



MEDICAL COVERAGE GUIDELINES
SECTION: SURGERY

ORIGINAL EFFECTIVE DATE: 02/10/15
LAST REVIEW DATE: 09/18/18
LAST CRITERIA REVISION DATE:
ARCHIVE DATE:

LUNG TRANSPLANT

Non-Discrimination Statement and Multi-Language Interpreter Services information are located at the end of this document.

Coverage for services, procedures, medical devices and drugs are dependent upon benefit eligibility as outlined in the member's specific benefit plan. This Medical Coverage Guideline must be read in its entirety to determine coverage eligibility, if any.

This Medical Coverage Guideline provides information related to coverage determinations only and does not imply that a service or treatment is clinically appropriate or inappropriate. The provider and the member are responsible for all decisions regarding the appropriateness of care. Providers should provide BCBSAZ complete medical rationale when requesting any exceptions to these guidelines.

The section identified as "Description" defines or describes a service, procedure, medical device or drug and is in no way intended as a statement of medical necessity and/or coverage.

The section identified as "Criteria" defines criteria to determine whether a service, procedure, medical device or drug is considered medically necessary or experimental or investigational.

State or federal mandates, e.g., FEP program, may dictate that any drug, device or biological product approved by the U.S. Food and Drug Administration (FDA) may not be considered experimental or investigational and thus the drug, device or biological product may be assessed only on the basis of medical necessity.

Medical Coverage Guidelines are subject to change as new information becomes available.

For purposes of this Medical Coverage Guideline, the terms "experimental" and "investigational" are considered to be interchangeable.

BLUE CROSS®, BLUE SHIELD® and the Cross and Shield Symbols are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans. All other trademarks and service marks contained in this guideline are the property of their respective owners, which are not affiliated with BCBSAZ.



MEDICAL COVERAGE GUIDELINES
SECTION: SURGERY

ORIGINAL EFFECTIVE DATE: 02/10/15
LAST REVIEW DATE: 09/18/18
LAST CRITERIA REVISION DATE:
ARCHIVE DATE:

LUNG TRANSPLANT (cont.)

Description:

Lung Transplant:

A lung transplant is a surgical procedure in which one or both lungs from a single cadaver donor is placed in the body of a recipient.

Lobar Transplant:

A lobar transplant is a surgical procedure in which a lobe of a lung from a living or a cadaveric donor is placed in the body of a recipient. Living donors for lobar transplant are primarily related donors. If a bilateral transplant is required, one lobe is obtained from each of two donors (e.g., mother and father).

Potential Contraindications:

Potential contraindications subject to the judgment of the transplant center:

- Known current malignancy, including metastatic cancer
- Recent malignancy with high risk of recurrence
- Untreated systemic infection making immunosuppression unsafe, including chronic infection
- Other irreversible end-stage disease not attributed to lung disease
- History of cancer with a moderate risk of recurrence
- Systemic disease that could be exacerbated by immunosuppression
- Psychosocial conditions or chemical dependency affecting ability to adhere to therapy
- Coronary artery disease (CAD) not amenable to percutaneous intervention or bypass grafting, or associated with significant impairment of left ventricular function (may be candidate for combined heart-lung transplantation)
- Colonization with highly resistant or highly virulent bacteria, fungi or mycobacteria

LUNG TRANSPLANT (cont.)

Criteria:

Lung transplants will be reviewed by the medical director(s) and/or clinical advisor(s).

Pretransplantation Evaluation:

- Pretransplantation evaluation criterion is met with documentation of psychosocial screen and **ALL** of the following:
 1. Drug/alcohol screen with documentation of **ONE** of the following:
 - No drug/alcohol abuse by history
 - Drug and alcohol free for a period greater than or equal to 6 months
 2. Behavioral health disorder screening with documentation of **ONE** of the following:
 - No behavioral health disorder by history
 - Behavioral health disorder by history with documentation of **BOTH** of the following:
 - No severe psychosis/personality disorder
 - Mood/anxiety disorder excluded/treated
 3. Individual understands surgical risk and post procedure compliance and follow-up
 4. Adequate social/family support
- Lung transplantation for individuals with irreversible progressively disabling, end-stage pulmonary disease unresponsive to maximum medical therapy is considered **medically necessary** with documentation that pre-transplantation evaluation criterion is met.
- Lobar lung transplantation for individuals with end-stage pulmonary disease is considered **medically necessary** with documentation that pre-transplantation evaluation criterion is met.
- Lung or lobar lung retransplantation after a failed lung or lobar lung transplant is considered **medically necessary** in individuals who meet above criteria for lung transplantation.



MEDICAL COVERAGE GUIDELINES
SECTION: SURGERY

ORIGINAL EFFECTIVE DATE: 02/10/15
LAST REVIEW DATE: 09/18/18
LAST CRITERIA REVISION DATE:
ARCHIVE DATE:

LUNG TRANSPLANT (cont.)

Criteria: (cont.)

- Lung transplantation for all other indications not previously listed or if above criteria not met is considered **experimental or investigational** based upon:
 1. Insufficient scientific evidence to permit conclusions concerning the effect on health outcomes, and
 2. Insufficient evidence to support improvement of the net health outcome, and
 3. Insufficient evidence to support improvement of the net health outcome as much as, or more than, established alternatives, and
 4. Insufficient evidence to support improvement outside the investigational setting.

Resources:

Literature reviewed 09/18/18. We do not include marketing materials, poster boards and non-published literature in our review.

The BCBS Association Medical Policy Reference Manual (MPRM) policy is included in our guideline review. References cited in the MPRM policy are not duplicated on this guideline.

1. 7.03.07 BCBS Association Medical Policy Reference Manual. Lung and Lobar Lung Transplant. Re-issue date 08/09/2018; issue date 07/31/1996.



MEDICAL COVERAGE GUIDELINES
SECTION: SURGERY

ORIGINAL EFFECTIVE DATE: 02/10/15
LAST REVIEW DATE: 09/18/18
LAST CRITERIA REVISION DATE:
ARCHIVE DATE:

LUNG TRANSPLANT (cont.)

Non-Discrimination Statement:

Blue Cross Blue Shield of Arizona (BCBSAZ) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. BCBSAZ provides appropriate free aids and services, such as qualified interpreters and written information in other formats, to people with disabilities to communicate effectively with us. BCBSAZ also provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, call (602) 864-4884 for Spanish and (877) 475-4799 for all other languages and other aids and services.

If you believe that BCBSAZ has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with: BCBSAZ's Civil Rights Coordinator, Attn: Civil Rights Coordinator, Blue Cross Blue Shield of Arizona, P.O. Box 13466, Phoenix, AZ 85002-3466, (602) 864-2288, TTY/TDD (602) 864-4823, crc@azblue.com. You can file a grievance in person or by mail or email. If you need help filing a grievance BCBSAZ's Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>

Multi-Language Interpreter Services:

Spanish: Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Blue Cross Blue Shield of Arizona, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 602-864-4884.

Navajo: Díí kwe'é atah nilinígíí Blue Cross Blue Shield of Arizona haada yit'éego bina'idííkidgo éí doodago Háida bíjá anilyeedígíí t'áadoo le'é yina'idííkidgo beehaz'áanii hólg díí t'áa hazaadk'ehjí háká a'doowołgo bee haz'ą doo baqah ilínígóó. Ata' halne'ígíí kojí' bich'í' hodíilnih 877-475-4799.

Chinese: 如果您，或是您正在協助的對象，有關於插入項目的名稱 Blue Cross Blue Shield of Arizona 方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 在此插入數字 877-475-4799。

Vietnamese: Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Blue Cross Blue Shield of Arizona quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 877-475-4799.

Arabic:

إن كان لديك أو لدى شخص تساعد أسئلة بخصوص Blue Cross Blue Shield of Arizona، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم اتصل بـ 877-475-4799.

