



## Clinical Medical Policy Transplants

### **Benefit Coverage:**

Transplant services are covered for Rhody Health Plan, Rite Care, Children with Special Health Care Needs and Substitute Care when ordered by a plan physician. Authorization is required.

Transplant services include non-experimental human organ transplant of an organ or tissue from one person to another or from a cadaver. Organs that can be transplanted include heart, lung, kidney, kidney-pancreas (for members with Type 1 Diabetes only), liver, bone marrow and stem cell.

Except as otherwise required by law, Neighborhood Health Plan of Rhode Island (Neighborhood) does not cover experimental or investigative treatment or drugs. In compliance with Rhode Island General Law (RIGL) 27-18-36.2, New Cancer Therapies, Neighborhood covers new cancer therapies still under investigation.

### **Description:**

Autologous transplantation involves the transplanting of tissue from one part of the body to another, as when a person's blood or stem cells are removed, stored, and later given back to the patient.

Allogenic transplantation involves transplanting of tissue or organs from one patient to another, as in the case of transplanting stem cells from donor to recipient.

### **Coverage Determination:**

Organ transplantation requires coordination of financial and clinical information to facilitate optimal outcomes. Neighborhood's Transplant Contract Coordination Case Management program provides a framework for an organized flow of information exchange and decision making between internal departments and external parties.

Neighborhood's expectation is that transplant facilities follow best practices to ensure the best outcomes for our members. The facility's protocol may be reviewed as needed.

Neighborhood's benefit coverage determines if the type of transplant procedure identified can be considered for authorization. Industry standard ICD-9 Transplant Reference Guides are utilized as a guideline to determine, for covered transplant procedures, if the requested procedure is appropriate for the member's diagnosis.

The requesting transplant facility utilizes the *Neighborhood Transplant Request Checklist* to prepare the required documentation for submission.



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The following is a list of the more common transplants and at what point a member may be considered as a potential candidate.

### Liver

Liver transplant necessity for members age 12 and older is based on the MELD (Model for end stage liver disease) which is a numerical scale ranging from 6 (less ill) to 40 (gravely ill). The higher the score, the more likely they will become an imminent transplant candidate. PELD (Pediatric end stage liver disease) is a similar scale for members less than 12 years of age. Both have an exception which is a Status I category for acute liver failure and a life expectancy of hours to a few days without a transplant. Hepatocellular carcinoma may be classified as a Status I.

A MELD/PELD status of 20 or greater increases the likelihood of qualifying for a liver transplant within 3- 6 months.

### Lung:

Facilities notify Neighborhood when the member is on the “top 10 list” to receive a transplant, and/or if an admission date has been established.

Diagnoses that may result in a lung transplant include alpha I antitrypsin deficiency, pulmonary fibrosis, primary pulmonary hypertension and cystic fibrosis.

### Bone Marrow (BMT):

Facilities notify Neighborhood when the member has been scheduled for admission.

Diagnoses that may result in a BMT include Acute Myelogenous Leukemia (AML), Acute Lymphocytic Leukemia (ALL), Hodgkin’s, Multiple Myeloma and aplastic anemia.

### Heart:

Facilities notify Neighborhood when the member’s status changes.

Note: 1A = top of the list (heart), 1B lesser level

The following diagnoses/conditions may result in a need for a heart transplant, depending on the level of severity:

- End stage heart disease (New York Heart Association Class III or IV).
- severe systolic or diastolic ventricular dysfunction
- Life threatening arrhythmias
- Intractable angina
- Primary cardiac tumors without metastases
- Other advanced, irreversible cardiac disease, including refractory CHF



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- Congenital heart disease that is not amendable to surgical therapy including: hypoplastic left heart syndrome, single ventricle, truncus arteriosus, AV canal, ebstein anomaly, Tetralogy of Fallot, transposition of the great arteries

### Kidney:

Facilities notify Neighborhood when the member is on the top 10 list, with donor confirmed and an admission date has been set.

### **Criteria:**

All three of the following criteria must be met for authorization of a covered transplant:

- 1) All members being considered for a transplant are evaluated by the clinicians from the transplant facilities. Neighborhood requires that this evaluation is sent at the time of the request for authorization of the transplant. This evaluation should include all of the following (as applicable to the organ being requested):
  - All medical and behavioral health diagnoses
  - Listing status
  - Prior transplant history
  - Progress notes including disease progression and current status (acute/chronic, remission, etc.)
  - Facility Transplant Protocol/criteria
  - Test results
  - MELD/PELD score (Liver only)
  - Availability of donor (if applicable)
  - Behavioral health and Social Worker evaluations and protocols
  - Documentation of member adherence to medical, behavioral health and substance abuse appointments and treatment plans
  - Consults and all other evaluations
  - Facility's smoking cessation protocol, documentation of member's adherence to the protocol
  - Psycho-social support network
- 2) There is evidenced based literature that supports the requested transplant procedure for the diagnoses present.
- 3) There is evidenced based literature and clinical documentation that indicates an optimal outcome can be expected, based on the evaluation of the member's current status, adherence history and psycho-social supports.

### **Exclusions:**



## Clinical Medical Policy Transplants

Neighborhood does not cover experimental procedures or treatments, except as otherwise required by law. Also refer to Clinical Medical Policy “Experimental or Investigational Services.” Transplants of the pancreas, face, and intestines are considered experimental and therefore are not covered.

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*CMP Number:* CMP-048

*CMP Cross Reference:* CMP-026 Experimental/Investigational Services

### *References:*

Optum ICD-9 Transplant Reference Guide, or similar.

Rhode Island Laws - Chapter 27-41-41, New Cancer Therapies, Under Investigation (Health Maintenance Organizations)

<http://www.rilin.state.ri.us/Statutes/TITLE27/27-41/27-41-41.HTM>

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## Clinical Medical Policy Transplants

Please refer to Neighborhood's *Clinical Medical Policy for Transplants* available on Neighborhood's web site, [www.nhpri.org](http://www.nhpri.org) for more detailed information about this benefit, authorization requirements, and coverage criteria.

### CHECK LIST

|                                      |                       |           |               |
|--------------------------------------|-----------------------|-----------|---------------|
| Member Name _____                    | NHPRI ID _____        | DOB _____ |               |
| Provider _____                       | Phone _____           | Fax _____ | Contact _____ |
| Transplant Procedure Requested _____ | Date of Request _____ |           |               |

Please use the following list to ensure all the appropriate documentation is submitted for review. All documents should be sent with this cover sheet complete, to ensure timely turn-around time of Neighborhood's decision.

- All medical and behavioral health diagnoses
- Listing status
- Prior transplant history
- Facility protocol/criteria
- Progress notes including disease progression and current status (acute/chronic, remission, etc.) Please be sure to include height and weight or BMI
- Test results
- MELD/PELD score (Liver only)
- Availability of donor (if applicable)
- Behavioral health and Social Worker evaluations and protocols
- Documentation of member adherence to medical, behavioral health and substance abuse appointments and treatment plans
- Consults and all other evaluations
- Facility's smoking cessation protocol, documentation of member's adherence to the protocol
- Psycho-social support network