CHAPTER 4
SECTION 24.8

KIDNEY TRANSPLANTATION

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I. CPT[1] PROCEDURE CODE RANGE

50300 - 50380

II. POLICY

A. Cadaver and living donor kidney transplantation is covered when the transplant is performed at a Medicare-certified kidney transplantation center (pediatric consortia are not applicable for kidney transplantation at this time), for beneficiaries who:

1. Are suffering from concomitant, irreversible renal failure; and

2. Have exhausted more conservative medical and surgical treatment; and

3. Have plans for long-term adherence to a disciplined medical regimen that are feasible and realistic.

B. Benefits may be allowed for services and supplies during the Medicare waiting period for those beneficiaries who qualify for Medicare coverage as a result of end stage renal disease.

C. Services and supplies related to kidney transplantation are covered for:

1. Evaluation of potential candidate's suitability for kidney transplantation, whether or not the patient is ultimately accepted as a candidate for transplantation.

2. Pre- and post-transplant inpatient hospital and outpatient services.

3. Pre- and post-operative services of the transplant team.

4. The donor acquisition team, including the costs of transportation to the location of the donor organ and transportation of the team and the donated organ to the location of the transplantation center.

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5. The maintenance of the viability of the donor organ after all existing legal requirements for excision of the donor organ have been met.

6. Donor costs.

7. Blood and blood products.

8. FDA approved immunosuppression drugs to include off-label uses when reliable evidence documents that the off-label use is safe, effective and in accordance with nationally accepted standards of practice in the medical community (proven).

9. Complications of the transplant procedure, including inpatient care, management of infection and rejection episodes.

10. Periodic evaluation and assessment of the successfully transplanted patient.

11. Transportation of the patient by air ambulance and the services of a certified life support attendant.

12. DNA-HLA tissue typing determining histocompatibility.

III. POLICY CONSIDERATIONS

A. If a TRICARE beneficiary becomes eligible for Medicare benefits because of end stage renal disease, TRICARE is always the secondary payer.

B. When a TRICARE beneficiary does not qualify for the Medicare end stage renal disease program because they do not have enough work quarters, TRICARE is primary payer. Before benefits can be allowed, a statement from Medicare is required indicating the patient is not eligible for Medicare benefits.

C. Kidney transplants are paid under the DRG.

D. Benefits will only be allowed for transplants performed at a Medicare approved kidney transplant center. Refer to Chapter 11, Section 7.1 for organ transplant certification center requirements.

E. Acquisition and donor costs are not considered to be components of the services covered under the DRG. These costs must be billed separately on a standard UB-92 claim form in the name of the TRICARE patient.

F. The appropriate hospital standard kidney acquisition costs (live donor or cadaver) required for Medicare in every instance must be used as the acquisition cost for purposes of providing TRICARE benefits.

IV. EXCLUSIONS

Kidney transplantation is excluded as a benefit if any of the following contraindications exist:

A. Malignancies metastasized to or extending beyond the margins of the kidney.

B. Significant systemic or multisystemic disease (because the presence of multi-organ involvement limits the possibility of full recovery and may compromise the function of the newly transplanted organs).

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