TRANSPLANTATION SERVICES

Policy Number: BIP188.H
Effective Date: November 1, 2019

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Covered benefits are listed in three (3) Sections - A, B and C. All services must be medically necessary. Each benefit plan contains its own specific provisions for coverage, limitations and exclusions as stated in the member’s Evidence of Coverage (EOC)/Schedule of Benefits (SOB). If there is a discrepancy between this policy and the member’s EOC/SOB, the member’s EOC/SOB provision will govern.

Essential Health Benefits for Individual and Small Group

For plan years beginning on or after January 1, 2014, the Affordable Care Act of 2010 (ACA) requires fully insured non-grandfathered individual and small group plans (inside and outside of Exchanges) to provide coverage for ten categories of Essential Health Benefits (“EHBs”). Large group plans (both self-funded and fully insured), and small group ASO plans, are not subject to the requirement to offer coverage for EHBs. However, if such plans choose to provide coverage for benefits which are deemed EHBs (such as maternity benefits), the ACA requires all dollar limits on those benefits to be removed on all Grandfathered and Non-Grandfathered plans. The determination of which benefits constitute EHBs is made on a state by state basis. As such, when using this guideline, it is important to refer to the member specific benefit document to determine benefit coverage.

A. FEDERAL/STATE MANDATED REGULATIONS

None

B. STATE MARKET PLAN ENHANCEMENTS

In addition to the covered benefits listed in Section C, some members may have additional Organ and Tissue Transplant benefits. Refer to the member’s Evidence of Coverage (EOC)/Schedule of Benefits (SOB) for additional information.

Additional resources for Transplantation Services: Referrals may be made to Optum as follows:
Phone Referrals: 866-300-7736 or Fax: 888-361-0502

Transplantation Services: Benefit Interpretation Policy (Effective 11/01/2019)
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C. COVERED BENEFITS

IMPORTANT NOTE: Covered benefits are listed in Sections A, B and C. Always refer to Sections A and B for additional covered benefits not listed in this section.

Note: UnitedHealthcare shall intermittently review new developments in medical technology based on scientific evidence to determine if the list of covered Transplants should be revised.

1. Human Organ and tissue Transplants are limited to non-experimental and non-investigational procedures that are determined to be medically necessary (refer to the Benefit Interpretation Policy titled Medical Necessity). Coverage is provided for the pre- and post-operative medical, surgical, hospital services and medically necessary ambulance transportation to the UnitedHealthcare Designated Facility. All Transplant procedures must be Prior Authorized by UnitedHealthcare and performed in a Designated Facility or other transplant facility.

Covered Transplant procedures include:
- Bone Marrow Transplants (either from the member or from a compatible Donor) and peripheral stem cell Transplants, with or without high dose chemotherapy, including Chimeric Antigen Receptor (CAR)-T Cell Therapy. Not all Bone Marrow Transplants or peripheral stem cell Transplants meet the definition of a Covered Health Service.
- Heart
- Heart/lung
- Lung
- Kidney
- Kidney/pancreas
- Liver
- Liver/small bowel
- Pancreas
- Small bowel

If OptumHealth Transplant Solutions has determined that another Transplant (not listed above) is proven, then that Transplant is also eligible for coverage.

2. When the Transplant recipient is a UnitedHealthcare member, reasonable and necessary services of the living Donor solely for the Transplant procedure are covered if the Donor does not have insurance or the Donor primary insurance does not cover Donor hospital services (the Donor does not need to be a UnitedHealthcare member for Transplant services to be covered).

3. Listing at two UnitedHealthcare Designated facilities.
   a. Dual listing is allowed only when the Regional Organ Procurement agency used is different
   b. Member is financially responsible for all costs associated with the 2nd Transplant Evaluation

Note: UnitedHealthcare will pay for the Transplant surgery, living Donor inpatient services and surgery, and post-transplant services at the facility which performs the Transplant.

4. Pre-transplant testing and evaluation, including Histocompatibility testing for the Transplant recipient and Donor when the intended Transplant recipient is a UnitedHealthcare member. The testing of immediate blood relatives to determine the compatibility of Bone Marrow and stem cells is limited to immediate blood relatives who are sisters, brothers, parents and natural children.

5. Organ acquisition from cadaver or living Donor

6. An oral or dental examination performed on an inpatient basis as part of a comprehensive workup prior to Transplant surgery

7. Tooth extraction prior to a major organ Transplant
8. Outpatient post-transplant, immunosuppressive drug therapy only if the member has a supplemental pharmacy benefit

9. Storage costs of any organ or Bone Marrow only as part of an authorized treatment protocol as determined by the UnitedHealthcare Designated Facility Medical Director or designee

10. Bone Marrow and stem cells Donor search and testing (Note: Specific requirements and limitations apply, refer to the member’s EOC/SOB)

11. Transportation, food and housing expense of the member and one escort to the UnitedHealthcare Designated Facility (Note: Specific requirements and limitations apply, refer to the member’s EOC/SOB)

12. Covered services for living Donors are limited to Medically Necessary clinical services once a donor is identified.

   Also refer to Medical Management Guideline (MMG) titled Total Artificial Heart.

D. NOT COVERED

1. Artificial heart implantation

2. Non-human organ Transplantation

3. Equipment and medication that is experimental/investigational and/or not medically necessary (refer to the Benefit Interpretation Policy titled Medical Necessity)

4. Storage costs of any organ or Bone Marrow unless criteria in section C are met

5. Transplant services, including donor costs, when the Transplant recipient is not a UnitedHealthcare member

6. Transplantation performed in a non-UnitedHealthcare Designated Facility

7. Transportation of any potential Donor for typing and matching

8. Unauthorized or not prior authorized organ procurement and Transplant related services

9. Transportation, food and housing expenses of the member
   a. When the member is not receiving medically necessary Transplant services
   b. Above and beyond the allowed benefit for the member (Note: Refer to the member’s EOC/SOB)

10. Transportation and other non-clinical expenses of a living Donor

11. Duplicated diagnostic costs for a Transplant Evaluation at the 2nd Regional Organ Procurement facility

E. DEFINITIONS

1. Designated Facility (Includes UnitedHealthcare National Preferred Transplant Network [NPTN]): A facility that has entered into an agreement with UnitedHealthcare, or with an organization contracting on UnitedHealthcare’s behalf, to render covered services for the treatment of specified diseases or conditions. A Designated Facility may or may not be located within the service area. The fact that a hospital is a participating/contracting hospital does not mean that it is a Designated Facility.

2. Donor: A person who undergoes a surgical procedure for the purpose of donating either a body organ or body tissue for transplant surgery
3. **Histocompatibility Testing**: Testing that involves the matching or typing of the human leukocyte antigen in preparation for organ/tissue transplantation.

4. **Regional Organ Procurement Agency**: An organization designated by the federal government and responsible for procurement of organs for transplantation and the promotion of organ donation.

5. **Transplant Evaluation (Bone Marrow)**: Begins with initial consult with transplant physician and ends upon acceptance or denial into the transplant program. Services include, but are not limited to:
   - Consultation with transplant physician(s), psychiatrist(s), specialist(s), transplant coordinator(s), social services
   - Hematology, blood banking, serology, chemistry, histocompatibility testing according to Member’s Benefit Program
   - X-rays, pulmonary function tests, skin tests, leukopheresis consultation, CT scan, tissue typing, MRI
   - Restaging of disease
   - Inpatient or outpatient, including professional, room and board, nursing, inpatient pharmacy and all other ancillary services

6. **Transplant Evaluation (Solid Organ)**: Pre-Transplant medically necessary services required to assess and evaluate the Member to determine acceptance to transplant program. This phase ends upon acceptance or denial into the transplant program. Services include, but are not limited to:
   - Consultation with surgeon(s), psychiatrist(s), specialist(s), transplant coordinator(s), social services
   - Hematology, blood banking, serology, chemistry, histocompatibility
   - X-rays, pulmonary function tests, skin tests, leukopheresis consultation, CT scan, tissue typing, MRI
   - Inpatient or outpatient services, including professional, room and board, nursing, inpatient pharmacy and all other ancillary services

7. **Transplant Facility Authorized by UnitedHealthcare**: A facility that is licensed in the State in which it operates; certified by Medicare as a transplant facility for a specific organ transplant; and authorized by the Company to perform transplant services under the Policy provisions.
F. POLICY HISTORY/REVISION INFORMATION

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<th>Date</th>
<th>Action/Description</th>
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<tr>
<td>11/01/2019</td>
<td><strong>Covered Benefits</strong>&lt;br&gt;• Revised benefit coverage guidelines for human organ and tissue transplants; replaced language indicating “all transplants procedures must be performed at a UnitedHealthcare designated facility” with “all transplant procedures must be prior authorized by UnitedHealthcare and performed in a designated facility or other transplant facility”&lt;br&gt;<strong>Supporting Information</strong>&lt;br&gt;• Archived previous policy version BIP188.G</td>
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