

<p>Policy Name</p> <p>Adult Liver Transplantation</p>	<p>Policy Number</p> <p>MP-LT-FP-02-23</p>	<p>Scope</p> <p><input checked="" type="checkbox"/> MMM MA <input type="checkbox"/> MMM Multihealth</p>
<p>Service Category</p> <p> <input type="checkbox"/> Anesthesia <input type="checkbox"/> Surgery <input type="checkbox"/> Radiology Procedures <input type="checkbox"/> Pathology and Laboratory Procedures </p> <p> <input type="checkbox"/> Medicine Services and Procedures <input type="checkbox"/> Evaluation and Management Services <input type="checkbox"/> DME/Prosthetics or Supplies <input checked="" type="checkbox"/> <u>Other Transplants</u> <u>Adult Liver Transplantation</u> </p>		
<p>Service Description</p> <p>NCD 260.1 Adult Liver Transplantation</p> <p>A. General</p> <p>Liver transplantation, which is in situ replacement of a patient’s liver with a donor liver, in certain circumstances, may be an accepted treatment for patients with end-stage liver disease due to a variety of causes. The procedure is used in selected patients as a treatment for malignancies, including primary liver tumors and certain metastatic tumors, which are typically rare but lethal with very limited treatment options. It has also been used in the treatment of patients with extrahepatic perihilar malignancies.</p> <p>Examples of malignancies include extrahepatic unresectable cholangiocarcinoma (CCA), liver metastases due to a neuroendocrine tumor (NET), and hemangioendothelioma (HAE). Despite potential short- and long-term complications, transplantation may offer the only chance of cure for selected patients while providing meaningful palliation for some others.</p> <p>Please note that all services described in this policy require prior authorization.</p> <ul style="list-style-type: none"> • Please refer to the member’s contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member. • Providers should report all services using the most up-to-date industry-standard procedure, revenue, and diagnosis codes, including modifiers where applicable. • Providers must submit all required and requested documentation for case evaluation and determination. • The plan may request additional documentation and information not received and or provided initially related to condition and diagnosis for case evaluation and determination. • Any additional documentation submitted specifying medical necessity criteria and considered important for case evaluation and determination will be reviewed by Clinical Team utilizing guidelines and regulation criteria. 		

Medical Necessity Guidelines

Indications and Limitations of Coverage

B. Nationally Covered Indications

Effective July 15, 1996, 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.

Effective December 10, 1999, 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.

Effective September 1, 2001, Medicare covers adult liver transplantation for hepatocellular carcinoma when the following conditions are met:

- The patient is not a candidate for subtotal liver resection;
- The patient's tumor(s) is less than or equal to 5 cm in diameter;
- There is no macrovascular involvement;
- 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, Medicare Administrative Contractors acting within their respective jurisdictions may determine coverage of adult liver transplantation for the following malignancies: (1) extrahepatic unresectable cholangiocarcinoma (CCA); (2) liver metastases due to a neuroendocrine tumor (NET); and, (3) hemangioendothelioma (HAE).

1. 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.

2. 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.

C. Nationally Non-Covered Indications

Adult liver transplantation for other malignancies remains excluded from coverage.

Limits or Restrictions

Covered under Medicare when performed in a facility which is approved by CMS as meeting institutional coverage criteria.

Reference Information

NCD 260.1

Adult Liver Transplantation

Medicare Coverage Database (MCD)

Link: <https://www.cms.gov/medicare-coverage-database/view/ncd.aspx>

Policy History

Date	Version	Comments
12/07/2023	Draft	New Medical Policy
12/15/2023	Final	Approved by Medical Policy Committee