

## Transplants

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These services may or may not be covered by all HealthPartners plans. Please see your plan documents for your own coverage information. If there is a difference between this general information and your plan documents, your plan documents will be used to determine your coverage.

### Administrative Process

#### Requires Prior Notification

**Prior Notification** at the time of transplant consultation is required when performed at a **HealthPartners Transplant Center of Excellence (COE)** for the following transplants:

1. Kidney
2. Heart
3. Liver
4. Lung
5. Simultaneous pancreas kidney (SPK) and pancreas after kidney (PAK)
6. Stem cell and bone marrow transplants for diagnoses listed below under **Indications that are Covered, #8 and #9.**

#### Requires Prior Approval

**Prior approval** is required for all of the following transplants:

1. New techniques for transplants listed above as only requiring prior notification.
2. Any transplant at non-designated COEs (Out of Network, need for transfer, etc.)
3. Any transplant for a diagnosis that is not listed below under **Indications that are Covered, #1 through #9.**
4. Pancreas transplant alone (PTA)
5. Small bowel transplant
6. Multiple organ transplants

**Note:** Cornea transplants are not limited to Designated Transplant Centers. They do not require prior approval from the health plan or prior notification.

### Designated Transplant Providers HealthPartners Centers of Excellence

Many plans require that transplant procedures be performed at HealthPartners Designated Transplant Centers. Some plans allow for use of Non-Designated transplant facilities. Check your plan documents to determine what facilities are available to you and how your choice will affect your coverage. For more information, please view the [HealthPartners Transplant Centers of Excellence website](#).

### Coverage

Generally covered per the indications/limits listed below. The list of covered transplants is subject to periodic review and modification by the HealthPartners medical director or his or her designee.

#### Indications that are Covered

The following transplants are eligible for coverage:

1. Kidney transplants for end stage disease.
2. Cornea transplants.
3. Heart transplants for end stage disease.
4. Lung transplants or heart/lung transplants for:
  - a. Primary pulmonary hypertension;
  - b. Eisenmenger's syndrome;

- c. End stage pulmonary fibrosis;
  - d. Alpha 1 antitrypsin disease;
  - e. Cystic fibrosis;
  - f. Emphysema.
5. Liver transplants for:
- a. Biliary atresia in children;
  - b. Primary biliary cirrhosis;
  - c. Post acute viral infection (including hepatitis A, hepatitis B antigen e negative and hepatitis C) causing acute atrophy or post-necrotic cirrhosis;
  - d. Primary sclerosing cholangitis;
  - e. Alcoholic cirrhosis,
  - f. Hepatocellular carcinoma.
6. Pancreas transplants for simultaneous pancreas-kidney transplants for diabetes, pancreas after kidney, living related segmental simultaneous pancreas kidney transplantation and pancreas transplant alone. For more specific coverage information, please select the link in the upper right corner titled pancreas transplant.
7. Small bowel transplantation on a case by case basis.
8. Allogeneic bone marrow transplants or peripheral stem cell support (myeloablative or non-myeloablative) associated with high dose chemotherapy for:
- a. Acute lymphocytic leukemia;
  - b. Chronic myelogenous leukemia;
  - c. Severe combined immunodeficiency disease;
  - d. Wiskott-Aldrich syndrome;
  - e. Aplastic anemia;
  - f. Acute myelogenous leukemia.
  - g. Sickle Cell Anemia;
  - h. Non-relapsed or relapsed non-Hodgkin's Lymphoma;
  - i. Multiple Myeloma;
  - j. Testicular cancer.
9. Autologous bone marrow transplants or peripheral stem cell support associated with high dose chemotherapy for the following (list may not be all-inclusive):
- a. Acute leukemias;
  - b. Non-Hodgkin's Lymphoma;
  - c. Hodgkin's Disease;
  - d. Burkitt's Lymphoma;
  - e. Neuroblastoma.
  - f. Multiple myeloma;
  - g. Chronic myelogenous leukemia;
  - h. Non relapsed non-Hodgkin's lymphoma.

### Indications Not Covered

Hand Transplants are not covered because they are considered experimental/investigational.

### Definitions

**Autologous bone marrow transplant** refers to harvesting the bone marrow from the patient and storing it for future use. The patient undergoes treatment including tumor ablation with high-dose chemotherapy and/or radiation. After the treatment, the bone marrow is reinfused (transplanted) into the patient.

**Allogeneic bone marrow transplant** refers to harvesting the bone marrow from a related or unrelated donor and storing it for future use. The patient undergoes treatment including tumor ablation with high-dose chemotherapy and/or radiation. After the treatment, the bone marrow is reinfused (transplanted) into the patient.

**Autologous/Allogeneic Stem Cell Support** is a treatment process that includes stem cell harvest from either bone marrow or peripheral blood, tumor ablation with high-dose chemotherapy and/or radiation, stem cell reinfusion, and supportive care. Autologous/allogeneic bone marrow transplantation and high dose chemotherapy with peripheral stem cell rescue/support are considered to be autologous/allogeneic stem cell support.

**A Designated Transplant Center** is any health care provider, group or association of health care providers designated by HealthPartners to provide services, supplies or drugs for the specified transplant performed on a covered person. For more information, please select the link under Transplants, Related Policies titled, "Designated Transplant Centers".

**Transplant services** include the transplant (or re-transplant) of the human organs or tissues listed below, including all related post-surgical treatment and drugs and multiple transplants for a related cause. Transplant services do not include other organ or tissue transplants or surgical implantation of mechanical devices functioning as human organs, except surgical implantation of FDA approved ventricular assist devices (VAD), functioning as a temporary bridge to heart transplantation or as destination therapy for members end stage heart failure meeting the criteria specified in the VAD coverage policy. (See the VAD policy by selecting the link under Transplants, Related Policies titled "Ventricular Assist Device- VAD".)

### Codes (list may not be all inclusive)

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32851 - Lung transplant, single; without cardiopulmonary bypass  
32852 - Lung transplant, single; with cardiopulmonary bypass  
32853 - Lung transplant, double (bilateral sequential or en bloc); without cardiopulmonary bypass  
32854 - Lung transplant, double (bilateral sequential or en bloc); with cardiopulmonary bypass  
33935 - Heart-lung transplant with recipient cardiectomy-pneumonectomy  
33945 - Heart transplant, with or without recipient cardiectomy  
38240 - Bone marrow or blood-derived peripheral stem cell transplantation; allogenic  
38241 - Bone marrow or blood-derived peripheral stem cell transplantation; autologous  
38242 - Bone marrow or blood-derived peripheral stem cell transplantation; allogeneic donor lymphocyte infusions  
47135 - Liver allotransplantation; orthotopic, partial or whole, from cadaver or living donor, any age  
47136 - Liver allotransplantation; heterotopic, partial or whole, from cadaver or living donor, any age  
48160 - Pancreatectomy, total or subtotal, with autologous transplantation of pancreas or pancreatic islet cells  
48554 - Transplantation of pancreatic allograft  
50360 - Renal allotransplantation, implantation of graft; without recipient nephrectomy  
50365 - Renal allotransplantation, implantation of graft; with recipient nephrectomy  
50380 - Renal autotransplantation, reimplantation of kidney  
0141T - Pancreatic islet cell transplantation through portal vein, percutaneous  
0142T - Pancreatic islet cell transplantation through portal vein, open  
0143T - Laparoscopy, surgical, pancreatic islet cell transplantation through portal vein  
S2065 - Simultaneous pancreas kidney transplantation

### Products

This information is for most, but not all, HealthPartners plans. Please read your plan documents to see if your plan has limits or will not cover some items. If there is a difference between this general information and your plan documents, your plan documents will be used to determine your coverage. These coverage criteria may not apply to Medicare Products if Medicare requires different coverage. For more information regarding Medicare coverage criteria or for a copy of a Medicare coverage policy, contact Member Services at 952-883-7979 or 1-800-233-9645.

Number: T007-09; Approved: Medical Director & Benefits Committees 07/01/95; Revised 7/9/04, 1/24/11; Annual Review 7/9/04, 6/1/05, 7/1/06, 8/1/07, 6/25/08, 9/9/09, 7/6/10, 7/2011.