

Information Required for a Proposal

Organ and Tissue Transplant Risk



CLIENT SPECIFIC INFORMATION

Health Plan Name/Employer: _____

Primary Contact Name: _____

Address: _____ Phone: _____

Affiliates/Subsidiaries: _____

HISTORICAL COST/UTILIZATION:

CATEGORY	Last Year	2 nd Prior Year	3 rd Prior Year
Transplant Encounters by Type:			
Average Transplant Cost Per Day:			
Primary Transplant Network:			
Inpatient Days Per Thousand:			

PROJECTED UTILIZATION:

Covered Persons have been categorized in the following ways:

1. Covered Persons who have been referred for consultation or who are in the process of being referred for a consultation, with regard to an organ or tissue transplant
2. Covered Persons who have had an organ or tissue transplant evaluation or who are in the process of being evaluated for an organ or tissue transplant.
3. Covered Persons who are currently on the organ or tissue transplant waiting list
4. Covered Persons who have received an organ or tissue transplant within the last 12 months.

Please provide the following details for each Covered Person in the 4 categories mentioned above:

- Product Type
- Patient Name and Date of Birth
- Diagnosis
- Evaluation Status – Has an evaluation been performed? If so, please provide the date of the evaluation and its outcome.
- Date placed on Transplant Waiting List
- Transplant Type
- Facility/Is there a transplant contract arrangement in place?
- Current condition
- Total amount paid for this Covered Person for the prior 12 months

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DEMOGRAPHICS:

For the prior three consecutive 12-month periods, by month, provide for each Covered Person:

- Name/Member ID#
- Age
- Gender
- Zip Code

DOCUMENTS TO ATTACH WITH THIS FORM

For each year, provider contracting arrangements for transplant services
Membership Services Agreement (Covered Benefit Plan)

CLAIM EXPERIENCE

1. Identify ALL Organ and Tissue Transplant encounters for each of the prior three 12-month periods by Member ID, Date of Birth, Population Type, Gender
2. Extract ALL claim records for each Covered Person identified in number one
3. The records are to include the items:
 - Medical Costs
 - Hospital costs
 - Pharmacy costs
 - Laboratory costs
 - Professional costs
 - DME costs
 - Home Health costs
 - Ancillary costs

Standardized Code Information

Provider Type	(Hospital, SNF, PCP, Specialist)
Provider Name	(Provider ID Number)
Code Description of Service	(CPT, HCPCS, Revenue Code, Modifiers – Uniform Codes)
Site of Service HCFA Standard	(Office, Lab, Outpatient or Inpatient Hospital)
Referral Provider	(Authorization for Out-of-Area or Non-Contracted Provider)
Dates of Service	(From and To Dates)
Quantity of Service	(# of Identically Coded Services or Length of Stay)
Charge for Service	(Billed Amount)
Paid/Value of Service	(Note: use "Value" for Capitated Services)
Paid Date Transaction Date	(Process Date)
Diagnosis	(UB92 Revenue Codes, CPT/HCPCS Procedures, ICD9 Diagnostic (Primary and Secondary), Home Grown)
DRG	(If contract requires or "Paid" based on DRG)

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MEDICAL MANAGMENT

Does your organization perform UM/CM? If not, what organization performs this service?

Does your organization or the delegated organization have specialized case management for organ and tissue transplant candidates? If so, provide the experience and training of the team.

Describe your UM/CM process for organ and tissue transplant candidates during the pre-transplant, transplant and post-transplant phases

How many case managers on staff perform specialized transplant case management only, and what is their average caseload?

Describe the preventative measures for complications taken during the pre and post-transplant phase for organ and tissue transplant recipients.

Describe the benefit plan design as it relates to the critical and ongoing care provided to Organ and Tissue Transplant candidates throughout the continuum of care.

Describe any special products and services specifically designed for the medical management of Organ and Tissue candidates.

SIGNATURE

The proposal will be based upon information transmitted with this form. The undersigned warrants that he or she has made a diligent effort to verify this information; and that, to the best of his or her knowledge and belief, this information accurately represents the facts, and no requested information has been omitted or altered.

Signature: _____ Date: _____

Title: _____

Phone: _____ Fax: _____

E-mail Address: _____

CONFIDENTIALITY

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