MEDICAL COVERAGE POLICY	
SERVICE: Transplantation Services	
Policy Number:	**129**
Effective Date:	**07/01/2021**
Last Review:	**05/27/2021**
Next Review Date:	**05/27/2022**

Important note:
Unless otherwise indicated, this policy will apply to all lines of business.
Even though this policy may indicate that a particular service or supply may be considered medically necessary and thus covered, this conclusion is not based upon the terms of your particular benefit plan. Each benefit plan contains its own specific provisions for coverage and exclusions. Not all benefits that are determined to be medically necessary will be covered benefits under the terms of your benefit plan. You need to consult the Evidence of Coverage (EOC) or Summary Plan Description (SPD) to determine if there are any exclusions or other benefit limitations applicable to this service or supply. If there is a discrepancy between this policy and your plan of benefits, the provisions of your benefits plan will govern. However, applicable state mandates will take precedence with respect to fully insured plans and self-funded non-ERISA (e.g., government, school boards, church) plans. Unless otherwise specifically excluded, Federal mandates will apply to all plans. With respect to Medicare-linked plan members, this policy will apply unless there are Medicare policies that provide differing coverage rules, in which case Medicare coverage rules supersede guidelines in this policy. Medicare-linked plan policies will only apply to benefits paid for under Medicare rules, and not to any other health benefit plan benefits. CMS's Coverage Issues Manual can be found on the CMS website. Similarly, for Medicaid-linked plans, the Texas Medicaid Provider Procedures Manual (TMPPM) supersedes coverage guidelines in this policy where applicable.

SERVICE: Transplantation Services

PRIOR AUTHORIZATION: Required.

POLICY: Please review the plan's EOC (Evidence of Coverage) or Summary Plan Description (SPD) for coverage details.

For Medicare plans, please refer to appropriate Medicare LCD (Local Coverage Determination). If there is no applicable LCD, use the criteria set forth below.

For Medicaid plans, please confirm coverage as outlined in the Texas Medicaid TMPPM.

SWHP may consider transplantation medically necessary for stem cells and the following organs individually and in certain combinations:

- kidney
- liver
- heart
- heart-kidney
- heart-lung
- Intestine
- lung
- pancreas
- pancreas-kidney
- liver-kidney
- autologous pancreatic islet cell transplantation as an adjunct to a pancreatectomy for individuals with chronic pancreatitis
- Other organs or organ combinations will be reviewed case by case for medical necessity.

NOTE: Evidence of Coverage (EOC) documents may list specific organ transplants covered. Coverage should be verified by consulting the EOC.

Similarly, Self-Funded groups may list organ transplants covered or excluded in their documentation.

Donor/procurement costs for covered transplants for matching, removal, and transportation of the organ are covered if:

1. the recipient of the organ is covered, and
2. the donor and/or procurements costs are not covered by the donor's health insurance.

If the donor's health insurance does not cover donor/procurement costs, such costs will be covered.

To be considered for approval for transplantation of one or more of the organs listed above:

1. Prior Authorization request for transplant evaluation must be submitted by an applicable contracted specialist to SWHP which details the indication for the proposed transplant and the suitability of the patient as a candidate recipient
2. SWHP will work with the referring specialist to identify a qualified transplant center, contracted in our network, for the indicated organ(s)
3. The patient undergoes transplant evaluation at the specified transplant center and recommendation is submitted to SWHP for potential listing and procedure approval
4. SWHP reviews the evaluation and recommendation and renders a coverage determination

EXCLUSIONS: organ transplantation is NOT considered medically necessary if:

1. Transplantation occurs without following the steps above
2. Transplantation occurs in a non-contracted center
3. Transplantation involves an organ or organ-pair not listed above, UNLESS with prior approval
4. Transplantation involves a non-human organ

In addition, organ transplantation is NOT considered medically necessary if there is significant organ system failure of organ(s) not to be transplanted and that will not reverse after a new organ(s) have been transplanted.

OVERVIEW:

Organ transplantation may become necessary when the functioning of a critical organ deteriorates and is no longer (or will no longer be) capable of supporting normal life. Organ transplantation requires intensive long term follow up. Potential organ recipients must undergo evaluation to make sure they are reasonable candidates for transplantation. Once an individual becomes a candidate for transplantation, they are typically placed on a waiting list. Transplanted organs may come from cadaveric human donors or living (often related) human donors.

MANDATES: None

CODES:

Important note:

CODES: Due to the wide range of applicable diagnosis codes and potential changes to codes, an inclusive list may not be presented, but the following codes may apply. Inclusion of a code in this section does not guarantee that it will be reimbursed, and patient must meet the criteria set forth in the policy language.

CPT Codes:	32850 Donor pneumonectomy 32851 - 32854 Lung transplant 32855 Backbench preparation of donor lung 32856 Backbench preparation of donor lung

	33930 Donor cardiectomy-pneumonectomy 33933 Backbench standard preparation of cadaver donor heart/lung allograft 33935 Heart-lung transplant with recipient cardiectomy-pneumonectomy 33940 Donor cardiectomy 33944 Backbench standard preparation of cadaver donor heart 33945 Heart transplant with or without recipient cardiectomy 38204 Management of recipient hematopoietic progenitor cell donor search and cell acquisition 38205 Blood-derived hematopoietic progenitor cell harvesting for transplantation, per collection; allogeneic 38206 Blood-derived hematopoietic progenitor cell harvesting for transplantation, per collection; autologous 38207 - 38215 Transplant preparation of hematopoietic progenitor cells 38230 Bone marrow harvesting for transplantation; allogeneic 38232 Bone marrow harvesting for transplantation; autologous 38240 Hematopoietic progenitor cell (HPC); allogeneic transplantation 38241 Hematopoietic progenitor cell (HPC); autologous transplantation 38242 Allogeneic lymphocyte infusion 44132 - 44133 Donor enterectomy 44135 Intestinal allotransplantation 44136 Intestinal allotransplantation 47133 Donor hepatectomy 47135 Liver allotransplantation 47140 - 47142 Donor hepatectomy 47143 - 47147 Backbench preparation/reconstruction of cadaver or living donor liver graft 48160 Pancreatectomy, total or subtotal, with autologous transplantation of pancreas or pancreatic islet cells 48550 Donor pancreatectomy 48551 - 48552 Backbench preparation of donor pancreas 48554 Transplantation of pancreatic allograft 50300 Donor nephrectomy 50320 Donor nephrectomy 50323 - 50329 Backbench reconstruction of cadaver or living donor renal allograft 50340 Recipient nephrectomy (separate procedure) 50360 Renal allotransplantation, implantation of graft; without recipient nephrectomy 50365 Renal allotransplantation 50380 Renal autotransplantation, reimplantation of kidney 50547 Laparoscopy, surgical; donor nephrectomy
CPT Not Covered:	
ICD10 codes::	

CMS:

LCD: None

NCDs:

1. Heart Transplants (260.9) – may be covered in a Medicare approved facility.

2. Pancreas Transplants (260.3) – may be covered in a Medicare approved facility when performed simultaneously with or after kidney transplantation. May be covered alone if specific criteria are met, as specified in NCD.
3. Islet Cell Transplants [allogenic] (260.3.1) - may be covered in a Medicare approved facility when performed for Medicare beneficiaries participating in a National Institutes of Health (NIH)-sponsored clinical trial(s).
4. Adult Liver Transplantation (260.1) – may be covered in a Medicare approved facility for end stage liver disease (not due to malignancy), and for hepatocellular carcinoma if specific criteria are met, as specified in NCD.
5. Intestinal and Multi-Visceral Transplantation (260.5) – may be covered in a Medicare approved facility for irreversible intestinal failure in individuals who have failed total parenteral nutrition and meet specific criteria, as specified in NCD.
6. Pediatric Liver Transplantation (260.2) – may be covered in a Medicare approved facility for children (under age 18) with extrahepatic biliary atresia or any other form of end stage liver disease, except that coverage is not provided for children with a malignancy extending beyond the margins of the liver or those with persistent viremia.
7. Stem Cell Transplantation (110.23) – may be covered in a Medicare approved facility for mobilization, harvesting, and transplant of bone marrow or peripheral blood stem cells and the administration of high dose chemotherapy or radiotherapy prior to the actual transplant.

There is no NCD for kidney transplantation. However, kidney transplants are defined as a Medicare Part A/B benefit.

POLICY HISTORY:

Status	Date	Action
New	12/3/2010	New policy
Reviewed	10/18/2011	Reviewed.
Reviewed	10/4/2012	Reviewed.
Reviewed	07/11/2013	Extensively revised
Reviewed	05/22/2014	No changes
Reviewed	07/02/2015	No changes
Reviewed	12/17/2015	Added islet cell transplant to list.
Reviewed	07/28/2016	Updated multi-organ transplant list. Organ failure exclusion added
Reviewed	07/18/2017	Updated to include stem cell transplant
Reviewed	05/22/2018	Minor updates
Reviewed	10/17/2019	No changes
Updated	05/28/2020	Reviewed and aligned for FirstCare and SWHP
Reviewed	05/27/2021	Added “heart-kidney” as covered transplant (during external review)

REFERENCES:

The following scientific references were utilized in the formulation of this medical policy. SWHP will continue to review clinical evidence related to this policy and may modify it at a later date based upon the evolution of the published clinical evidence. Should additional scientific studies become available and they are not included in the list, please forward the reference(s) to SWHP so the information can be reviewed by the Medical Coverage Policy Committee (MCPC) and the Quality Improvement Committee (QIC) to determine if a modification of the policy is in order.

1. CMS NCD for Heart Transplants (260.9), version 3, effective May 1, 2008.
2. CMS NCD for Pancreas Transplants (260.3), version 3, effective April 26, 2006.
3. CMS NCD for Islet Cell Transplants (260.3.1), version 1, effective October 1, 2004.
4. CMS NCD for Adult Liver Transplantation (260.1), version 3, effective June 21, 2012.

5. CMS NCD for Intestinal and Multi-Visceral Transplantation (260.5), version 2, effective May 11, 2006.
6. CMS NCD for Pediatric Liver Transplantation (260.2), version 1, effective April 12, 1991
7. CMS NCD for Stem Cell Transplantation (110.23), version 1, effective January 27, 2016
8. United Network for Organ Sharing: https://unos.org/