BENEFIT COVERAGE POLICY

Title: BCP-33 Pre-Transplant Services

Effective Date: 1/1/2021

Physicians Health Plan
PHP Insurance Company
PHP Service Company

Important Information - Please Read Before Using This Policy

The following coverage policy applies to health benefit plans administered by PHP and may not be covered by all PHP plans. Please refer to the member's benefit document for specific coverage information. If there is a difference between this general information and the member's benefit document, the member's benefit document will be used to determine coverage. For example, a member's benefit document may contain a specific exclusion related to a topic addressed in a coverage policy.

Coverage determinations for individual requests require consideration of:

- The terms of the applicable benefit document in effect on the date of service.
- Any applicable laws and regulations.
- Any relevant collateral source materials including coverage policies.
- The specific facts of the particular situation.

Contact PHP Customer Service to discuss plan benefits more specifically.

1.0 Policy:

All pre-transplant related services require prior approval for coverage of Covered Health Services provided at a Health Plan designated transplant facility. Contact the Transplant Case Manager to verify if a provider is contracted as a designated transplant facility.

Non-network services are not covered.

Refer to member's benefit coverage document for specific benefit description, guidelines, coverage and exclusions.

2.0 Background:

Transplantation programs typically include three phases: pre-transplant services, the transplant period and post-transplant services. Pre-transplants are considered medically necessary when all the following guidelines below are met for the following:

1. Heart Transplant .
2. Hematopoietic Stem Cell Transplant.
3. Kidney Transplant.
4. Liver Transplant.
5. Lung Transplant.
6. Pancreas-Kidney Transplant.
7. Pancreas Alone Transplant.

3.0 Clinical Determination Guidelines:

A. Pre-transplant services are eligible for coverage as follows:

1. Prior authorization/approval for pre-transplant services is required (evaluation, specialist consult, outpatient diagnostics and labs) at a Health Plan designated transplant facility linked to one of the transplant networks: Interlink, LifeTrac or Cigna LifeSource. If a member is not receiving services at a Health Plan designated facility, the member will be redirected to a designated facility
2. One evaluation per transplant approval.

   Note: A second opinion consult only would be approved to determine candidacy at a Health Plan designated transplant facility if a second transplant evaluation is requested and the member has been previously turned down for transplant.

4.0 Coding:

ICD-10 DIAGNOSIS CODES (not all-inclusive)	
Code	**Description**
I25.10 – I25.799	Chronic ischemic heart disease
I25.5	Ischemic cardiomyopathy
I25.89	Other forms of chronic ischemic heart disease
I25.9	Chronic ischemic heart disease, unspecified
I42.2, I42.5, I42.8,	Other cardiomyopathies
I42.1	Obstructive hypertrophic cardiomyopathy
I50.1, I50.20, I5.21, I50.22, I50.23, I50.30-33, I50.40-43, I50.9,	Heart failure
N18.6	End stage renal disease
C22.0	Liver Cell Carcinoma
C22.2	Hepatoblastoma
C22.7	Other specified carcinomas of liver
C22.8	Malignant neoplasm of liver, primary, unspecified as to type
K70.30	Alcoholic cirrhosis of liver without ascites
K72.00	Acute and subacute hepatic failure without coma
K72.90	Hepatic failure, unspecified without coma
K74.0	Hepatic fibrosis
K74.3	Primary biliary cirrhosis
K74.4	Secondary biliary cirrhosis
K74.5	Biliary cirrhosis, unspecified
K74.60, K74.69	Cirrhosis of liver
K76.2	Central hemorrhagic necrosis of liver
D86.09	Sarcoidosis of lung (must be carefully evaluated to ensure disease is primarily confined to lung)
D89.810-D89.813	Graft-versus-host disease
E84.0 – E84.19	Cystic fibrosis
E88.01	Alpha1-antitrypsin deficiency
E88.89	Other specified metabolic disorders
I27.0	Primary pulmonary hypertension
J43.0 – J43.9	Emphysema
J44.0 – J44.9	Chronic obstructive pulmonary disease (contraindicated for single lung)
J47.0 – J47.9	Bronchiectasis (contraindicated for single lung)

ICD-10 DIAGNOSIS CODES (not all-inclusive)	
Code	**Description**
J61	Pneumoconiosis due to asbestos and other mineral fibers
J67.4 - J67.9	Allergic alveolitis (extrinsic)
J44.9	Chronic obstructive pulmonary disease, unspecified
J84.10	Pulmonary fibrosis, unspecified
J84.89	Other specified interstitial pulmonary diseases
J84.111 – J84.117	Idiopathic interstitial pneumonitis
J84.81	Lymphangioleiomyomatosis
M31.0	Hypersensitivity angiitis (must be carefully evaluated to ensure disease is primarily confined to lung)
M34.81	Systemic sclerosis with lung involvement (must be carefully evaluated to ensure disease is primarily confined to lung)
P27.0 - P27.9	Chronic respiratory disease arising in the perinatal period (bronchopulmonary dysplasia)
Q21.8	Other congenital malformations of cardiac septa (Eisenmenger's defect or complex)
Q33.0	Congenital cystic lung
Q33.3	Agenesis of lung
Q33,4	Congenital bronchiectasis
Q33.6	Congenital hypoplasia and dysplasia of lung

5.0 Unique Configuration/Prior Approval/Coverage Details

Fully insured SPD (prefix of Product ID) PPO plans have unique language: Hematopoietic Stem Cell Transplants do not have to be done at designated facilities and are also covered at non-network facilities.

Under fully insured DSP (prefix of Product ID) PPO plans, Kidney transplants do not have to be done at designated facilities.

6.0 Terms & Definitions:

None.

7.0 References, Citations & Resources:

InterQual®, subset Transplantation, Liver, 4-17-2020.

InterQual®, subset Transplantation, Cardiac, 4-17-2020.

InterQual®, subset Transplantation, Renal, 4-17-2020.

InterQual®, subset Transplantation, Allogenic Stem Cell, 4-17-2020.

InterQual®, subset Transplantation, Allogenic Stem Cell (Pediatric), 4-17-2020.

InterQual®, subset Transplantation, Autologous Stem Cell, 4-17-2020.

InterQual®, subset Transplantation, Autologous Stem Cell (Pediatric), 4-17-2020.

8.0 Associated Documents [For internal use only]:

Policies and Procedures (P&Ps) - MMP-02 Transition/Continuity of Care; MMP-06 Peer-to-Peer Conversations; MMP-09 Benefit Determinations.

Standard Operating Procedure (SOP) –MMS-03 Algorithm for Use of Criteria for Benefit Determinations; MMS-05 Completing a High Cost Notification Form; MMS-10 Pre-Transplant Process, MMS-11 Transplant Event and Listing, and MMS-12 Post-Transplant Process.

Sample Letter – TCS Approval Letter; Clinically Reviewed Exclusion Letter; Specific Exclusion Denial Letter.

Form – Out of Network/ Prior Authorization; High Cost Notification Form; Transplant Travel and Lodging Reimbursement Form.

Other – Transplant Network contracts with Cigna LifeSource, Interlink, and LifeTrac.

9.0 Revision History:

Original Effective Date: 12/31/2020

Next Review Date: 01/01/2022

Revision Date & Approval	Reason for Revision
9/29/2020	Policy created