a Medicare contracted coordinated care plan that has a Medicaid contract with the State of Florida Agency for Health Care Administration to provide benefits or arrange for benefits to be provided to enrollees. Enrollment in Simply Healthcare Plans, Inc. depends on contract renewal.
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# SECTION I: Scope

Unless otherwise expressly indicated in this operations manual, all terms used shall have the meaning in the Stand Alone Agreement or Transplant Attachment to the Simply Healthcare Plans, Inc. and Clear Health Alliance (Simply) Hospital Agreement.

The Simply 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 Simply products will have access to the Network:

- Government programs: Medicaid, Medicare Advantage
- Children’s Health Insurance Program (CHIP)
- Other (includes other products such as: transplant)

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

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

# SECTION II: Quality Oversight of the Simply CME Network

The Simply 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 Simply Contract Manager to express interest. The Simply Contract Manager will notify the Simply 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 Simply 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 Simply'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 Simply Provider Manual.

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

Simply CME will provide a one-level reconsideration process for currently designated health care facilities or

programs that are terminated from the Simply CME transplant network if an appeal is submitted in writing to the Simply 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:
Simply CME Program Manager
3350 Peachtree Rd. NE
GAG006-0005
Atlanta, GA. 30326

## Provider responsibility

As a participation provider in the Simply 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 Simply 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: **844-430-6801**

To contact the member's Case Manager:
- Phone number: **800-600-4441**
- 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 Simply 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 Simply a request for transplant authorization and the covered individual's clinical records to support this request. Simply 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 contact the member's Transplant Pre-Authorization Review 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 including 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 bases.

## 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 individual's 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 Simply Provider Manual.

# *Attachment Form A1: Transplant Services Notification Form*

**When filling out this form:**

- Use the tab key to go from field to field.
- Remember to print and sign this form.

| Referring Simply Healthcare Plans, Inc. plan: | | | | | |
|---|---|---|---|---|---|
| Patient name: | | Patient ID: | | Date of birth: | |
| Group name/ID number: | | Subscriber name/ID number: | | | |
| Primary insurance carrier name: | | | | | |
| Secondary insurance carrier: | | | | | |

| **Transplant type (please check all that apply)** | | | | | |
|---|---|---|---|---|---|
| **<u>Bone marrow stem cell</u>** | **Patient diagnosis:** | | | | |
| Type: | Autologous ☐ | Allogenic ☐ | "Mini" allogenic ☐ | Tandem #1 ☐ | Tandem #2 ☐ |
| Cell source: | Bone marrow ☐ | Peripheral blood stem cell ☐ | Coord blood ☐ | | |
| Donor (if allogenic): | Related ☐ | Unrelated ☐ | Matched ☐ | Mismatched ☐ | |
| **<u>Solid organ</u>** | **Patient diagnosis:** | | | | |
| Organ type: | | Initial transplant ☐ | Re-transplant ☐ | | |
| Donor: | Cadaveric ☐ | Living donor ☐ | | | |

| Transplant hospital name: | |
|---|---|
| Transplant hospital address: | |

*This patient meets the medical necessity guidelines of* ______ *(name of Simply plan) for the above noted transplant, for included transplant service. All eligible transplant services and global/outlier rates are listed in the Centers of Medical Excellence Hospital Participation Agreement.*

| Contact: | | at: | | for precertification and to verify continued eligibility for medical benefits prior to beginning CME Transplant Services. |
|---|---|---|---|---|

| Authorized plan representative signature: | | | | | |
|---|---|---|---|---|---|
| Title: | | Exp. Date: | | Print name: | |
| Area code + phone number: | | | | Fax number: | |
| Contact: | | at: | | For Case Management Services. | |

**Hospital:** Submit bundled, global claim (including the CME Attachment C or D), and a copy of this *Attachment Form A1: Transplant Services Notification Form* to:

| Name: | | Address: | | Phone number: | |
|---|---|---|---|---|---|

(Please reconfirm this plan claim contact information prior to submitting bundled global claim. Hospital is to collect any applicable coinsurance, deductibles, and co-payments.) **Plan:** Provide any additional information or special instructions below (i.e., LTM, COB, deductibles, co-payments, etc.)

# *Attachment Form A2:*
# *Hospital Notification Of Transplant Admission Form*

| From: | | | |
|---|---|---|---|
| Name: | | Institution: | |
| Phone #: | | Fax #: | |

| Patient name: | | Patient ID: | | DOB: | |
|---|---|---|---|---|---|
| Referring plan: | | | | | |

**Note: Please complete a separate *Hospital Notification of Transplant Admission Form* for each transplant.**

| **Solid organ transplant** | | | |
|---|---|---|---|
| Solid organ type: | | Diagnosis: | |
| Initial transplant: | Initial transplant ☐ Re-transplant ☐ Cadaveric ☐Living donor ☐ | | |
| Inpatient admission date: | | Inpatient transplant date: | |
| Simply CME dates: | | to | |

| **Bone marrow/stem cell transplant** | | | | |
|---|---|---|---|---|
| Diagnosis: | | | | |
| Check all that apply:<br>Autologous ☐ Allogeneic ☐ Mini allogeneic ☐ Tandem #1 ☐ Tandem # 2 ☐ Bone marrow ☐<br>Peripheral stem cell ☐ Cord Blood ☐ Related ☐ Unrelated ☐ Matched ☐ Mismatched ☐ | | | | |
| | | | | |
| Mobilization therapy date(s): | Inpatient: | | Outpatient: | |
| Marrow/stem cell harvesting date(s): | Inpatient: | | Outpatient: | |
| Marrow ablative therapy date(s): | Inpatient: | | Outpatient: | |
| Reinfusion/transplant date(s): | Inpatient: | | Outpatient: | |
| Simply Healthcare Plans, Inc. CME dates: | | | to | |

# Attachment Form B: Patient Discharge Care Notification Form

| Date: | |
|---|---|

| Patient name: | | ID number: | |
|---|---|---|---|
| Referring plan: | | | |
| Date of transplant: | | Type of transplant: | |
| CME dates: | | to: | |
| Institution: | | Date of discharge: | |

| Hospital | | Referring plan | |
|---|---|---|---|
| Signature: | | Signature: | |
| Print name: | | Print name: | |
| Title: | | Title: | |
| Date: | | Date: | |

**After completion of form**: Fax one copy to the Referring or Transplant Coordinator. Refer to the Referring and Servicing Contact List in the Procedure Manual. Keep one copy for your records.

# SECTION IV: Simply 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 Simply 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.

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 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 Simply facility, professional or ancillary agreements with providers.

# SECTION V: Simply 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 Simply facility agreement and the current Simply professional agreement.

### Cell 2 Processing Guidelines (if applicable)

These services will be reimbursed according to the terms of the current Simply facility agreement and the current Simply 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 Simply 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 Simply Facility Agreement and the current Simply 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-Simply membership Cell 3 Transplant Services

Cell 3 transplant services for non-Simply 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 Simply 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 Simply 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 Simply 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

# Form C: Billing Summary Form
# Solid Organ Transplant

| Initial form ☐ Additional form ☐ Revised form ☐ | Date revised: | |
|---|---|---|

| Patient name: | | ID number: | |
|---|---|---|---|
| DOB: | | | |
| Transplant hospital: | | | |
| Payment address: | | | |
| Transplant type: | Initial transplant ☐ Re-transplant ☐ | Cadaveric ☐ | Living donor ☐ |

| **Pre-transplant period dates/charges** | | |
|---|---|---|
| Pre-transplant (inpatient) dates: | | |
| | to: | |
| Inpatient pre-transplant rate if applicable | | |
| Hospital charges: | $ | |
| Professional charges: | $ | |
| **Total billed charges:** | **$** | |
| **Case rate/amount due** | | |
| Per diem rate: | $ | |
| or | | % of charges |
| • Lesser of | | % of charges |
| • Other: | | |
| Pre-transplant period amount due: | | |
| $ | | |
| *Total adjustments (attach itemization and/or claims): | | |
| $ | | |
| **Pre-transplant period total adjusted amount due:** | | |
| **$** | | |

| **Case rate period dates/charges** | | |
|---|---|---|
| Case rate period dates: | | |
| | to: | |
| Transplant date: | | |
| Inpatient discharge date(s): | | |
| **Readmission date(s):** | | |
| **Organ procurement charges** | | |
| Hospital charges: | $ | |
| Professional charges: | $ | |
| Ancillary charges: | $ | |
| **Total billed charges:** | **$** | |
| **Case rate/amount due** | | |
| Applicable rate: | | |
| • Case rate amount: | $ | |
| • Lesser of | | % of charges |
| • Other: | | |
| Case rate period amount due: | | |
| $ | | |
| *Total adjustments (attach itemization and/or claims): | | |
| $ | | |
| Case rate period total adjusted amount due: | | |
| $ | | |

| **Outlier period dates/charges** | | |
|---|---|---|
| Outlier (inpatient) dates: | | |
| | to: | |
| Hospital charges: | $ | |
| Professional charges: | $ | |
| **Total billed charges:** | **$** | |
| **Case rate/amount due** | | |
| Per diem rate: | $ | |
| or | | % of charges |
| Lesser of | | % of charges |
| Other: | | |
| Outlier period amount due: | | |
| $ | | |
| *Total adjustments (attach itemization and/or claims): | | |
| $ | | |
| **Outlier period total adjusted amount due:** | | |
| **$** | | |

| ***Hospital:*** *A separate form must be completed for each transplant. Copies of all claims for the dates of service noted above and included in the case rate(s) agreement must be attached. *Total adjustments may include e.g., Payor prior payments for services included in the case rate(s) agreement.* | | | | | |
|---|---|---|---|---|---|
| Form completed by (print): | | Phone: | | Date: | |
| Plan contact (print name): | | | | | |

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

| Initial form ☐ Additional form ☐ Revised form ☐ | | Date revised: | |
|---|---|---|---|
| Patient name: | | ID number: | |
| DOB: | | | |
| Transplant hospital: | | | |
| Payment address: | | | |
| Transplant type: | Autologous ☐ Allogenic ☐ "Mini" Allogenic ☐ Tandem #1 ☐ Tandem #2 ☐ Peripheral stem cells ☐<br>Bone Marrow ☐ Cord Blood ☐ Related ☐ Unrelated ☐ Matched ☐ Mismatched ☐ | | |

| **Pre-transplant period dates/charges** | | |
|---|---|---|
| Pre-transplant (inpatient) dates: | | |
| | to: | |
| Inpatient pre-transplant rate if applicable | | |
| Hospital charges: | $ | |
| Professional charges: | $ | |
| **Total billed charges:** | **$** | |
| **Case rate/amount due** | | |
| Per diem rate: | $ | |
| or | | % of charges |
| • Lesser of | | % of charges |
| • Other: | | |
| Pre-transplant period amount due: | | |
| $ | | |
| *Total adjustments (attach itemization and/or claims): | | |
| $ | | |
| **Pre-transplant period total adjusted amount due:** | | |
| **$** | | |

| **Mobilization/harvesting dates/charges** | | |
|---|---|---|
| Mobilization therapy dates: | | |
| IP: | | |
| OP: | | |
| **Mobilization total billed charges:** | | |
| Hospital: | $ | |
| Professional: | $ | |
| Harvesting dates: | | |
| IP: | | |
| OP: | | |
| **Harvesting total billed charges:**<br>**(for unrelated donors, i.e., NMDP charges)** | | |
| Hospital: | $ | |
| Professional: | $ | |
| **Case rate dates/charges** | | |
| Case rate period dates: | | |
| | to: | |
| *Marrow ablative therapy (or preparative regimen date(s):* | | |
| IP: | | |
| OP: | | |
| Transplant date: | | |
| Hospital charges: | $ | |
| Professional charges: | $ | |
| Ancillary charges: | $ | |
| **Total billed charges:**<br>(Inc. any mobilization/harvesting charge above) | **$** | |
| **Case rate/amount due** | | |
| Case rate amount: | $ | |
| Lesser of | | % of charges |
| Other: | | |
| Case rate period amount due:<br>*(Inc. any mobilization/harvesting charge above)* | | |
| $ | | |
| *Total adjustments (attach itemization and/or claims): | | |
| $ | | |
| Case rate period total adjusted amount due: | | |
| $ | | |

| **Outlier period dates/charges** | | |
|---|---|---|
| Outlier (inpatient) dates: | | |
| | to: | |
| Hospital charges: | $ | |
| Professional charges: | $ | |
| **Total billed charges:** | **$** | |
| **Case rate/amount due** | | |
| Per diem rate: | $ | |
| or | | % of charges |
| Lesser of | | % of charges |
| Other: | | |
| Outlier period amount due: | | |
| $ | | |
| *Total adjustments (attach itemization and/or claims): | | |
| $ | | |
| **Outlier period total adjusted amount due:** | | |
| **$** | | |

***Hospital:*** *A separate form must be completed for each transplant. Copies of all claims for the dates of service noted above and included in the case rate(s) agreement must be attached. *Total adjustments may include e.g., Payor prior payments for services included in the case rate(s) agreement.*

| Form completed by (print): | | Phone: | | Date: | |
|---|---|---|---|---|---|
| Plan contact (print name): | | | | | |

# SECTION VI: Simply CME Transplant Claim Billing Contacts (as of January 1, 2020)

## Simply CME transplant claim billing guidelines and claim submission requirements

Please refer to the Simply 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

Simply Healthcare Plans, Inc.
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<br>(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])<br>(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

[Provider Attach Contract Reimbursement Schedule Here]

https://provider.simplyhealthcareplans.com/florida-provider
https://provider.clearhealthalliance.com/florida-provider

Simply Healthcare Plans, Inc. is a Managed Care Plan with a Florida Medicaid contract.
Simply Healthcare Plans, Inc. dba Clear Health Alliance is a Managed Care Plan with a Florida Medicaid contract.
Simply Healthcare Plans, Inc. is a Medicare contracted coordinated care plan that has a Medicaid contract with the State of Florida Agency for Health Care Administration to provide benefits or arrange for benefits to be provided to enrollees. Enrollment in Simply Healthcare Plans, Inc. depends on contract renewal.
SFL-SPM-0001-20