Policy: MP020
Section: Medical Benefit Policy
Subject: Solid Organ Transplant Services

I. Policy: Solid Organ Transplant Services

II. Purpose/Objective:
To provide a policy of coverage regarding Solid Organ Transplant Services

III. Responsibility:
A. Medical Directors
B. Medical Management Department

IV. Required Definitions
1. Attachment – a supporting document that is developed and maintained by the policy writer or department requiring/authoring the policy.
2. Exhibit – a supporting document developed and maintained in a department other than the department requiring/authoring the policy.
3. Devised – the date the policy was implemented.
4. Revised – the date of every revision to the policy, including typographical and grammatical changes.
5. Reviewed – the date documenting the annual review if the policy has no revisions necessary.

V. Additional Definitions
Medical Necessity or Medically Necessary means Covered Services rendered by a Health Care Provider that Geisinger Health Plan (GHP) determines are:

- a. appropriate for the symptoms and diagnosis or treatment of the Member's condition, illness, disease or injury;
- b. provided for the diagnosis, and the direct care and treatment of the Member's condition, illness disease or injury;
- c. in accordance with current standards of good medical treatment practiced by the general medical community;
- d. not primarily for the convenience of the Member, or the Member’s Health Care Provider; and
the most appropriate source or level of service that can safely be provided to the Member. When applied to hospitalization, this further means that the Member requires acute care as an inpatient due to the nature of the services rendered or the Member's condition, and the Member cannot receive safe or adequate care as an outpatient.

Medicaid Business Segment
Medical Necessity shall mean a service or benefit that is compensable under the Medical Assistance Program and if it meets any one of the following standards:

(i) the service or benefit will, or is reasonably expected to, prevent the onset of an illness, condition or disability.
(ii) the service or benefit will, or is reasonably expected to, reduce or ameliorate the physical, mental or development effects of an illness, condition, injury or disability.
(iii) the service or benefit will assist the Member to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the Member and those functional capacities that are appropriate for members of the same age.

DESCRIPTION: Approved solid organ transplantation is covered when medically indicated. Transplant evaluation, transplant services and post-transplant care are coordinated through the current contracted transplant management vendor.

INDICATIONS: REQUIRES PRIOR MEDICAL DIRECTOR AUTHORIZATION (except corneal transplant)

Treatment guidelines for transplant and related follow-up are continuously changing due to rapid advances and research. Approved transplant services are covered according to the individual contract language. Except for corneal transplants, Geisinger Health Plan (GHP) requires prior authorization for services related to transplants and follow-up treatment. The following transplants are considered for coverage when appropriate criteria, as determined by GHP medical director and the current contracted transplant management vendor, are met. In order to assess the medical necessity of the transplant, adequate information must be submitted to GHP. Please see the appropriate attachment as listed below for the required information:

- Heart
- Heart & Lung
- Lung & Lobar Lung
- Liver
- Renal
- Renal & Pancreas/ Solitary Pancreas (after a successful Kidney)
- Small Bowel
- Small Bowel/Liver and Multi-visceral

Additional consultation and/or evaluation may be required in the following situations. Documentation of those consultations and reports of additional testing must be submitted to GHP for review.

- Documented evidence of recent graft loss
- Documented evidence of malignancy (treated) within the last 5 years
- Active psychiatric and behavioral disorder
- HIV infection without AIDS and with sustained CD4 counts greater than 200/mm$^3$
- Chronic peptic ulcer disease, GI bleeding, diverticulitis.

GHP covers the following services to the extent of any limitation as may be listed in the benefit document, applicable rider or applicable medical benefit policy when a covered organ or tissue transplant is performed:

- Compatibility testing of prospective organ/tissue donors who are members of the family of a patient selected for an organ transplant; and
- Live organ/tissue donor fees; and
- Cadaveric organ/tissue procurement preservation, storage and transportation fees as billed by the Organ Procurement Organization (OPO); and
- Charges for activating the donor search process for donors in the registry, HLA-DR sample procurement and typing, donor physical examinations and laboratory tests as well as bone marrow/stem cell procurement.

For Medicare Business Segment

GHP covers all medically necessary and non-investigational/experimental organ and tissue transplants, as covered by Medicare. When Medically Necessary, the following transplants are covered: Kidney (cadaver and living donor), kidney/pancreas, cornea, heart, heart/lung, single lung, double lung, liver (cadaver and living donor), liver/pancreas, small bowel, pancreas/small bowel, bone marrow, stem cell, pancreas, liver/small bowel transplants, and multivisceral transplants.

For Medicaid Business Segment:

GHP covers all medically necessary and non-investigational/experimental organ and tissue transplants, as approved by the PA Dept. of Human Services.
EXCLUSIONS:
GHP does NOT provide coverage for procedures and services provided as being related to an investigational technology, including, but not limited to, services and procedures that would otherwise be covered, and hospital admissions solely for the purpose of providing an investigational technology, or research protocol. Routine care provided during an approved clinical trial is covered. Please see MP312 Routine Care in Clinical trials. These services and procedures are considered experimental, investigational or unproven because of insufficient evidence in the peer-reviewed published medical literature to establish the effectiveness of these treatments on health outcomes when compared to established treatments or technologies.

LINE OF BUSINESS:
Eligibility and contract specific benefit limitations and/or exclusions will apply. Coverage statements found in the line of business specific benefit document will supersede this policy. For Medicare, applicable LCD’s and NCD’s will supercede this policy For PA Medicaid Business segment, this policy applies as written.

REFERENCES:


Center for Medicare and Medicaid Services, National Coverage Determination number 260.9, Heart transplantation, Available at http://www.cms.hhs.gov/mcd/results.asp?show=all&t=200762614430 Accessed on 09/24/08.


Center for Medicare and Medicaid Services, National Coverage Determination number 260.1, Adult Liver Transplantation, revision effective 6-19-06, Available at: http://www.cms.hhs.gov/mcd/search.asp Accessed on 09/24/08.


Centers for Medicare and Medicaid Services, National Coverage Decision number 260.5 Intestinal and Muti-Visceral Transplantation, revised May, 2006, Available at; www.cms.hhs, Accessed on 09/24/08.

This policy will be revised as necessary and reviewed no less than annually.

Medical Management Committee Approval Date: 8/6/03

Medical management Administrative Committee Approval Date: 8/15/03

Devised: 8/03

Revised: 8/04; 8/06; 8/07(wording); 10/08 (addition of documentation requirements); 10/15 revised title; 10/16

Reviewed: 8/05; 10/09; 10/10, 10/11, 10/12, 10/13, 10/14, 9/17, 9/18