CHAPTER 4
SECTION 24.6

COMBINED LIVER-KIDNEY TRANSPLANTATION

ISSUE DATE: October 26, 1994
AUTHORITY: 32 CFR 199.4(e)(5)

I. CPT[1] PROCEDURE CODES

47133 - 47135, 50300, 50340, 50360, 50365

II. POLICY

A. Benefits are allowed for combined liver-kidney transplantation (CLKT).

1. A TRICARE Prime enrollee must have a referral from his/her Primary Care Manager (PCM) and an authorization from the contractor before obtaining transplant-related services. If network providers furnish transplant-related services without prior PCM referral and contractor authorization, penalties will be administered according to TRICARE network provider agreements. If Prime enrollees receive transplant-related services from non-network civilian providers without the required PCM referral and contractor authorization, Managed Care Support (MCS) contractors shall reimburse charges for the services on a Point of Service basis. Special cost-sharing requirements apply to Point of Service claims.

2. For Standard and Extra patients residing in a Managed Care Support (MCS) region, preauthorization authority is the responsibility of the MCS Medical Director or other designated utilization staff.

B. Combined liver-kidney transplantation (CLKT) is covered when the transplant is performed at a TRICARE or Medicare-certified liver transplant center or TRICARE-certified pediatric consortium liver transplantation center, for beneficiaries who:

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

2. Have exhausted more conservative medical and surgical treatments for hepatic and renal failure.

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

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C. Transplants performed for beneficiaries suffering from hepatic failure resulting from hepatitis B or C are covered.

D. Services and supplies related to CLKT are covered for:

1. Evaluation of a potential candidate's suitability for CLKT 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.

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 the national 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. Hepatitis B and pneumococcal vaccines for patients undergoing transplantation.

12. DNA-HLA tissue typing in determining histocompatibility.

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

III. POLICY CONSIDERATIONS

A. In those cases where the beneficiary fails to obtain preauthorization, benefits may be extended if the services or supplies otherwise would qualify for benefits but for the failure to obtain preauthorization. If preauthorization is not received, the appropriate preauthorizing authority is responsible for reviewing the claims to determine whether the beneficiary's condition meets the clinical criteria for the CLKT benefit. charges for transplant and transplant-related services provided to TRICARE Prime enrollees who failed to obtain PCM referral and contractor authorization will be reimbursed only under Point of Service rules.

B. Benefits will only be allowed for transplants performed at a TRICARE or Medicare-certified liver transplantation center. Benefits are also allowed for transplants performed at a pediatric facility that is TRICARE-certified as a liver transplantation center on the basis that the center belongs to a pediatric consortium program whose combined experience and survival data meet the TRICARE criteria for certification. The contractor in whose jurisdiction the center is located is the certifying authority for TRICARE approval as a liver transplantation center. Refer to Chapter 11, Section 7.1 for organ transplant center certification requirements.

C. Claims for services and supplies related to the transplant will be reimbursed based on billed charges. Effective August 1, 2003, CLKTs shall be paid under the assigned DRG based on the patient's diagnosis.

D. Claims for transportation of the donor organ and transplant team shall be adjudicated on the basis of billed charges, but not to exceed the transport service's published schedule of charges, and cost-shared on an inpatient basis. Scheduled or chartered transportation may be cost-shared.

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 CMS 1450 UB-04 claim form in the name of the TRICARE patient.

F. When a properly preauthorized candidate is discharged less than 24-hours after admission because of extenuating circumstance, such as the available organ is found not suitable or other circumstances which prohibit the transplant from being timely performed, all otherwise authorized services associated with the admission shall be cost-shared on an inpatient basis, since the expectation at admission was that the patient would remain more than 24 hours.

G. CLKTs performed on an emergency basis in an unauthorized liver transplant facility may be cost shared only when the following conditions have been met:

1. The unauthorized center must consult with the nearest TRICARE or Medicare-certified liver transplantation center regarding the transplantation case; and

2. It must be determined and documented by the transplant team physician(s) at the certified liver transplantation center that transfer of the patient (to the certified liver transplantation center) is not medically reasonable, even though transplantation is feasible and appropriate.

H. This policy does not apply to beneficiaries who become eligible for Medicare coverage due to isolated renal disease. This policy applies only to those individuals suffering from concomitant hepatic and renal failure. Coordination of benefits with Medicare is not required for CLKTs.

IV. EXCLUSIONS

A. Combined liver-kidney transplantation is excluded when the following contraindications exist:

1. Significant systemic or multisystemic disease (other than hepatorenal failure) which limits the possibility of full recovery and may compromise the function of the newly transplanted organs.

2. Active alcohol or other substance abuse that interferes with compliance to strict treatment regimen.

3. Malignancies metastasized to or extending beyond the margins of the liver and/ or kidney.

B. The following are also excluded:

1. Expenses waived by the transplant center, (i.e., beneficiary/ sponsor not financially liable.)

2. Services and supplies not provided in accordance with applicable program criteria, (i.e., part of a grant or research program, unproven procedure).

3. Administration of an unproven immunosuppressant drug that is not FDA approved or has not received approval as an appropriate "off-label" drug indication.

4. Pre- or post-transplant nonmedical expenses (i.e., out-of-hospital living expenses, to include, hotel, meals, privately owned vehicle for the beneficiary or family members).

5. Transportation of an organ donor.

V. EFFECTIVE DATES

A. November 12, 1992.

B. November 1, 1994, for hepatitis C.

C. December 1, 1996, for hepatitis B.

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