# DEPARTMENT OF HUMAN SERVICES, DEPARTMENTAL ADMINISTRATION AND MEDICAL ASSISTANCE PROGRAMS

## DIVISION 124

## TRANSPLANT SERVICES

410-124-0000 Transplant Services

410-124-0005 Donor Services

410-124-0010 Eligibility for Transplant Services

410-124-0020 Prior Authorization for All Covered Transplants, Except Cornea and Kidney

410-124-0040 Emergency Transplants

410-124-0060 Criteria and Contraindications for Heart Transplants

410-124-0063 Criteria and Contraindications for Heart-Lung Transplants

410-124-0065 Criteria and Contraindications for Single Lung Transplants

410-124-0070 Criteria and Contraindications for Bilateral Lung Transplants

410-124-0080 Criteria and Contraindications for Autologous and Allogeneic Bone Marrow, Autologous and Allogeneic Peripheral Stem Cell and Allogeneic Cord Blood Transplants

410-124-0090 Criteria and Contraindications for Harvesting Autologous Bone Marrow and Peripheral Stem Cells

410-124-0100 Criteria and Contraindications for Liver and Liver-Kidney Transplants

410-124-0120  Criteria and Contraindications for Simultaneous Pancreas-Kidney and Pancreas After Kidney Transplants

410-124-0140  Kidney Transplants

410-124-0160  Cornea Transplants

**410-124-0000 Transplant Services**

(1) The Office of Medical Assistance Programs (OMAP) will make payment for prior authorized and emergency transplant services identified in these rules as covered for eligible clients receiving the Basic Benefit Health Care Package and when OMAP transplant criteria described in OAR 410-124-0010 and 410-124-0060 through 410-124-0160 is met. All other Benefit Packages do not cover transplant.

(2) OMAP will only prior authorize and reimburse for transplants if:

(a) All OMAP criteria are met; and

(b) Both the transplant center's and the specialist's evaluations recommend that the transplant be authorized; and

(c) The ICD-9-CM diagnosis code(s) and CPT transplant procedure code(s) are paired on the same currently funded line on the Prioritized List of Health Services adopted under OAR 410-141-0520.

(3) Simultaneous multiple organ transplants are covered only if specifically identified as paired on the same currently funded line on the Oregon Health Plan (OHP) Prioritized List of Health Services whether the transplants are for the same underlying disease or for unrelated, but concomitant, underlying diseases.

(4) Not Covered Transplant Services: The following types of transplants are not covered by OMAP:

(a) Transplants which are considered experimental or investigational or which are performed on an experimental or investigational basis, as determined by OMAP;

(b) Transplant services which are contraindicated, as described in OAR 410-124-0060 through 410-124-0160;

(c) Transplants which have not been prior authorized for payment by OMAP or the client's managed health care plan;

(d) Transplants which do not meet the guidelines for an emergency transplant in OAR 410-124-0040;

(e) Transplants which are not described as covered in OAR 410-141-0480 and 410-141-0520.

(5) Selection of Transplant Centers: Transplant services will be reimbursed only when provided in a transplant center that provides quality services, demonstrates good patient outcomes and compliance with all OMAP facility criteria. The transplant center must have provided transplant services for a period of at least two years and must have completed a minimum of 12 cases in the most recent year. The patient-and-graft-survival rates must be equal to or greater than the appropriate standard indicated in this rule. A transplant center which has had at least two years of experience in transplantation of any solid organ (heart, liver, lung, pancreas) and which has met or exceeded the appropriate standards may be considered for reimbursement for the transplantation of other solid organs and/or autologous or allogeneic bone marrow transplantation:

(a) An experienced and proficient transplant team and a well established transplant support infrastructure at the same physical location as the transplant service is required for transplant services rendered to OMAP clients. These transplant criteria are crucial to successful transplant outcome. Therefore, consortia will not be approved or contracted with for the provision of transplant services for OMAP clients. No OMAP transplant contract, prior approval or reimbursement will be made to consortia for transplant services where, as determined by OMAP, there is no assurance that the individual facilities that make up the consortia independently meet OMAP criteria. OMAP transplant criteria must be met individually by a facility to demonstrate substantial experience with the procedure;

(b) Once a transplant facility has been approved and contracted for OMAP transplant services, it is obliged to report immediately to OMAP any events or changes that would affect its approved status. Specifically, a transplant facility is required to report, within a reasonable period of time, any significant decrease in its experience level or survival rates, the departure of key members of the transplant

team or any other major changes that could affect the performance of transplants at the facility. Changes from the terms of approval may lead to prospective withdrawal of approval for OMAP coverage of transplants performed at the facility;

(c) Fully Capitated Health Plans (FCHPs) that contract with non-OMAP contracted facilities for Basic Health Care Package clients will develop and use appropriate transplant facility criteria to evaluate and monitor for quality services at the transplant facility;

(d) Transplant centers which have less than two years experience in solid organ transplant may be reimbursed, at OMAP's discretion, for allogeneic or autologous bone marrow transplants upon completion of two years of experience in bone marrow transplantation with patient survival rates equal to or exceeding those defined in section (5) of this rule;

(e) OMAP will discontinue the contract with a transplant center when the graft and/or survival rates fall below the standards indicated in this rule for a period of two consecutive years.

(6) Standards for Transplant Centers:

(a) Heart, heart-lung and lung transplants:

(A) Heart: One-year patient survival rate of at least 80%;

(B) Heart-Lung: One-year patient survival rate of at least 65%;

(C) Lung: One-year patient survival rate of at least 65%.

(b) Bone Marrow (autologous and allogeneic), peripheral stem cell (autologous and allogeneic) and cord blood (allogeneic) transplants: One-year patient survival rate of at least 50%;

(c) Liver transplants: One year patient survival rate of at least 70% and one year graft survival rate of at least 60%;

(d) Simultaneous pancreas-kidney and pancreas-after-kidney transplants: One year patient survival rate of at least 90% and one year graft survival rate of at least 60%;

(e) Kidney transplants: One year patient survival rate of at least 92% and one year graft survival rate of at least 85%.

(7) Selection of transplant centers by geographic location: If the services are available in the state of Oregon, reimbursement will not be made to out-of-state transplant centers. Out-of-state centers will be considered only if:

(a) The type of transplant required is not available in the state of Oregon and/or the type of transplant (for example, liver transplant) is available in the state of Oregon but the Oregon transplant center does not provide that type of transplant for all clients or all covered diagnoses, (e.g., pediatric transplants); and

(b) An in-state transplant center requests the out-of-state transplant referral; and

(c) An in-state transplant facility recommends transplantation based on in-state facility and OMAP criteria; or

(d) It would be cost effective as determined by OMAP. For example, if the transplant service is covered by the client's benefit package and the client's primary insurer (i.e., Medicare) requires the use of an out-of-state transplant center; or

(e) It is a contiguous, out-of-state transplant center that has a contract or special agreement for reimbursement with OMAP.

(8) Professional and other services will be covered according to administrative rules in the applicable provider guides.

(9) Reimbursement for covered transplants and follow-up care for transplant services is as follows:

(a) For transplants for fee-for-service or Primary Care Case Manager (PCCM) clients:

(A) Transplant facility services -- by contract with OMAP;

(B) Professional services -- at OMAP maximum allowable rates;

(b) For emergency services, when no special agreement has been established, the rate will be:

(A) 75% of standard inpatient billed charge; and

(B) 50% of standard outpatient billed charge; or

(C) The payment rate set by the Medical Assistance program of the state in which the center is located, whichever is lower.

(c) For clients enrolled in FCHPs, reimbursement for transplant services will be by agreement between the FCHP and the transplant center.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: HR 8-1990(Temp), f. 3-30-90, cert. ef. 4-1-90; HR 22-1990, f. & cert. ef. 7-17-90; HR 37-1990, f. 11-6-90, cert. ef. 11-9-90; HR 17-1992, f. & cert. ef. 7-1-92; HR 4-1994, f. & cert. ef. 2-1-94; HR 19-1995, f. 9-28-95, cert. ef. 10-1-95; HR 17-1997, f. & cert. ef. 7-11-97; OMAP 18-2000 f. 9-28-00, cert. ef. 10-1-00; OMAP 21-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 34-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 1-2003, f. 1-31-03, cert. ef. 2-1-03

**410-124-0005 Donor Services**

(1) Living and cadaver donor search and procurement services are covered for covered transplants.

(2) All living or cadaver donor services are payable under the recipient's Medicaid identification number and not under the donor.

(3) Living donor services -- prior authorization requirements for fee-for-service and Primary Care Case Manager (PCCM) clients:

(a) Bone marrow, stem cells and cord blood:

(A) Screening of potential living related donors does not require prior authorization;

(B) Unrelated/voluntary donor search requires prior authorization;

(C) Collection and testing of related cord blood requires prior authorization;

(D) Donor search costs up to the maximum amount of $15,000 are covered only if donor search is prior authorized;

(E) Procurement requires prior authorization of the transplant.

(b) Kidney alone -- no prior authorization required for testing of or procurement from living or cadaver donors;

(c) Other solid organs -- testing and procurement are covered if transplant is prior authorized;

(d) Payment is limited to donor expenses incurred directly in connection with the transplant. Complications of the donor that are directly and immediately related or attributable to the donation procedure are covered.

(4) Cadaver procurement services -- prior authorization requirements for fee-for-service and PCCM clients:

(a) Covered if transplant is prior authorized;

(b) Procurement charges are included in the Organ Procurement Organization (OPO) charges to the transplant facility;

(c) Payable only to the transplant facility per contract.

(5) For Fully Capitated Health Plan (FCHP) clients, contact the client's FCHP for authorization requirements.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 18-2000 f. 9-28-00, cert. ef. 10-1-00

**410-124-0010 Eligibility for Transplant Services**

(1) To be eligible for transplant services the client must be on the Basic Health Care Package at the time the transplant services are provided.

(2) Clients covered under the following Benefit Packages do not have coverage for transplants:

(a) Limited Benefit Package (LMH, LMM) -- coverage only for mental health, alcohol/drug, pharmacy, and medical transportation services;

(b) Qualified Medicare Beneficiary (MED) -- coverage only for services covered by Medicare;

(c) Citizen/Alien-Waived Emergency Medical (CWM) -- Federal rules exclude coverage of transplants, even if emergent.

(3) If an individual is not eligible for the Basic Health Care Package at the time the transplant is performed, but is later made retroactively eligible for the Basic Health Care Package, the Office of Medical Assistance Programs (OMAP) will apply the same criteria found in OAR 410-124-0020 through OAR 410-124-0160 in determining whether to cover the transplant and transplant-related services. Payment can only be made for services provided during the period of time the individual is eligible.

(4) OMAP prior authorization is valid for transplant services provided only while the client is enrolled under fee-for-service or a Primary Care Case Manager. If a client moves from the fee-for-service arena to a Fully Capitated Health Plan (FCHP), any prior authorizations which had been approved by OMAP are void and prior authorization must be obtained from the new FCHP. If a client moves out of an FCHP into another FCHP, or into fee-for-service, any prior authorizations approved by the original FCHP or OMAP are void, and prior authorization must again be obtained from the new FCHP or OMAP.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065
Hist.: HR 37-1990, f. 11-6-90, cert. ef. 11-9-90; HR 17-1992, f. & cert. ef. 7-1-92; HR 4-1994, f. & cert. ef. 2-1-94; HR 19-1995, f. 9-28-95, cert. ef. 10-1-95; OMAP 18-2000 f. 9-28-00, cert. ef. 10-1-00

**410-124-0020 Prior Authorization for All Covered Transplants, Except Cornea and Kidney**

(1) Prior authorization is required as follows:

(a) All non-emergency transplant services require prior authorization of payment, except for kidney alone and cornea transplants which require prior authorization only if performed out-of-state;

(b) Pre-transplant evaluations provided by the transplant center require prior authorization. Prior Authorization will only be made for evaluations for covered transplants.

(2) The prior authorization request for all covered transplants is initiated by the client's in-state referring physician or the transplant physician. The initial request should contain all available information outlined in subsection (3) of this rule, below:

(a) For fee-for-service and Primary Care Case Manager (PCCM) clients, the request should be sent to the Office of Medical Assistance Programs (OMAP);

(b) For clients enrolled in a Fully Capitated Health Plan (FCHP), requests for transplant services should be sent directly to the FCHP.

(3) A completed request for authorization must contain the following information. Failure to submit all the information will delay processing of the request. An optional form is provided at the end of the Transplant Services guide for provider convenience in submitting requests for evaluations only:

(a) The name, age, Medical Assistance Identification number, and birth date of the client;

(b) A description of the medical condition and full ICD-9-CM coding which necessitates a transplant;

(c) The type of transplant proposed, with CPT code;

(d) The results of a current HIV test, (completed within 6 months of request for transplant authorization);

(e) Any other evidence of contraindications for the type of transplant being considered (see contraindications under each transplant type);

(f) The client's prognosis, with and without a transplant, including estimated life expectancy with and without the transplant;

(g) Transplant treatment alternatives:

(A) A history of other treatments which have been tried;

(B) Treatments that have been considered and ruled out, including discussion of why they have been ruled out.

(h) An evaluation based upon a comprehensive examination completed by a board certified specialist in a field directly related to the condition of the client which necessitates the transplant;

(i) If already done before requesting prior authorization, the results of any medical and/or social evaluation completed by a transplant center should be included in the prior authorization request. The completion of an evaluation by a transplant center before receiving prior authorization from OMAP does not obligate OMAP to reimburse that transplant center for the evaluation or for any other transplant services not prior authorized.

(4) Prior authorization approval process and requirements:

(a) For clients receiving services on a fee-for-service basis and/or enrolled with a PCCM:

(A) After receiving a completed request, OMAP will notify the referring physician within two weeks if an evaluation at a transplant center is approved or denied;

(B) A final determination for the actual transplant requires an evaluation by a selected transplant center, which will include:

(i) A medical evaluation;

(ii) An estimate of the client's motivation and ability, both physical and psychological, to adhere to the post-transplant regimen;

(iii) The transplant center's assessment of the probability of a successful outcome, based on the type of transplant requested, the condition of the client, and the client's ability to adhere to the post-transplant regimen; and

(iv) A recommendation using both the transplant center's own criteria, and OMAP's criteria.

(b) For Oregon Health Plan (OHP) transplant eligible clients who are in an FCHP: Refer to the FCHP for approval process and requirements;

(c) The prior authorization request will be approved if:

(A) All OMAP criteria are met; and

(B) Both the transplant center's and the specialist's evaluations recommend that the transplant be authorized; and

(C) The ICD-9-CM diagnosis code(s) and CPT transplant procedure code(s) are paired on the same currently funded line on the Prioritized List of Health Services.

(5) The referring physician, transplant center, and the client will be notified in writing by OMAP or the FCHP of the prior authorization decision.

(6) Prior authorization of a transplant does not guarantee reimbursement for the services of any provider if, at the time the transplant is performed, intercurrent events have caused the

individual's medical condition to deteriorate to the point at which survival with or without transplant for a period of more than sixty days is unlikely.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: HR 8-1990(Temp), f. 3-30-90, cert. ef. 4-1-90; HR 22-1990, f. & cert. ef. 7-17-90; HR 17-1992, f. & cert. ef. 7-1-92; HR 4-1994, f. & cert. ef. 2-1-94; HR 19-1995, f. 9-28-95, cert. ef. 10-1-95; HR 17-1997, f. & cert. ef. 7-11-97; OMAP 18-2000 f. 9-28-00, cert. ef. 10-1-00; OMAP 21-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 34-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 1-2003, f. 1-31-03, cert. ef. 2-1-03

**410-124-0040 Emergency Transplants**

(1) An Emergency Transplant is one in which medical appropriateness requires that a covered transplant be performed less than five days after determination of the need for a transplant.

(2) Emergency transplants are subject to post transplant review of the client's medical records by the Office of Medical Assistance Programs (OMAP), or the Fully Capitated Health Plan (FCHP), to determine if the client and the transplant center met the criteria in these rules at the time of the transplant. Related charges, including transportation, physician's services, and donor charges will be covered if payment is approved. OMAP will make payment as described in OAR 410-124-0000 (9) for OMAP-covered transplants. FCHPs will make payment as described in their contract.

(3) Transplants are not covered by Citizen/Alien-Waived Emergency Medical (CWM) clients, even when emergent.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: HR 8-1990(Temp), f. 3-30-90, cert. ef. 4-1-90; HR 22-1990, f. & cert. ef. 7-17-90; HR 4-1994, f. & cert. ef. 2-1-94; OMAP 18-2000 f. 9-28-00, cert. ef. 10-1-00; OMAP 1-2003, f. 1-31-03, cert. ef. 2-1-03

**410-124-0060 Criteria and Contraindications for Heart Transplants**

(1) Prior authorization for a heart transplant will only be approved for a client in whom irreversible heart disease has advanced to the point where conventional therapy offers no prospect for prolonged survival, there is no reasonable alternative medical or surgical therapy and the client's five (5) year survival rate, subsequent to the transplant, is at least 20 percent as supported by medical literature.

(2) A client considered for a heart transplant must have a poor prognosis, i.e., less than a 50% chance of survival for 18 months without a transplant as a result of poor cardiac functional status or cardio/pulmonary functional status.

(3) All alternative medically accepted treatments that have a one year survival rate comparable to that of heart transplantation must have been tried or considered.

(4) Requests for transplant services for children suffering from early congenital heart disease may be approved before attempting alternative treatments if medical evidence suggests an early date of transplant is likely to improve the outcome.

(5) A client with one or more of the following contraindications is ineligible for heart transplant services:

(a) Untreatable systemic vasculitis;

(b) Incurable malignancy;

(c) Diabetes with end-organ damage;

(d) Active infection which will interfere with the client's recovery;

(e) Refractory bone marrow insufficiency;

(f) Irreversible renal disease;

(g) Irreversible hepatic disease;

(h) HIV positive test results.

(6) The following may be considered contraindications to the extent that the evaluating transplant center and/or the specialist who completed the comprehensive evaluation of the client believe the following condition(s) may interfere significantly with the recovery process:

(a) Hyperlipoproteinemia;

(b) Curable malignancy;

(c) Significant cerebrovascular or peripheral vascular disease;

(d) Unresolved or continuing thromboembolic disease or pulmonary infarction;

(e) Irreversible pulmonary hypertension;

(f) Serious psychological disorders;

(g) Drug or alcohol abuse.

(7) OMAP will only prior authorize and reimburse for heart transplants if:

(a) All OMAP criteria are met; and

(b) Both the transplant center's and the specialist's evaluations recommend that the transplant be authorized; and

(c) The ICD-9-CM diagnosis code(s) and CPT transplant procedure code(s) are paired on the same currently funded line on the Prioritized List of Health Services adopted under OAR 410-141-0520.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065
Hist.: HR 8-1990(Temp), f. 3-30-90, cert. ef. 4-1-90; HR 22-1990, f. & cert. ef. 7-17-90; HR 17-1992, f. & cert. ef. 7-1-92; HR 4-1994, f. & cert. ef. 2-1-94; OMAP 18-2000 f. 9-28-00, cert. ef. 10-1-00; OMAP 21-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 34-2001, f. 9-24-01, cert. ef. 10-1-01

**410-124-0063 Criteria and Contraindications for Heart-Lung Transplants**

(1) Prior authorization for a heart-lung transplant will only be approved for a client in whom irreversible cardio-pulmonary disease has advanced to the point where conventional therapy offers no prospect for prolonged survival, there is no reasonable alternative medical or surgical therapy and the client's five (5) year survival rate, subsequent to the transplant, is at least 20 percent as supported by medical literature.

(2) A client considered for a heart-lung transplant must have cardio-pulmonary failure with a poor prognosis, i.e., less than a 50% chance of survival for 18 months without a transplant as a result of poor cardiac functional status or cardio/pulmonary functional status.

(3) All alternative medically accepted treatments that have a one year survival rate comparable to that of heart-lung transplantation must have been tried or considered.

(4) Requests for transplant services for children suffering from early cardio-pulmonary disease may be approved before attempting alternative treatments if medical evidence suggests an early date of transplant is likely to improve the outcome.

(5) A client with one or more of the following contraindications is ineligible for heart-lung transplant services:

(a) Untreatable systemic vasculitis;

(b) Incurable malignancy;

(c) Diabetes with end-organ damage;

(d) Active infection which will interfere with the client's recovery;

(e) Refractory bone marrow insufficiency;

(f) Irreversible renal disease;

(g) Irreversible hepatic disease;

(h) HIV positive test results.

(6) The following may be considered contraindications to the extent that the evaluating transplant center and/or the specialist who completed the comprehensive evaluation of the client believe the following condition(s) may interfere significantly with the recovery process:

(a) Hyperlipoproteinemia;

(b) Curable malignancy;

(c) Significant cerebrovascular or peripheral vascular disease;

(d) Unresolved or continuing thromboembolic disease or pulmonary infarction;

(e) Serious psychological disorders;

(f) Drug or alcohol abuse.

(7) OMAP will only prior authorize and reimburse for heart-lung transplants if:

(a) All OMAP criteria are met; and

(b) Both the transplant center's and the specialist's evaluations recommend that the transplant be authorized; and

(c) The ICD-9-CM diagnosis code(s) and CPT transplant procedure code(s) are paired on the same currently funded line on the Prioritized List of Health Services adopted under OAR 410-141-0520.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065
Hist.: HR 4-1994, f. & cert. ef. 2-1-94; HR 19-1995, f. 9-28-95, cert. ef. 10-1-95; OMAP 18-2000 f. 9-28-00, cert. ef. 10-1-00; OMAP 34-2001, f. 9-24-01, cert. ef. 10-1-01

**410-124-0065 Criteria and Contraindications for Single Lung Transplants**

(1) Prior authorization for a single lung transplant will only be approved for a client in whom irreversible lung disease has advanced to the point where conventional therapy offers no prospect for prolonged survival, there is no reasonable alternative medical or surgical therapy and the client's five (5) year survival rate, subsequent to the transplant, is at least 20 percent as supported by medical literature.

(2) The client must have a poor prognosis, i.e., less than a 50% chance of survival for 18 months without a transplant as a result of poor pulmonary functional status.

(3) All alternative medically accepted treatments that have a one year survival rate comparable to that of single lung transplantation must have been tried or considered.

(4) Requests for transplant services for children suffering from early pulmonary disease may be approved before attempting alternative treatments if medical evidence suggests an early date of transplant is likely to improve the outcome.

(5) A client with one or more of the following contraindications is ineligible for single lung transplant services:

(a) Untreatable systemic vasculitis;

(b) Incurable malignancy;

(c) Diabetes with end-organ damage;

(d) Active infection which will interfere with the client's recovery;

(e) Refractory bone marrow insufficiency;

(f) Irreversible renal disease;

(g) Irreversible hepatic disease;

(h) HIV positive test results.

(6) The following may be considered contraindications to the extent that the evaluating transplant center and/or the specialist who completed the comprehensive evaluation of the client believe the following condition(s) may interfere significantly with the recovery process:

(a) Hyperlipoproteinemia;

(b) Curable malignancy;

(c) Significant cerebrovascular or peripheral vascular disease;

(d) Unresolved continuing thromboembolic disease or pulmonary infarction;

(e) Serious psychological disorders;

(f) Drug or alcohol abuse.

(7) OMAP will only prior authorize and reimburse for single lung transplants if:

(a) All OMAP criteria are met; and

(b) Both the transplant center's and the specialist's evaluations recommend that the transplant be authorized; and

(c) The ICD-9-CM diagnosis code(s) and CPT transplant procedure code(s) are paired on the same currently funded line on the Prioritized List of Health Services adopted under OAR 410-141-0520.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065

Hist.: HR 4-1994, f. & cert. ef. 2-1-94; HR 19-1995, f. 9-28-95, cert. ef. 10-1-95; OMAP 18-2000 f. 9-28-00, cert. ef. 10-1-00; OMAP 21-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 34-2001, f. 9-24-01, cert. ef. 10-1-01

**410-124-0070 Criteria and Contraindications for Bilateral Lung Transplants**

(1) Prior authorization for a bilateral lung transplant will only be approved for a client in whom irreversible lung disease has advanced to the point where conventional therapy offers no prospect for prolonged survival, there is no reasonable alternative medical or surgical therapy and the client's five (5) year survival rate, subsequent to the transplant, is at least 20 percent as supported by medical literature.

(2) The client must have a poor prognosis, i.e., less than a 50% chance of survival for 18 months without a transplant as a result of poor pulmonary functional status.

(3) All alternative medically accepted treatments that have a one year survival rate comparable to that of bilateral lung transplantation must have been tried or considered.

(4) Requests for transplant services for children suffering from early pulmonary disease may be approved before attempting alternative treatments if medical evidence suggests an early date of transplant is likely to improve the outcome.

(5) A client with one or more of the following contraindications is ineligible for bilateral lung transplant services:

(a) Untreatable systemic vasculitis;

(b) Incurable malignancy;

(c) Diabetes with end-organ damage;

(d) Active infection which will interfere with the client's recovery;

(e) Refractory bone marrow insufficiency;

(f) Irreversible renal disease;

(g) Irreversible hepatic disease;

(h) HIV positive test results.

(6) The following may be considered contraindications to the extent that the evaluating transplant center and/or the specialist who completed the comprehensive evaluation of the client believe the following condition(s) may interfere significantly with the recovery process:

(a) Hyperlipoproteinemia;

(b) Curable malignancy;

(c) Significant cerebrovascular or peripheral vascular disease;

(d) Unresolved continuing thromboembolic disease or pulmonary infarction;

(e) Serious psychological disorders;

(f) Drug or alcohol abuse.

(7) OMAP will only prior authorize and reimburse for bilateral lung transplants if:

(a) All OMAP criteria are met; and

(b) Both the transplant center's and the specialist's evaluations recommend that the transplant be authorized; and

(c) The ICD-9-CM diagnosis code(s) and CPT transplant procedure code(s) are paired on the same currently funded line on the Prioritized List of Health Services adopted under OAR 410-141-0520.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065

Hist.: HR 4-1994, f. & cert. ef. 2-1-94; HR 19-1995, f. 9-28-95, cert. ef. 10-1-95; OMAP 18-2000 f. 9-28-00, cert. ef. 10-1-00; OMAP 21-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 34-2001, f. 9-24-01, cert. ef. 10-1-01

**410-124-0080 Criteria and Contraindications for Autologous and Allogeneic Bone Marrow, Autologous and Allogeneic Peripheral Stem Cell and Allogeneic Cord Blood Transplants**

(1) The following criteria will be used to evaluate the prior authorization request for all bone marrow and peripheral stem cell transplants:

(a) Transplantation must be the most effective medical treatment, when compared to other alternatives, in prolonging life expectancy to a reasonable degree;

(b) The client must have a maximum probability of a successful clinical outcome and the expectation of not less than a 20 percent five (5) year survival rate, subsequent to the transplant, as supported by medical literature considering each of the following factors:

(A) The type of transplant, i.e., autologous or allogeneic;

(B) The specific diagnosis of the individual;

(C) The stage of illness, i.e., in remission, not in remission, in second remission;

(D) Satisfactory antigen match between donor and recipient in allogeneic transplants;

(c) All alternative treatments with a one year survival rate comparable to that of bone marrow transplantation must have been tried or considered.

(2) Allogeneic transplants will be approved for payment only when there is a minimum of 5-out-of-6 antigen match for bone marrow and peripheral stem cell transplants, or 4-out-of-6 match for cord blood transplants, considering the HLA-A, B, and DR loci. Donor search costs up to an amount of $15,000 will be covered only if prior authorized.

(3) Donor leukocyte infusions are covered only when:

(a) An early failure or relapse post allogeneic bone marrow transplant occurs; and

(b) Peripheral stem cells are from the original donor.

(4) The following are contraindications for autologous and allogeneic bone marrow, autologous and allogeneic peripheral stem cell and allogeneic cord blood transplants:

(a) Irreversible terminal state (moribund or on life support);

(b) An irreversible disease of any other major organ system likely to limit life expectancy to five (5) years or less;

(c) Positive HIV test results;

(d) Positive pregnancy test.

(5) The following may be considered contraindications to the extent the evaluating transplant center and/or the specialist who completed the comprehensive evaluation of the client believe these condition(s) may interfere significantly with the recovery process:

(a) Serious psychological disorders;

(b) Alcohol or drug abuse.

(6) OMAP will prior authorize and reimburse for autologous and allogeneic bone marrow, autologous and allogeneic peripheral stem cell and allogeneic cord blood transplants only if:

(a) All OMAP criteria are met; and

(b) Both the transplant center's and the specialist's evaluations recommend that the transplant be authorized; and

(c) The ICD-9-CM diagnosis code(s) and CPT transplant procedure code(s) are paired on the same currently funded line on the Prioritized List of Health Services adopted under OAR 410-141-0520.

(7) OMAP will prior authorize and reimburse for autologous and allogeneic bone marrow, autologous and allogeneic peripheral stem cell and allogeneic cord blood transplants for pediatric solid malignancies only if:

(a) Requirements of 410-124-0080(6)(a), (b) and (c) are met; and

(b) There is documentation of a morphology code listed on the currently funded line for pediatric solid tumor in the Prioritized List of Health Services adopted under OAR 410-141-0520.

(8) Prior authorization for harvesting of autologous bone marrow or peripheral stem cells does not guarantee reimbursement for the transplant; the patient must meet the criteria specified above and in 410-124-0020 at the time the transplant is performed.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: HR 8-1990(Temp), f. 3-30-90, cert. ef. 4-1-90; HR 22-1990, f. & cert. ef. 7-17-90; HR 35-1991(Temp), f. & cert. ef. 8-29-91; HR 47-1991, f. & cert. ef. 10-16-91; HR 17-1992, f. & cert. ef. 7-1-92; HR 4-1994, f. & cert. ef. 2-1-94; HR 34-1994, f. & cert. ef. 12-1-94; HR 19-1995, f. 9-28-95, cert. ef. 10-1-95; HR 17-1997, f. & cert. ef. 7-11-97; OMAP 14-1998(Temp), f. & cert. ef. 5-1-98 thru 9-1-98; OMAP 29-1998, f. & cert. ef. 9-1-98; OMAP 33-1999(Temp), f. & cert. ef. 10-1-99 thru 2-1-00; OMAP 34-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 49-2002, f. & cert. ef. 10-1-02

**410-124-0090 Criteria and Contraindications for Harvesting Autologous Bone Marrow and Peripheral Stem Cells**

(1) The following are contraindications for the harvesting and storage of autologous bone marrow or peripheral stem cells for a potential transplant. The potential transplant recipient has:

(a) Irreversible terminal state (moribund or on life support);

(b) An irreversible disease of any other major organ system likely to limit life expectancy to five (5) years or less;

(c) Positive HIV test results;

(d) Positive pregnancy test.

(2) The following may be considered contraindications for the harvesting and storage of autologous bone marrow or peripheral stem cells for a transplant to the extent the evaluating transplant center and/or the specialist who completed the comprehensive evaluation of the client believe these condition(s) may interfere significantly with the recovery process. The potential transplant recipient has:

(a) Serious psychological disorders;

(b) Alcohol or drug abuse.

(3) The Office of Medical Assistance Programs (OMAP) will prior authorize and reimburse for the harvesting and storage of autologous bone marrow or autologous peripheral stem cells for a potential transplant recipient only if:

(a) All OMAP criteria are met; and

(b) Both the transplant center's and the specialist's evaluations recommend that the transplant be authorized; and

(c) The ICD-9-CM diagnosis code(s) and the CPT bone marrow or peripheral stem cell harvesting for transplantation procedure code(s) are paired on a currently funded line on the Prioritized List of Health Services adopted under OAR 410-141-0520; and

(d) There is documentation of a morphology code listed on the currently funded line for pediatric solid tumor in the Prioritized List of Health Services adopted under OAR 410-141-0520; and

(e) The client's marrow meets the clinical standards of remission at the time of storage; and

(f) A board certified hematologist/oncologist with specific experience in bone marrow transplant (BMT) services (i.e., cryopreservation and immunosuppressive treatment) has recommended the storage of autologous bone marrow or peripheral stem cell collection for possible future transplant/reinfusion; and

(g) The client has no contraindications for the harvesting and storage of autologous bone marrow or peripheral stem cells; and

(h) The client has no contraindications for bone marrow transplant or peripheral stem cell transplant.

(4) Prior authorization for harvesting of autologous bone marrow or peripheral stem cells does not guarantee reimbursement for the transplant. The client must meet the criteria specified in this rule and OAR 410-124-0080, and the transplant must be prior authorized by OMAP before reimbursement will be approved.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 34-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 49-2002, f. & cert. ef. 10-1-02

**410-124-0100 Criteria and Contraindications for Liver and Liver-Kidney Transplants**

(1) Prior authorization for liver or liver-kidney transplants will be approved only for a client in whom irreversible, progressive liver disease has advanced to the point where conventional therapy offers no prospect for prolonged survival, there is no reasonable alternative medical or surgical therapy and the client's five (5) year survival rate, subsequent to the transplant, is at least 20 percent as supported by medical literature.

(2) Liver-kidney transplant is covered only for a medically documented diagnosis of Caroli's disease (ICD-9-CM 751.62).

(3) The following are contraindications for liver or liver-kidney transplants:

(a) Incurable and untreatable malignancy outside the hepatobiliary system;

(b) Terminal state due to diseases other than liver disease;

(c) Uncontrolled sepsis, or active systemic infection;

(d) HIV positive test results;

(e) Active alcoholism or active substance abuse;

(f) Alternative effective medical or surgical therapy;

(g) Presence of uncorrectable significant organ system failure other than liver (excluding short-bowel syndrome or congenital intractable diarrhea).

(4) The following may be considered contraindications to the extent that the evaluating transplant center and/or the specialist who completed the comprehensive evaluation of the client believe these condition(s) may interfere significantly with the recovery process:

(a) Crigler-Najjar Syndrome Type II;

(b) Amyloidosis;

(c) Other major system diseases affecting brain, lung, heart, or renal systems;

(d) Major, not correctable congenital anomalies;

(e) Serious psychological disorders.

(5) The transplant center will review for current risk of alcohol or other substance abuse and risk of recidivism and will inform the Office of Medical Assistance Programs (OMAP) of its findings prior to the provision of the transplant.

(6) OMAP will only prior authorize and reimburse for liver and liver-kidney transplants if:

(a) All OMAP criteria are met; and

(b) Both the transplant center's and the specialist's evaluations recommend that the transplant be authorized; and

(c) The ICD-9-CM diagnosis code(s) and CPT transplant procedure code(s) are paired on the same currently funded line on the Prioritized List of Health Services adopted under OAR 410-141-0520.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: HR 8-1990(Temp), f. 3-30-90, cert. ef. 4-1-90; HR 22-1990, f. & cert. ef. 7-17-90; HR 17-1992, f. & cert. ef. 7-1-92; HR 4-1994, f. & cert. ef. 2-1-94; HR 19-1995, f. 9-28-95, cert. ef. 10-1-95; OMAP 18-2000 f. 9-28-00, cert. ef. 10-1-00; OMAP 21-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 34-2001, f. 9-24-01, cert. ef. 10-1-01

**410-124-0120 Criteria and Contraindications for Simultaneous Pancreas-Kidney and Pancreas After Kidney Transplants**

(1) Prior authorization for a Simultaneous Pancreas-Kidney (SPK) or Pancreas after Kidney (PAK) transplant will be approved only for a client in whom irreversible kidney and/or pancreatic disease has advanced to the point where conventional therapy offers no prospect for prolonged survival, there is no reasonable alternative medical or surgical therapy and the client's five (5) year survival rate, subsequent to the transplant, is at least 20 percent as supported by medical literature.

(2) Simultaneous pancreas-kidney (SPK) transplant is covered only for Type I diabetes mellitus with end stage renal disease (ICD-9-CM codes 250.41 or 250.43).

(3) Pancreas after kidney (PAK) transplantation will be considered for clients suffering from insulin dependent Type I diabetes after prior successful renal transplant. Pancreas after kidney (PAK) transplant is covered only for Type I diabetes mellitus (ICD-9-CM codes 250.01, 250.03, 250.11, 250.13, 250.21, 250.23, 250.31, 250.33, 250.51, 250.53, 250.61, 250.63, 250.81, 250.83, 250.91, 250.93, 996.81 or 996.86) with a secondary diagnosis V42.0.

(4) The following are contraindications to SPK and PAK transplants:

(a) Uncorrectable severe coronary artery disease;

(b) Major irreversible disease of any other major organ system likely to limit life expectancy to five years or less;

(c) HIV positive test results.

(5) The following may be considered contraindications to the extent that the evaluating transplant center and/or the specialist who completed the comprehensive evaluation of the client believe these condition(s) may interfere significantly with the recovery process:

(a) Serious psychological disorders;

(b) Drug abuse or alcohol abuse.

(6) OMAP will only prior authorize and reimburse for Simultaneous Pancreas-Kidney (SPK) or Pancreas after Kidney (PAK) transplants if:

(a) All OMAP criteria are met; and

(b) Both the transplant center's and the specialist's evaluations recommend that the transplant be authorized; and

(c) The ICD-9-CM diagnosis code(s) and CPT transplant procedure code(s) are paired on the same currently funded line on the Prioritized List of Health Services adopted under OAR 410-141-0520.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: HR 8-1990(Temp), f. 3-30-90, cert. ef. 4-1-90; HR 22-1990, f. & cert. ef. 7-17-90; HR 17-1992, f. & cert. ef. 7-1-92; HR 4-1994, f. & cert. ef. 2-1-94; HR 19-1995, f. 9-28-95, cert. ef. 10-1-95; OMAP 18-2000 f. 9-28-00, cert. ef. 10-1-00; OMAP 34-2001, f. 9-24-01, cert. ef. 10-1-01

**410-124-0140 Kidney Transplants**

(1) Kidney transplants do not require prior authorization when accomplished in-state.

(2) Out-of-state kidney transplant services are prior authorized by the Office of Medical Assistance Programs or the Fully Capitated Health Plan (FCHP):

(a) Submit the request to the FCHP or OMAP;

(b) The request must contain the following information:

(A) Name and Medical Assistance Identification number of the client;

(B) A description of the condition which necessitates a transplant;

(C) The results of any evaluation performed by an in-state provider of kidney transplant services;

(D) An explanation of the reason out-of-state services are requested.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: HR 8-1990(Temp), f. 3-30-90, cert. ef. 4-1-90; HR 22-1990, f. & cert. ef. 7-17-90; HR 4-1994, f. & cert. ef. 2-1-94; OMAP 1-2003, f. 1-31-03, cert. ef. 2-1-03

**410-124-0160 Cornea Transplants**

(1) Cornea transplants do not require prior authorization when accomplished in-state.

(2) Out-of-state corneal transplant services are prior authorized by the Office of Medical Assistance Programs or the Fully Capitated Health Plan (FCHP):

(a) Submit the request to the FCHP or OMAP;

(b) The request must contain the following information:

(A) Name and Medical Assistance Identification number of the client;

(B) A description of the condition which necessitates a transplant;

(C) The results of any evaluation performed by an in-state provider of cornea transplant services;

(D) An explanation of the reason out-of-state services are requested.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: HR 8-1990(Temp), f. 3-30-90, cert. ef. 4-1-90; HR 22-1990, f. & cert. ef. 7-17-90; HR 4-1994, f. & cert. ef. 2-1-94; OMAP 1-2003, f. 1-31-03, cert. ef. 2-1-03