

Healthcare Services Department

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Policy Name	Policy Number	Scope			
Pancreas Transplant	MP-PT-FP-04-23		MMM Multihealth		
Service Category					
Anesthesia	Medicine Services and Procedures				
Surgery	Evaluation and Management Services				
Radiology Procedures	DME/Prosthetics or Supplies				
Pathology and Laboratory Procedures	Other Transplant				
	Pancreas Transplant				
Service Description					
NCD 260.3					
Pancreas Transplant					
A. General					
Pancreas transplantation is performed to induce an insulin-independent, euglycemic state in diabetic					
patients. The procedure is generally limited to those patients with severe secondary complications of					
diabetes, including kidney failure. However, pancreas transplantation is sometimes performed on patients with labile diabetes and hypoglycemic unawareness. See enclosed specific coverage and non-covered service					
criteria.					
Please note that all services described in this policy require prior authorization.					
Please refer to the member's contract benefits in effect at the time of service to determine coverage					
or non-coverage of these services as it applies to an individual member.					
Providers should report all services using the most up-to-date industry-standard procedure, revenue,					
and diagnosis codes, including modifiers where applicable.					
 Providers must submit all required and requested documentation for case evaluation and determination 					
determination.					
 The plan may request additional documentation and information not received and or provided initially related to condition and diagnosis for case evaluation and determination. 					
 Any additional documentation submitted specifying medical necessity criteria and considered 					
• Any additional documentation submitted specifying medical necessity chiena and considered important for case evaluation and determination will be reviewed by Clinical Team utilizing guidelines					
and regulation criteria.					
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Healthcare Services Department

Medical Necessity Guidelines

Indications and Limitations of Coverage

B. Nationally Covered Indications

Effective for services performed on or after July 1, 1999, whole organ pancreas transplantation is nationally covered by Medicare when performed simultaneous with or after a kidney transplant. If the pancreas transplant occurs after the kidney transplant, immunosuppressive therapy begins with the date of discharge from the inpatient stay for the pancreas transplant.

Effective for services performed on or after April 26, 2006, pancreas transplants alone (PA) are reasonable and necessary for Medicare beneficiaries in the following limited circumstances:

PA will be limited to those facilities that are Medicare-approved for kidney transplantation. (Approved centers can be found at http://www.cms.gov/ESRDGeneralInformation/02_Data.asp#TopOfPage
 Patients must have a diagnosis of type I diabetes:

-Patient with diabetes must be beta cell autoantibody positive; or

-Patient must demonstrate insulinopenia defined as a fasting C-peptide level that is less than or equal to 110% of the lower limit of normal of the laboratory's measurement method. Fasting C-peptide levels will only be considered valid with a concurrently obtained fasting glucose \leq 225 mg/dL;

3. Patients must have a history of medically-uncontrollable labile (brittle) insulin-dependent diabetes mellitus with documented recurrent, severe, acutely life-threatening metabolic complications that require hospitalization. Aforementioned complications include frequent hypoglycemia unawareness or recurring severe ketoacidosis, or recurring severe hypoglycemic attacks;

4. Patients must have been optimally and intensively managed by an endocrinologist for at least 12 months with the most medically-recognized advanced insulin formulations and delivery systems;

5. Patients must have the emotional and mental capacity to understand the significant risks associated with surgery and to effectively manage the lifelong need for immunosuppression; and,

6. Patients must otherwise be a suitable candidate for transplantation.

Limits or Restrictions

C. Nationally Non-Covered Indications

The following procedure is not considered reasonable and necessary within the meaning of section 1862(a)(1)(A) of the Social Security Act:

Transplantation of partial pancreatic tissue or islet cells (except in the context of a clinical trial (see section 260.3.1 of the National Coverage Determinations Manual). D. Other

Not applicable.

(This NCD last reviewed April 2006.



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Reference Information

CMS

Medicare Processing Manual Chapter 3 section 90.4, 90.4.1, 90.4.2 Pancreas with Kidney Transplants Link: https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c03.pdf

CMS NCD 260.3 Pancreas Transplant

Medicare Coverage Database (MCD) Link: <u>https://www.cms.gov/medicare-coverage-database/view/ncd.aspx</u>

Policy History

Date	Version	Comments
12/07/2023	Draft	New Medical Policy
12/15/2023	Final	Approved by Medical
		Policy Committee