MEDICAL POLICY – 7.03.04
Isolated Small Bowel Transplant

BCBSA Ref. Policy: 7.03.04, 7.03.14
Effective Date: Nov. 1, 2020
Last Revised: Oct. 22, 2020
Replaces: 7.03.511

RELATED MEDICAL POLICIES:
7.03.05 Small Bowel/Liver and Multivisceral Transplant

Select a hyperlink below to be directed to that section.

POLICY CRITERIA | DOCUMENTATION REQUIREMENTS | CODING
RELATED INFORMATION | EVIDENCE REVIEW | REFERENCES | HISTORY

∞ Clicking this icon returns you to the hyperlinks menu above.

Introduction

An organ transplant is the surgical process of replacing a severely diseased organ with a healthy one from a donor. The donated organ can come from a living person or a person who passed away from an accident or illness. Organ failure is the most common reason a transplant is needed. Organ failure can occur because of illness, injury, or birth defect. There are many factors that go into finding a donor organ that matches. These include blood type and the size of the organ. Other factors include how long a person has been on the waiting list, the level of illness, and the distance the donated organ must be transported. This policy describes when transplanting a small bowel may be considered medically necessary. This policy notes that a plan physician will review solid organ transplant requests together with the criteria of the transplant center.

Note: The Introduction section is for your general knowledge and is not to be taken as policy coverage criteria. The rest of the policy uses specific words and concepts familiar to medical professionals. It is intended for providers. A provider can be a person, such as a doctor, nurse, psychologist, or dentist. A provider also can be a place where medical care is given, like a hospital, clinic, or lab. This policy informs them about when a service may be covered.

Policy Coverage Criteria
<table>
<thead>
<tr>
<th>Transplant</th>
<th>Medical Necessity</th>
</tr>
</thead>
</table>
| **Small bowel transplant using cadaveric intestine** | A small bowel transplant using cadaveric intestine may be considered medically necessary in adult and pediatric patients with All of the following:  
  • Patients with intestinal failure  
      o characterized by loss of absorption and the inability to maintain protein-energy, fluid, electrolyte, or micro nutrient balance;  
  AND  
  • Patients who have established long-term dependence on total parenteral nutrition (TPN);  
  AND  
  • Patients who are developing or have developed severe complications due to total parenteral nutrition |
| **Small bowel transplant using a living donor**   | A small bowel transplant using a living donor may be considered medically necessary only when a cadaveric intestine is not available for transplantation in a patient who meets the criteria noted above for a cadaveric intestinal transplant.  
  A small bowel transplant using living donors is considered not medically necessary in all other situations. |
| **Small bowel retransplant**                     | A small bowel retransplant may be considered medically necessary after a failed primary small bowel transplant.                                                                                                  |

<table>
<thead>
<tr>
<th>Transplant</th>
<th>Investigational</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Small bowel transplant</strong></td>
<td>A small bowel transplant is considered investigational for adult and pediatric patients with intestinal failure who can tolerate total parenteral nutrition.</td>
</tr>
<tr>
<td><strong>HCV (hepatitis C)- viremic organs</strong></td>
<td>The transplantation of HCV-viremic solid organs (kidney, lung, heart, liver, small bowel, pancreas) to an HCV non-viremic recipient combined with direct-acting antiviral treatment for HCV is considered investigational.</td>
</tr>
</tbody>
</table>

**Documentation Requirements**  
The patient’s medical records submitted for review for all conditions should document that medical necessity criteria are met. The record should include the following:
**Documentation Requirements**

- Office visit notes that contain the relevant history and physical supporting that patient has intestinal failure, has had long-term dependence on TPN, and has now developed severe complications due to the TPN. Specify if the request is for cadaveric, living donor, or retransplantation

**Coding**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>CPT</td>
<td></td>
</tr>
<tr>
<td>44135</td>
<td>Intestinal allotransplantation; from cadaver donor</td>
</tr>
<tr>
<td>44136</td>
<td>Intestinal allotransplantation; from living donor.</td>
</tr>
<tr>
<td>HCPCS</td>
<td></td>
</tr>
<tr>
<td>S2152</td>
<td>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</td>
</tr>
</tbody>
</table>

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**Related Information**

**Small Bowel-Specific Criteria**

Intestinal failure results from surgical resection, congenital defect, or disease-associated loss of absorption and is characterized by the inability to maintain protein-energy, fluid, electrolyte, or micronutrient balance. Short bowel syndrome is one cause of intestinal failure.

Patients who are developing or have developed severe complications due to total parenteral nutrition (TPN) include, but are not limited to, the following: multiple and prolonged hospitalizations to treat TPN-related complications (especially repeated episodes of catheter-related sepsis) or the development of progressive liver failure. In the setting of progressive liver
failure, small bowel transplant may be considered a technique to avoid end-stage liver failure related to chronic TPN, thus avoiding the necessity of a multivisceral transplant. In those receiving TPN, liver disease with jaundice (total bilirubin >3 mg/dL) is often associated with development of irreversible, progressive liver disease. The inability to maintain venous access is another reason to consider small bowel transplant in those who are dependent on TPN.

**Contraindications**

Potential contraindications for solid organ transplant are subject to the judgment of the transplant center include the following:

- 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 diseases not attributed to intestinal failure
- 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.

**Benefit Application**

See member’s plan contract language for organ transplant benefits and specific benefits related to transport, lodging, and donor services. Please note limitations in coverage based on the transplant benefit, if applicable.
Description

A small bowel transplant may be performed as an isolated procedure or in conjunction with other visceral organs, including the liver, duodenum, jejunum, ileum, pancreas, or colon. Isolated small bowel transplant is commonly performed in patients with short bowel syndrome. Small bowel/liver transplants and multivisceral transplants are considered in a Related Policy.

Background

Short Bowel Syndrome

Short bowel syndrome is a condition in which the absorbing surface of the small intestine is inadequate due to extensive disease or surgical removal of a large portion of the small intestine. The spectrum of clinical disease is widely variable from only single micronutrient malabsorption to complete intestinal failure, defined as the reduction of gut function below the minimum necessary for the absorption of macronutrients and/or water and electrolytes. In adults, etiologies of short bowel syndrome include ischemia, trauma, volvulus, and tumors. In children, gastroschisis, volvulus, necrotizing enterocolitis, and congenital atresia are predominant causes. Although the actual prevalence of short bowel syndrome is not clear primarily due to under-reporting and a lack of reliable patient databases, its prevalence is estimated to be 30 cases per million in the U.S.

Treatment

The small intestine, particularly the ileum, can adapt to some functions of the diseased or removed portion over a period of one to two years. Prognosis for recovery depends on the degree and location of small intestine damage. Therapy focuses on achieving adequate macro- and micronutrient uptake in the remaining small bowel. Pharmacologic agents have been studied to increase villous proliferation and slow transit times, and surgical techniques have been advocated to optimize remaining small bowel.

However, some patients with short bowel syndrome are unable to obtain adequate nutrition from enteral feeding and become chronically dependent on total parenteral nutrition. For patients with short bowel syndrome, the rate of parenteral nutrition dependency at 1, 2, and 5 years has been reported to be 74%, 64%, and 48%, respectively. Patients with complications from total parenteral nutrition may be considered candidates for a small bowel transplant. Complications include catheter-related mechanical problems, infections, hepatobiliary disease,
and metabolic bone disease. While cadaveric intestinal transplant is the most commonly performed transplant, there has been a recent interest in using living donors.

Intestinal transplants (including multivisceral and bowel/liver) represent a small minority of all solid organ transplants. In 2018, 104 intestinal transplants were performed in the U.S. (59% of which were intestine-liver transplants). Overall, both the number of new patients added to the intestinal transplant waiting list (n=135) and the number of intestinal transplants performed declined to their lowest levels in 2018.

Summary of Evidence

For individuals who have intestinal failure who receive a small bowel transplant, the evidence includes case series. The relevant outcomes are overall survival, morbid events, and treatment-related mortality and morbidity. Small bowel transplant is infrequently performed, and only relatively small case series, generally single-center, are available. Risks after small bowel transplant are high, particularly related to infection, but may be balanced against the need to avoid the long-term complications of total parenteral nutrition dependence. In addition, early small bowel transplant may obviate the need for a later combined liver/small bowel transplant. Transplantation is contraindicated in patients in whom the procedure is expected to be futile due to comorbid disease or in whom posttransplantation care is expected to worsen comorbid conditions significantly. Guidelines and U.S. federal policy no longer view HIV infection as an absolute contraindication for solid organ transplantation. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

For individuals who have failed small bowel transplant without contraindication(s) for retransplant who receive a small bowel retransplant, the evidence includes case series. The relevant outcomes are overall survival, morbid events, and treatment-related mortality and morbidity. Data from a small number of patients undergoing retransplantation are available. Although limited in quantity, the available data have suggested a reasonably high survival rate after small bowel retransplantation in patients who continue to meet criteria for transplantation. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

For individuals who are HCV non-viremic who have end-stage organ disease and are candidates for a solid organ transplant such as for small bowel or pancreas, evidence for the use of HCV viremic donor organs as an alternative to continuing appropriate medical treatment and remaining on the transplant wait-list has not been reported in the last five years in the published
literature. The evidence is insufficient to determine the effects of the technology on health outcomes.

Ongoing and Unpublished Clinical Trials

A search of ClinicalTrials.gov in June 2020 did not identify any ongoing or unpublished trials that would likely influence this review.

Clinical Input Received from Physician Specialty Societies and Academic Medical Centers

While the various physician specialty societies and academic medical centers may collaborate with and make recommendations during this process, through the provision of appropriate reviewers, input received does not represent an endorsement or position statement by the physician specialty societies or academic medical centers, unless otherwise noted.

In response to requests, input was received from two physician specialty societies and two academic medical centers while this policy was under review in 2009. The consensus of those providing input was that small bowel transplant should be performed in patients who are developing severe total parenteral nutrition-related complications and that small bowel transplant from living donors may be considered when cadaveric intestinal transplants are not available.

Practice Guidelines and Position Statements

American Gastroenterological Association

In 2003, the American Gastroenterological Association produced a medical position statement on short bowel syndrome and intestinal transplantation. It recommended dietary, medical, and surgical solutions. Indications for intestinal transplantation mirrored those of the Centers for Medicare & Medicaid Services. The guidelines acknowledged the limitations of transplant for these patients. The statement recommended the following Medicare-approved indications, pending availability of additional data:

1. "Impending or overt liver failure..."
2. Thrombosis of major central venous channels...

3. Frequent central line-related sepsis...

4. Frequent severe dehydration.

**American Society of Transplantation**

In 2001, the American Society of Transplantation issued a position paper on indications for pediatric intestinal transplantation. The Society listed the following disorders in children as potentially treatable by intestinal transplantation: short bowel syndrome, defective intestinal motility, and impaired enterocyte absorptive capacity. Contraindications for intestinal transplant to treat pediatric patients with intestinal failure are similar to those of other solid organ transplants: profound neurologic disabilities, life-threatening comorbidities, severe immunologic deficiencies, nonresectable malignancies, autoimmune diseases, and insufficient vascular patency.

The American Society of Transplantation (2017) convened a consensus conference of experts to address issues related to the transplantation of hepatitis C virus (HCV) viremic solid organs into HCV non-viremic recipients. Key findings and recommendations are summarized in Table 1.

**Table 1. American Society of Transplantation Consensus Conference - Use of Hepatitis C Virus Viremic Donors**

<table>
<thead>
<tr>
<th>Content Area</th>
<th>Key Point</th>
</tr>
</thead>
<tbody>
<tr>
<td>Definition of HCV positive</td>
<td>HCV viremic reflecting a positive NAT should be adopted</td>
</tr>
<tr>
<td>Data interpretation</td>
<td>HCV antibody status alone limits interpretation of outcomes of transplantation of HCV &quot;positive&quot; organs</td>
</tr>
<tr>
<td>Transmission and Treatment</td>
<td>Highest risk for unexpected HCV transmission is associated with organ donation from a person who injected drugs within the eclipse or pre-viremic period</td>
</tr>
<tr>
<td>OPTN policy</td>
<td>No current policies prevent transplantation of HCV-viremic organs into HCV non-viremic recipients</td>
</tr>
<tr>
<td>Ethical considerations</td>
<td>Transplantation of HCV-viremic organs into HCV non-viremic recipients should be conducted under site specific IRB approved protocols with multi-step informed consent.</td>
</tr>
</tbody>
</table>
Medicare National Coverage

The Centers for Medicare & Medicaid have a national coverage determination on intestinal and multivisceral transplantation. The determination covers these types of transplants only when performed for patients who have failed total parenteral nutrition (TPN) and only when performed in centers that meet approval criteria.

1. Failed TPN

The TPN delivers nutrients intravenously, avoiding the need for absorption through the small bowel. TPN failure includes the following:

- Impending or overt liver failure due to TPN induced liver injury.
- Thrombosis of the major central venous channels; jugular, subclavian, and femoral veins.
- Frequent line infection and sepsis.
- Frequent episodes of severe dehydration despite intravenous fluid supplement in addition to TPN.

2. Approved Transplant Facilities

The criteria for approval of centers will be based on a volume of 10 intestinal transplants per year with a 1-year actuarial survival of 65 percent using the Kaplan-Meier technique.\textsuperscript{35}

Regulatory Status

Small bowel transplantation is a surgical procedure and, as such, is not subject to regulation by the U.S. Food and Drug Administration.

The U.S. Food and Drug Administration regulates human cells and tissues intended for implantation, transplantation, or infusion through the Center for Biologics Evaluation and Research, under Code of Federal Regulation Title 21, parts 1270 and 1271. Small bowel transplants are included in these regulations.

References


### History

<table>
<thead>
<tr>
<th>Date</th>
<th>Comments</th>
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<tbody>
<tr>
<td>11/01/19</td>
<td>New policy, approved October 4, 2019. This policy replaces policy 7.03.511 which is now deleted. Policy created with literature review through June 2019. A cadaveric or living donor small bowel transplant may be considered medically necessary when</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Date</th>
<th>Comments</th>
</tr>
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PAUNAWA: Kung nagasalita ka ng Tagalog, maari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad.

Tumawag sa 800-596-3440 (TTY: 711).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 800-596-3440 (TTY: 711).

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