Transplants - effective 1/1/19

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:
4. Kidney
5. Heart
6. Liver
7. Lung
8. Simultaneous pancreas kidney (SPK) and pancreas after kidney (PAK)
9. 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

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. 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 transplant alone (PTA) 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 so severe as 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 (myeloblastic or non-myeloblastic) 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;
   K. Myelodysplastic syndromes associated with intermediate – very high IPSS-R scores

9. Autologous bone marrow transplants or blood 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.
   I. AL amyloidosis

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
3. Uterine 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.

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>
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<tbody>
<tr>
<td>32851</td>
<td>Lung transplant, single; without cardiopulmonary bypass</td>
</tr>
<tr>
<td>32852</td>
<td>Lung transplant, single; with cardiopulmonary bypass</td>
</tr>
<tr>
<td>32853</td>
<td>Lung transplant, double (bilateral sequential or en bloc); without cardiopulmonary bypass</td>
</tr>
<tr>
<td>32854</td>
<td>Lung transplant, double (bilateral sequential or en bloc); with cardiopulmonary bypass</td>
</tr>
<tr>
<td>33935</td>
<td>Heart-lung transplant with recipient cardiectomy- pneumonectomy</td>
</tr>
<tr>
<td>33945</td>
<td>Heart transplant, with or without recipient cardiectomy</td>
</tr>
<tr>
<td>38240</td>
<td>Hematopoietic progenitor cell (HPC); allogeneic transplantation per donor</td>
</tr>
<tr>
<td>38241</td>
<td>Hematopoietic progenitor cell (HPC); autologous transplantation</td>
</tr>
<tr>
<td>38242</td>
<td>Allogeneic lymphocyte infusions</td>
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<tr>
<td>38243</td>
<td>Hematopoietic progenitor cell (HPC); HPC boost</td>
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<tr>
<td>47135</td>
<td>Liver allotransplantation; orthotopic, partial or whole, from cadaver or living donor, any age</td>
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<td>47399</td>
<td>Unlisted procedure, liver</td>
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<td>48160</td>
<td>Pancreatectomy, total or subtotal, with autologous transplantation of pancreas or pancreatic islet cells</td>
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<tr>
<td>48554</td>
<td>Transplantation of pancreatic allograft</td>
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<td>48999</td>
<td>Unlisted procedure, pancreas</td>
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<td>50360</td>
<td>Renal allotransplantation, implantation of graft; without recipient nephrectomy</td>
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<tr>
<td>50365</td>
<td>Renal allotransplantation, implantation of graft; with recipient nephrectomy</td>
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<tr>
<td>50380</td>
<td>Renal autotransplantation, reimplantation of kidney</td>
</tr>
<tr>
<td>52065</td>
<td>Simultaneous pancreas kidney transplantation</td>
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</tbody>
</table>

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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 952-883-7979 or 1-800-233-9645.

References


Approved: Medical Director & Benefits Committees 07/01/95, 3/21/18; Revised 7/9/04, 1/24/11, 1/25/13, 1/1/16, 3/8/16, 1/19/2017, 3/12/18, 8/29/18, 10/15/18; 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, 7/2012, 1/25/13, 1/1/2014, 1/2015, 1/2016, 1/2017, 1/2018