Tufts Medicare Preferred HMO and Tufts Health Plan Senior Care Options
Transplant Facility Payment Policy

The following payment policy applies to Tufts Medicare Preferred HMO and Tufts Health Plan Senior Care Options (SCO) contracting inpatient transplant facilities. For information on Commercial products, click here.

In addition to the specific information contained here, providers must adhere to the policy information outlined in the professional payment policies for Commercial and Tufts Medicare Preferred HMO/Tufts Health Plan SCO products, located in the Provider Resource Center or on the Payment Policies page.

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

**POLICY**

Tufts Medicare Preferred HMO and Tufts Health Plan SCO cover medically necessary organ and stem cells transplants according to the policies outlined below.

**GENERAL BENEFIT INFORMATION**

When the transplant 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

Per Medicare requirements, all heart, heart, lung, liver, intestinal, kidney and pancreas transplants must be performed at a Medicare-approved facility. Tufts Health Plan does not routinely compensate for services rendered at a non-Medicare-approved facility and contracted providers cannot hold the member liable for these services. Refer to the approved facilities lists for Tufts Medicare Preferred HMO and Tufts Health Plan SCO for additional information.

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 our secure Provider website or by contacting Provider Relations.

Note: There is no member responsibility for Tufts Health Plan SCO members.

**AUTHORIZATION REQUIREMENTS**

Tufts Medicare Preferred HMO and Tufts Health Plan SCO members require a referral for transplants. The group-specific Tufts Medicare Preferred HMO care manager or delegated care manager may help facilitate the referral.

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 prior notification at the time of admission.

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

- 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.

**BILLING INSTRUCTIONS**

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>Service Description</th>
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</thead>
<tbody>
<tr>
<td>0811</td>
<td>Organ acquisition; live donor</td>
</tr>
<tr>
<td>0812</td>
<td>Organ acquisition; cadaver donor</td>
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COMPENSATION/REIMBURSEMENT INFORMATION
Tufts Health Plan currently uses the Medicare DRG as established by CMS to assign a DRG to an inpatient claim.

If a member terminates with Tufts Medicare Preferred HMO or Tufts Health Plan SCO while receiving inpatient services, Tufts Health Plan is responsible for the entire admission until the patient is discharged.

DOCUMENT HISTORY
- April 2017: Reviewed by committee; added Tufts Health Plan SCO references and clarified authorization and notification requirements for urgent vs elective admissions
- January 2017: Template updates
- September 2015: Template conversion
- April 2014: Added information regarding Tufts Health Plan Senior Care Options, template updates
- May 2013: Template updates
- October 2011: Policy reviewed; information added regarding procurement; clarified authorization requirements and DRG information
- January 2010: Removed references to the Tufts Medicare Preferred PPO product
- April 2009: Moved Tufts Medicare Preferred information to its own document

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 your office/facility did not comply with this payment policy, Tufts Health Plan will expect your office/facility to refund all payments related to non-compliance. For more information about Tufts Health Plan’s audit policies, refer to our website. 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 provides information on Tufts Medicare Preferred HMO and Tufts Health Plan Senior Care Options claims adjudication processing guidelines. As every claim is unique, the use of this policy is neither a guarantee of payment nor a final prediction 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 guidelines when applicable, adherence to plan policies and procedures and claims editing logic.