Transplants

These services may or may not be covered by your HealthPartners plan. Please see your plan documents for your specific 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

HealthPartners Centers of Excellence
Many plans require that transplant procedures be performed at HealthPartners Transplant Centers of Excellence (COE). Some plans allow for use of non-Center of Excellence transplant facilities. Check your plan documents or contact Member Services to determine what facilities are available to you and how your choice will affect your coverage.

Please note: Cornea transplants are outside the scope of this policy. They are covered without prior notification or authorization. Cornea transplants may be received from providers outside the HealthPartners Transplant COEs.

Prior Notification/Authorization Process

1. Prior to selecting a transplant provider submission of a transplant pre-consultation prior authorization form from the referring physician is required. This prior authorization will support the initiation of care and benefit coordination.
2. Prior notification or prior authorization is required before the actual visit date for pre-transplant evaluation as outlined below.
3. Prior notification or prior authorization is required at the time of pre-transplant listing or start of treatment for deemed transplant candidate as outlined below.

For more information, please see the related content at right for the HealthPartners Transplant Resources and COE Networks and for the transplant prior notification and authorization process and form.

Prior notification is required for the following situations
Prior notification is required at the time of pre-transplant evaluation and at the time of pre-transplant listing 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, blood and bone marrow transplants for diagnoses listed below under Indications that are Covered, #8 and #9.

Prior authorization is required for the following situations
Prior authorization is required at the time of pre-transplant evaluation and at the time of pre-transplant listing 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 section, #1 through #9.
4. Pancreas transplant alone (PTA)
5. Small bowel transplant
6. Multiple organ transplants

Does Not Require Prior Authorization or Prior Notification for consultation, evaluation or listing

1. Donor Lymphocyte Infusion

Prior authorization is not applicable for the following transplants, because these services are considered investigational/experimental:

1. Hand transplants
2. Face transplants
3. Uterine transplants
4. Penile transplants

Coverage

Transplants are generally covered per the indications listed below and per your plan documents. 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 eligible for coverage**

The following transplants are eligible for coverage:

1. Kidney transplants for end stage disease.
2. Heart transplants for end stage disease.
3. 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
4. Liver transplants for:
   A. Biliary atresia in children
   B. Primary biliary cirrhosis
   C. Chronic hepatitis A, B, or C resulting in acute liver failure, cirrhosis or post necrotic cirrhosis
   D. Primary sclerosing cholangitis
   E. Alcoholic cirrhosis
   F. Hepatocellular carcinoma
5. Simultaneous pancreas-kidney transplant (SPK), pancreas after kidney transplant (PAK), and living related segmental simultaneous pancreas kidney transplantation, as treatment for diabetic patients with renal disease.
6. Pancreas transplant alone (PTA) for treatment of diabetes when the following indications are met:
   A. A history of frequent, acute and severe metabolic complications, such as hypoglycemia, hyperglycemia, or ketoacidosis requiring medical attention.
   B. Clinical and emotional problems with exogenous insulin therapy that are severe enough to be incapacitating, such as hypoglycemic unawareness.
   C. Consistent failure of insulin-based management to prevent acute complications.
7. Small bowel transplantation on a case by case basis.
8. Allogeneic bone marrow transplants or blood stem cell support (myeloablative or non-myeloablative) associated with high dose chemotherapy for:
   A. Acute lymphocytic/lymphoblastic leukemia
   B. Chronic myelogenous/myeloid leukemia
   C. Severe combined immunodeficiency disease
   D. Wiskott-Aldrich syndrome
   E. Aplastic anemia
   F. Acute myelogenous/myeloid leukemia
   G. Sickle cell anemia
   H. Non-relapsed or relapsed non-Hodgkin's lymphoma
   I. Multiple myeloma
   J. Myelodysplastic syndromes associated with intermediate, high, or very high revised international prognostic scoring system (IPSS-R) scores
9. Autologous bone marrow transplants or blood stem cell support associated with high dose chemotherapy for the following:
   A. Acute leukemias
   B. Non-relapsed or relapsed non-Hodgkin's lymphoma
   C. Hodgkin's Disease
   D. Burkitt's lymphoma
   E. Neuroblastoma
   F. Multiple myeloma
   G. Chronic myelogenous/myeloid leukemia
   H. Immunoglobulin light chain (AL) amyloidosis
   I. Testicular cancer
10. Donor Lymphocyte Infusion following a relapsed allogeneic bone marrow or blood stem cell transplantation.

**Indications not covered**

The following are not covered because they are considered experimental/investigational.

1. Hand transplants
2. Face transplants
Definitions

**Autologous bone marrow or stem cell transplant** refers to harvesting the bone marrow or stem cells 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 or stem cells are reinfused (transplanted) into the patient.

**Allogeneic bone marrow or stem cell transplant** refers to harvesting the bone marrow or stem cells 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 or stem cells are reinfused (transplanted) into the patient.

**Transplant Center of Excellence** 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, “Transplant Resources and COE Networks”.

**Donor lymphocyte infusion (DLI) therapy** is usually done after an allogeneic bone marrow transplant (BMT) has failed. The DLI procedure involves taking a blood donation from the original bone marrow or peripheral blood stem cell donor. This blood is separated, and certain white cells (lymphocytes) are selected to give to the patient. The goal of the therapy is to assist in remission or recovery of the patient's bone marrow.

**Revised international prognostic scoring system (IPSS-R)** The International Prognostic Scoring System (IPSS-R) is the most widely used system for classifying the severity of myelodysplastic syndrome (MDS). The IPSS-R considers the percentage of blasts in the bone marrow, the types of blood abnormalities, and a panel of chromosome abnormalities. Based on these criteria, the IPSS-R score defines five risk groups. The score helps determine treatment recommendations for the patient.

<table>
<thead>
<tr>
<th>Risk group</th>
<th>IPSS-R score</th>
</tr>
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<tbody>
<tr>
<td>Very low</td>
<td>≤1.5</td>
</tr>
<tr>
<td>Low</td>
<td>&gt;1.5 to 3</td>
</tr>
<tr>
<td>Intermediate</td>
<td>&gt;3 to 4.5</td>
</tr>
<tr>
<td>High</td>
<td>&gt;4.5 to 6</td>
</tr>
<tr>
<td>Very high</td>
<td>&gt;6</td>
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</table>

**Evaluation period** is the first step in the process for the patient transplant candidate. The transplant program will schedule visits for biopsychosocial assessments based on protocols.

**Listing or treatment period** occurs when the evaluation is complete, and the patient is deemed a transplant candidate. The program places the patient on a national waiting list or will initiate the blood and marrow treatment protocol.

**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**

If available, codes are listed below for informational purposes only, and do not guarantee member coverage or provider reimbursement. The list may not be all-inclusive.

<table>
<thead>
<tr>
<th>Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>21299</td>
<td>Unlisted craniofacial and maxillofacial procedure, when used to report face transplant</td>
</tr>
<tr>
<td>21499</td>
<td>Unlisted musculoskeletal procedure, head, when used to report face transplant</td>
</tr>
<tr>
<td>26989</td>
<td>Unlisted procedure, hands or fingers, when used to report hand or finger transplant</td>
</tr>
<tr>
<td>32851</td>
<td>Lung transplant, single; without cardiopulmonary bypass</td>
</tr>
</tbody>
</table>
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 caridiectomy- pneumonectomy
33945  Heart transplant, with or without recipient caridiectomy
38240  Hematopoietic progenitor cell (HPC); allogeneic transplantation per donor
38241  Hematopoietic progenitor cell (HPC); autologous transplantation
38242  Allogeneic lymphocyte infusions
38243  Hematopoietic progenitor cell (HPC); HPC boost
44135  Intestinal allotransplantation; from cadaver donor
47135  Liver allotransplantation; orthotopic, partial or whole, from cadaver or living donor, any age
47399  Unlisted procedure, liver, when used to report liver transplant
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
55899  Unlisted procedure, male genital system, when used to report penile transplant
58999  Unlisted procedure, female genital system (nonobstetrical), when used to report uterine transplant
0667T  Donor hysterectomy (including cold preservation); recipient uterus allograft transplantation from cadaver or living donor
S2053  Transplantation of small intestine and liver allografts
S2065  Simultaneous pancreas-kidney transplantation

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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 952-983-7979 or 1-800-233-9645.

References

1. Alhamad, T., Stratta, R. Pancreas-kidney transplantation in diabetes mellitus: Benefits and complications In: UpToDate, Brennan, D., Nathan, D., UpToDate, Waltham, MA. (Accessed on October 26, 2021.)
10. Dispenzieri, A. Treatment and prognosis of immunoglobulin light chain (AL) amyloidosis and light and heavy chain deposition disease In: UpToDate, Glassoic, R., Rajkumar S., Schwab, S. (Ed), UpToDate, Waltham, MA. (Accessed on November 30, 2022)
14. Erlichman, J., Loomes K., Biliary atresia In: UpToDate, Rand, E. (Ed), UpToDate, Waltham, MA. (Accessed on November 30, 2022)

