Transplantation Services

Policy Number: BIP187.M
Effective Date: August 1, 2024

➲ Instructions for Use

Related Benefit Interpretation Policy
- Medical Necessity

Related Clinical Guideline
- Transplant Review Guidelines: Solid Organ Transplantation

Federal/State Mandated Regulations

Note: The most current federal/state mandated regulations for each state can be found in the links below.

Oklahoma

2023 Oklahoma Statues Title 63. Public Health and Safety

Section 63-2200.28, Short Title, Everett's Law

Oklahoma Statutes §63-2200.28 (2023) - Short title - Everett's Law. :: 2023 Oklahoma Statutes :: US Codes and Statutes :: US Law :: Justia
This act shall be known and may be cited as "Everett's Law".

Section 63-2200.29, Definitions

Oklahoma Statutes §63-2200.29 (2023) - Definitions. :: 2023 Oklahoma Statutes :: US Codes and Statutes :: US Law :: Justia
As used in this act:
1. "Anatomical gift" means a donation of all or part of a human body to take effect after the donor's death for the purpose of transplantation or transfusion;
2. "Auxiliary aids or services" means an aid or service that is used to provide information to an individual with a cognitive, developmental, intellectual, neurological or physical disability and is available in a format or manner that allows the individual to better understand the information. An auxiliary aid or service may include:
   a. Qualified interpreters or other effective methods of making aurally delivered materials available to persons with hearing impairments,
   b. Qualified readers, taped texts, texts in accessible electronic format or other effective methods of making visually delivered materials available to persons with visual impairments,
   c. Supported decision-making services, including:
      (1) The use of a support individual to communicate information to the individual with a disability, ascertain the wishes of the individual, or assist the individual in making decisions,
      (2) The disclosure of information to a legal guardian, authorized representative or another individual designated by the individual with a disability for such purpose, as long as the disclosure is consistent with state and federal law including the Health Insurance Portability and Accountability Act of 1996, 42 U.S.C. 1320d et seq. and any regulations promulgated by the United States Department of Health and Human Services to implement the act,
      (3) If an individual has a court-appointed guardian or other individual responsible for making medical decisions on behalf of the individual, any measures used to ensure that the individual is included in decisions involving the individual's health care and that medical decisions are in accordance with the individual's own expressed interests, or

(4) Any other aid or service that is used to provide information in a format that is easily understandable and accessible to individuals with cognitive, neurological, developmental or intellectual disabilities, including assistive communication technology;

3. "Covered entity" means:
   a. Any licensed provider of health care services including licensed health care practitioners, hospitals, nursing facilities, laboratories, intermediate care facilities, psychiatric residential treatment facilities, institutions for individuals with intellectual or developmental disabilities and prison health centers, or
   b. Any entity responsible for matching anatomical gift donors to potential recipients;
4. "Disability" has the meaning stated in the Americans with Disabilities Act of 1990, as amended by the ADA Amendments Act of 2008, 42 U.S.C. § 12102;
5. "Organ transplant" means the transplantation or transfusion of a part of a human body into the body of another for the purpose of treating or curing a medical condition; and
6. "Qualified recipient" means an individual who has a disability and meets the essential eligibility requirements for the receipt of an anatomical gift with or without any of the following:
   a. Individuals or entities available to support and assist the individual with an anatomical gift or transplantation,
   b. Auxiliary aids or services, or
   c. Reasonable modifications to the policies, practices or procedures of a covered entity including modifications to allow for either or both of the following:
      (1) Communication with one or more individuals or entities available to support or assist with the recipient's care and medication after surgery or transplantation, or
      (2) Consideration of support networks available to the individual including family, friends and home and community-based services including home and community-based services funded through Medicaid, Medicare, another health plan in which the individual is enrolled or any program or source of funding available to the individual, when determining whether the individual is able to comply with post-transplant medical requirements.

Section 63-2200.30, Application of Act, Consideration of Factors by Covered Entities

Oklahoma Statutes §63-2200.30 (2023) - Application of act – Consideration of factors by covered entities. :: 2023 Oklahoma Statutes :: US Codes and Statutes :: US Law :: Justia

A. The provisions of this section shall apply to all stages of the organ transplant process.
B. A covered entity shall not, solely on the basis of an individual's disability:
   1. Consider the individual ineligible to receive an anatomical gift or organ transplant;
   2. Deny medical services or other services related to organ transplantation including diagnostic services, evaluation, surgery, counseling, post-operative treatment and services;
   3. Refuse to refer the individual to a transplant center or other related specialist for the purpose of being evaluated for or receiving an organ transplant;
   4. Refuse to place a qualified recipient on an organ transplant waiting list;
   5. Place a qualified recipient on an organ transplant waiting list at a lower priority position than the position at which the individual would have been placed if the individual did not have a disability; or
   6. Refuse to accept health insurance coverage for any procedure associated with being evaluated for or receiving an anatomical gift or organ transplant including post-transplantation and post-transfusion care.
C. Notwithstanding subsection B of this section, a covered entity may take an individual's disability into account when making treatment or coverage recommendations or decisions, solely to the extent that the disability has been found by a physician or surgeon, following an individualized evaluation of the individual, to be medically significant to the receipt of the anatomical gift.
D. If an individual has the necessary support system to assist the individual in complying with post-transplant medical requirements, a covered entity shall not consider the individual's inability to independently comply with post-transplant medical requirements to be medically significant for the purposes of subsection C of this section.
E. A covered entity shall make reasonable modifications to its policies, practices or procedures to allow individuals with disabilities access to transplantation-related services including diagnostic services, surgery, coverage, post-operative treatment and counseling, unless the entity can demonstrate that making such modifications would fundamentally alter the nature of such services.
F. A covered entity shall take steps necessary to ensure that an individual with a disability is not denied medical services or other services related to organ transplantation including diagnostic services, surgery, post-operative treatment or counseling, due to the absence of auxiliary aids or services, unless the covered entity demonstrates that taking the steps would fundamentally alter the nature of the medical services or other services related to organ transplantation or would result in an undue burden for the covered entity.
G. Nothing in this section shall be construed to require a covered entity to make a referral or recommendation for or perform a medically inappropriate organ transplant.

H A covered entity shall otherwise comply with the requirements of Titles II and III of the Americans with Disabilities Act of 1990, as amended by the ADA Amendments Act of 2008.

Section 63-2200.31, Civil Actions Against Covered Entities

Oklahoma Statutes §63-2200.31 (2023) - Civil actions against covered entities. :: 2023 Oklahoma Statutes :: US Codes and Statutes :: US Law :: Justia

A. Whenever it appears that a covered entity has violated or is in violation of any of the provisions of this act, the affected individual may commence a civil action for injunctive and other equitable relief against the covered entity for purposes of enforcing compliance with this act. The action may be brought in the district court for the county where the affected individual resides or resided or was denied the organ transplant or referral.

B. In an action brought under this act, the court shall give priority on its docket and expedited review, and may grant injunctive or other equitable relief including:
   1. Requiring auxiliary aids or services to be made available for a qualified recipient;
   2. Requiring the modification of a policy, practice or procedure of a covered entity; or
   3. Requiring facilities be made readily accessible to and usable by a qualified recipient.

C. Nothing in this act is intended to limit or replace available remedies under the Americans with Disabilities Act or any other applicable law.

D. This act does not create a right to compensatory or punitive damages against a covered entity.

Section 63-2200.32, Prohibited Actions by Health Carriers

Oklahoma Statutes §63-2200.32 (2023) - Prohibited actions by health carriers. :: 2023 Oklahoma Statutes :: US Codes and Statutes :: US Law :: Justia

A. For purposes of this section:
   1. "Covered person" means a policyholder, subscriber, enrollee, member or individual covered by a health benefit plan;
   2. "Health benefit plan" means a policy, contract, certificate, or agreement entered into, offered or issued by a health carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services. Health benefit plan shall not include a plan providing coverage for excepted benefits and short term policies that have a term of less than twelve (12) months; and
   3 "Health carrier" means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the Insurance Commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services including through a health benefit plan as defined in this section, and shall include a sickness and accident insurance company, a health maintenance organization, a preferred provider organization or any similar entity, or any other entity providing a plan of health insurance or health benefits.

B. A health carrier that provides coverage for anatomical gifts, organ transplants or related treatment and services shall not:
   1. Deny coverage to a covered person solely on the basis of the person's disability;
   2. Deny to a patient eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the health benefit plan, solely for the purpose of avoiding the requirements of this section;
   3. Penalize or otherwise reduce or limit the reimbursement of an attending provider, or provide monetary or nonmonetary incentives to an attending provider, to induce such provider to provide care to an insured or enrollee in a manner inconsistent with this section; or
   4. Reduce or limit coverage benefits to a patient for the medical services or other services related to organ transplantation performed pursuant to this section as determined in consultation with the attending physician and patient.

C. In the case of a health benefit plan maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers, any plan amendment made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement imposed pursuant to this section shall not be treated as a termination of the collective bargaining agreement.

D. Nothing in this section shall be construed to require a health carrier to provide coverage for a medically inappropriate organ transplant.

E. The Insurance Commissioner shall promulgate rules to implement the provisions of this section.

Added by Laws 2021, c. 87, § 5, eff. Nov. 1, 2021.

Oregon

Oregon Administrative Rules Section 836-053-0012

https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=204285

Essential Health Benefits for Plan Years Beginning on and after January 1, 2017

(1) This rule applies to plan years beginning on and after January 1, 2017.
(2) As used in the Insurance Code and OAR chapter 836:
  (b) "Base benchmark health benefit plan" means the PacificSource Health Plans Preferred CoDeduct Value 3000 35 70 small group health benefit plan, including prescription drug benefits, as provided in Exhibit 1 to this rule;
  (d) "Essential health benefits" or "EHB" means the following coverage provided in compliance with 45 CFR 156:
    (A) The base-benchmark health benefit plan with the exclusions and modifications of provisions of that plan as set forth in section (3) to (7) of this rule.
(3) (a) The following treatment limitations and exclusions of coverage currently included in the base-benchmark health benefit plan are excluded:
    (A) The 24-month waiting period for transplant benefits;

Washington

WAC Section 284-43-5642, Essential Health Benefit Categories

https://apps.leg.wa.gov/wac/default.aspx?cite=284-43-5642

(3) A health benefit plan must cover "hospitalization" in a manner substantially equal to the base-benchmark plan. For purposes of determining a plan's actuarial value, an issuer must classify as hospitalization services the medically necessary services delivered in a hospital or skilled nursing setting including, but not limited to, professional services, facility fees, supplies, laboratory, therapy or other types of services delivered on an inpatient basis.
  (a) A health benefit plan must include the following services which are specifically covered by the base-benchmark plan and classify them as hospitalization services:
    (i) Hospital visits, facility costs, provider and staff services and treatments delivered during an inpatient hospital stay, including inpatient pharmacy services;
    (ii) Skilled nursing facility costs, including professional services and pharmacy services and prescriptions filled in the skilled nursing facility pharmacy;
    (iii) Transplant services, supplies and treatment for donors and recipients, including the transplant or donor facility fees performed in either a hospital setting or outpatient setting;
    (iv) Dialysis services delivered in a hospital;
    (v) Artificial organ transplants based on an issuer's medical guidelines and manufacturer recommendations; and
    (vi) Respite care services delivered on an inpatient basis in a hospital or skilled nursing facility.
    (vii) Inpatient hospitalization where mental illness is the primary diagnosis.

State Market Plan Enhancements

In addition to the covered benefits listed in *Covered Benefits* section, some members may have additional organ and tissue transplant benefits. Refer to the member's Evidence of Coverage (EOC)/Schedule of Benefits (SOB) for additional information.

Additional resources for transplantation services: Referrals may be made to Optum as follows:
Phone Referrals: 866-300-7736 or Fax: 888-361-0502

Covered Benefits

Important Note: Covered benefits are listed in *Federal/State Mandated Regulations*, *State Market Plan Enhancements*, and *Covered Benefits* sections. Always refer to the *Federal/State Mandated Regulations* and *State Market Plan Enhancements* sections for additional covered services/benefits not listed in this section.

Note: UnitedHealthcare shall intermittently review new developments in medical technology based on scientific evidence to determine if the list of covered transplants should be revised.

- Human organ and tissue transplants are limited to non-experimental and non-investigational procedures that are determined to be medically necessary (Refer to the Benefit Interpretation Policy titled Medical Necessity).

  Coverage is provided for the pre-and post-operative medical, surgical, hospital services and medically necessary ambulance transportation to the UnitedHealthcare designated facility. All transplant procedures must be preauthorized by UnitedHealthcare and performed in a designated facility.

  Covered transplant procedures include:

- Bone marrow transplants (either from the member or from a compatible donor) and peripheral stem cell transplants, with or without high dose chemotherapy, including chimeric antigen receptor (CAR)-T cell therapy. Not all Bone marrow transplants or peripheral stem cell transplants meet the definition of a covered health service.
- Heart
- Heart/lung
- Lung
- Kidney
- Kidney/pancreas
- Liver
- Liver/small bowel
- Pancreas
- Small bowel

If OptumHealth Transplant Solutions has determined that another transplant (not listed above) is proven, then that transplant is also eligible for coverage.

- When the transplant recipient is a UnitedHealthcare member, reasonable and necessary services of the living donor solely for the transplant procedure are covered if the donor does not have insurance or the donor's primary insurance does not cover donor hospital services (the donor does not need to be a UnitedHealthcare member for transplant services to be covered)
- Listing at two UnitedHealthcare designated facilities.
  - Dual listing is allowed only when the regional organ procurement agency used is different
  - Member is financially responsible for all costs associated with the 2nd transplant evaluation.

  Note: UnitedHealthcare will pay for the transplant surgery, living donor inpatient-services and surgery, and post-transplant services at the facility which performs the transplant.
- Pre-transplant testing and evaluation, including histocompatibility testing for the transplant recipient and donor when the intended transplant recipient is a UnitedHealthcare member. The testing of immediate blood relatives to determine the compatibility of bone marrow and stem cells is limited to immediate blood relatives who are sisters, brothers, parents and natural children.
- Organ acquisition from cadaver or living donor
- An oral or dental examination performed on an inpatient basis as part of a comprehensive workup prior to transplant surgery
- Tooth extraction prior to a major organ transplant
- Outpatient post-transplant, immunosuppressive drug therapy only if the member has a supplemental pharmacy benefit
- Storage costs of any organ or bone marrow only as part of an authorized treatment protocol as determined by the UnitedHealthcare designated facility medical director or designee
- Bone marrow and stem cells donor search and testing
  Note: Specific requirements and limitations apply, refer to the member's EOC/SOB
- Transportation, food and housing expense of the member and one escort to the UnitedHealthcare designated facility
  Note: Specific requirements and limitations apply, refer to the member's EOC/SOB
- Covered services for living donors are limited to medically necessary clinical services once a donor is identified.

Not Covered

- Artificial heart implantation (Refer to the member's Evidence of Coverage (EOC)/Schedule of Benefits (SOB) for additional information)
- Non-human organ transplantation
- Equipment and medication that is experimental/investigational and/or not medically necessary (Refer to the Medical Management Guideline titled Medical Necessity)
- Storage costs of any organ or bone marrow unless criteria in the *Covered Benefits* section are met
- Transplant services, including donor costs, when the transplant recipient is not a UnitedHealthcare member
- Transplantation performed in a non-UnitedHealthcare designated facility
- Transportation of any potential donor for typing and matching
- Unauthorized or not prior authorized organ procurement and transplant related services
- Transportation, food and housing expenses of the member
  - When the member is not receiving medically necessary transplant services

- Above and beyond the allowed benefit for the member
  Note: Refer to the member's EOC/SOB
- Transportation and other non-clinical expenses of a living donor
- Duplicated diagnostic costs for a transplant evaluation at the 2nd regional organ procurement facility

Policy History/Revision Information

Date	State(s) Affected	Summary of Changes
10/01/2024	All	**Related Policy** • Removed reference link to the Medical Management Guideline titled *Total Artificial Heart and Ventricular Assist Devices* (retired Oct. 1, 2024)
08/01/2024	All	**Not Covered** • Added instruction to refer to the member's Evidence of Coverage (EOC)/Schedule of Benefits (SOB) for additional information for artificial heart implantation **Supporting Information** • Archived previous policy version BIP187.L
	Oklahoma	**Federal/State Mandated Regulations** • Revised language pertaining to *Oklahoma Statutes Title 63, Public Health and Safety*: ○ *Section 63-2200.28* ○ *Section 63-2200.29* ○ *Section 63-2200.30* ○ *Section 63-2200.31* ○ *Section 63-2200.32*
	Washington	**Federal/State Mandated Regulations** • Revised language pertaining to *Washington Administrative Code Section 284-43-5642*

Instructions for Use

Covered benefits are listed in three (3) sections: *Federal/State Mandated Regulations*, *State Market Plan Enhancements*, and *Covered Benefits*. All services must be medically necessary. Each benefit plan contains its own specific provisions for coverage, limitations, and exclusions as stated in the member's Evidence of Coverage (EOC)/Schedule of Benefits (SOB). If there is a discrepancy between this policy and the member's EOC/SOB, the member's EOC/SOB provision will govern.