



Medical Policy

Liver Transplant and Combined Liver-Kidney Transplant

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Policy Number: 198

BCBSA Reference Number: 7.03.06 (For Plan internal use only)

Related Policies

None

Policy

Commercial Members: Managed Care (HMO and POS), PPO, and Indemnity

A liver transplant using a cadaver or living donor may be considered **MEDICALLY NECESSARY** for carefully selected individuals with end-stage liver failure due to irreversibly damaged livers.

Etiologies of end-stage liver disease include, but are not limited to, the following:

A. Hepatocellular diseases

- Alcoholic liver disease
- Viral hepatitis (either A, B, C, or non-A, non-B)
- Autoimmune hepatitis
- Alpha-1 antitrypsin deficiency
- Hemochromatosis
- Nonalcoholic steatohepatitis
- Protoporphyria
- Wilson's disease

B. Cholestatic liver diseases

- Primary biliary cirrhosis
- Primary sclerosing cholangitis with development of secondary biliary cirrhosis
- Biliary atresia

C. Vascular disease

- Budd-Chiari Syndrome

D. Primary hepatocellular carcinoma

E. Inborn errors of metabolism

F. Trauma and toxic reactions

G. Miscellaneous

- Familial amyloid polyneuropathy
- Amyloidosis¹
- Cryptogenic cirrhosis¹
- End-stage liver disease in children¹
- Familial cholestasis¹
- Intrahepatic bile duct paucity (Alagill's syndrome).¹

Liver transplantation may be considered **MEDICALLY NECESSARY** in patients with polycystic disease of the liver who have massive hepatomegaly causing obstruction or functional impairment.

One of the following complications should be present:

- Enlargement of liver impinging on respiratory function
- Extremely painful enlargement of liver
- Enlargement of liver significantly compressing and interfering with function of other abdominal organs.

Liver transplantation may be considered **MEDICALLY NECESSARY** in individuals with unresectable hilar cholangiocarcinoma.

Liver transplantation may be considered **MEDICALLY NECESSARY** in pediatric patients with nonmetastatic hepatoblastoma.

Liver *retransplantation* may be considered **MEDICALLY NECESSARY** in individuals with:

- Primary graft nonfunction
- Hepatic artery thrombosis
- Chronic rejection
- Ischemic type biliary lesions after donation after cardiac death
- Recurrent non-neoplastic disease-causing late graft failure.

Combined liver-kidney transplantation may be considered **MEDICALLY NECESSARY** in individuals who qualify for liver transplantation and have advanced irreversible kidney disease.

Liver transplantation is **INVESTIGATIONAL** in the following situations:

- Individuals with intrahepatic cholangiocarcinoma
- Individuals with neuroendocrine tumors metastatic to the liver.

Liver transplantation is considered **INVESTIGATIONAL** in the following patients:

- Individuals with hepatocellular carcinoma that has extended beyond the liver
- Individuals with ongoing alcohol and/or drug abuse. (Evidence for abstinence may vary among liver transplant programs, but generally a minimum of 3 months is required.)

Liver transplantation is **INVESTIGATIONAL** in all other situations not described above.

In addition to the above information, we do not cover liver transplantation when any of the following conditions are present:

- Known current malignancy, including metastatic cancer
- Recent malignancy with high risk of recurrence
 - Note: the assessment of risk of recurrence for a previously treated malignancy is made by the transplant team; providers must submit a statement with an explanation of why the patient with a recently treated malignancy is an appropriate candidate for a transplant.
- Untreated systemic infection making immunosuppression unsafe, including chronic infection

- Other irreversible end-stage disease not attributed to liver disease
- History of cancer with a moderate risk of recurrence
- Systemic disease that could be exacerbated by immunosuppression
- Psychosocial conditions or chemical dependency affecting ability to adhere to therapy
 - Patients with liver disease related to alcohol or drug abuse must be actively involved in a substance abuse treatment program (e.g., weekly meetings such as Alcoholics Anonymous, partial or full day programs or inpatient programs).

Prior Authorization Information

Inpatient

- For services described in this policy, precertification/preauthorization **IS REQUIRED** for all products if the procedure is performed **inpatient**.

Outpatient

- For services described in this policy, see below for products where prior authorization **might be required** if the procedure is performed **outpatient**.

	Outpatient
Commercial Managed Care (HMO and POS)	This procedure is performed in the inpatient setting.
Commercial PPO and Indemnity	This procedure is performed in the inpatient setting.

CPT Codes / HCPCS Codes / ICD Codes

Inclusion or exclusion of a code does not constitute or imply member coverage or provider reimbursement. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage 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.

The following codes are included below for informational purposes only; this is not an all-inclusive list.

The above medical necessity criteria MUST be met for the following codes to be covered for Commercial Members: Managed Care (HMO and POS), PPO, and Indemnity:

CPT Codes

CPT codes:	Code Description
47135	Liver allotransplantation; orthotopic, partial or whole, from cadaver or living donor, any age

ICD-10 Procedure Codes

ICD-10-PCS procedure codes:	Code Description
0FB03ZZ	Excision of Liver, Percutaneous Approach
0FB00ZZ	Excision of Liver, Open Approach
0FB04ZZ	Excision of Liver, Percutaneous Endoscopic Approach
0FB10ZZ	Excision of Right Lobe Liver, Open Approach
0FB13ZZ	Excision of Right Lobe Liver, Percutaneous Approach
0FB14ZZ	Excision of Right Lobe Liver, Percutaneous Endoscopic Approach
0FB20ZZ	Excision of Left Lobe Liver, Open Approach
0FB23ZZ	Excision of Left Lobe Liver, Percutaneous Approach
0FB24ZZ	Excision of Left Lobe Liver, Percutaneous Endoscopic Approach
0FT00ZZ	Resection of Liver, Open Approach
0FY00Z0	Transplantation of Liver, Allogeneic, Open Approach

0FY00Z1	Transplantation of Liver, Syngeneic, Open Approach
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Description

Solid organ transplantation offers a treatment option for patients with different types of end stage organ failure that can be lifesaving or provide significant improvements to a patient's quality of life.¹ Many advances have been made in the last several decades to reduce perioperative complications. Available data supports improvement in long-term survival as well as improved quality of life particularly for liver, kidney, pancreas, heart, and lung transplants. Allograft rejection remains a key early and late complication risk for any organ transplantation. Transplant recipients require life-long immunosuppression to prevent rejection. Patients are prioritized for transplant by mortality risk and severity of illness criteria developed by Organ Procurement and Transplantation Network and United Network of Organ Sharing.

Liver transplantation

Liver transplantation is routinely performed as a treatment of last resort for patients with end-stage liver disease. Liver transplantation may be performed with liver donation after a brain or cardiac death or with a liver segment donation from a living donor. Certain populations are prioritized as Status 1A (eg, acute liver failure with a life expectancy of fewer than 7 days without a liver transplant) or Status 1B (pediatric patients with chronic liver disease). Following Status 1, donor livers are prioritized to those with the highest scores on the Model for End-stage Liver Disease (MELD) and Pediatric End-stage Liver Disease (PELD) scales. Due to the scarcity of donor livers, a variety of strategies have been developed to expand the donor pool. For example, a split graft refers to dividing a donor liver into 2 segments that can be used for 2 recipients. Living donor (LD) liver transplantation (LT) is now commonly performed for adults and children from a related or unrelated donor. Depending on the graft size needed for the recipient, either the right lobe, left lobe, or the left lateral segment can be used for LD LT. In addition to addressing the problem of donor organ scarcity, LD LT allows the procedure to be scheduled electively before the recipient's condition deteriorates or serious complications develop. Living donor LT also shortens the preservation time for the donor liver and decreases disease transmission from donor to recipient.

Summary

Description

Liver transplantation is currently the treatment of last resort for patients with end-stage liver disease. Liver transplantation may be performed with a liver donation after a brain or cardiac death or with a liver segment donation from a living donor. Individuals are prioritized for transplant by mortality risk and severity of illness criteria developed by the Organ Procurement and Transplantation Network and the United Network of Organ Sharing. The severity of illness is determined by the Model for End-stage Liver Disease and Pediatric End-stage Liver Disease scores.

Summary of Evidence

For individuals who have a hepatocellular disease who receive a liver transplant, the evidence includes registry studies and systematic reviews. Relevant outcomes include overall survival (OS), morbid events, and treatment-related morbidity and mortality. Studies on liver transplantation for viral hepatitis have found that survival is lower than for other liver diseases. Although these statistics raise questions about the most appropriate use of a scarce resource (donor livers), the long-term survival rates are significant in a group of patients who have no other treatment options. Also, survival can be improved by the eradication of the hepatitis virus before transplantation. For patients with nonalcoholic steatohepatitis, OS rates have been shown to be similar to other indications for liver transplantation. The evidence is sufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who have primary hepatocellular carcinoma who receive a liver transplant, the evidence includes systematic reviews of observational studies. Relevant outcomes include OS, morbid events, and treatment-related morbidity and mortality. In the past, long-term outcomes in patients with primary hepatocellular malignancies had been poor (19%) compared with the OS of liver transplant recipients. However, the recent use of standardized patient selection criteria (eg, the Milan criteria diameter) has dramatically improved OS rates. In the appropriately selected patients, a liver transplant has been shown to result in higher survival rates than resection. In patients who present with unresectable organ-confined

disease, transplant represents the only curative approach. The evidence is sufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who have extrahepatic cholangiocarcinoma who receive a liver transplant, the evidence includes systematic reviews of observational studies and individual registry studies. Relevant outcomes include OS, morbid events, and treatment-related morbidity and mortality. For patients with extrahepatic (hilar or perihilar) cholangiocarcinoma who are treated with adjuvant chemotherapy, 5-year survival rates have been reported as high as 76%. The evidence is sufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who have intrahepatic cholangiocarcinoma who receive a liver transplant, the evidence includes registry studies and a systematic review of observational studies. Relevant outcomes include OS, morbid events, and treatment-related morbidity and mortality. In a registry study comparing outcomes in patients with intrahepatic cholangiocarcinoma who received liver transplantation to those who received surgical resection of the liver, no differences were found in OS, length of stay, or unplanned 30-day readmission rates between groups. Additional studies reporting survival rates in patients with intrahepatic cholangiocarcinoma or in mixed populations of patients with extrahepatic and intrahepatic cholangiocarcinoma have reported 5-year survival rates of less than 30%. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who have metastatic neuroendocrine tumors who receive a liver transplant, the evidence includes systematic reviews of case series. Relevant outcomes include OS, morbid events, and treatment-related morbidity and mortality. In select patients with nonresectable, hormonally active liver metastases refractory to medical therapy, liver transplantation has been considered as an option to extend survival and minimize endocrine symptoms. While some centers may perform liver transplants on select patients with neuroendocrine tumors, the available studies are limited by their heterogeneous populations. Further studies are needed to determine the appropriate selection criteria. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who have pediatric hepatoblastoma who receive a liver transplant, the evidence includes case series. Relevant outcomes include OS, morbid events, and treatment-related morbidity and mortality. The literature on liver transplantation for pediatric hepatoblastoma is limited, but case series have demonstrated good outcomes and high rates of long-term survival. Additionally, nonmetastatic pediatric hepatoblastoma is among the United Network for Organ Sharing criteria for patients eligible for liver transplantation. The evidence is sufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who have a failed liver transplant who receive a liver retransplant, the evidence includes observational studies. Relevant outcomes include OS, morbid events, and treatment-related morbidity and mortality. Case series have demonstrated favorable outcomes with liver retransplantation in certain populations, such as when criteria for original liver transplantation are met for retransplantation. While some evidence has suggested outcomes after retransplantation may be less favorable than for initial transplantation in some patients, long-term survival benefits have been demonstrated. The evidence is sufficient to determine that the technology results in an improvement in the net health outcome.

For individuals with indications for liver and kidney transplant who receive a combined liver-kidney transplant, the evidence includes a systematic review of retrospective observational studies in adults and several individual registry studies. Relevant outcomes include OS, morbid events, and treatment-related morbidity and mortality. Most of the evidence involves adults with cirrhosis and kidney failure. Indications for combined liver-kidney transplant in children are rare and often congenital and include liver-based metabolic abnormalities affecting the kidney, along with structural diseases affecting both the liver and kidney. In both adults and children, comparisons with either liver or kidney transplantation alone would suggest that combined liver-kidney transplant is no worse, and possibly better, for graft and patient survival. The evidence is sufficient to determine that the technology results in an improvement in the net health outcome.

Policy History

Date	Action
10/2024	Annual policy review. Summary and references updated. Policy statements unchanged.
10/2023	Annual policy review. References added and updated. Minor editorial refinements to policy statements; intent unchanged.
9/2021	Annual policy review. Description, summary, and references updated. Policy statements unchanged.
1/2021	Medicare information removed. See MP #132 Medicare Advantage Management for local coverage determination and national coverage determination reference.
10/2020	Annual policy review. Description, summary, and references updated. Policy statements unchanged.
10/2019	Annual policy review. Description, summary, and references updated. Policy statements unchanged.
10/2018	Annual policy review. Description, summary, and references updated. Policy statements unchanged.
2/2018	Annual policy review. Combined liver-kidney transplantation considered medically necessary. Clarified coding information. Policy title changed to Liver Transplant and Combined Liver-Kidney Transplant. Effective 2/1/2018.
4/2016	Policy statement on psychosocial conditions or chemical dependency affecting ability to adhere to therapy clarified. 4/1/2016
1/2016	Medical policy criteria clarified. Clarified coding information. 1/1/2016
11/2015	Added coding language.
3/2015	Annual policy review. New references added.
10/2014	Medical policy remediation: New indications for non-coverage. Coding information clarified. Effective 10/1/2014.
6/2014	Annual policy review. New medically necessary and investigational indications described. Effective 6/1/2014.
6/2014	Updated Coding section with ICD10 procedure and diagnosis codes, Effective 10/2015.
12/2013	Removed ICD-9 diagnosis codes as the policy requires prior authorization.
7/2013	Annual policy review. New medically and investigational indications described. Effective 7/1/2013.
11/2012	CMS NCD medical policy review. Changes to policy statements. Effective 6/21/2012.
11/2011-4/2012	Medical policy ICD 10 remediation: Formatting, editing and coding updates. No changes to policy statements.
10/2011	Reviewed - Medical Policy Group - Gastroenterology, Nutrition and Organ Transplantation. No changes to policy statements.
11/2010	Reviewed - Medical Policy Group - Gastroenterology, Nutrition and Organ Transplantation. No changes to policy statements.
11/2009	Reviewed - Medical Policy Group - Gastroenterology, Nutrition and Organ Transplantation. No changes to policy statements.
2/2009	Annual policy review. No changes to policy statements.
11/2008	Reviewed - Medical Policy Group - Gastroenterology, Nutrition and Organ Transplantation. No changes to policy statements.
11/2007	Reviewed - Medical Policy Group - Gastroenterology, Nutrition and Organ Transplantation. No changes to policy statements.
8/2007	Annual policy review. No changes to policy statements.

Information Pertaining to All Blue Cross Blue Shield Medical Policies

Click on any of the following terms to access the relevant information:

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Endnotes

¹ Based on expert opinion, NEMCI