Harvard Pilgrim Health Care | TUFTS Health Plan

Point32Health companies

Medical Necessity Guidelines: Solid Organ Transplants (Heart, Heart/Lung, Intestinal, Kidney, Liver, Lung, Pancreas, Pancreas/Kidney)

Effective: August 1, 2026

Prior Authorization Required If REQUIRED, submit supporting clinical documentation (electronically recommended or by fax)	Yes ☒ No ☐
Notification Required	Yes ☐ No ☒

Applies to:

- Harvard Pilgrim Health Care Commercial products
- Tufts Health Plan Commercial products
- Tufts Health Direct
- Tufts Health Together
- Tufts Health RITogether
- Tufts Health One Care

We recommend submitting prior authorization electronically. If you opt to submit prior authorization requests via fax, please refer to this reference chart for the appropriate fax number (varies by product). For details on all our products, please visit the Our Plans page on our provider website. For additional Prior Authorization and Notification details on other lines of business not listed on our Medical Necessity Guidelines page, please also reference our Prior Authorization Resources page.

Note: While you may not be the provider responsible for obtaining prior authorization or notifying Point32Health, as a condition of payment you will need to ensure that any necessary prior authorization has been obtained and/or Point32Health has received proper notification. If notification is required, providers may additionally be required to provide updated clinical information to qualify for continued service.

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Overview

According to the United Network for Organ Sharing (UNOS), 48,000 organ transplants were performed in the United States in 2024. This represents a 3.3 percent increase over the past year and 23.3 percent over the past five years. Solid organ transplant is a valuable treatment option for patients with end-stage diseases and improves survival and quality of life. Multi-organ transplantation, a more medically complex surgical procedure should only be performed in centers with experience in such procedures and where transplant specialists are available to manage each of the transplanted organs. The success of transplantation involves reducing the risk of allograft rejection and preventing complications such as malignancies, nephrotoxicity, cardiovascular disease, or infections. Transplant eligibility should include a comprehensive clinical

assessment, cardiac and pulmonary assessments, central nervous system and functional status evaluation, as well as screening for infections and tumors.

Point32 Health covers medically necessary transplant for the following transplants based on the below criteria:

- Heart
- Heart/Lung
- Kidney
- Kidney/pancreas
- Liver
- Lung
- Small bowel
- Bowel-Liver
- Pancreas

Note:

- For specific information about benefits and reimbursement, refer to the Transplant Payment Policy, Transplant Payment Policy
- **To initiate the prior authorization process**, it is necessary to complete and submit the appropriate Transplant Request Form: Transplant Forms

Clinical Guideline General Coverage Criteria

The Plan uses guidance from the Centers for Medicare and Medicaid Services (CMS) and MassHealth for coverage determinations for its Dual Product Eligible plan Members. MassHealth Medical Necessity Determinations and CMS National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Local Coverage Articles (LCAs) and documentation included in the Medicare manuals are the basis for coverage determinations where available. For **Tuft's Health One Care** plan Members the following criteria is used:

Heart Transplant: Heart Transplant NCD 260.9 and MassHealth Medical Necessity Determinations for Organ Transplant Procedures
Intestinal Transplant: NCD - Intestinal and Multi-Visceral Transplantation (260.5) and MassHealth Guidelines for Medical Necessity Determination for Organ Transplant Procedures | Mass.gov
Kidney Transplant: MassHealth Medical Necessity Determinations for Organ Transplant Procedures
Liver Transplant: Adult Liver Transplant NCD 206.1 and MassHealth Medical Necessity Determinations for Organ Transplant Procedures
Lung Transplant: MassHealth Medical Necessity Determinations for Organ Transplant Procedures
Pancreas Transplant: Pancreas Transplants NCD 206.3 and MassHealth Medical Necessity Determinations for Organ Transplant Procedures

Consideration for prior approval will only be for those Members accepted for transplantation by a transplantation center and eligible for transplant listing.

Note: Xenotransplantation is considered investigational and not medically necessary

Heart Transplant:

Heart transplantation is a treatment for many patients with end-stage heart failure (HF) who have poor functional capacity and prognosis and remain symptomatic despite optimal medical or surgical therapy.[7] A damaged or diseased heart is replaced with a healthy donor heart.

The Plan considers heart transplant as reasonable and medically necessary for Members ≤ 70* with end-stage heart disease who have a satisfactory psychosocial profile and support systems in place and **ONE** of the following conditions:

1. Complex congenital heart disease (e.g., severe cyanotic heart disease, refractory HF due to post-Fontan procedure, pulmonary hypertension) not amenable to surgical correction; **or**
2. New York Heart Association (NYHA) functional class IV heart failure (HF) symptoms refractory to optimal medical and surgical therapy (including use of devices); **or**
3. Intractable life-threatening arrhythmias refractory to medical and surgical treatment, including implantable cardioverter-defibrillator; **or**
4. Intractable severe ischemia consistently limiting routine activity not amenable to bypass surgery or percutaneous coronary intervention (PCI); **or**
5. NYHA Class III and IV and cardiomyopathy (restrictive and hypertrophic) refractory to medical therapy
6. Cardiogenic shock requiring either continuous intravenous inotropic support or circulatory support with an intraaortic

balloon pump counter pulsation device or mechanical circulatory support (such as left ventricular assist device) to maintain adequate organ perfusion; **or**

7. Cardiac amyloidosis (excluding severe extracardiac amyloid organ dysfunction).

*****Members greater than 70 years of age may be approved under special circumstances on a case-by-case basis where the Member can be shown to have exceptional pre-morbid performance and has a life expectancy > 5 years. Consideration will occur in the absence of end-stage complications of systemic disease such as diabetes mellitus or chronic obstructive lung disease.[8,11]

Heart-Lung Transplantation:

The Plan considers heart and lung transplant as reasonable and medically necessary for concomitant end-stage cardiac and pulmonary dysfunction for a Member with a satisfactory psychosocial profile and support systems in place. The most common indication for a heart-lung transplant is pulmonary hypertension, secondary to idiopathic pulmonary arterial hypertension or congenital heart disease (CHD). Indications for Heart-lung transplant include, but may not be limited to:

1. Non-specific severe pulmonary fibrosis
2. Heart failure and
    a. Irreversible primary pulmonary hypertension
    b. Eisenmenger complex with irreversible pulmonary hypertension
    c. Chronic obstructive pulmonary disease
3. Pulmonary fibrosis with uncontrollable pulmonary hypertension or heart failure
4. Emphysema with severe heart failure
5. Cystic fibrosis with severe heart failure

Limitations:

The Plan will not authorize the coverage of a heart transplant for Members with **ONE** of the following:

1. Active or uncontrolled alcohol use disorder or substance use disorder
2. Any unresolved psychosocial concerns or history of noncompliance with medical management
3. Human immunodeficiency virus (HIV) infection unless all of the following are met[2]:
    a. CD4 count greater than 200 cells/mm3 for > 3 months prior to transplantation
    b. Undetectable HIV-1 ribonucleic acid (RNA)
    c. Stable anti-retroviral therapy for > 3 months
    d. Absence of serious complications associated with or secondary to HIV disease, (e.g., opportunistic infection, including aspergillus, tuberculosis, coccidioidomycosis, resistant fungal infections; Kaposi's sarcoma; or other neoplasm)
4. Active Hepatitis C
5. Clinically severe symptomatic cerebrovascular disease, which is not amenable to revascularization
6. Demonstrated non-compliance, which places the transplanted organ at serious risk of failure
7. Fixed pulmonary hypertension refractory to medical therapy:
    a. Pulmonary vascular resistance > 5 Woods units, unresponsive to medical therapy;
    b. Trans-pulmonary gradient > 15mm/Hg [mean pulmonary artery pressure minus pulmonary capillary wedge pressure]
8. Active malignancy, including metastatic cancer or recent malignancy with high risk of recurrence
9. Presence of irreversible end-organ diseases (e.g., renal, hepatic, pulmonary) (unless Member is to undergo dual organ transplantation, e.g., heart-lung, heart-kidney, etc.)
10. Recurrent infections; uncontrolled or untreated
11. Systemic illness that will limit survival despite heart transplant such as:
    a. Systemic lupus erythematosus or sarcoid that has multisystem involvement and is still active
    b. Any systemic process with a high probability of recurring in the transplanted heart as determined by the requesting physician

Note: In adult patients, obesity is a relative contraindication for heart transplant. A pre-transplant body mass index (BMI) of ≥ 35 kg/m^2 is associated with a worse outcome after cardiac transplantation. It is recommended that patients achieve a BMI of < 35 kg/m^2 before listing for heart transplant.[11]

The following code(s) require prior authorization:

Table 1: CPT/HCPCS Codes

Code	Description
33940	Donor cardiectomy (including cold preservation)
33944	Backbench standard preparation of cadaver donor heart allograft prior to transplantation, including

Code	Description
	dissection of allograft from surrounding soft tissues to prepare aorta, superior vena cava, inferior vena cava, pulmonary artery, and left atrium for implantation
33945	Heart transplant, with or without recipient cardiectomy

References:

1. Authors/Task Force Members:, McDonagh TA, Metra M, et al. 2023 Focused Update of the 2021 ESC Guidelines for the diagnosis and treatment of acute and chronic heart failure: Developed by the task force for the diagnosis and treatment of acute and chronic heart failure of the European Society of Cardiology (ESC) With the special contribution of the Heart Failure Association (HFA) of the ESC. Eur J Heart Fail. 2024;26(1):5-17. doi:10.1002/ejhf.3024.
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6. Commonwealth of Massachusetts. Mass Health Guidelines for Medical Necessity Determination for Organ Transplant Procedures. MassHealth Guidelines for Medical Necessity Determination for Organ Transplant Procedures | Mass.gov. Accessed May 18, 2026.
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12. United Network of Organ Sharing (UNOS), Pediatric heart allocation policy and system changes. Pediatric heart allocation policy and system changes - OPTN (hrsa.gov). Accessed May 12, 2025.
13. Tecson KM, Bass K, Felius J, Hall SA, Jamil AK, Carey SA. Patient "Activation" of Patients Referred for Advanced Heart Failure Therapy. Am J Cardiol. 2019;123(4):627-631. doi:10.1016/j.amjcard.2018.11.013.

Intestinal Implants

A small bowel transplant is the transplantation of an intestinal allograft to an individual with irreversible intestinal failure. The purpose of this transplant is to restore intestinal function. An allograft refers to when transplanted cells, tissues or organs are sourced from a genetically non-identical Member of the same species.

Small Bowel Transplant:

The Plan considers small bowel transplant as reasonable and medically necessary for adult and pediatric Members who have a satisfactory psychosocial profile and support systems in place and when **BOTH** of the following criteria are met:

1. Irreversible intestinal failure (e.g., loss of absorption and the inability to maintain protein-energy, fluid, electrolyte, or micronutrient balance); **and**
2. Long-term dependence on total parenteral nutrition (TPN) with evidence of severe complications due to TPN. Evidence of complications includes any **ONE** of the following:
    a. Impending or overt liver failure
    b. Thrombosis of ≥ 2 central veins typically used for TPN (e.g., subclavian, internal jugular, femoral veins) or occlusion of a brachiocephalic vein in children; **or**

c. Two or more episodes per year of systemic sepsis due to line infection requiring hospitalization, or a single episode of line-related fungemia; septic shock and/or acute respiratory distress syndrome; **or**
d. Frequent episodes of severe dehydration despite intravenous fluid hydration and parenteral nutrition

Small Bowel-Liver Transplant or Multivisceral Transplant:

Common indications for multivisceral transplantation for adults include short bowel syndrome, mesenteric ischemia (arterial or venous), abdominal neoplasms, inflammatory bowel disease, radiation enteritis, and trauma. Common indications for children include volvulus, gastroschisis, necrotizing enterocolitis, congenital intestinal dysmotility diseases (ex aganglionosis, Hirschsprung's disease), and intestinal atresias.

The Plan considers a small bowel/liver transplant or multivisceral transplant as reasonable and medically necessary in Members who meet the criteria above for bowel transplant and who have developed impending end-stage liver failure as evidenced by **ONE** of the following conditions:

1. Elevated serum bilirubin and/or liver enzymes
2. Splenomegaly
3. Thrombocytopenia
4. Gastroesophageal varices
5. Coagulopathy
6. Stomal bleeding
7. Hepatic fibrosis/cirrhosis

Limitations:

The plan will not authorize the coverage of a small bowel, simultaneous small bowel and liver or multivisceral transplant for Members with **ONE** of the following:

1. Active or uncontrolled alcohol use disorder or substance use disorder;
2. Any unresolved psychosocial concerns or history of noncompliance with medical management
3. Human immunodeficiency virus (HIV) infection unless all of the following are met[2]:
    a. CD4 count greater than 200 cells/mm3 for > 3 months prior to transplantation
    b. Undetectable HIV-1 ribonucleic acid (RNA)
    c. Stable anti-retroviral therapy for > 3 months
    d. Absence of serious complications associated with or secondary to HIV disease, (e.g., opportunistic infection, including aspergillus, tuberculosis, coccidioidomycosis, resistant fungal infections; Kaposi's sarcoma; or other neoplasm)
4. Other severe uncontrolled medical condition expected to limit survival after transplant (e.g., multisystem organ failure, cerebral edema)
5. Active malignancy, including metastatic cancer or recent malignancy with high risk of recurrence
6. Systemic disease affecting multiple body systems, including but not limited to scleroderma, amyloidosis, diffuse atheromatous disease
7. Uncontrolled or untreatable infection, any source

Note: Smoking has been strongly correlated to adverse health and surgical outcomes. There is evidence to show that smoking, both by donors and by recipients, has a major impact on outcomes after organ transplantation. Smoking cessation is strongly recommended for both donors and recipients prior to transplantation.

The following code(s) require prior authorization:

Table 1: CPT/HCPCS Codes

Code	Description
44132	Donor enterectomy (including cold preservation), open; from cadaver donor
44133	Donor enterectomy (including cold preservation), open; partial, from living donor
44135	Intestinal allotransplantation; from cadaver donor
44136	Intestinal allotransplantation; from living donor
44715	Backbench standard preparation of cadaver or living donor intestine allograft prior to transplantation, including mobilization and fashioning of the superior mesenteric artery and vein
44720	Backbench reconstruction of cadaver or living donor intestine allograft prior to transplantation; venous anastomosis, each
44721	Backbench reconstruction of cadaver or living donor intestine allograft prior to transplantation;

Code	Description
	arterial anastomosis, each

References:

1. American Gastroenterological Association. American Gastroenterological Association medical position statement: short bowel syndrome and intestinal transplantation. Gastroenterology. 2003;124(4):1105-1110. doi:10.1053/gast.2003.50139.
2. Blumberg EA, Rogers CC; American Society of Transplantation Infectious Diseases Community of Practice. Solid organ transplantation in the HIV-infected patient: Guidelines from the American Society of Transplantation Infectious Diseases Community of Practice. Clin Transplant. 2019;33(9):e13499. doi:10.1111/ctr.13499.
3. Centers for Medicare and Medicaid Services. National Coverage Determination for Intestinal and Multivisceral Transplantation (260.5). 2006; https://www.cms.gov/medicare-coverage-database/details/ncddetails.aspx?NCDId=280&ncdver=2&DocID=260.5&SearchType=Advanced&bc=IAAAABAAAAAA&. Accessed May 18. 2026.
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Kidney Transplant:

The Plan considers kidney transplant as reasonable and medically necessary for adult and pediatric Members with end stage renal disease (ESRD), of any cause, with a Glomerular Filtration Rate (GFR) < 20 ml/min and/or requiring dialysis, and who have a satisfactory psychosocial profile and support systems in place.

Note: The Plan supports the use of non-race-based calculations of GFR, such as the CKD-EPI Creatinine Equation.

Limitations:

The Plan will not authorize the coverage of a kidney transplant in Members with **ONE** of the following:

1. Active or uncontrolled alcohol use disorder or substance use disorder
2. Active Hepatitis B infection
3. Active malignancy, including metastatic cancer or recent malignancy with high risk of recurrence
4. AL amyloidosis with significant extrarenal involvement
5. Active pulmonary disease including:
    a. Uncontrolled asthma
    b. Irreversible moderate to severe pulmonary hypertension
    c. Cor pulmonale
    d. Severe chronic obstructive pulmonary disease
    e. Severe interstitial lung disease
    f. Severe restrictive lung disease
    g. Requiring home oxygen
6. Any unresolved psychosocial concerns or a history of noncompliance with medical management including, but limited to not attending follow-up appointments, not taking prescription medications, and attending dialysis.
7. Other severe uncontrolled medical condition expected to limit survival after transplant (e.g., multisystem organ failure, cerebral edema)
8. Advanced liver disease due to viral or other etiologies

9. Decompensated cirrhosis (consider for combined liver-kidney transplant)
10. Severe uncorrectable and symptomatic heart disease NYHA III/IV cardiac disease (e.g., ejection fraction < 30%)
11. Human immunodeficiency virus (HIV) disease unless all of the following are met[2]:
    a. CD4 count >200 cells/μL during 3 months prior to transplantation
    b. Undetectable HIV-1 ribonucleic acid (RNA)
    c. Stable anti-retroviral therapy for > 3 months
    d. Absence of serious complications associated with or secondary to HIV disease (e.g., opportunistic infection, including aspergillus, tuberculosis, coccidioidomycosis, resistant fungal infections; Kaposi's sarcoma; or other neoplasms
12. Progressive central neurodegenerative disease
13. Recent stroke or transient ischemic attack
14. Recurrent infection, uncontrolled or untreated

Note: Smoking has been strongly correlated to adverse health and surgical outcomes. There is evidence to show that smoking, both by donors and by recipients, has a major impact on outcomes after organ transplantation. Smoking cessation is strongly recommended for both donors and recipients prior to transplantation

The following code(s) require prior authorization:

Table 1: CPT/HCPCS Codes

Code	Description
50300	Donor nephrectomy (including cold preservation); from cadaver donor, unilateral or bilateral
50320	Donor nephrectomy (including cold preservation); open, from living donor
50323	Backbench standard preparation of cadaver donor renal allograft prior to transplantation, including dissection and removal or perinephric fat, diaphragmatic and retroperitoneal attachments, excision of adrenal gland, and preparation of ureter(s), renal vein(s), and renal artery(s), ligating branches, as necessary
50325	Backbench standard preparation of living donor renal allograft (open or laparoscopic) prior to transplantation, including dissection and removal or perinephric fat and preparation of ureter(s), renal vein(s), and renal artery(s), ligating branches, as necessary
50327	Backbench reconstruction of cadaver or living donor renal allograft prior to transplantation; venous anastomosis, each
50328	Backbench reconstruction of cadaver or living donor renal allograft prior to transplantation; arterial anastomosis, each
50329	Backbench reconstruction of cadaver or living donor renal allograft prior to transplantation; ureteral anastomosis, each
50340	Recipient nephrectomy (separate procedure)
50360	Renal allotransplantation, implantation of graft; without recipient nephrectomy
50365	Renal allotransplantation, implantation of graft; with recipient nephrectomy
50370	Removal of transplanted renal allograft
50380	Renal autotransplantation, reimplantation of kidney
50547	Laparoscopic donor nephrectomy (including cold preservation), from living donor

References:

1. Abramyan S, Hanlon M. Kidney Transplantation. [Updated 2023 Jan 2]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2024 Jan-. Available from: https://www.ncbi.nlm.nih.gov/books/NBK567755/.
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7. Kidney transplantation in adults: Evaluation of the potential kidney transplant recipient: UpToDate.com/login [via subscription only]. Published December 15, 2025. Accessed May 22, 2026.
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Liver Transplant:

Liver transplantation or hepatic transplantation is the replacement of a diseased liver with a healthy liver or split organ from a living or cadaveric donor. Indications for liver transplant include conditions that cause end-stage liver disease, acute liver failure, and certain benign and malignant liver tumors. Priority for liver transplant is by mortality risk and severity of illness criteria developed by the Organ Procurement and Transplantation Network (OPTN) and the United Network of Organ Sharing (UNOS). The severity of illness is determined by the Model for End-stage Liver Disease (MELD) and Pediatric End-stage Liver Disease (PELD) scores.[12,13]

The Plan considers liver transplant as reasonable and medically necessary for Members who have a satisfactory psychosocial profile and support systems in place and have end-stage organ failure due to irreversible liver damage that includes, but is not limited to **ONE** of the following conditions:

1. Acute fulminant hepatic failure
    a. Hepatic Encephalopathy
    b. Progressive Coagulopathy
    c. Progressive Hyperbilirubinemia
2. Cholestatic liver diseases
    a. Primary biliary cirrhosis
    b. Primary sclerosing cholangitis with development of secondary biliary cirrhosis
    c. Biliary atresia
    d. Caroli's disease
    e. Familial cholestasis
    f. Arteriohepatic dysplasia
    g. Cystic Fibrosis
3. Hepatocellular conditions
    a. Alpha-1 antitrypsin deficiency
    b. Alcoholic cirrhosis
    c. Viral induced hepatitis
    d. Autoimmune hepatitis
    e. Drug induced/Toxin exposure, e.g., Acetaminophen/Tylenol
    f. Hemochromatosis
    g. Nonalcoholic steatohepatitis
4. Inborn errors of metabolism
5. Malignancy/Neoplasm
    a. Epithelioid hemangioendothelioma
    b. Neuroendocrine tumor, and **all** of the following[12]:
        i. Age < 60 years; **and**
        ii. Resection of primary malignancy and extra-hepatic disease without any evidence of recurrence at least six months prior to MELD exception request; **and**
        iii. Neuroendocrine liver metastasis (NLM) limited to the liver, bi-lobar, not amenable to resection
    c. Unresectable perihilar or hilar cholangiocarcinoma (CCA) ≤ 3cm and absence of intrahepatic or extahepatic metastasis
    d. Primary hepatocellular carcinoma confined to the liver and **All** of the following[13]:
        i. Member is not a candidate for subtotal liver resection, **and**
        ii. No evidence of extrahepatic disease/spread of tumor beyond the liver (e.g., surrounding lymph nodes, lungs, abdominal organs); **and**
        iii. No macrovascular involvement; **and**
        iv. Meets criteria for tumor size and number, **ONE**:
            1) Single tumor 5 cm or less in diameter or 3 tumors each measuring less than 3 cm with no evidence of macrovascular invasion (Milan Criteria)[10]; **or**
            2) Member meets UNOS criteria for tumor size and number[13]

e. Hepatoblastoma confined to the liver

6. Metabolic disorders and metabolic liver diseases with cirrhosis (not an all-inclusive list)
    a. Alpha 1-antitrypsin deficiency
    b. Hemochromatosis
    c. Inborn errors of metabolism
    d. Wilson's disease
7. Vascular diseases
    a. Budd-Chiari syndrome
8. Miscellaneous
    a. Cryptogenic cirrhosis
    b. Familial amyloid polyneuropathy
    c. Hepato-pulmonary syndrome
    d. Polycystic liver disease and massive hepatomegaly associated with obstruction or impaired function when alternative interventions have failed
    e. Porto-pulmonary hypertension (pulmonary hypertension associated with liver disease or portal hypertension)

Limitations:

The Plan will not authorize the coverage of a liver transplant for Members with **ONE** of the following:

1. Active or uncontrolled alcohol use disorder. Evidence for alcohol abstinence may vary among liver transplant programs, but generally a minimum of 3 months is required.
2. Active or uncontrolled substance use disorder
3. Any unresolved psychosocial concerns or history of noncompliance with medical management
4. Any evidence of extrahepatic, lymphatic or vascular tumor spread
5. Extrahepatic malignancy within the past 5 years (excluding superficial skin cancers) or those not meeting oncologic criteria for cure
6. Human immunodeficiency virus (HIV) disease unless all of the following are met[1]:
    a. Pre-transplant evaluation by an infectious disease specialist with expertise in HIV and transplantation as well as confirmation of plans for continued follow-up after transplantation with an infectious disease specialist of same expertise
    b. CD4 count greater than 200 cells/mm3 during 3 months prior to transplantation
    c. Undetectable HIV-1 ribonucleic acid (RNA)
    d. Stable anti-retroviral therapy for > three months
    e. Absence of serious complications associated with or secondary to HIV disease (e.g., opportunistic infection, including aspergillus, tuberculosis, coccidioidomycosis, resistant fungal infections, Kaposi's sarcoma, and/or other neoplasm)
7. Uncontrolled sepsis
8. Untreated/unstable cardiopulmonary disease

Note: Smoking has been strongly correlated to adverse health and surgical outcomes. There is evidence to show that smoking, both by donors and by recipients, has a major impact on outcomes after organ transplantation. Smoking cessation is strongly recommended for both donors and recipients prior to transplantation.

The following code(s) require prior authorization:

Table 1: CPT/HCPCS Codes

Code	Description
47135	Liver allotransplantation; orthotopic, partial or whole, from cadaver or living donor, any age
47140	Donor hepatectomy (including cold preservation), from living donor; left lateral segment only (segments II and III)
47141	Donor hepatectomy (including cold preservation), from living donor; total left lobectomy (segments II, III and IV)
47142	Donor hepatectomy (including cold preservation), from living donor; total right lobectomy (segments V, VI, VII and VIII)
47143	Backbench standard preparation of cadaver donor whole liver graft prior to allotransplantation, including cholecystectomy, if necessary, and dissection and removal of surrounding soft tissues to prepare the vena cava, portal vein, hepatic artery, and common bile duct for implantation; without trisegment or lobe split
47144	Backbench standard preparation of cadaver donor whole liver graft prior to allotransplantation, including cholecystectomy, if necessary, and dissection and removal of surrounding soft tissues to

Code	Description
	prepare the vena cava, portal vein, hepatic artery, and common bile duct for implantation; with trisegment split of whole liver graft into 2 partial liver grafts (i.e., left lateral segment [segments II and III] and right trisegment (segments I and IV through VIII)
47145	Backbench standard preparation of cadaver donor whole liver graft prior to allotransplantation, including cholecystectomy, if necessary, and dissection and removal of surrounding soft tissues to prepare the vena cava, portal vein, hepatic artery, and common bile duct for implantation; with lobe split of whole liver graft into two partial liver grafts (i.e., left lobe (segments II, III, and IV) and right lobe (segments I and V through VIII)
47146	Backbench reconstruction of cadaver or living donor liver graft prior to allotransplantation; venous anastomosis, each
47147	Backbench reconstruction of cadaver or living donor liver graft prior to allotransplantation; arterial anastomosis, each

References:

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Lung Transplant

A lung transplant is surgery to replace one or both diseased lungs with healthy lungs from a human donor. Indications for lung transplant include but are not limited to the following: interstitial lung disease (including idiopathic pulmonary fibrosis), chronic obstructive pulmonary disease, cystic fibrosis, alpha-1 antitrypsin deficiency, idiopathic pulmonary hypertension, Lymphangioleiomyomatosis, sarcoidosis, Eisenmenger's syndrome, and severe bronchiectasis. In general, transplant recipients over the age of 70 years have an increased likelihood for poor outcome and worse long-term survival compared to younger recipients.

The Plan considers lung transplant as reasonable and medically necessary for Adult Members < 65 years of age* with advanced lung disease who have a satisfactory psychosocial profile and support systems in place and when **All** of the following criteria are met:

1. The Member has clinically and physiologically irreversible disease unresponsive to maximum medical or surgical treatment resulting in progressive symptoms and **All** of the following[7]:

    a. High (>50%) risk of death due to lung disease within 2 years if lung transplantation is not performed; **and**
    b. High (>80%) likelihood of 5-year post-transplant survival from a general medical perspective provided there is adequate graft function; **and**
    c. High functional status (i.e., ambulatory) with good rehabilitation potential.

Considerations for listing children < 18 for lung transplant include the following[6]: **

- Cystic fibrosis (CF) and FEV_1 < 30% predicated
- Pulmonary arterial hypertension (PAH) in the high-risk category European Pediatric Pulmonary Vascular Disease Network (EPPVDN) high risk category and on optimal therapy without improvement
- Other rare conditions with a poor prognosis may be appropriate for transplant including alveolar capillary dysplasia, pulmonary vein stenosis refractory to intervention, and pulmonary veno-occlusive disease (PVOD)

*According to the International Society for Heart and Lung Transplantation (ISHLT) consensus document for the selection of lung transplant candidates, patients who are more than 70 years of age have a high or substantially increased risk and likelihood for a poor outcome following lung transplant. However, patients may be considered for transplant in a facility with special expertise in managing the particular conditions. When the risk of age is coupled with another high-risk factor, the risk may be prohibitive. For lung transplant patients 65 to 70 years of age, this is considered an unfavorable risk factor for transplant. When transplant programs have considered these risks acceptable, individual consideration will be given.[6]

**The ISHLT recommends pediatric candidates should be referred to a transplant center as early as possible because the waiting times are longer, particularly for smaller children. In particular, pediatric patients who have cystic fibrosis should be referred to a transplant center in the presence of any of the following: FEV_1 is < 50% predicted with markers of increased disease severity, or FEV_1 is < 50% predicted with rapidly declining FEV_1, or FEV1 is < 40% predicted.[6]

Special Considerations:

The Plan will consider the following types of transplants for the circumstances and/or diagnoses listed below:

Bilateral Lung Transplantation:

- Generalized bronchiectasis
- Cystic fibrosis disease
- Severe pulmonary hypertension with pulmonary arterial pressure > 40 mmHg

Living Lobar Lung Transplant:

- May be medically necessary in children or small adults with small chest size if size matching is acceptable
- May be medically necessary in cases where it is clear a Member will not live long enough to receive a cadaveric transplant
- Will not be authorized in cases where the patient is in extremis (emergency situations)

Limitations:

The Plan will not authorize the coverage of a lung transplant for Members meeting **ONE** of the following:

1. Active inhaled substance use (e.g., smoking cigarettes, marijuana smoking, inhaling e-cigarettes, vaping)
2. Active or uncontrolled alcohol use disorder or substance use disorder
3. Active extrapulmonary or disseminated infection
4. Active tuberculosis infection
5. Acute liver failure
6. Acute renal failure with rising creatinine or on dialysis and low likelihood of recovery

7. Acute coronary syndrome or myocardial infarction within 30 days (excluding demand ischemia)
8. Liver cirrhosis with portal hypertension or synthetic dysfunction unless being considered for multi-organ transplant
9. Any unresolved psychosocial concerns or history of noncompliance with medical management
10. Glomerular filtration rate < 40 mL/min/1.73m2 unless being considered for multi-organ transplant
11. Human immunodeficiency virus (HIV) infection unless all of the following are met[1]:
    a. CD4 count greater than 200 cells/mm3 for > 3 months prior to transplantation
    b. Undetectable HIV-1 ribonucleic acid (RNA)
    c. Stable anti-retroviral therapy for > 3 months
    d. Absence of serious complications associated with or secondary to HIV disease, (e.g., opportunistic infection, including aspergillus, tuberculosis, coccidioidomycosis, resistant fungal infections; Kaposi's sarcoma; or other neoplasm)
12. Limited functional status (e.g., non-ambulatory) with poor potential for post-transplant rehabilitation
13. Malignancy with high risk of recurrence or death
14. Septic shock
15. Stroke within 30 days or progressive cognitive impairment
16. Uncontrolled or untreatable infection, any source
17. Untreatable hematologic disorders
18. Other severe uncontrolled medical condition expected to limit survival after transplant

The following code(s) require prior authorization:

Table 1: CPT/HCPCS Codes

Code	Description
32850	Donor pneumonectomy(s) (including cold preservation), from cadaver donor
32851	Lung transplant, single; without cardiopulmonary bypass
32852	Lung transplant, single; with cardiopulmonary bypass
32853	Lung transplant, double (bilateral sequential or en bloc); without cardiopulmonary bypass
32854	Lung transplant, double (bilateral sequential or en bloc); with cardiopulmonary bypass
32855	Backbench standard preparation of cadaver donor lung allograft prior to transplantation, including dissection of allograft from surrounding soft tissues to prepare pulmonary venous/atrial cuff, pulmonary artery, and bronchus; unilateral
32856	Backbench standard preparation of cadaver donor lung allograft prior to transplantation, including dissection of allograft from surrounding soft tissues to prepare pulmonary venous/atrial cuff, pulmonary artery, and bronchus; bilateral
33930	Donor cardiectomy-pneumonectomy (including cold preservation)
33933	Backbench standard preparation of cadaver donor heart/lung allograft prior to transplantation, including dissection of allograft from surrounding soft tissue to prepare aorta, superior vena cava, inferior vena cava, and trachea for implantation
33935	Heart-lung transplant with recipient cardiectomy-pneumonectomy

References:

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Pancreas Transplant, Pancreas-Kidney Transplant, Pancreas Autologous Islet Cell Transplant

Pancreas Transplantation Alone (PTA):

The Plan considers pancreas transplant alone as reasonable and medically necessary for Members with insulin-dependent, Type I DM and who have a satisfactory psychosocial profile and support systems in place and when **ONE** of the following criteria are met[1,12]:

1. Failure of insulin-based management to prevent acute complications, **ONE**:
    a. Frequent, acute and severe potentially life-threatening metabolic complications that require medical treatment as documented by chart notes, emergency room visits, or hospitalizations, including **ONE** of the following:
        i. Hypoglycemia unawareness
        ii. Recurring severe hypoglycemia attacks; **or**
        iii. Recurring severe diabetic ketoacidosis, **or**
        iv. Recurring, severe and/or persistent hyperglycemia
2. Severe pancreatic exocrine insufficiency (inability to properly digest food because of a lack of digestive enzymes)
3. Requires pancreas transplant as a part of a multiple organ transplant for technical reasons and Member meets criteria for Kidney transplant

Note: Most transplant candidates have Type 1 diabetes mellitus. Select candidates with Type 2 DM who are insulin dependent may also be appropriate for transplant when there is no evidence of both insulin resistance and significant obesity (BMI is < 30 kg/m^2), in addition to the indications mentioned above for Type 1 DM.

Simultaneous Pancreas-Kidney Transplant (SPK):

The Plan considers simultaneous pancreas-kidney transplant (SPK) as reasonable and medically necessary in insulin dependent diabetic individuals or those with pancreatic exocrine insufficiency with end-stage renal disease who meet all of the criteria for a kidney transplant.

Pancreas Transplantation after a previous kidney transplant (PAK):

The Plan considers pancreas transplantation after a previous kidney transplant as reasonable and medically necessary in Members who are post-uremic and who have insulin dependent diabetes. Additionally, the Member has had a successful kidney transplant without significant chronic rejection of kidney transplant. The Member must have a satisfactory psychosocial profile and support systems in place.

Autologous Islet Cell Transplantation:

The Plan considers autologous pancreatic islet cell transplantation as an adjunct to a total or near total pancreatectomy as reasonable and medically necessary for Members who have a satisfactory psychosocial profile and support systems in place.

Limitations:

The Plan will not authorize coverage of a pancreas-kidney, pancreas, or pancreas islet cell transplant for Members with **ONE** of the following:

1. Active or uncontrolled alcohol use disorder or substance use disorder

2. Advanced cardiopulmonary disease (e.g., significant coronary artery disease - which is not correctable, myocardial infarction within six months, left ventricular ejection fraction < 30%, pulmonary artery systolic pressure over 50mm Hg)
3. Advanced vascular disease
4. Moderate to severe dysfunction in lung, liver, and/or central nervous system, including cirrhosis, portal hypertension, advanced chronic obstructive pulmonary disease, dementia, or severe neurologic deficits
5. Severe local or systemic infection (e.g., active tuberculosis, systemic or localized solid organ fungal infection excluding candida dermatitis, solid organ viral infection (e.g., hepatitis, encephalitis, mumps) and malignant neoplasm other than basal cell carcinoma within the past five years
6. Life expectancy projected to be < 5 years
7. Active malignancy, including metastatic cancer or recent malignancy with high risk of recurrence
8. Any unresolved psychosocial concerns or history of noncompliance with medical management
9. Human immunodeficiency virus (HIV) disease unless all of the following are met[2]:
    a. CD4 count greater than 200 cells/mm3 during 3 months prior to transplantation
    b. Undetectable HIV-1 ribonucleic acid (RNA)
    c. Stable anti-retroviral therapy for > 3 months
    d. Absence of serious complications associated with or secondary to HIV disease (e.g., opportunistic infection, including aspergillus, tuberculosis, coccidioidomycosis, resistant fungal infections; Kaposi's sarcoma; or other neoplasm)
10. Non-insulin-requiring diabetes
11. Serous conditions that create an inability to tolerate transplant surgery or post-transplant care
12. The Plan will not authorize coverage of an Islet cell transplant alone for diabetes mellitus because it is considered to be experimental and investigational

Note: Smoking has been strongly correlated to adverse health and surgical outcomes. There is evidence to show that smoking, both by donors and by recipients, has a major impact on outcomes after organ transplantation. Smoking cessation is strongly recommended for both donors and recipients prior to transplantation.

The following code(s) require prior authorization:

Table 1: CPT/HCPCS Codes

Code	Description
48160	Pancreatectomy, total or subtotal, with autologous transplantation or pancreas or pancreatic islet cells
48550	Donor pancreatectomy (including cold preservation), with or without duodenal segment for transplantation
48551	Backbench standard preparation of cadaver donor pancreas allograft prior to transplantation, including dissection of allograft from surrounding soft tissues, splenectomy, duodenotomy, ligation of bile duct, ligation of mesenteric vessels, and Y-graft arterial anastomoses from iliac artery to superior mesenteric artery and to splenic artery
48552	Backbench reconstruction of cadaver donor pancreas allograft prior to transplantation, venous anastomosis, each
48554	Transplantation of pancreatic allograft
48556	Removal of transplanted pancreatic allograft
50300	Donor nephrectomy (including cold preservation); from cadaver donor, unilateral or bilateral
50320	Donor nephrectomy (including cold preservation); open, from living donor
0584T	Islet cell transplant, includes portal vein catheterization and infusion, including all imaging, including guidance, and radiological supervision and interpretation, when performed; percutaneous
0585T	Islet cell transplant, includes portal vein catheterization and infusion, including all imaging, including guidance, and radiological supervision and interpretation, when performed; laparoscopic
0586T	Islet cell transplant, includes portal vein catheterization and infusion, including all imaging, including guidance, and radiological supervision and interpretation, when performed; open

References:

1. American Diabetes Association. Position statement: pancreas and islet transplantation in type 1 diabetes. Diabetes Care. April 2006;29(4):93
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organ transplantation in the HIV-infected patient: Guidelines from the American Society of Transplantation Infectious Diseases Community of Practice. Clin Transplant. 2019;33(9):e13499. doi:10.1111/ctr.13499.
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12. United Network for Organ Sharing (UNOS). Organ Procurement and Transplantation Network Policies. Pancreas Policy. Accessed July 13, 2026.

Approval And Revision History

November 21, 2024: Reviewed by the Medical Policy Approval Committee (MPAC); Transplant medical policies combined into one new medical policy and criteria updated based on evidence review including society guidelines, effective January 1, 2025

Subsequent endorsement date(s) and changes made:

- December 13, 2024: Reviewed and approved by the UM Committee, effective January 1, 2025
- August 20, 2025: Reviewed by MPAC for annual review, renewed without changes effective October 1, 2025
- September 17, 2025: Reviewed by the UM Committee, renewed without changes effective October 1, 2025
- September 18, 2025: Fax number for Senior Care Options, Tufts Medicare Preferred HMO and Tufts Medicare Preferred PPO updated; language for Carelink removed; Harvard Pilgrim Health Care Stride Medicare Advantage removed as an applicable product from the template
- June 17, 2026: Reviewed by MPAC, Annual Review, criteria updated for small bowel transplants, and pancreas transplants, criteria updates consistent with UNOS and other society guidelines; and administrative update to guideline template, effective August 1, 2026

Background, Product and Disclaimer Information

Medical Necessity Guidelines are developed to determine coverage for benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. We make coverage decisions using these guidelines, along with the Member's benefit document, and in coordination with the Member's physician(s) on a case-by-case basis considering the individual Member's health care needs.

Medical Necessity Guidelines are developed for selected therapeutic or diagnostic services found to be safe and proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in our service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. We revise and update Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern. For Tufts Health Together (Medicaid), coverage may be available beyond these guidelines for pediatric members under age 21 under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits of the plan in accordance with 130 CMR 450.140 and 130 CMR 447.000, and with prior authorization.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this guideline is not a guarantee of payment, or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to eligibility and benefits on the date of service, coordination of benefits, referral/authorization, utilization management guidelines when applicable, and adherence to plan policies, plan procedures, and claims editing logic.