Clinical Policy: Pediatric Liver Transplant

Reference Number: CP.MP.120
Date of Last Revision: 02/23
Effective Date: 07/01/23

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

End-stage liver disease presents unique clinical considerations in the pediatric population. Liver transplantation provides a therapeutic option for pediatric patients with end stage disease. This policy establishes the medical necessity requirements for pediatric liver transplants.

Policy/Criteria

I. It is the policy of health plans affiliated with Centene Corporation® that pediatric liver transplantation for pediatric members/enrollees (age < 18) with end-stage liver disease is **medically necessary** when all of the following conditions are met:

A. End-stage liver disease has resulted in any of the following:
   1. Life expectancy ≤ 18 months without liver transplant;
   2. Unacceptable quality of life;
   3. Growth failure or reversible neurodevelopment impairment;

B. End-stage liver disease is due to one of the following:
   1. Cholestatic diseases, one of the following:
      a. Biliary atresia, any of the following:
         i. Pre-hepatoportoenterostomy in infants with evidence of decompensated liver disease;
         ii. Post-hepatoportoenterostomy, and any of the following:
            a) Total bilirubin > 6 mg/dL beyond three months from hepatoportoenterostomy;
            b) Total bilirubin remains between 2 to 6 mg/dL;
            c) Total bilirubin < 2 with unmanageable complications due to biliary cirrhosis or portal hypertension;
      b. Familial intrahepatic cholestasis 1 (FIC1) disease if partial external biliary diversion or ileal exclusion failed or could not be performed;
      c. Primary sclerosing cholangitis;
      d. Alagille Syndrome;
   2. Acute liver failure, all of the following:
      a. Absence of a known, chronic liver disease;
      b. Liver-based coagulopathy that is not responsive to parenteral vitamin K;
      c. International Normalized Ratio (INR), one of the following:
         i. Between 1.5 and 1.9 with clinical evidence of encephalopathy;
         ii. ≥ 2.0 regardless of the presence of clinical encephalopathy;
   3. Hepatocellular or vascular disease, any of the following:
      a. Autoimmune hepatitis with any of the following:
         i. Acute liver failure associated with encephalopathy;
         ii. Complications of end-stage liver disease not responsive to medical therapy;
      b. Decompensated liver disease, recurrent cholangitis, unmanageable bile duct strictures, or concerns for the risk of cholangiocarcinoma;

c. Budd-Chiari Syndrome;

4. Malignancies, any of the following:
   a. Hepatoblastoma, either of the following:
      i. Nonmetastatic and unresectable;
      ii. At the time of diagnosis or no later than after two rounds of chemotherapy;
   b. Hepatoblastoma with pulmonary metastases, any of the following:
      i. Chest CT is clear of metastases following chemotherapy;
      ii. A pulmonary wedge resection of the identified tumor reveals margins free of the tumor;
   c. Hepatocellular carcinoma with no evidence of extrahepatic disease;
   d. Infantile hemangioma, any of the following:
      i. The hemangioendothelioma is not responding to medical therapy;
      ii. The hemangioendothelioma is associated with life-threatening complications;
5. Metabolic or genetic disorders, any of the following:
   a. Alpha-1 antitrypsin deficiency;
   b. Wilson's disease;
   c. Severe urea cycle defects in the first year of life;
   d. Crigler-Najjar Type I at the time of diagnosis;
   e. Gestational alloimmune liver disease (previously known as neonatal hemochromatosis);
   f. Cystic fibrosis with unmanageable complications of portal hypertension;
   g. Multidrug resistance protein-3 (MDR-3) disease that fails to respond to ursodeoxycholic acid;
   h. Hereditary tyrosinemia type 1, any of the following:
      i. Progressive liver disease despite compliance with NTBC;
      ii. Rising AFP while on NTBC;
      iii. Change in liver imaging with a single nodule measuring > 10 mm or an increase in the number or size of hepatic nodules;
      iv. Management with NTBC and diet cannot be adequately maintained;
   j. Glycogen storage disease (GSD), any of the following:
      i. GSD I, any of the following:
         a) Poor metabolic control;
         b) Multiple hepatic adenomas;
         c) Concern for hepatocellular carcinoma;
      ii. GSD III or GSD IV, any of the following:
         a) Poor metabolic control;
         b) Complications of cirrhosis;
         c) Progressive hepatic failure;
         d) Suspected liver malignancy;
   k. Fatty acid oxidation defects, any of the following:
      i. Failed medical therapy;
      ii. Experience recurrent episodes of complications;
   l. Primary hyperoxaluria type 1 at the time of diagnosis;
   m. Organic acidemia, any of the following:
      i. Metabolic decompensation despite conventional therapy;
      ii. Uncontrollable hyperammonemia;

iii. Restricted growth;
iv. Severe impairment of health-related quality of life, despite conventional therapy;

n. Inborn errors of bile acid synthesis or those refractory to medical therapy;

6. Fibrotic or cirrhotic conditions, any of the following:
   a. Ductal plate malformations with recurrent cholangitis or complications of portal hypertension;
   b. Parenteral nutrition-associated liver disease with enteral autonomy and complications of cirrhosis;
7. Miscellaneous conditions, any of the following:
   a. Non-cirrhotic portal hypertension with cardiopulmonary complications;
   b. Factor VII deficiency with complications from or failure of medical management;
   c. Protein C deficiency, any of the following:
      i. Failed medical therapy;
      ii. Experience complications;
   d. Hepatopulmonary syndrome (HPS) and any of the following:
      i. Portosystemic shunting resulting from either a congenital or acquired vascular anomaly or liver disease (cirrhotic or noncirrhotic);
      ii. Portal hypertension who are not candidates for closure of the shunt;

C. Does not have any of the following contraindications:
1. Active infection with highly virulent and/or resistant microbes that are poorly controlled pre-transplant;
2. HIV infection with detectable viral load;
3. Malignancy with high risk of recurrence or death related to cancer (excluding malignancies that transplant could sufficiently address, as noted in I.B.4);
4. Glomerular filtration rate < 40 mL/min/1.73m^2 unless being considered for multi-organ transplant;
5. Stroke, acute coronary syndrome, or myocardial infarction (excluding demand ischemia) within 30 days;
6. Severe, life threatening extrahepatic multi-organ mitochondrial disease;
7. Alpers syndrome;
8. Valproate-associated liver failure;
9. Severe portopulmonary hypertension that is not responsive to medical therapy;
10. Niemann-Pick disease type C;
11. Hemophagocytic lymphohistiocytosis presenting acute liver failure;
12. Acute renal failure with rising creatinine or on dialysis and low likelihood of recovery;
13. Septic shock;
14. Progressive cognitive impairment;
15. Other severe uncontrolled medical condition expected to limit survival after transplant;
16. Inability to adhere to the regimen necessary to preserve the transplant, even with caregiver support;
17. Absence of an adequate or reliable social support system;
18. Active substance use or dependence including current tobacco use, vaping, marijuana use (unless prescribed by a licensed practitioner), or IV drug use without convincing

evidence of risk reduction behaviors, (unless urgent transplant timelines are present, in which case a commitment to reducing behaviors is acceptable). Serial blood and urine testing may be used to verify abstinence from substances that are of concern.

Background

Liver transplantation is an effective therapeutic option for an assortment of acute and chronic hepatic disorders that lead to end stage liver disease in the pediatric population. According to the practice guideline of the American Association for the Study of Liver Diseases (AASLD), pediatric liver transplants account for ~7.8% of all liver transplants in the United States.[1] The evaluation of children for liver transplants should include a multidisciplinary team of specialists that achieve psychosocial, neurocognitive, and developmental needs as well as the complex clinical necessities of these patients.

For adult liver transplants (and children ≥ 12 years of age), the Model for Endstage Liver Disease (MELD) formula is commonly utilized to determine assess organ allocation for liver candidates. The Pediatric Endstage Liver Disease (PELD) score was analogously developed for children < 12 years of age and utilizes total serum bilirubin, INR, height, weight, and albumin; however, this scoring system is not ubiquitously utilized.[1]

Common indications for pediatric liver transplants are acute liver failure, biliary atresia and other cholestatic diseases, metabolic diseases, immune disorders, and hepatic malignancies. A recent multicenter analysis of five-year survival of 461 children revealed an 88% survival rate for the first year.[5] The majority of these children also show strong graft function at five years, but there are multiple chronic post-transplantation complications in extrahepatic organs.[5]

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2020, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT® Codes	Description
47133	Donor hepatectomy (including cold preservation), from cadaver donor
47135	Liver allotransplantation, orthotopic, partial or whole, from cadaver or living donor, any age
47140	Donor hepatectomy (including cold preservation), from living donor; left lateral segment only (segments II and III)
47141	Donor hepatectomy (including cold preservation), from living donor; total left lobectomy (segments II, III and IV)
47142	Donor hepatectomy (including cold preservation), from living donor; total right lobectomy (segments V, VI, VII and VIII)

CPT® Codes	Description
47143	Backbench standard preparation of cadaver donor whole liver graft prior to allotransplantation, including cholecystectomy, if necessary, and dissection and removal of surrounding soft tissues to prepare the vena cava, portal vein, hepatic artery, and common bile duct for implantation; without trisegment or lobe split
47144	Backbench standard preparation of cadaver donor whole liver graft prior to allotransplantation, including cholecystectomy, if necessary, and dissection and removal of surrounding soft tissues to prepare the vena cava, portal vein, hepatic artery, and common bile duct for implantation; with trisegment split of whole liver graft into 2 partial liver grafts (ie, left lateral segment [segments II and III] and right trisegment [segments I and IV through VIII])
47145	Backbench standard preparation of cadaver donor whole liver graft prior to allotransplantation, including cholecystectomy, if necessary, and dissection and removal of surrounding soft tissues to prepare the vena cava, portal vein, hepatic artery, and common bile duct for implantation; with lobe split of whole liver graft into 2 partial liver grafts (ie, left lobe [segments II, III, and IV] and right lobe [segments I and V through VIII])
47146	Backbench reconstruction of cadaver or living donor liver graft prior to allotransplantation; venous anastomosis, each
47147	Backbench reconstruction of cadaver or living donor liver graft prior to allotransplantation; arterial anastomosis, each

HCPCS Codes	Description
S2152	Solid organ(s), complete or segmental, single organ or combination of organs; deceased or living donor (s), procurement, transplantation, and related complications; including drugs; supplies; hospitalization with outpatient follow-up; medical/surgical, diagnostic, emergency, and rehabilitative services, and the number of days of pre and posttransplant care in the global definition

Reviews, Revisions, and Approvals	Review Date	Approval Date
Policy developed	02/18	04/18
Under fatty acid oxidation defects, changed recurrent episodes to “recurrent episodes of complications.” Other minor wording changes for clarity	12/18	
Added to the valproate-associated liver failure contraindication that it applies to children under 10. Specialist reviewed. References reviewed and updated.	02/19	02/19
Added contraindication of substance use or dependence. Removed duplicative codes K72.01, K72.90 and K72.9. Updated K83.0 to K83.01-K83.09	01/20	01/20

Reviews, Revisions, and Approvals	Review Date	Approval Date
Edited malignancy contraindication adding exceptions: cancer that has been completely resected, or that has been treated and poses acceptable future risk.	05/20	05/20
10/1/20 ICD-10 code update: replaced code range K74.0-K74.69 with K74.00- K74.69 to include new codes included in this range. Replaced "member" with "member/enrollee" in all instances	10/20	
Clarified in I.B.5.e, neonatal hemochromatosis is now referred to as Gestational alloimmune liver disease. References reviewed and updated. Revised description of ICD-10 code E72.53.	12/20	01/21
Replaced contraindications regarding psychological condition preventing compliance with medical therapy and "current non-adherence to medical therapy" with "Inability to adhere to the regimen necessary to preserve the transplant, even with caregiver support." Changed "Review Date" in header to "Date of Last Revision," and "Date" in the revision log header to "Revision Date."	08/21	08/21
Annual review. References reviewed, updated, and reformatted.	01/22	02/22
Edited contraindications: Replaced "non-hepatic malignancy…" with malignancy with high risk of recurrence or death…"; added GFR restriction, added HIV infection with detectable viral load, added stroke, acute coronary syndrome, or MI; added acute renal failure…; added septic shock; added progressive cognitive impairment; replaced "untreatable significant dysfunction of another major organ system…" with "Other severe uncontrolled medical condition expected to limit survival after transplant;" slightly reworded substance use contraindication.	02/22	02/22
Annual review. Criteria I.B.1.a.ii. updated to remove "beyond 3 months from procedure" and added a) Total bilirubin > 6 mg/dL beyond three months from hepatoportoenterostomy b) Total bilirubin remains between 2 to 6 mg/dL. Updated Criteria I.B.1.b. to add "if partial external biliary diversion or ileal exclusion failed or could not be performed." Removed "acute liver failure associated with encephalopathy" in Criteria I.B.3.a. and added I.B.3.a.i. and ii. Added Criteria I.B.3.c. Budd-Chiari Syndrome. Added, "At the time of diagnosis…" to I.B.4.a.ii. Updated Criteria I.B.4.d. to infantile hemangioma as well as verbiage in I.B.4.d.i. and ii. Removed "that is not responsive to medical therapy" in criteria I.B.5.h. and added I.B.5.h.i. through iv. Criteria I.B.5.m.ii. changed from "hyper-ammonia" to "hyperammonemia." Criteria I.B.7.b. updated to Factor VII and updated to state, "with complications from or failure of medical management." Removed "that has failed medical therapy" from Criteria I.B.7.c. and added sub criteria i. and ii. Removed "Budd-Chiari Syndrome" from I.B.7.d. Added Hepatopulmonary syndrome (HPS) as I.B.7.d. and added sub criteria i. and ii. Criteria I.C.1. updated from "chronic" to "active" infection. Criteria I.C.3. updated and added note for exclusion of malignancies that transplant could sufficiently address. Criteria I.C.8. updated to remove age requirement. Criteria I.C.18.	02/23	02/23

Reviews, Revisions, and Approvals	Review Date	Approval Date
updated to exclude marijuana use when prescribed by a licensed practitioner and include required commitment to reducing substance use behaviors if urgent transplant timelines are present. Background updated with no impact on criteria. ICD-10 codes removed. References reviewed and updated. Reviewed by internal specialist and external specialist.		

References

1. Squires RH, Ng V, Romero R, et al. Evaluation of the pediatric patient for liver transplantation: 2014 practice guideline by the American Association for the Study of Liver Diseases, American Society of Transplantation and the North American Society for Pediatric Gastroenterology, Hepatology and Nutrition. *Hepatology*. 2014;60(1):362 to 398. doi:10.1002/hep.27191
2. Squires JE. Acute liver failure in children: Management, complications, and outcomes. UpToDate. www.uptodate.com. Published April 21, 2022. Accessed January 23, 2023.
3. Leonis MA, Balistreri WF. Evaluation and management of end-stage liver disease in children. *Gastroenterology*. 2008;134(6):1741 to 1751. doi:10.1053/j.gastro.2008.02.029
4. Ng VL, Fecteau A, Shepherd R, et al. Outcomes of 5-year survivors of pediatric liver transplantation: report on 461 children from a North American multicenter registry. *Pediatrics*. 2008;122(6):e1128 to e1135. doi:10.1542/peds.2008-1363
5. McKiernan P. Acute liver failure after valproate exposure: Liver transplantation may be indicated beyond childhood. *Liver Transpl*. 2014;20(11):1287 to 1289. doi:10.1002/lt.23988

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

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Note: For Medicaid members/enrollees, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members/enrollees, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.