Clinical Policy: Transplant Evaluation

Reference Number: MI.CP.MP.523
Date of Last Revision: 08/22

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description
Transplant Evaluations are requested by facilities in preparation for members to receive an Actual Transplant.

At the time of the evaluation request, the transplant coordinator or nurse will review with the requestor the items that will be needed once the facility is ready to request an actual transplant.

If any criteria point is not met, Transplant Coordinator will send to UM RN for further review

Policy/Criteria

I. It is the policy of MeridianHealth that transplant evaluation is **medically necessary** for the following indications:
   A. Transplant Coordinators will be able to approve the following members for transplant evaluations when **all** of the following are Met:
      i. Person receiving the transplant evaluation is an active member with Meridian Medicaid
      ii. Organ to be transplanted is kidney, heart, lung, liver, intestinal/viscera, pancreas or bone marrow or some combination thereof.
      iii. Underlying diagnosis is on the list for the respective transplant policy
      iv. Only one transplant evaluation will be approved for each organ/organ combination requested
   B. **Specific Diagnoses** - Most common diagnosis per organ (This list is not all inclusive; please check the appropriate policy):
      i. Kidney
         1. Chronic renal failure nearing dialysis or already on dialysis
      ii. Heart
         1. Heart failure for kids
         2. NYHA class 3 or 4 for adults
      iii. Lung
         1. Restrictive lung disease
         2. Cystic fibrosis
         3. Obstructive lung disease
         4. COPD/emphysema
         5. Primary pulmonary hypertension
      iv. Liver
         1. Cirrhosis
         2. Hepatocellular carcinoma
         3. Wilson’s disease

4. Hemochromatosis
5. Primary sclerosing cholangitis

v. Pancreas
1. Type 1 diabetes

vi. Small Bowel
1. Short gut syndrome or non-functioning bowel with TPN failure

vii. Bone Marrow
1. Sickle cell
2. Leukemia
3. Lymphoma
4. Aplastic anemia
5. Thalassemia major
6. Multiple myeloma
7. Primary immunodeficiency syndromes

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2019, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT®* Codes	Description
N/A	

HCPCS Codes	Description
N/A	

ICD-10-CM Diagnosis Codes that Support Coverage Criteria

+ Indicates a code(s) requiring an additional character

ICD-10-CM Code	Description
N/A	

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Original approval date		04/19/17
Annual review	09/2020	9/2020
Annual Review • Policy Criteria – removed reference to exchange insurance products	08/27/2021	09/28/2021

Reviews, Revisions, and Approvals	Revision Date	Approval Date
• Updated references MDHHS manual dates • Added terminology regarding intestinal and viscera transplant • Formatting updates to align with Centene corporate policy template.		

References

1. Michigan Department of Health and Human Services. Medicaid Provider Manual. Hospital. 3.22 Organ Transplants. Issued: July 1, 2021.

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise

professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.