



MASSACHUSETTS

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Medical Policy

Composite Tissue Allotransplantation of the Hand and Face

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Policy Number: 662

BCBSA Reference Number: 7.03.13

NCD/LCD: NA

Related Policies

None

Policy

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

Composite tissue allotransplantation of the hand and/or face is considered **INVESTIGATIONAL**.

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 is not a covered service.
Commercial PPO and Indemnity	This is not a covered service.
Medicare HMO Blue SM	This is not a covered service.
Medicare PPO Blue SM	This is not a covered service.

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.

CPT Codes

There are no specific CPT codes for this procedure.

Description

Composite Tissue Allotransplantation

Composite tissue allotransplantation refers to the transplantation of histologically different tissue that may include skin, connective tissue, blood vessels, muscle, bone, and nerve tissue. The procedure is also known as reconstructive transplantation. To date, primary applications of this type of transplantation have been of the hand and face (partial and full), although there are also reported cases of several other composite tissue allotransplantations, including that of the larynx, knee, and abdominal wall.

Hand and face transplants have been shown to be technically feasible. The first successful partial face transplant was performed in France in 2005, and the first complete facial transplant was performed in Spain in 2010. In the U. S., the first facial transplant was done in 2008; it was a near-total face transplant and included the midface, nose, and bone. The first hand transplant with short-term success occurred in 1998 in France. However, the patient failed to follow the immunosuppressive regimen, which led to graft failure and removal of the hand 29 months after transplantation. The first hand transplantation in the U. S. took place in 1999.

Composite tissue allotransplantation procedures are complex and involve a series of operations using a rotating team of specialists. For face transplantation, the surgery may last 8 to 15 hours. Hand transplant surgery typically lasts between 8 and 12 hours. Bone fixation occurs first, and this is generally followed by the artery and venous repair and then by suture of nerves and/or tendons. In all surgeries performed to date, the median and ulnar nerves were repaired. The radial nerve was reconstructed in about half of the procedures.

Unlike most solid organ transplantations (eg, kidney and heart transplants), composite tissue allotransplantation is not life-saving, and its primary aim rests mainly in a patient's cosmetic satisfaction and quality of life. In the case of facial transplantations, there is immense potential for the psychosocial benefits when surgery is successful. Moreover, the goal of composite tissue transplantation is to improve function (eg, grasping and lifting after hand transplants, blinking and mouth closure after face transplants) without alternative interventions such as prosthetics. Additionally, in the case of face transplantation, the procedure may be less traumatic than "traditional" facial reconstructive surgery using the patient's own tissue. For example, traditional procedures often involve dozens of operations, whereas facial transplantation only involves a few operations.

Adverse Events

Composite tissue allotransplantation is associated with potential risks and benefits, and patients who undergo face or hand transplantation must adhere to a lifelong regimen of immunosuppressive drugs. Risks of immunosuppression include acute and chronic rejection, an opportunistic infection that may be life-threatening, and metabolic disorders such as diabetes, kidney damage, and lymphoma. Other challenges include the need to participate actively in intensive physical therapy to restore functionality and the potential for frustration and disappointment if functional improvement does not meet expectations. Moreover, there is the potential for allograft loss, which would lead to additional procedures in hand transplant patients, and there are limited reconstructive options for facial transplantation. Furthermore, in the case of hand transplants, there is a risk that functional ability (eg, grasping and lifting objects) may be lower than with a prosthetic hand, especially compared with newer electronic prosthetic devices. Due to the importance of selecting candidates who can withstand these physical and mental challenges, potential hand and face transplant recipients undergo extensive screening for both medical and psychosocial suitability.

Summary

Composite tissue allotransplantation (also referred to as vascularized composite allotransplantation) is defined as transplantation of histologically different tissues. This type of transplantation is being proposed for facial transplants in patients with severely disfigured faces, and for hand transplants in patients dissatisfied with prosthetic hands. The treatment has potential benefits in terms of improving functional status and psychosocial well-being. It also has potential risks, most notably those associated with a lifelong regimen of immunosuppressive drugs.

For individuals who have a severely disfigured face due to burns or trauma who receive composite tissue allotransplantation, the evidence includes a small case series and several systematic reviews of case series. Relevant outcomes are functional outcomes, quality of life, resource utilization, and treatment-related mortality and morbidity. The available studies on composite tissue allotransplantation of the face have suggested that the surgery is technically feasible; however, to date, only a limited number of patients worldwide have undergone the procedure, and the data are not sufficiently robust to determine whether the potential benefits to patients outweigh the potential risks (eg, of surgical complications, immunosuppression, opportunistic infections). The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals who have hand and upper-extremity amputation(s) who receive composite tissue allotransplantation, the evidence includes a small case series, several systematic reviews of case series, and a nonrandomized comparative study. Relevant outcomes are functional outcomes, quality of life, resource utilization, and treatment-related mortality and morbidity. The available studies on composite tissue allotransplantation of the hand have suggested that the surgery is technically feasible. The only study comparing outcomes in patients who had hand transplants with those who received prostheses included 12 patients. It found no differences between groups in functional outcomes and little difference in the quality of life. Given the limited number of patients worldwide who have undergone the procedure and the limited amount of data comparing outcomes with the best available prosthetics, the evidence is not sufficiently robust to determine whether the potential benefits to patients outweigh the potential risks (eg, of surgical complications, immunosuppression, opportunistic infections). The evidence is insufficient to determine the effects of the technology on health outcomes.

Policy History

Date	Action
10/2020	BCBSA National medical policy review. Description, summary, and references updated. Policy statement(s) unchanged.
10/2019	BCBSA National medical policy review. No changes to policy statements. New references added. Background and summary clarified.
10/2018	BCBSA National medical policy review. No changes to policy statements. New references added. Background and summary clarified.
9/2017	New references added from BCBSA National medical policy.
3/2016	New references added from BCBSA National medical policy.
3/2015	New references added from BCBSA National medical policy.
5/2014	New references from BCBSA National medical policy.
8/2013	BCBSA National medical policy. New investigational indications described. Effective 8/1/2013.

Information Pertaining to All Blue Cross Blue Shield Medical Policies

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

[Medical Policy Terms of Use](#)

[Managed Care Guidelines](#)

[Indemnity/PPO Guidelines](#)

[Clinical Exception Process](#)

[Medical Technology Assessment Guidelines](#)

References

1. Infante-Cossio P, Barrera-Pulido F, Gomez-Cia T, et al. Facial transplantation: a concise update. *Med Oral Patol Oral Cir Bucal*. Mar 01 2013; 18(2): e263-71. PMID 23229268
2. Sosin M, Rodriguez ED. The Face Transplantation Update: 2016. *Plast Reconstr Surg*. Jun 2016; 137(6): 1841-50. PMID 27219239
3. Smeets R, Rendenbach C, Birkelbach M, et al. Face transplantation: on the verge of becoming clinical routine?. *Biomed Res Int*. 2014; 2014: 907272. PMID 25009821
4. Fischer S, Kueckelhaus M, Pauzenberger R, et al. Functional outcomes of face transplantation. *Am J Transplant*. Jan 2015; 15(1): 220-33. PMID 25359281
5. Shores JT, Brandacher G, Lee WP. Hand and upper extremity transplantation: an update of outcomes in the worldwide experience. *Plast Reconstr Surg*. Feb 2015; 135(2): 351e-60e. PMID 25401735
6. Petruzzo P, Dubernard JM. The International Registry on Hand and Composite Tissue allotransplantation. *Clin Transpl*. 2011: 247-53. PMID 22755418
7. Salminger S, Sturma A, Roche AD, et al. Functional and Psychosocial Outcomes of Hand Transplantation Compared with Prosthetic Fitting in Below-Elbow Amputees: A Multicenter Cohort Study. *PLoS ONE*. 2016; 11(9): e0162507. PMID 27589057
8. American Society for Surgery of the Hand Council. ASSH position statement on hand transplantation 2013. *J Hand Surg Am*. Nov 2013; 38(11): 2234-5. PMID 24206988
9. National Institute for Health and Care Excellence (NICE). Hand allotransplantation [IPG383]. 2011; <https://www.nice.org.uk/guidance/ipg383>. Accessed May 22, 2020
10. American Society for Reconstructive Microsurgery (ASRM), American Society of Plastic Surgeons (ASPS). Facial Transplantation-ASRM/ASPS Guiding Principles. n.d.; <http://www.microsurg.org/assets/1/13/ftGuidelines.pdf>. Accessed May 22, 2020.