Transplants

Policy Number: **M20260826048**

Effective Date: **10/1/2026**

Sponsoring Department: **Health Care Services**

Impacted Department(s): **Health Care Services**

Type of Policy: ☒ Internal ☒ External

Data Classification: ☐Confidential ☐Restricted ☒Public

Applies to (Line of Business):

☐ Corporate (All)

✦ State Products, if yes which plan(s): ☒MediSource; ☒MediSource Connect; ☒Child Health Plus; ☒Essential Plan

✦ Medicare, if yes, which plan(s): ☒MAPD; ☒PDP; ☒ISNP; ☒CSNP

✦ Commercial, if yes, which type: ☒Large Group; ☒Small Group; ☒Individual

☒ Self-Funded Services *(Refer to specific Summary Plan Descriptions (SPDs) to determine any pre-authorization or pre-certification requirements and coverage limitations. In the event of any conflict between this policy and the SPD of a Self-Funded Plan, the SPD shall supersede the policy.)*

Excluded Products within the Selected Lines of Business (LOB)

This section is intended to list specific LOB products that are excluded from adhering to this policy (due to differences in law/regulations). If not applicable, please indicate N/A.

Applicable to Vendors? Yes ☐ No☒

Purpose and Applicability:

To set forth the medical necessity criteria for transplants.

Policy:

Background

Transplantation is a viable treatment option for many members with end stage organ failure. The purpose of an organ transplant is not merely to prolong life, but to restore a quality of life that enables recipients to work and enjoy recreation with minimal disability.

A transplant candidate should have a realistic understanding of the implications of the organ transplant. Individuals must be able to comply with post-transplant therapies and outpatient management.

The following transplants will be considered for medical necessity review on a case-by-case basis:

•hematopoietic stem cell transplantation;

•kidney transplantation;
•kidney/heart transplantation;
•kidney/lung transplantation
•pancreas transplantation;
•simultaneous kidney/pancreas, or kidney /liver transplantation;
•liver transplantation;
•intestinal, liver/intestinal, or multivisceral transplantation;
•heart transplantation;
•lung transplantation;
•heart/lung transplantation; and
•tandem autologous stem cell transplantation for multiple myeloma.

All Transplant requests are reviewed by the Medical Director.

Commercial, Self-Funded, MediSource, MediSource Connect, and Child Health Plus:
Transplants are reviewed utilizing MCG guidelines.

Essential Plan: Independent Health covers only those transplants determined to be non-experimental and non-investigational. Covered transplants include but are not limited to: kidney, corneal, liver, heart, pancreas and lung transplants; and bone marrow transplants. All transplants must be prescribed by specialist(s). Additionally, all transplants must be performed at hospitals that Independent Health specifically approved and designated to perform these procedures.

Independent Health covers the hospital and medical expenses, including donor search fees, of the member recipient. We cover transplant services required when the member serves as an organ donor only if the recipient is covered by Independent Health. We do not cover the medical expenses of a non-covered individual acting as a donor for the member if the non-covered individual's expenses will be covered under another health plan or program.
We do not cover: travel expenses, lodging, meals, or other accommodations for donors or guests; donor fees in connection with organ transplant surgery; or routine harvesting and storage of stem cells from newborn cord blood.

Medicare Advantage: There is currently a National Coverage Determinations (NCD) and Local Coverage Determinations (LCD) for transplants. Please refer to the links listed in the Reference section for Medicare Advantage members. In the absence of CMS guidance, MCG guidelines will be utilized.

Pre-Authorization Required? Yes ☒ No ☐

Definitions

Enter definitions here. Remember to **bold** words throughout Policy section that require definitions. Definitions should be included when: 1) The word may be unclear or may mean something different, in different situations/contexts; 2) The word is not commonly used or known. Please refer to the Policy Writing Toolkit for additional information and direction.

References

Related Policies, Processes and Other Documents

Enter name of all Independent Health policies, processes or other documents that relates or that is referenced within this policy.

Non-Regulatory References

Farquhar C, Marjoribanks J, Basser R, Hetrick SE, Lethaby A. High dose chemotherapy and autologous bone marrow or stem cell transplantation versus conventional chemotherapy for women with metastatic breast cancer. Cochrane Database of Systemic Reviews. 2005 Last assessed as up-to-date: March 16, 2007. Available: www.cochrane.org

Regulatory References

Centers for Medicare and Medicaid (CMS) [web site]. National Coverage Determination (NCD) for Pediatric Liver Transplantation (NCD) (260.2). Available at: https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?ncdid=71&ncdver=1&bc=0 Accessed August 11, 2026.

Centers for Medicare and Medicaid (CMS) [web site]. National Coverage Determination (NCD) for Islet Cell Transplantation in the Context of a Clinical Trial (260.3.1). Available at: https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?ncdid=286&ncdver=1&bc=0 Accessed August 11, 2026.

Centers for Medicare and Medicaid (CMS) [web site]. National Coverage Determination (NCD) for Heart Transplants (260.9). Available at: https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?ncdid=112&ncdver=3&bc=0 Accessed August 11, 2026.

Centers for Medicare and Medicaid (CMS) [web site]. National Coverage Determination (NCD) for Pancreas Transplants (260.3). Available at: https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?ncdid=107&ncdver=3&bc=0 Accessed August 11, 2026.

Centers for Medicare and Medicaid (CMS) [web site]. National Coverage Determination (NCD) for Adult Liver Transplantation (260.1). Available at: https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?ncdid=70&ncdver=3&bc=0 Accessed August 11, 2026.

Centers for Medicare and Medicaid (CMS) [web site]. National Coverage Determination (NCD) for Intestinal and Multi-Visceral Transplantation (260.5). Available at: https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?ncdid=280&ncdver=2&bc=0 Accessed August 11, 2026.

Centers for Medicare and Medicaid (CMS) [web site]. Local Coverage Determination (LCD) for Allogeneic Hematopoietic Cell Transplantation for Primary Refractory or Relapsed Hodgkin and Non-Hodgkin Lymphoma with B-cell or T-cell Origin (L39513). Available at: https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?lcdid=39513&ver=4&bc=0 Accessed August 10, 2026.

Centers for Medicare and Medicaid (CMS) [web site]. National Coverage Determination (NCD) for) for Stem Cell Transplantation (Formerly 110.8.1) (110.23). Available at: https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?ncdid=366&ncdver=2&bc=0 Accessed August 11, 2026.

Centers for Medicare and Medicaid Services. Medicare Program; Hospital Conditions of Participation: Requirements for Approved and Re-Approval of Transplant Centers to Perform Organ Transplants. Federal Register. Vol 7. No 23. Feb 4, 2005. Available: http://www.gpo.gov/fdsys/pkg/FR-2005-02-04/pdf/05-1696.pdf

New York State Department of Health [web site]. New York State Medicaid Program Physician Surgery Procedure Codes. April 2026. Available at: https://www.emedny.org/ProviderManuals/Physician/PDFS/Physician%20Procedure%20Codes%20Sect5.pdf Accessed August 10, 2026.

Version Control

Signature / Approval on File? Yes ☒ No☐

Revision Date	Policy Author / Owner	Notes
10/1/2026	Health Care Services	New Policy
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