

Adult Liver Transplantation (NCD 260.1)

Guideline Number: MPG006.06
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[↪ Terms and Conditions](#)

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<p>Related Medicare Advantage Policy Guideline</p> <ul style="list-style-type: none"> Pediatric Liver Transplantation (NCD 260.2)
<p>Related Medicare Advantage Coverage Summary</p> <ul style="list-style-type: none"> Transplants: Organ and Tissue Transplants

Policy Summary

[↪ See Purpose](#)

Overview

Liver transplantation, which is in situ replacement of a patient’s liver with a donor liver, may be an accepted treatment for patients with end-stage liver disease due to a variety of causes. Liver transplantation in selected patients is a treatment for malignancies, including primary liver tumors and certain metastatic tumors, which are typically rare. It can also be used in the treatment of patients with extrahepatic perihilar malignancies. Examples of malignancies include extrahepatic unresectable cholangiocarcinoma (CCA), hemangi endothelioma (HAE), and, liver metastases due to a neuroendocrine tumor (NET). Transplantation may offer the only chance of cure for selected patients while providing meaningful palliation for some others.

Guidelines

Nationally Covered Indications

Adult liver transplantation when performed on beneficiaries with end-stage liver disease other than hepatitis B or malignancies is covered under Medicare when performed in a facility which is approved by the Centers for Medicare & Medicaid Services (CMS) as meeting institutional coverage criteria.

Adult liver transplantation when performed on beneficiaries with end-stage liver disease other than malignancies is covered under Medicare when performed in a facility which is approved by CMS as meeting institutional coverage criteria.

Medicare covers adult liver transplantation for hepatocellular carcinoma when the following conditions are met:

- The patient is not a candidate for subtotal liver resection;
- There is no macrovascular involvement;
- The patient’s tumor(s) is less than or equal to 5 cm in diameter;
- There is no identifiable extrahepatic spread of tumor to surrounding lymph nodes, lungs, abdominal organs or bone; and
- The transplant is furnished in a facility that is approved by CMS as meeting institutional coverage criteria for liver transplants (see 65 FR 15006).

Effective June 21, 2012, UnitedHealthcare acting within their respective jurisdictions may determine coverage of adult liver transplantation for the following malignancies: (1) extrahepatic unresectable cholangiocarcinoma (CCA); (2) hemangi endothelioma (HAE); and, (3) liver metastases due to a neuroendocrine tumor (NET).

Follow-Up Care

Follow-up care or re-transplantation required as a result of a covered liver transplant is covered, provided such services are otherwise reasonable and necessary. Follow-up care is also covered for patients who have been discharged from a hospital after receiving non-covered liver transplant. Coverage for follow-up care is for items and services that are reasonable and necessary as determined by Medicare guidelines.

Immunosuppressive Drugs

See the Medicare Benefit Policy Manual, Chapter 15, "Covered Medical and Other Health Services," §50.5.1 and the Medicare Claims Processing Manual, Chapter 17, "Drugs and Biologicals," §80.3.

Nationally Non-Covered Indications

Adult liver transplantation for other malignancies remains excluded from coverage.

Applicable Codes

The following list(s) of codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this guideline does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

CPT Code	Description
47135	Liver allotransplantation; orthotopic, partial or whole, from cadaver or living donor, any age
47399	Unlisted procedure, liver

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ICD-10 Procedure Code	Description
0FY00Z0	Transplantation of liver, allogeneic, open approach
0FY00Z1	Transplantation of liver, syngeneic, open approach

Questions and Answers

1	Q:	Does CMS require that liver transplants be performed at a CMS approved facility?
	A:	Yes, CMS approved facility locations are linked to the The Scientific Registry of Transplant Recipients on the CMS website .

References

CMS National Coverage Determinations (NCDs)

[NCD 260.1 Adult Liver Transplantation](#)

Reference NCD: [NCD 260.2 Pediatric Liver Transplantation](#)

CMS Claims Processing Manual

[Chapter 3: § 90.4 Liver Transplants](#)

CMS Transmittal(s)

[Transmittal 146, Change Request 7908, Dated 08/03/2012 \(Liver Transplantation for Patients with Malignancies\)](#)

[Transmittal 2200, Change Request 10859, Dated November 8, 2018 \(International Classification of Diseases, Tenth Revision \(ICD-10\) and Other Coding Revisions to National Coverage Determinations \(NCDs\)\)](#)

MLN Matters

[Article MM7908. Liver Transplantation for Patients with Malignancies](#)

Other(s)

[The Scientific Registry of Transplant Recipients](#)

Guideline History/Revision Information

Revisions to this summary document do not in any way modify the requirement that services be provided and documented in accordance with the Medicare guidelines in effect on the date of service in question.

Date	Summary of Changes
04/01/2021	Template Update <ul style="list-style-type: none">Reformatted policy; transferred content to new template
07/08/2020	Supporting Information <ul style="list-style-type: none">Updated <i>References</i> section to reflect the most current informationArchived previous policy version MPG006.05

Purpose

The Medicare Advantage Policy Guideline documents are generally used to support UnitedHealthcare Medicare Advantage claims processing activities and facilitate providers' submission of accurate claims for the specified services. The document can be used as a guide to help determine applicable:

- Medicare coding or billing requirements, and/or
- Medical necessity coverage guidelines; including documentation requirements.

UnitedHealthcare follows Medicare guidelines such as NCDs, LCDs, LCAs, and other Medicare manuals for the purposes of determining coverage. It is expected providers retain or have access to appropriate documentation when requested to support coverage. Please utilize the links in the [References](#) section below to view the Medicare source materials used to develop this resource document. This document is not a replacement for the Medicare source materials that outline Medicare coverage requirements. Where there is a conflict between this document and Medicare source materials, the Medicare source materials will apply.

Terms and Conditions

The Medicare Advantage Policy Guidelines are applicable to UnitedHealthcare Medicare Advantage Plans offered by UnitedHealthcare and its affiliates.

These Policy Guidelines are provided for informational purposes, and do not constitute medical advice. Treating physicians and healthcare providers are solely responsible for determining what care to provide to their patients. Members should always consult their physician before making any decisions about medical care.

Benefit coverage for health services is determined by the member specific benefit plan document* and applicable laws that may require coverage for a specific service. The member specific benefit plan document identifies which services are covered, which are excluded, and which are subject to limitations. In the event of a conflict, the member specific benefit plan document supersedes the Medicare Advantage Policy Guidelines.

Medicare Advantage Policy Guidelines are developed as needed, are regularly reviewed and updated, and are subject to change. They represent a portion of the resources used to support UnitedHealthcare coverage decision making. UnitedHealthcare may modify these Policy Guidelines at any time by publishing a new version of the policy on this website. Medicare source materials used to develop these guidelines include, but are not limited to, CMS National Coverage

Determinations (NCDs), Local Coverage Determinations (LCDs), Medicare Benefit Policy Manual, Medicare Claims Processing Manual, Medicare Program Integrity Manual, Medicare Managed Care Manual, etc. The information presented in the Medicare Advantage Policy Guidelines is believed to be accurate and current as of the date of publication and is provided on an "AS IS" basis. Where there is a conflict between this document and Medicare source materials, the Medicare source materials will apply.

You are responsible for submission of accurate claims. Medicare Advantage Policy Guidelines are intended to ensure that coverage decisions are made accurately based on the code or codes that correctly describe the health care services provided. UnitedHealthcare Medicare Advantage Policy Guidelines use Current Procedural Terminology (CPT®), Centers for Medicare and Medicaid Services (CMS), or other coding guidelines. References to CPT® or other sources are for definitional purposes only and do not imply any right to reimbursement or guarantee claims payment.

Medicare Advantage Policy Guidelines are the property of UnitedHealthcare. Unauthorized copying, use, and distribution of this information are strictly prohibited.

*For more information on a specific member's benefit coverage, please call the customer service number on the back of the member ID card or refer to the [Administrative Guide](#).