MEDICAL COVERAGE POLICY	
SERVICE:	**Transplantation Services**
Policy Number:	**129**
Effective Date:	**05/01/2024**
Last Review:	**04/08/2024**
Next Review:	**04/08/2025**

Important note: *Unless otherwise indicated, medical policies will apply to all lines of business. Medical necessity as defined by this policy does not ensure the benefit is covered. This medical policy does not replace existing federal or state rules and regulations for the applicable service or supply. In the absence of a controlling federal or state coverage mandate, benefits are ultimately determined by the terms of the applicable benefit plan documents. See the member plan specific benefit plan document for a complete description of plan benefits, exclusions, limitations, and conditions of coverage. In the event of a discrepancy, the plan document always supersedes the information in this policy.*

SERVICE: Transplantation Services

PRIOR AUTHORIZATION: Required

POLICY: Please review the plan's EOC (Evidence of Coverage) or Summary Plan Description (SPD) for coverage details. Plan documents may list specific organ transplant coverage and exclusions. Coverage should be verified by consulting the specific plan document.

Note: Unless otherwise indicated (see below), this policy will apply to all lines of business.

For Medicare plans, please refer to appropriate Medicare NCD (National Coverage Determination) or LCD (Local Coverage Determination). Medicare NCD or LCD specific InterQual criteria may be used when available. If there are no applicable NCD or LCD criteria, use the criteria set forth below.

1. NCD 260.9 Heart Transplants – May be covered in a Medicare approved facility.
2. NCD 260.3 Pancreas Transplants – 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.
3. NCD 260.3.1 Islet Cell Transplantation in the Context of a Clinical Trial – 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. NCD 260.1 Adult Liver Transplantation – 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.
5. NCD 260.5 Intestinal and Multi-Visceral Transplantation – May be covered in a Medicare approved facility for irreversible intestinal failure in individuals who have failed total parenteral nutrition and meet specific criteria.
6. NCD 260.2 Pediatric Liver Transplantation – 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. NCD 110.23 Stem Cell Transplantation – 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.
8. **Kidney Transplantation** – There is no NCD for kidney transplantation. However, kidney transplants are defined as a Medicare Part A/B benefit.

For Medicaid plans, please confirm coverage as outlined in the Texas Medicaid Provider Procedures

Manual | TMHP (TMPPM). If there are no applicable criteria to guide medical necessity decision making in the TMPPM, use the criteria set forth below.

BSWHP may consider transplantation medically necessary for stem cells (use InterQual® for criteria) 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.

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 BSWHP which details the indication for the proposed transplant and the suitability of the patient as a candidate recipient.
2. BSWHP 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 BSWHP for potential listing and procedure approval.
4. BSWHP 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
5. There is significant organ system failure of organ(s) not to be transplanted which will not reverse after a new organ(s) have been transplanted

BACKGROUND:

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 Codes Not Covered	
ICD-10 Codes	

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)
Reviewed	05/26/2022	No changes
Reviewed	06/22/2023	Minor clarifications
Reviewed	04/08/2024	Formatting changes, added hyperlinks to NCD and TMPPM resources, beginning and ending note sections updated to align with CMS requirements and business entity changes

REFERENCES:

The following scientific references were utilized in the formulation of this medical policy. BSWHP 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 BSWHP 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.CMS NCD for Pancreas Transplants (260.3), version 3, effective April 26, 2006.
2. CMS NCD for Islet Cell Transplants (260.3.1), version 1, effective October 1, 2004.
3. CMS NCD for Adult Liver Transplantation (260.1), version 3, effective June 21, 2012.
4. CMS NCD for Intestinal and Multi-Visceral Transplantation (260.5), version 2, effective May 11, 2006.
5. CMS NCD for Pediatric Liver Transplantation (260.2), version 1, effective April 12, 1991
6. CMS NCD for Stem Cell Transplantation (110.23), version 1, effective January 27, 2016
7. United Network for Organ Sharing: https://unos.org/

***Note**:*
Health Maintenance Organization (HMO) products are offered through Scott and White Health Plan dba Baylor Scott & White Health Plan, and Scott & White Care Plans dba Baylor Scott & White Care Plan. Insured PPO and EPO products are offered through Baylor Scott & White Insurance Company. Scott and White Health Plan dba Baylor Scott & White Health Plan serves as a third-party administrator for self-funded employer-sponsored plans. Baylor Scott & White Care Plan and Baylor Scott & White Insurance Company are wholly owned subsidiaries of Scott and White Health Plan. These companies are referred to collectively in this document as Baylor Scott & White Health Plan.

RightCare STAR Medicaid plans are offered through Scott and White Health Plan in the Central Managed Care Service Area (MRSA) and STAR and CHIP plans are offered through SHA LLC dba FirstCare Health Plans (FirstCare) in the Lubbock and West MRSAs.