Transplant Program: Guidelines & FAQ

PROGRAM DESCRIPTION

Our program guidelines for organ and bone marrow/stem cell transplants are designed to help your patients get the care needed in the most effective setting, with the best possible outcome. We want to ensure your patients have enough information to make evidence-based decisions about their medical care and that they understand their diagnosis and care plan.

To support these goals, we:

- Require prior authorization for all transplant services, including pre-transplant evaluations.
- Offer benefit coordination and readiness coaching to you and your patient. (Access these services by calling 1-888-906-0958 (toll free) between 8:00 am and 5:00 pm, Monday – Friday.)
- Provide information about facilities ranked as Centers of Excellence for transplant procedures.

FAQ

When did Medica begin requiring prior authorization for both pre-transplant evaluations and transplants?

This new policy was effective October 1, 2016.

What information does Medica need to determine coverage for a transplant?

Medica requires health care providers to obtain prior authorization before rendering services, both for pre-transplant evaluation and the actual transplant for organ and bone marrow/stem cell transplants. Without prior authorization, these services may not be covered and Medica may not pay for a claim.

Transplant prior authorization requests

The Transplant Prior Authorization and Notification form should be returned to Medica by fax to 952-992-3556.

- Submit this form for pre-transplant evaluation and notification.
- If a transplant is then recommended, update and resubmit this same form for transplant authorization and notification.

Please Note: Please fill out this form completely. It has essential information we need to make a coverage decision quickly. Medica reserves the right to conduct a medical necessity review at the time the claim is received.

What happens if the Transplant Prior Authorization and Notification form is not submitted?

If any items are submitted for payment without obtaining a prior authorization, the claim or claims will be denied as provider liability. The provider has 60 days from the date of the claim denial to appeal and supply supporting documentation required to determine medical necessity. **It is important to note that Medica reserves the right to conduct a medical necessity review at the time the claim is received**

What types of transplants require prior authorization?

Prior authorization is required for pre-transplant evaluations and the following types of transplants:

- Bone Marrow or Stem Cell (Peripheral or Umbilical Cord Blood)
- Heart-Lung Transplantation
- Heart Transplantation (Adult and Pediatric)
- Intestinal Transplantation
- Kidney Transplantation
- Liver Transplantation
- Lung Transplantation (Single or Double)
- Pancreas-Kidney (SPK, PAK) Transplantation
- Pancreas Transplantation (Pancreas Alone)

What does pre-transplant evaluation involve?

Pre-transplant evaluation generally includes an evaluation of the patient's medical, social, and psychological conditions. The pre-transplant evaluation can include patient education and discussion of selection criteria, testing, psychosocial factors, nutritional considerations, and medical suitability for transplant.

Why is prior authorization needed for pre-transplant evaluation and transplants?

Medica's aim is to support our members in making evidence-based decisions about appropriate, medically necessary care. Prior authorization is also important for providers and our members to assure that claims are not denied because a facility or provider did not meet the medical criteria for coverage outlined in the member's policy.

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Which Medica plans require prior authorization for pre-transplant evaluation and transplants?

Prior authorization is required for all Medica products, including government products, unless a particular health plan (whether commercial, Medicare or Medicaid) requires different coverage. For example, Medica Medicare products follow the National Coverage Determinations (NCD) guidelines.

How does Medica make coverage decisions?

We have a formal utilization management (UM) policy containing clinical criteria. Medica refers to it for prior authorization, appropriateness of care determination and coverage. The criteria are specific to the clinical characteristics of the population that will benefit from the treatment or technology.

The needs of individual patients who may not meet these criteria must be considered and are addressed by the process in the section labeled "Coverage Policies" on the UM policy.

Below is a complete list of available transplant – organ & bone marrow utilization management policies:

- Bone Marrow or Stem Cell (Peripheral or Umbilical Cord Blood)
- Heart-Lung Transplantation
- Heart Transplantation (Adult and Pediatric)
- Intestinal Transplantation
- Kidney Transplantation
- Liver Transplantation
- Lung Transplantation (Single or Double)
- Pancreas-Kidney (SPK, PAK) Transplantation
- Pancreas Transplantation (Pancreas Alone)

View all Utilization Management Policies for Transplants - Organ & Bone Marrow

What if a transplant is urgently needed? Can I ask for a faster review?

The earlier you send requests for prior authorizations, the better. Prompt and complete notifications and responses to Medica's requests for medical records help us provide you with faster review and answers about coverage decisions. In some cases, you may want to request an expedited review.

Please Note: Medica may review health services before, during or afterward to determine if medical necessity criteria were met. C*laims maybe denied as provider liability* if facilities have not met medical criteria.

What sources does Medica use to make coverage decisions?

Medica medical policies are a clinical reference that includes Utilization Management policies, coverage policies, drug management policies, Institute for Clinical Systems Improvement (ICSI) guidelines and Medica clinical guidelines. We also may use tools developed by third parties, such as the MCG Care Guidelines®, to assist us in administering health benefits.

Medica Utilization Management policies and MCG Care Guidelines are not intended to be used without the independent clinical judgment of a qualified health care provider taking into account the individual circumstances of each member's case. Our policies and care guidelines do not constitute the practice of medicine or medical advice. The treating health care providers are solely responsible for diagnosis, treatment, and medical advice.

Is transplant case management provided?

Yes, you or your patient can request transplant case management services. Case managers work with transplant facilities on your patient's behalf to manage prior authorization requirements. They will also help to find network facilities that offer the best benefit for pre- and post-transplant services, such as home health care, home therapy and social service support.

Questions?

Call the Medica Provider Service Center at 1-800-458-5512 (toll free) or email caremanagement@medica.com

Medica Utilization Management and Clinical Appeals Department

PO Box 9310 CP440
Minneapolis, MN 55440

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