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

Applies to the following Tufts Health Plan products:

☐ Tufts Health Plan Commercial (including Tufts Health Freedom Plan)¹
☒ 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 Commercial products, click here.

In addition to the specific information contained in this policy, providers must adhere to the 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 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 the secure Provider website or by contacting Senior Products Provider Relations.

Note: There is no member responsibility for covered services 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

¹ Commercial products include HMO, POS, PPO, Tufts Health Freedom Plan, and CareLinkSM when Tufts Health Plan is the primary administrator.
- 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>
</tr>
</thead>
<tbody>
<tr>
<td>0811</td>
<td>Organ acquisition; live donor</td>
</tr>
<tr>
<td>0812</td>
<td>Organ acquisition; cadaver donor</td>
</tr>
</tbody>
</table>

**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**

- June 2018: Template updates
- 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 SCO, 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 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 CareLink™ 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.