# Coverage Summary

## Transplants: Organ and Tissue Transplants

<table>
<thead>
<tr>
<th>Policy Number:</th>
<th>T-005</th>
<th>Products: UnitedHealthcare Medicare Advantage Plans</th>
<th>Original Approval Date: 11/05/2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>Approved by:</td>
<td>UnitedHealthcare Medicare Benefit Interpretation Committee</td>
<td>Last Review Date: 9/15/2020</td>
<td></td>
</tr>
</tbody>
</table>

### Related Medicare Advantage Policy Guidelines:

- Adult Liver Transplantation (NCD 260.1)
- Dental Examination Prior to Kidney Transplantation (NCD 260.6)
- Heart Transplants (NCD 260.9)
- Heartbeart Test for Heart Transplant Rejection (NCD 260.10)
- Histocompatibility Testing (NCD 190.1)
- Intestinal and Multi-Visceral Transplantation (NCD 260.5)
- Islet Cell Transplantation in the Context of a Clinical Trial (NCD 260.3.1)
- Pancreas Transplant (NCD 260.3)
- Pediatric Liver Transplantation (NCD 260.2)
- Stem Cell Transplantation (Formerly 110.8.1) (NCD 110.23)

---

This information is being distributed to you for personal reference. The information belongs to UnitedHealthcare and unauthorized copying, use, and distribution are prohibited. This information is intended to serve only as a general reference resource and is not intended to address every aspect of a clinical situation. Physicians and patients should not rely on this information in making health care decisions. Physicians and patients must exercise their independent clinical discretion and judgment in determining care. Each benefit plan contains its own specific provisions for coverage, limitations, and exclusions as stated in the member’s Evidence of Coverage (EOC)/Summary of Benefits (SB). If there is a discrepancy between this policy and the member’s EOC/SB, the member’s EOC/SB provision will govern. The information contained in this document is believed to be current as of the date noted.

The benefit information in this Coverage Summary is based on existing national coverage policy, however, Local Coverage Determinations (LCDs) may exist and compliance with these policies is required where applicable.

There are instances where this document may direct readers to a UnitedHealthcare Commercial Medical Policy, Medical Benefit Drug Policy, and/or Coverage Determination Guide (CDG). In the absence of a Medicare National Coverage Determination (NCD), Local Coverage Determination (LCD), or other Medicare coverage guidance, CMS allows a Medicare Advantage Organization (MAO) to create its own coverage determinations, using objective evidence-based rationale relying on authoritative evidence ([Medicare IOM Pub. No. 100-16, Ch. 4, §90.5](https://www.cms.gov/files/document/mip100-16-ch04-0905.pdf)).

---

## INDEX TO COVERAGE SUMMARY

<table>
<thead>
<tr>
<th>1.</th>
<th>COVERAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Heart and Heart Lung Transplants</td>
</tr>
<tr>
<td>2.</td>
<td>Kidney, Kidney-Pancreas, Pancreas Transplants</td>
</tr>
<tr>
<td>3.</td>
<td>Adult Liver Transplants</td>
</tr>
<tr>
<td>4.</td>
<td>Pediatric Liver Transplants</td>
</tr>
<tr>
<td>5.</td>
<td>Intestinal and Multi-Visceral Transplantation</td>
</tr>
<tr>
<td>6.</td>
<td>Stem Cell Transplantation and Bone Marrow Transplantation</td>
</tr>
<tr>
<td>7.</td>
<td>Islet Cell Transplantation in the Context of a Clinical Trial</td>
</tr>
<tr>
<td>8.</td>
<td>Immunosuppressive Drugs</td>
</tr>
<tr>
<td>9.</td>
<td>Dental/Oral examination</td>
</tr>
<tr>
<td>10.</td>
<td>Thoracic Duct Drainage</td>
</tr>
<tr>
<td>11.</td>
<td>Histocompatibility Testing (HLA typing)</td>
</tr>
<tr>
<td>12.</td>
<td>Solid Organ Acquisition</td>
</tr>
<tr>
<td>13.</td>
<td>Transportation, Food and Housing</td>
</tr>
</tbody>
</table>
I. COVERAGE

Coverage Statement: Human organ and tissue transplants, including pre-and post-operative medical, surgical, hospital services, and medically necessary ambulance transportation are covered when Medicare coverage criteria are met.

Notes:
- All transplant procedures, including Ventricular Assist Devices, for UnitedHealthcare Medicare Advantage Plan members must be performed by Optum Transplant Network facility and/or Medicare-Approved Transplant facility.

Guidelines/Notes:
1. Heart and Heart-Lung Transplants
   Heart and heart-lung transplants are covered when criteria are met. See the NCD for Heart Transplants (260.9). (Accessed September 2, 2020)
   
   For artificial heart implants, see the Coverage Summary for Ventricular Assist Device (VAD) and Artificial Heart.

2. Kidney, Pancreas and Kidney-Pancreas Transplants
   Kidney, pancreas and kidney-pancreas transplants are covered when criteria are met.
   
   See the NCD for Pancreas Transplantation (260.3). Also see the Medicare Benefit Policy Manual, Chapter 11 End Stage Renal Disease (ESRD), §140 - Transplantation. (Accessed September 2, 2020)
   
   Note: When the medical evaluation for a transplant is performed on the recipient or the living donor during the same inpatient stay in which the actual transplant occurs, all such services will be billed, and the costs will be accumulated in the normal manner. For example, all hospital services rendered to the donor will be considered kidney acquisition services. However, all physicians’ services rendered to the living donor and all hospital and physicians’ services rendered to the recipient will be billed in the same manner as any other inpatient services on the account of the recipient. See the Medicare Benefit Policy Manual, Chapter 11, §140.8 - Kidney Recipient Admitted for Transplantation and Evaluation. (Accessed September 2, 2020)

3. Adult Liver Transplants
   Adult liver transplants are covered when criteria are met. See the NCD for Adult Liver Transplantation (260.1). (Accessed September 2, 2020)

4. Pediatric Liver Transplants
   Pediatric liver transplants are covered when criteria are met. See the NCD for Pediatric Liver Transplantation (260.2). (Accessed September 2, 2020)
5. **Intestinal and Multi-Visceral Transplantation**  
Intestinal and multi-visceral transplantation are covered when criteria are met.  
*See the NCD for Intestinal and Multi-Visceral Transplantation (260.5).* (Accessed September 2, 2020)

6. **Stem Cell Transplantation and Bone Marrow Transplantation**  
Allogeneic Hematopoietic Stem Cell Transplantation (HSCT) and Autologous Stem Cell Transplantation (AuSCT) are covered when criteria are met. *See the NCD for Stem Cell Transplantation Formerly 110.8.1 (110.23).* (Accessed September 2, 2020)

**Notes:**
- Effective for services performed on or after August 4, 2010, allogeneic HSCT for myelodysplastic syndromes (MDS) is covered by Medicare pursuant to Coverage with Evidence Development (CED) in the context of a Medicare-approved, prospective clinical study.
- Effective for services performed on or after January 27, 2016, allogeneic HSCT for multiple myeloma (MM), myelofibrosis (MF), and sickle cell disease (SCD) is covered by Medicare pursuant to Coverage with Evidence Development (CED) in the context of a Medicare-approved, prospective clinical study.

*See the NCD for Stem Cell Transplantation Formerly 110.8.1 (110.23).* (Accessed September 2, 2020)


For payment rules for NCDs requiring CED, see the Coverage Summary for Experimental Procedures and Items, Investigational Devices and Clinical Trials.

- Acquisition charges for stem cell transplants apply only to allogeneic transplants, for which stem cells are obtained from a donor (other than the recipient himself or herself). Acquisition charges do not apply to autologous transplants (transplanted stem cells are obtained from the recipient himself or herself), because autologous transplants involve services provided to the beneficiary only (and not to a donor), for which the hospital may bill and receive payment. See the Medicare Claims Processing Manual, Chapter 4, §231.11 - Billing for Allogeneic Stem Cell Transplants. (Accessed September 2, 2020)

7. **Islet Cell Transplantation in the Context of a Clinical Trial**  
Transplantation of partial pancreatic tissue or islet cells is not covered by UnitedHealthcare.

**Notes:**
- Members may have coverage by Medicare in a Medicare certified Clinical Trials. Effective October 1, 2004, as a result of section 733 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003, Medicare will cover pancreatic islet cell transplantation for patients with Type I diabetes who are participating in National Institutes of Health-sponsored clinical trials.

*Because this legislative change in benefits meets the significant cost threshold described in section 1852(a)(5) of the Social Security Act, MA organizations are not required to assume risk for the costs of this service until payments /can be appropriately adjusted to take into account the cost of this legislative change in benefits. As is the case for other qualifying clinical trial services, CMS will make payments directly to providers of*
covered islet cell transplant clinical trial services on a fee-for-service basis.

For detailed information, see the NCD for Islet Cell Transplantation in the Context of a Clinical Trial (260.3.1) (Accessed September 2, 2020)

- **CMS Payment Guidelines:** CMS will make payment directly on a fee-for-service basis for the routine costs of pancreatic islet cell transplants as well as transplantation and appropriate related items and services, for MA beneficiaries participating in an NIH-sponsored clinical trial. MA organizations will not be liable for payment for routine costs of this new clinical trial until MA payments can be appropriately adjusted to take into account the cost of this national coverage decision. Medicare contractors shall make payment on behalf of MA organizations directly to providers of these islet cell transplants in accordance with Medicare payment rules, except that beneficiaries are not responsible for the Part A and Part B deductibles. MA members will be liable for any applicable coinsurance amounts MA organizations have in place for clinical trial benefits. See the Medicare Claims Processing Manual, Chapter 32, §705 - Special Billing and Payment Requirements Medicare Advantage (MA) Beneficiaries, (Accessed September 2, 2020)

8. **Immunosuppressive Drugs**
   Post-transplant, immunosuppressive drug therapy following a Medicare covered organ transplant is covered. See the Coverage Summary for Medications/Drugs (Outpatient/Part B) for detailed coverage guideline.

9. **Dental/Oral Examination**
   Dental/oral examination performed on an inpatient basis prior to a kidney transplant is covered when criteria are met. See the NCD for Dental Examination Prior to Kidney Transplantation (260.6). (Accessed September 2, 2020)

10. **Thoracic Duct Drainage (TDD)**
    Thoracic duct drainage (TDD) is covered when used in renal transplantation. See the NCD for Thoracic Duct Drainage in Renal Transplantation (20.3). (Accessed September 2, 2020)

11. **Histocompatibility Testing (HLA Typing)**
    Histocompatibility testing (HLA typing) for the transplant recipient and donor when the intended transplant recipient is a UnitedHealthcare Medicare member is covered when criteria are met. See the NCD for Histocompatibility Testing (190.1). (Accessed September 2, 2020)

12. **Solid Organ Acquisition**
    Solid organ acquisition from cadaver or live donor is covered. See the Medicare Benefit Policy Manual, Chapter 11 End Stage Renal Disease (ESRD), §140 – Transplantation. (Accessed September 2, 2020)

13. **Transportation, Food and Housing**
    Transportation, food and housing expense of the member and one escort may be covered. Refer to the member’s EOC/SOB to determine coverage eligibility. Note: Although not described in the EOC for UnitedHealthcare MedicareDirect plans, if the member is sent outside of the member’s community for a transplant, UnitedHealthcare will arrange or pay for appropriate lodging and transportation costs for the member and a companion. This applies to all Medicare Advantage plans.

14. **Heartsbreath Test for Heart Transplant Rejection**
Heartsbreath test for heart transplant rejection is not covered; see the NCD for Heartsbreath Test for Heart Transplant Rejection (260.10). (Accessed September 2, 2020)

15. Umbilical Cord Blood Harvesting and Storage for Future Use
   - Medicare does not have a National Coverage Determination (NCD) for umbilical cord blood harvesting and storage for future use.
   - Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist at this time.
     (IMPORTANT NOTE: After searching the Medicare Coverage Database, if no LCD/LCA is found, then use the above referenced policy.)
   - Committee approval date: September 15, 2020
   - Accessed September 2, 2020

II. DEFINITIONS

None

III. REFERENCES

See above

IV. REVISION HISTORY

09/15/2020  • Routine review; no change to coverage guidelines