Intestinal Transplant with or without Combined Liver Transplant or Other Visceral Organs

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Effective Date	3/2009
Next Review Date	8/15/2024
Coverage Policy	Surgical 92
Version	3

All requests for authorization for the services described by this medical policy will be reviewed per Early and Periodic Screening, Diagnostic and Treatment (EPSDT) guidelines. These services may be authorized under individual consideration for Medicaid members under the age of 21-years if the services are judged to be medically necessary to correct or ameliorate the member's condition. Department of Medical Assistance Services (DMAS), Supplement B - EPSDT (Early and Periodic Screening, Diagnosis and Treatment) Manual.*.

Purpose:

This policy addresses Intestinal Transplant with or without Combined Liver Transplant or Other Visceral Organs.

Description & Definitions:

Intestinal and multivisceral transplantation is a surgical procedure with cadaver or living donor organ to replace and repair the damaged structure to restore proper function.

Criteria:

Intestinal transplant is considered medically necessary for **1 or more of the following**:

- Evidence of advanced or progressive intestinal failure associated with liver disease with:
  - Hyperbilirubinemia >75 µmol/L[b] (4.5 mg/dL) despite intravenous lipid modification strategies that persists for >2 months
  - Any combination of elevated serum bilirubin, reduced synthetic function (subnormal albumin or elevated international normalized ratio), and laboratory indications of portal hypertension and hypersplenism, especially low platelet count, persisting for >1 month in the absence of confounding infectious event(s)
- Thrombosis of 2 or more major vessels (e.g., jugular, subclavian, and iliac veins) or occlusion of a brachiocephalic vein in children (in adults, this criterion should be evaluated in a case-by-case basis)
- Life-threatening morbidity in the setting of indefinite parenteral nutrition dependence of either anatomical or functional cause as suggested by **1 or more of the** following:
  - In children, 2 admission to an intensive care unit (after initial recovery from the event resulting in intestinal failure) because of cardiorespiratory failure (mechanical ventilation or inotrope infusion) due to sepsis or other complications of intestinal failure
  - In adults, on a case-by-case basis

- Catheter-related sepsis has resulted in repeated episodes of disseminated infections and/or repeated bacteremia
- Invasive intra-abdominal desmoids in adolescents and adults
- Acute diffuse intestinal infarction with hepatic failure
- Failure of first intestinal transplant

Intestinal Transplant with or without Combined Liver Transplant or Other Visceral Organs is considered **not medically necessary** for any use other than those indicated in clinical criteria.

Coding:

Medically necessary with criteria:

Coding	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
44137	Removal of transplanted intestinal allograft, complete
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; arterial anastomosis, each
S2053	Transplantation of small intestine and liver allografts
S2054	Transplantation of multivisceral organs
S2055	Harvesting of donor multivisceral organs, with preparation and maintenance of allografts; from cadaver donor

Considered Not Medically Necessary:

Coding	Description
	None

U.S. Food and Drug Administration (FDA) - approved only products only.

Document History:

Revised Dates:

- 2022: August

- 2021: October
- 2019: November
- 2016: May
- 2015: May
- 2013: May, October
- 2011: March

Reviewed Dates:

- 2023: August
- 2020: October
- 2019: October
- 2018: March
- 2017: January
- 2014: May
- 2012: May
- 2010: March

Effective Date:

- March 2009

References:

Specialty Association Guidelines; Government Regulations; Winifred S. Hayes, Inc; UpToDate; Literature Review; Specialty Advisors; National Coverage Determination (NCD); Local Coverage Determination (LCD).

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Special Notes: *

This medical policy express Sentara Health Plan's determination of medically necessity of services, and they are based upon a review of currently available clinical information. These policies are used when no specific guidelines for coverage are provided by the Department of Medical Assistance Services of Virginia (DMAS). Medical Policies may be superseded by state Medicaid Plan guidelines. Medical policies are not a substitute for clinical judgment or for any prior authorization requirements of the health plan. These policies are not an explanation of benefits.

Medical policies can be highly technical and complex and are provided here for informational purposes. These medical policies are intended for use by health care professionals. The medical policies do not constitute medical advice or medical care. Treating health care professionals are solely responsible for diagnosis, treatment and medical advice. Sentara Health Plan members should discuss the information in the medical policies with their treating health care professionals. Medical technology is constantly evolving and these medical policies are subject to change without notice, although Sentara Health Plan will notify providers as required in advance of changes that could have a negative impact on benefits.

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) covers services, products, or procedures for children, if those items are determined to be medically necessary to "correct or ameliorate" (make better) a defect, physical or mental illness, or condition (health problem) identified through routine medical screening or examination, regardless of whether coverage for the same service or support is an optional or limited service under the state plan. Children enrolled in the FAMIS Program are not eligible for all EPSDT treatment services. All requests for authorization for the services described by this medical policy will be reviewed per EPSDT guidelines. These services may be authorized under individual consideration for Medicaid members under the age of 21-years if the services are judged to by medically necessary to correct or ameliorate the member's condition. *Department of Medical Assistance Services (DMAS), Supplement B - EPSDT (Early and Periodic Screening, Diagnosis and Treatment) Manual.*

Keywords:

SHP Intestinal Transplant With or Without Combined Liver Transplant or Other Visceral Organs, SHP Surgical 92, total parenteral nutrition, TPN, liver failure, thrombosis, elevated serum bilirubin, liver enzymes, splenomegaly, thrombocytopenia, gastroesophageal varices, coagulopathy, stomal bleeding, hepatic fibrosis/cirrhosis, systemic sepsis, jugular vein, subclavian vein, femoral vein, line-related fungemia, septic shock, acute respiratory distress syndrome, severe dehydration, intestinal failure, Dysmotility disorders, Hirschsprung's disease, megacystis microcolon, intestinal pseudo obstruction, microvillus inclusion disease, tufting enteropathy, familial adenomatous polyposis, Neoplastic tumors, combined transplant, retransplantation