Transplant Facility Payment Policy

Applies to the following Tufts Health Plan products:

☒ Tufts Health Plan Commercial (including Tufts Health Freedom Plan)
☐ Tufts Medicare Preferred HMO (a Medicare Advantage product)
☐ Tufts Health Plan Senior Care Options (SCO) (a dual-eligible product)

The following payment policy applies to Tufts Health Plan contracting inpatient transplant facilities. For information on Tufts Medicare Preferred HMO and Tufts Health SCO, click here.

In addition to the specific information contained here, providers must adhere to the policy information outlined in the Professional Services and Facilities Payment Policy.

Note: Audit and disclaimer information is located at the end of this document.

POLICY
Tufts Health Plan covers medically necessary organ and stem cells transplants, as described below.

GENERAL BENEFIT INFORMATION
When the recipient is a member, the following services related to the procurement of the organ or stem cells from the donor are covered, but only to the extent that such services are not covered by any other plan of health benefits or health care coverage:

- Evaluation and preparation of the donor
- Surgical intervention and recovery services when those services relate directly to donating the organ or stem cells to the member

Tufts Health Plan does not routinely provide coverage for donor services under the following circumstances:

- Members who donate organs or stem cells to nonmembers
- Potential donors who do not become the ultimate donor

Services and subsequent payment are pursuant to the member's benefit plan document. Member eligibility and benefit specifics should be verified prior to initiating services by logging on to the secure Provider website or by contacting Commercial Provider Services.

AUTHORIZATION REQUIREMENTS
All inpatient admissions require inpatient notification prior to services being rendered, except for urgent or emergency care. Elective admissions require notification to Tufts Health Plan both when the transplant has been scheduled and when the member is admitted for the procedure. Urgent admissions require notification at the time of admission.

Admitting practitioners and facilities are responsible for notifying Tufts Health Plan, following the procedures outlined in the Authorizations chapter of the Commercial Provider Manual and in accordance with the following timelines:

- Elective admissions must be reported no later than five business days prior to admission
- Urgent or emergency admissions must be reported by 5 p.m. the next business day following admission.

Prior authorization is required for transplants, including stem cells, by the Tufts Health Plan Care Management Department (617.972.9470).

Note: Prior authorization is not required for corneal transplants.

1 Commercial products include HMO, POS, PPO, Tufts Health Freedom Plan, and CareLinkSM when Tufts Health Plan is the primary administrator.
COMPENSATION/REIMBURSEMENT INFORMATION
Refer to the DRG Inpatient Facility Payment Policy or the Non-DRG Inpatient Facility Payment Policy for additional information, including compensation, late charges and billing instructions.

DOCUMENT HISTORY
- June 2018: Template updates
- April 2017: Policy reviewed by committee; updated elective and urgent/emergency transplant notification process
- January 2017: Template updates
- September 2015: Template conversion, template updates
- December 2014: Policy reviewed, template updates
- September 2013: Template conversion, template updates
- May 2013: Added information regarding the submission of late charges effective for claims adjudicated on or after July 1, 2013.
- April 2012: Updated CareLink disclaimer language
- October 2011: Policy reviewed, added circumstances in which donor services are not covered, clarified DRG information, template updates
- February 2008: Revised general benefit information with self-service channels information

AUDIT AND DISCLAIMER INFORMATION
Tufts Health Plan reserves the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in this payment policy. If such an audit determines that an office/facility did not comply with this payment policy, Tufts Health Plan will expect the office/facility to refund all payments related to noncompliance. For more information about Tufts Health Plan’s audit policies, refer to the Provider website.

This policy provides information on Tufts Health Plan claims adjudication processes. As every claim is unique, this policy is neither a guarantee of payment, nor a final indication of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management requirements (when applicable), adherence to plan policies and procedures, and claims editing logic. An authorization is not a guarantee of payment. Claims for services subject to authorization may be reviewed for accuracy and compliance with payment policies.

This policy applies to the Tufts Health Plan products, as identified in the checkboxes on the first page, and to CareLinkSM for providers in Massachusetts and Rhode Island service areas. Providers in the New Hampshire service area are subject to Cigna’s provider agreements with respect to CareLink members. This policy does not apply to the Private Health Care Systems (PHCS) network (also known as Multiplan). Tufts Health Plan reserves the right to amend a payment policy at its discretion.