Transplant Payment Policy

Policy

The Plan reimburses services related to the evaluation for and transplant of human solid organ, bone marrow, and stem cell when:

1. The recipient of the transplant is a Plan member, and
2. The Plan member meets the eligibility and medical criteria.

The Plan member must complete a transplant evaluation at an authorized facility. For Fallon Medicare Plus Plan members, all transplant related activity must be provided at a Medicare approved transplant center.

Services for the donor are covered, including the evaluation, preparation, surgery, and recovery directly related to the donation, except for those services covered by another insurer.

If the Plan member is the donor and the recipient is not a Plan member, no coverage is provided for either the donor or the recipient.

If both the donor and the recipient are Plan members, the donor's expenses are reimbursed through the recipient's coverage.

Reimbursement

The following services are covered for an eligible Plan member who is the intended recipient of a reimbursable transplant:

- Initial consultation, transplant evaluation, and other pre-transplant related services.
- Compatibility testing of potential organ/tissue donors who are family members.
- Charges related to activating the National Marrow Donor Program search process at the donor registry and compatibility testing of potential organ/tissue donors identified through the search process.
- A second opinion provided at another suitable affiliated transplant facility.
- Donor costs for procurement, including evaluation, preparation, surgery, and recovery directly related to the actual donation or possible donation of a living organ.
- Donor costs related to the recovery, storage, and transportation of a non-living (cadaver) organ.
- Services and supplies that would ordinarily be furnished while the Plan member is an inpatient, including but not limited to room and board, anesthesia, surgery and recovery services, diagnostic lab and X-ray services, medications, meals, medical supplies, and medical, surgical, and psychiatric professional charges.
- Immunosuppressive drug therapy following the date of transplant when the member's benefits include outpatient prescription drugs (according to the terms of the member's Evidence of Coverage).

Reimbursable transplants include bone marrow (allogeneic and autologous), cornea, heart, heart-lung, small bowel, simultaneous small bowel and liver, multivisceral, kidney, liver, lung, simultaneous pancreas and kidney, pancreas after kidney, peripheral stem cell and autologous stem cell transplants.

When the transplant is part of a clinical trial, please refer to the Clinical Trials Payment Policy.

The Plan generally reimburses organ, bone marrow, and stem cell transplants at a single, all-inclusive, negotiated rate determined by the transplant facility contract. This "global payment" typically includes facility and professional charges for the transplant period that is specified in the transplant facility contract, generally, beginning on the date of admission for transplant or the day prior to transplant and ending on the date of discharge from the transplant facility. Occasionally transplant facility contracts may exclude professional and ancillary charges, whereupon providers

may submit claims for their services separately. These services may be paid at a discounted rate specified in the transplant facility contract.

The global payment includes the organ acquisition (donor) costs, including psychological evaluation prior to surgery, preparation, surgery, and recovery. In situations where an organ is harvested and transported to the transplant facility, all applicable charges related to the harvesting and transporting of the organ are billed to the transplant facility. The transplant facility's global payment reflects the cost for these services.

The Plan reimburses the following services separately from the global payment:

- The initial consultation to determine the need for transplant.
- Transplant evaluation and other pre-transplant related services (outlier period) for the transplant recipient, including inpatient and outpatient facility and professional charges provided to evaluate a patient for acceptance into a facility's transplant program; the transplant-related services provided to a patient prior to the transplant, such as management and monitoring of the underlying disease condition for which the transplant is needed. Outlier services are generally paid at a rate specified in the transplant facility contract.
- Charges for activating the National Marrow Donor Program (NMDP) registry and compatibility testing of potential organ/tissue donors identified through the search process. NMDP charges are payable at invoice price.
- A transplant recipient's stay that exceeds the contracted number of inlier days. The transplant period is for a specific number of days (inlier period), based on the type of transplant.
- Post-transplant related services (outlier period) provided to the transplant recipient, including inpatient and outpatient services provided during the 12-month period immediately following the end of the transplant period, including services provided to maintain or monitor the patient for recurrence of the underlying disease condition for which the transplant was performed. Outlier services are generally paid at a rate specified in the transplant facility contract.
- Services unrelated to the underlying disease for which the transplant is needed, before or after the transplant.
- Outpatient immunosuppressive drug therapy, if the member's plan type includes prescription drugs.

The following services are not covered:

- Services related to any transplant that is not reimbursable. This includes, but is not limited to experimental or investigational transplants, bio-artificial transplants, such as the transplant of a total artificial heart, and xenotransplants, such as the transplant of animal tissue into human.
- Services for the donor if the recipient is not a Plan member.
- Services of the donor that are covered by another insurer.
- Dental services.
- Transportation or housing costs for the donor or the recipient.
- House cleaning costs incurred in preparation for a transplant recipient's discharge.

Referral/notification/prior authorization requirements

Prior authorization is required.

Billing/coding guidelines

Facility:

- Hospitals bill the appropriate Revenue Codes using the UB-92 or ANSI 837I 4010.
- Itemization should be available upon request.
- Submit claims with appropriate ICD diagnosis procedure code(s) such as:
  ICD-10:

30230G0, 30233G0, 30240G0, 30243G0, 30250G0, 30253G0, 30260G0, 30263G0, 0FY00Z0, 0FY00Z1, 0FY00Z2, 0TY00Z0, 0TY00Z1, 0TY00Z2, 0TY10Z0, 0TY10Z1, 0TY10Z2.

- Submit organ acquisition costs, including any costs for a living donor during the transplant period and outlier period.
- The excising hospital (removal of organs) does not submit a claim to the Plan.
- All services related to the acquisition of an organ (i.e. tissue typing, post-operative evaluation, etc.) should be submitted on the inpatient claim. They will be reimbursed at the contracted rate.
- All donor charges regardless if a Plan member should be submitted under the recipient's name and member identification number.
- Facility and physician charges may be billed separately or together.

Physician/Ancillary:

- Physicians bill professional physician services using the CMS-1500 claim form or ANSI 837P 4010.
- Physician and facility charges may be billed separately or together.

Services will be reimbursed according to contract terms

Place of service

This policy applies to services rendered in all settings.

Policy history

Origination date:	01/18/2006
Previous revision date(s):	01/03/2007 07/01/2013 - Moved to new format and removed outdated discussion of limited time period for coverage of immunosuppressive drugs and outdated language under Billing/coding guidelines. 07/01/2014 - Updated list of codes to include ICD-10 codes. 01/01/2015 - Moved to new template. 01/01/2016 - Annual review and moved to new Plan template.
Connection date & details:	November 2016 – Annual review. January 2018 – Annual Review, no updates January 2019 – Annual Review, no updates. January 2020 – Annual Review, no updates.

The criteria listed above apply to Fallon Health plan and its subsidiaries. This payment policy has been developed to provide information regarding general billing, coding, and documentation guidelines for the Plan. Even though this payment policy may indicate that a particular service or supply is considered covered, specific provider contract terms and/or member individual benefit plans may apply and this policy is not a guarantee of payment. The Plan reserves the right to apply this payment policy to all of the Plan companies and subsidiaries. The Plan routinely verifies that charges billed are in accordance with the guidelines stated in this payment policy and are appropriately documented in the medical records. Payments are subject to post-payment audits and retraction of overpayments.