

410-124-100 CRITERIA AND CONTRAINDICATIONS FOR LIVER AND LIVER-KIDNEY TRANSPLANTS

1. Payment for liver transplants will be approved for clients in whom irreversible, progressive liver disease has advanced to the point where conventional therapy offers no prospect for prolonged survival, life expectancy is two years or less, and there is no reasonable alternative medical or surgical therapy and there is a maximum probability of a successful clinical outcome (i.e., the probability of the client's survival for a period of five years or more subsequent to the transplant must be at least 25 percent).
2. Payment for liver-kidney transplants will be approved for clients with damage to the renal system which may be corrected by a liver-kidney transplant.
3. All clients must also have one of the following diagnoses:
 - (a) End stage or acute liver failure (cirrhosis; acute/subacute necrosis of the liver),
 - (b) Inborn errors of metabolism or other genetic defects that do not respond to other treatments or will produce severe neurological damage and physical disability,
 - (c) Failure of a previous liver transplant,
 - (d) The following malformations:
 - (1) Biliary atresia,
 - (2) Choledochal cyst, when there is chronic biliary cirrhosis or end-stage renal disease,
 - (3) Congenital hepatic vein thrombosis (Budd-Chiari),
 - (4) Intrahepatic vascular malformations which have no other treatment, and for which liver transplantation is indicated as a last resort therapy; or
 - (5) Massive polycystic liver disease when there is chronic biliary cirrhosis or end-stage kidney disease and hepatomegaly renders the patient in a nonfunctioning status.
 - (e) Hepatic vein thrombosis inappropriate for, or not responding to, portacaval anastomosis.
4. Coverage for transplantation is based on the OHP Prioritized List of Health Services.
5. The following are **contraindications** for liver and liver-kidney transplants:
 - (a) ~~Incurable or untreatable malignancy outside the hepatobiliary system.~~

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- (b) Terminal state due to diseases other than liver disease,
 - (c) Uncontrolled sepsis or active systemic infection,
 - (d) Positive HIV 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 or kidney, (excluding short bowel syndrome or congenital intractable diarrhea),
 - (h) Hepatitis B e antigen positive (HBe Ag).
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) Bacterial or fungal infection outside the hepatobiliary system,
 - (b) Hepatitis B,
 - (c) Crigler-Najjar Syndrome Type II,
 - (d) Amyloidosis,
 - (e) Other major system diseases affecting brain, lung, heart, or renal systems,
 - (f) Major, not correctable, congenital anomalies,
 - (g) Serious psychological disorders.
6. The transplant center will review for current risk of alcohol or other substance abuse and risk of recidivism and will inform OMAP of its findings prior to the provision of the transplant.

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410-124-120 CRITERIA AND CONTRAINDICATIONS FOR SIMULTANEOUS PANCREAS-KIDNEY AND PANCREAS AFTER KIDNEY TRANSPLANTS

1. The client must have a critical medical need for transplantation and a maximum probability of a successful clinical outcome, i.e., the likelihood of survival of the patient after transplantation for a period of three or more years is 80% or more and the likelihood of the survival of the donor organ for a period of three or more years is 40% or more.
2. SPK (simultaneous pancreas-kidney transplant) and PAK (pancreas transplant after successful kidney transplant) transplantation will be considered for clients suffering from insulin dependent Type I diabetes and end-stage renal failure or non-uremic renal dysfunction.
3. Coverage for transplantation is based on the OHP Prioritized List of Health Services.
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) Positive HIV test.
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.

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410-124-140 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:

Office of Medical Assistance Programs
Medical Director's Office/Transplants
Human Resources Building, Third Floor
500 Summer St NE, 3rd Floor
Salem, Oregon 97310-1014

Telephone: 503-945-6488

Facsimile: 503-373-7689

(b) The request must contain the following information:

- (1) Name and Medical Assistance I.D. number of the client.
- (2) A description of the condition which necessitates a transplant.
- (3) The results of any evaluation performed by an in-state provider of kidney transplant services.
- (4) An explanation of the reason out-of-state services are requested.

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410-124-160 CORNEA TRANSPLANTS

1. Cornea transplants do not require prior authorization when accomplished in-state.
2. Out-of-state cornea 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:

Office of Medical Assistance Programs
Medical Director's Office/Transplants
Human Resources Building, 3rd Floor
500 Summer St NE
Salem, Oregon 97310-1014

Telephone: 503-945-6488
Facsimile: 503-373-7689

- (b) The request must contain the following information:
 - (1) Name and Medical Assistance I.D. number of the client.
 - (2) A description of the condition which necessitates a transplant.
 - (3) The results of any evaluation performed by an in-state provider of cornea transplant services.
 - (4) An explanation of the reason out-of-state services are requested.

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