Allogeneic Hematopoietic Cell Transplant (HCT) Donor Billing

Transplant centers (TCs) **cannot** bill the donor or the donor's insurance provider for any donor search and cell acquisition charges associated with the recipient's allogeneic hematopoietic cell transplant (HCT). This resource contains general guidance on how TCs **can** code and bill for donor services.

General Billing Instructions, Payer Relations and Tips

1. All donor-related charges, including those for donor search and acquisition costs and NMDP/Be The Match invoice fees, should be held and included on the recipient's transplant procedure claim itself using revenue code 0815 (inpatient or outpatient setting) as a line-item charge. Some providers may also elect to also use the HCPCS/CPT code 38204.

2. A complete recipient transplant bill should contain the following: acquisition charges, cost report days, and utilization days for the donor's hospital stay (if applicable) and/or charges for other encounters in which stem cells were obtained from the donor.

    a. NMDP/Be The Match highly recommends that TC's adopt a process to identify, hold and itemize all donor-related charges until the transplant procedure. This will ensure that services furnished, the charges, and that the person receiving the service (donor or recipient), can be readily identified and reported in the stem cell/bone marrow acquisition cost center.

3. Transplant centers CANNOT charge the donor's days of care against the recipient's utilization record. For cost reporting purposes, the utilization record includes the covered donor days and charges as Medicare days and charges.

4. Ensure that commercial contracts are updated with language that reflects advancements in cell acquisition and the TC's current practices.

Donor Coding and Billing Summary

The coding and billing perspective for each phase is outlined below:

Donor Phase	Coding	Billing
Donor Search	CPT codes may include blood draws, HLA typing, IDM and genetic tests.	Charges are held until a superbill can be created under the transplant recipient's payer (Medicare, commercial, etc.).
Donor Workup	CPT codes may include various lab tests, outpatient exam, possible filgrastim injections, and blood sample collection, processing, and storage.	If donor acquisition services are provided, but a transplant does not occur (due to death of recipient or other cause), associated costs should be reflected on the Medicare cost report.
Collection	CPT codes may include various tests, imaging, medical evaluations, anesthesia, harvesting, observation or inpatient hospital care following procedure, possibly therapeutic apheresis, and IV infusion.	Be sure to track cost report days and utilization days for the donor's inpatient stay (if applicable). A superbill can be created incorporating donor and recipient charges under the appropriate revenue code (0815).
Post-Transplant	CPT codes will vary based on the status of the recipient (inpatient or outpatient) as well as the services required to manage post-transplant complications arising from the donation itself.	If complications occur, the coding and billing staff must make sure that the only services billed with the transplant procedure are those that are directly and immediately attributable to the stem cell donation procedure.

If you have any questions, please email NMDP Public and Payer Policy at PayerPolicy@NMDP.org.