

## **Title 23: Division of Medicaid**

### **Part 202: Hospital Services**

#### **Chapter 4: Solid Organ and Tissue Transplants**

##### *Rule 4.1: Transplant Provider Requirements*

Providers of transplant services must:

- A. Complete the requirements for participation in the Mississippi Medicaid program.
- B. Meet the following facility criteria:
  1. Solid organ transplant procedures must be performed in a facility which meets the Centers for Medicare and Medicaid Services (CMS) requirements for Conditions of Participation approved as a transplant facility unless otherwise authorized by the Division of Medicaid, and
  2. Bone marrow and stem cell transplant procedures must be performed in a facility accredited by a CMS-deemed national accreditation organization.
- C. Obtain prior authorization from a Utilization Management/Quality Improvement Organization (UM/QIO), the Division of Medicaid or designated entity for the inpatient hospital admission and for outpatient services, if required, for the transplant procedure as soon as it is determined that the beneficiary may be a potential candidate for the transplant.
  1. The prior authorization request must include, but is not limited to the following:
    - a) A description of the medical condition which necessitates the transplantation,
    - b) Diagnostic confirmation by clinical laboratory studies of the underlying pathological process,
    - c) A history of other treatments which have been tried and treatments which have been considered and ruled out, including an explanation as to why the treatment was ruled out,
    - d) Comprehensive assessments:
      - 1) Examination, evaluation and recommendations completed by a board-certified or board-eligible specialist in a field directly related to the beneficiary's condition which necessitates the transplantation,
      - 2) Psycho-social evaluation including a comprehensive history of substance abuse and compliance with any medical treatment of:

- (a) The beneficiary, and
  - (b) The parents or guardian/legal representative if the beneficiary is less than eighteen (18) years of age,
  - e) Psychiatric evaluation of the beneficiary if the beneficiary has a history of mental illness,
  - f) Infectious disease evaluation of a beneficiary with a recent or current suspected infectious episode,
  - g) Evaluation of a beneficiary diagnosed with cancer that includes staging of the cancer, laboratory tests, and imaging studies, and
  - h) Any other medical evidence needed to evaluate possible contraindications for the type of transplantation being considered.
2. Prior authorization is not required for transplants when the beneficiary has Medicare coverage.
  3. Prior authorization is required for transplants when the beneficiary has third party coverage and the hospital intends to bill Medicaid for any transplant related hospital charges.
- D. Ensure that the transplant procedure is performed at the facility requesting prior authorization for the transplant procedure.
- E. Submit documentation for a concurrent review for beneficiaries not enrolled in a Coordinated Care Organization (CCO) to a UM/QIO, the Division of Medicaid, or designated entity if a beneficiary's length of stay exceeds nineteen (19) days.
- F. Provide the appropriate medical records, progress or outcome reports as requested by a UM/QIO, the Division of Medicaid, or designated entity.

Source: 42 U.S.C. § 1320b-8; 21 C.F.R. Parts 1270 and 1271; 42 C.F.R. Part 121, 42 C.F.R. §§ 441.35, 482.12, 482.68-104; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised eff. 01/01/2017; Revised eff.10/01/2012.

*Rule 4.2: Covered Services*

- A. The Division of Medicaid covers the following solid organ transplant services when medically necessary and prior authorized by a Utilization Management/Quality Improvement Organization (UM/QIO), the Division of Medicaid, or designated entity:
1. Single organs:

- a) Heart, according to current criteria of the International Society for Heart and Lung Transplantation,
  - b) Intestine, according to current criteria of the American Gastroenterological Association and American Society of Transplantation,
  - c) Liver, according to current criteria of the American Association for the Study of Liver Diseases and the American Society of Transplantation,
  - d) Single lung, according to current criteria of the Pulmonary Transplantation Council of the International Society for Heart and Lung Transplantation, and
  - e) Bilateral lung, according to current criteria of the Pulmonary Transplantation Council of the International Society for Heart and Lung Transplantation,
2. Multiple-organs which meet the current criteria according to the respective single organ criteria in Rule 4.2.A.:
- a) Heart-lung,
  - b) Intestines with other organs,
  - c) Kidney-heart,
  - d) Kidney-pancreas, which only reimburses for the kidney transplant,
  - e) Liver-kidney, and
  - f) Other multi-organs.
- B. The Division of Medicaid covers kidney transplants when medically necessary with no prior authorization.
- C. The Division of Medicaid covers bone marrow transplantations, peripheral stem cell transplantations and cornea transplantations when medically necessary with no prior authorization, meets Medicare coverage guidelines and are not experimental or investigational.
- D. The Division of Medicaid covers all facility and physician charges relating to the procurement of an organ, whether from a cadaver or a living donor.
1. The Division of Medicaid covers donor related charges including, but not limited to, the following:
- a) A search for matching tissue, bone marrow, or organ,

- b) The donor's transportation,
  - c) Charges for the removal, withdrawal, and preservation/storage of the organ or tissue, and
  - d) The donor's hospitalization.
2. The Division of Medicaid covers medically necessary follow-up care outside of the transplant inpatient hospital admission for the living donor only if the donor is a Mississippi Medicaid beneficiary.

Source: 42 C.F.R. §§ 441.35, 482.90-104; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised eff. 01/01/2017; Revised eff. 10/01/2012.

*Rule 4.3: Non-Covered Services*

The Division of Medicaid does not cover the following transplant procedures/services including, but not limited to:

- A. Transplant procedures/services not medically necessary,
- B. Transplant procedures/services still in clinical trials and/or investigational or experimental in nature,
- C. Transplant procedures/services performed in a facility not approved by the Division of Medicaid and/or meeting the criteria in Miss. Admin. Code Part 202, Rule 4.1,
- D. Inpatient admissions or outpatient procedures, if required, for transplant procedures/services that have not been prior authorized by a UM/QIO, the Division of Medicaid, or designated entity, or
- E. Pancreas transplants.

Source: Miss. Code Ann. § 43-13-121.

History: Revised eff. 01/01/2017.

*Rule 4.4: Reimbursement*

- A. All fee-for-service (FFS) transplants performed in the state of Mississippi are paid under the Mississippi All Patient Refined-Diagnosis Related Group (APR-DRG) payment methodology, including a policy adjustor.
- B. All FFS transplants available in Mississippi but performed outside the state of Mississippi are

paid under the Mississippi APR-DRG payment methodology, including a policy adjustor.

- C. Payment for transplant services not available in Mississippi is made under the Mississippi APR-DRG payment methodology including a policy adjustor. If the Mississippi APR-DRG payment limits access to care, a case rate may be set.
  - 1. A case rate is set at forty percent (40%) of the sum of billed charges for transplant services as published in the State Plan according to *Milliman's U.S. Organ and Tissue Transplant Cost Estimates and Discussion*.
  - 2. The *Milliman* categories comprising the sum of billed charges include outpatient services received thirty (30) days pre-transplant, procurement, hospital transplant inpatient admission, physician services during transplant and one-hundred eighty (180) days post (transplant) hospital discharge. Outpatient immunosuppressants and other prescriptions are not included in the case rate.
  - 3. If the transplant hospital stay exceeds the hospital length of stay published by *Milliman*, an outlier per-diem payment will be made for each day that exceeds the hospital length of stay.
  - 4. Reimbursement for transplant services cannot exceed one-hundred percent (100%) of the sum of *Milliman's* billed charges for the categories listed in Miss. Admin. Code Part 202, Rule 4.4.C.2.
  - 5. Provisions listed in Miss. Admin. Code Part 202, Rule 4.4 apply to transplant services on or after October 1, 2012.
  - 6. Transplant services not available in Mississippi and not listed in the *Milliman's U.S. Organ and Tissue Transplant Cost Estimates and Discussion* will be reimbursed using the Mississippi APR-DRG payment methodology. If the Mississippi APR-DRG payment limits access to care, the Division of Medicaid will reimburse what the domicile state pays for the service.
- D. All conditions of third party liability procedures must be satisfied.
- E. All claims must be submitted according to the requirements of the Mississippi Medicaid program.
- F. All charges, both facility and physician, relating to procurement/storage must be billed by the transplant facility on the current uniform billing (UB) claim form with the appropriate revenue code(s).
- G. The Division of Medicaid reimburses all facility and physician charges relating to the procurement of an organ, whether from a cadaver or a living donor, to the transplant facility using the appropriate revenue codes.

Source: 42 C.F.R. §§ 441.35, 482.90 - 104; Miss. Code Ann. § 43-13-121.

History: Revised to correspond with SPA 15-018 (eff. 12/01/2015) eff. 01/01/2017; Revised eff. 10/01/2012.

*Rule 4.5: Fundraising*

- A. The Division of Medicaid allows fundraisers to obtain funds needed for transplant costs not covered by the Medicaid program.
- B. Fundraising criteria includes, but is not limited to, the following:
  - 1. Prior to accepting donations, arrangements must be made with the Division of Medicaid to deposit donations in a trust fund/special account.
  - 2. The trust fund/special account must be established and administered in compliance with all applicable federal and state rules and regulations.
  - 3. The trust fund/special account must be managed and administered by someone other than the beneficiary or the beneficiary's guardian, legal representative or family member. The beneficiary or the beneficiary's guardian, legal representative or family member cannot have direct access to the trust fund/special account.
  - 4. Trust fund/special account must be maintained separately from personal monies belonging to the beneficiary or the beneficiary's guardian, legal representative or family member.
  - 5. Legible and authentic documentation of income and expenditures must be made available to a Utilization Management/Quality Improvement Organization (UM/QIO), the Division of Medicaid, or designated entity upon request.
  - 6. The beneficiary must report all sources of income to the Division of Medicaid. Donated funds for the purpose of payment of medical services are considered a third party source.
  - 7. Transplant facilities/providers cannot participate in fundraising for beneficiaries to raise additional funds to pay for the transplant procedure and/or related services.

Source: 42 U.S.C. § 1396p; Miss. Code Ann. § 43-13-121.

History: Revised to correspond with SPA 15-018 (eff. 12/01/2015) eff. 01/01/2017; Revised eff. 10/01/2012.

*Rule 4.6: Documentation Requirements*

Providers of transplant services must document and maintain records in accordance with requirements set forth in Miss. Admin. Code Part 200, Rule 1.3 on each beneficiary receiving a

transplant and must include the following:

- A. Comprehensive history and physical.
- B. Treatments rendered that were unable to prevent progressive disability and/or death.
- C. Use of tobacco, alcohol, and/or illegal drugs within the last six (6) months.
- D. Absence of severe and irreversible organ dysfunction in organ(s) other than the organ(s) being transplanted.
- E. Relevant diagnostic studies and results including, but not limited to:
  - 1. X-rays,
  - 2. Lab reports,
  - 3. EKG reports,
  - 4. Pulmonary function studies,
  - 5. Psychosocial reports,
  - 6. Nutritional evaluation, and
  - 7. Performance status.
- F. Reports, consults or other documentation to substantiate the transplant including documentation of transplant approval by the facility's transplant review team.
- G. Copy of informed consent form signed by the beneficiary and/or guardian or legal representative.

Source: 42 C.F.R. § 482.90 -104; Miss. Code Ann. §§ 43-13-117; 43-13-118; 43-13-121.

History: Revised to correspond with SPA 15-018 (eff. 12/01/2015) eff. 01/01/2017.

*Rule 4.7: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)*

The Division of Medicaid pays for all medically necessary services for early and periodic screening, diagnosis, and treatment (EPSDT)-eligible beneficiaries in accordance with Miss. Admin. Code Part 223, without regard to service limitations and with prior authorization.

Source: Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Renumbered rule eff. 01/01/2017; Revised eff. 01/01/2013; Revised eff. 10/01/2012.

## Title 23: Division of Medicaid

### Part 202: Hospital Services

#### ~~Part 202~~ Chapter 4: Solid Organ and Tissue Transplants

##### *Rule 4.1: ~~Transplant Procedures~~ Provider Requirements*

Providers of transplant services must:

A. Complete the requirements for participation in the Mississippi Medicaid program.

B. Meet the following facility criteria:

1. Solid organ transplant procedures must be performed in a facility which meets the Centers for Medicare and Medicaid Services (CMS) requirements for Conditions of Participation approved as a transplant facility unless otherwise authorized by the Division of Medicaid, and
2. Bone marrow and stem cell transplant procedures must be performed in a facility accredited by a CMS-deemed national accreditation organization.

~~A. Medicaid covers benefits for transplant listed in Rules 4.9 — 4.18 in this Chapter if the transplant facility obtains prior approval (PA), when required, and satisfies all criteria listed in the Rule.~~

~~B.C. Requests for prior approval must be sent to Medicaid's~~ Obtain prior authorization from a Utilization Management/Quality Improvement Organization (UM/QIO), the Division of Medicaid or designated entity for the inpatient hospital admission and for outpatient services, if required, for the transplant procedure ~~Providers should submit requests as soon as it is determined that the beneficiary may be a potential candidate for the~~ transplant.

1. The prior authorization request must include, but is not limited to the following:

- a) A description of the medical condition which necessitates the transplantation,
- b) Diagnostic confirmation by clinical laboratory studies of the underlying pathological process,
- c) A history of other treatments which have been tried and treatments which have been considered and ruled out, including an explanation as to why the treatment was ruled out,
- d) Comprehensive assessments:

- 1) Examination, evaluation and recommendations completed by a board-certified or board-eligible specialist in a field directly related to the beneficiary's condition which necessitates the transplantation,
- 2) Psycho-social evaluation including a comprehensive history of substance abuse and compliance with any medical treatment of:
  - (a) The beneficiary, and
  - (b) The parents or guardian/legal representative if the beneficiary is less than eighteen (18) years of age,
- e) Psychiatric evaluation of the beneficiary if the beneficiary has a history of mental illness,
- f) Infectious disease evaluation of a beneficiary with a recent or current suspected infectious episode,
- g) Evaluation of a beneficiary diagnosed with cancer that includes staging of the cancer, laboratory tests, and imaging studies, and
- h) Any other medical evidence needed to evaluate possible contraindications for the type of transplantation being considered.
2. Prior authorization is not required for transplants when the beneficiary has Medicare coverage.
3. Prior authorization is required for transplants when the beneficiary has third party coverage and the hospital intends to bill Medicaid for any transplant related hospital charges.

~~C. Transplant benefits are dependent on all of the following:~~

- ~~1. The beneficiary must be eligible for Mississippi Medicaid.~~
- ~~2. The beneficiary's prior authorization request for the transplant must be approved by the UM/QIO. [Removed duplicative language]~~
- ~~3. Prior authorization is required for Medicaid hospital inpatient transplant admissions. [Moved to Miss. Admin. Code Part 202, Rule 4.1.B.]~~

D. Ensure that the transplant procedure is performed at the facility requesting prior authorization for the transplant procedure.

~~E. 4.A transplant beneficiary whose length of stay exceeds nineteen (19) days requires concurrent review by the UM. Submit documentation for a concurrent review for beneficiaries not enrolled in a Coordinated Care Organization (CCO) to a UM/QIO, the Division of Medicaid, or designated entity if a beneficiary's length of stay exceeds nineteen (19) days.~~

~~5. All conditions of third party liability procedures must be satisfied. [Revised and moved to Miss. Admin. Code Part 202, Rule 4.4]~~

~~6. All providers must complete requirements for participation in the Mississippi Medicaid program. [Moved to Miss. Admin. Code Part 202, Rule 4.1.A.]~~

~~7. All claims must be submitted according to the requirements of the Mississippi Medicaid program. [Moved to Miss. Admin. Code Part 202, Rule 4.4]~~

~~8. All charges, both facility and physician, relating to procurement/storage must be billed by the transplant facility on the current UB claim form with the appropriate revenue code(s). [Moved to Miss. Admin. Code Part 202, Rule 4.4]~~

~~F. 9. The transplant facility must provide the appropriate medical records, progress or outcome reports as requested by Medicaid, a the UM/QIO, or the fiscal agent. the Division of Medicaid, or designated entity.~~

~~10. The transplant procedure must be performed at the facility requesting transplant approval. [ Moved to Miss. Admin. Code Part 202, Rule 4.1.C.]~~

~~D. Transplant procedures/services subject to denial include, but are not limited to, the following: [ Moved to Miss. Admin. Code Part 202, Rule 4.3]~~

~~1. Transplant procedures/services when medical necessity has not been proven.~~

~~2. Transplant procedures/services still in clinical trials and/or investigative or experimental in nature.~~

~~3. Transplant procedures/services performed in a facility not approved by Medicaid.~~

~~4. Inpatient or outpatient admissions for transplant procedures/services that have not been certified/re-certified by the UM/QIO.~~

~~E. Pancreas transplants are not covered by Medicaid. Pancreas transplants done in conjunction with another covered transplant procedure will only be covered for those charges related to the covered transplant procedure. [Moved to Miss. Admin. Code Part 202, Rule 4.3]~~

Source: 42 U.S.C. § 1320b-8; 21 C.F.R. Parts 1270 and 1271; 42 C.F.R. Part 121, 42 C.F.R. §§ 441.35, 489.90, 482.12, 482.68-104; Miss. Code Ann. §§ 43-13-11724, 43-13-11721(A)(1)(e).

History: Revised eff. 01/01/2017; Revised eff.-10/01/2012.

Rule 4.2: ~~Organ Acquisition~~ Covered Services

A. The Division of Medicaid covers the following solid organ transplant services when medically necessary and prior authorized by a Utilization Management/Quality Improvement Organization (UM/QIO), the Division of Medicaid, or designated entity:

1. Single organs:

- a) Heart, according to current criteria of the International Society for Heart and Lung Transplantation,
- b) Intestine, according to current criteria of the American Gastroenterological Association and American Society of Transplantation,
- c) Liver, according to current criteria of the American Association for the Study of Liver Diseases and the American Society of Transplantation,
- d) Single lung, according to current criteria of the Pulmonary Transplantation Council of the International Society for Heart and Lung Transplantation, and
- e) Bilateral lung, according to current criteria of the Pulmonary Transplantation Council of the International Society for Heart and Lung Transplantation,

2. Multiple-organs which meet the current criteria according to the respective single organ criteria in Rule 4.2.A.:

- a) Heart-lung,
- b) Intestines with other organs,
- c) Kidney-heart,
- d) Kidney-pancreas, which only reimburses for the kidney transplant,
- e) Liver-kidney, and
- f) Other multi-organs.

B. The Division of Medicaid covers kidney transplants when medically necessary with no prior authorization.

C. The Division of Medicaid covers bone marrow transplantations, peripheral stem cell transplantations and cornea transplantations when medically necessary with no prior

authorization, meets Medicare coverage guidelines and are not experimental or investigational.

~~A.D. The Division of Medicaid covers all facility and physician charges, facility and physician, relating to acquisition, the procurement of an organ, whether from a cadaveric or a living donor, to the transplant facility using the appropriate revenue codes.~~

~~B. 1. The Division of Medicaid covers Donor related charges may include, but not limited to, the following:~~

~~a) 1. A search for matching tissue, bone marrow, or organ,~~

~~b) 2. The Donor's transportation,~~

~~c) 3. Charges for the removal, withdrawal, and preservation/storage of the organ or tissue, and~~

~~d) 4. The Donor's hospitalization.~~

~~C. 2. The Division of Medicaid covers Medically necessary follow-up care outside of the transplant inpatient hospital admission for the living donor is covered only if the donor is a Mississippi Medicaid beneficiary, and is reimbursed as routine benefits under the APR-DRG payment method.~~

Source: 42 C.F.R. §§ 441.35; 42 CFR § 482.90-482.104; Miss. Code Ann. §§ 43-13-11721, 43-13-11721(A)(1)(d), 43-13-117 (A)(2)(e).

History: Revised eff. 01/01/2017; Revised eff. 10/01/2012.

~~*Rule 4.3: Fundraising Criteria [Moved to Miss. Admin. Code Part 202, Rule 4.5] Non-Covered Services*~~

~~A. Fundraisers may be used to obtain funds needed for transplant costs not normally covered by Medicaid program.~~

~~B. Fundraising Criteria~~

~~1. Prior to accepting donations, arrangements must be made to place donations in a trust fund/ special account.~~

~~2. The trust fund/special account must be established/administered in compliance with all applicable federal and state rules/regulations.~~

~~3. The trust fund/special account must be managed/administered by someone other than the beneficiary or the beneficiary's family member/legal guardian. The beneficiary or the~~

~~beneficiary's family member/legal guardian may not have direct access to the fund/account.~~

- ~~4. The trust fund/special account must be maintained separate from personal monies belonging to the beneficiary or the beneficiary's family member/legal guardian. Mixed funds could be counted as income or an asset which could result in a loss or reduction of Medicaid benefits.~~
- ~~5. Legible documentation of income and expenditures must be maintained and must be made available to the Division of Medicaid, the fiscal agent, and/or the UM/QIO upon request.~~
- ~~6. The beneficiary must report all sources of income to the source of eligibility. Donated funds for the purpose of payment of medical services are considered a third party source.~~
- ~~7. Transplant facilities/providers cannot participate in fundraising for beneficiaries to raise additional funds to pay for the transplant procedure and/or related services.~~

The Division of Medicaid does not cover the following transplant procedures/services including, but not limited to:

- A. Transplant procedures/services not medically necessary,
- B. Transplant procedures/services still in clinical trials and/or investigational or experimental in nature,
- C. Transplant procedures/services performed in a facility not approved by the Division of Medicaid and/or meeting the criteria in Miss. Admin. Code Part 202, Rule 4.1,
- D. Inpatient admissions or outpatient procedures, if required, for transplant procedures/services that have not been prior authorized by a UM/QIO, the Division of Medicaid, or designated entity, or
- E. Pancreas transplants.

Source: Miss. Code Ann. § 43-13-121.

History: Revised eff. 01/01/2017.

Rule 4.4: ~~Prior Approval~~ [Revised and moved to Miss. Admin. Code Part 202, Rule 4.2] Reimbursement

- ~~A. Medical necessity for transplants, except those listed below, must be prior authorized by the Utilization Management and Quality Improvement Organization (UM/QIO), regardless of the age of the beneficiary.~~

- ~~1. Kidney transplants,~~
- ~~2. Cornea transplants, or~~
- ~~3. Bone marrow/peripheral stem cell transplants.~~

~~B. Prior authorization for all hospital transplant admissions is required from the UM/QIO.~~

~~C. Transplants on beneficiaries with Medicare coverage do not require prior approval. [Moved to Miss. Admin. Code Part 202, Rule 4.1]~~

~~D. Prior authorization from the UM/QIO is required on transplants when the beneficiary has third party coverage and the hospital intends to bill Medicaid for any transplant related hospital charges. [Moved to Miss. Admin. Code Part 202, Rule 4.1]~~

A. All fee-for-service (FFS) transplants performed in the state of Mississippi are paid under the Mississippi All Patient Refined-Diagnosis Related Group (APR-DRG) payment methodology, including a policy adjustor.

B. All FFS transplants available in Mississippi but performed outside the state of Mississippi are paid under the Mississippi APR-DRG payment methodology, including a policy adjustor.

C. Payment for transplant services not available in Mississippi is made under the Mississippi APR-DRG payment methodology including a policy adjustor. If the Mississippi APR-DRG payment limits access to care, a case rate may be set.

1. A case rate is set at forty percent (40%) of the sum of billed charges for transplant services as published in the State Plan according to *Milliman's U.S. Organ and Tissue Transplant Cost Estimates and Discussion*.

2. The *Milliman* categories comprising the sum of billed charges include outpatient services received thirty (30) days pre-transplant, procurement, hospital transplant inpatient admission, physician services during transplant and one-hundred eighty (180) days post (transplant) hospital discharge. Outpatient immunosuppressants and other prescriptions are not included in the case rate.

3. If the transplant hospital stay exceeds the hospital length of stay published by *Milliman*, an outlier per-diem payment will be made for each day that exceeds the hospital length of stay.

4. Reimbursement for transplant services cannot exceed one-hundred percent (100%) of the sum of *Milliman's* billed charges for the categories listed in Miss. Admin. Code Part 202, Rule 4.4.C.2.

5. Provisions listed in Miss. Admin. Code Part 202, Rule 4.4 apply to transplant services on or after October 1, 2012.

6. Transplant services not available in Mississippi and not listed in the *Milliman's U.S. Organ and Tissue Transplant Cost Estimates and Discussion* will be reimbursed using the Mississippi APR-DRG payment methodology. If the Mississippi APR-DRG payment limits access to care, the Division of Medicaid will reimburse what the domicile state pays for the service.

D. All conditions of third party liability procedures must be satisfied.

E. All claims must be submitted according to the requirements of the Mississippi Medicaid program.

F. All charges, both facility and physician, relating to procurement/storage must be billed by the transplant facility on the current uniform billing (UB) claim form with the appropriate revenue code(s).

G. The Division of Medicaid reimburses all facility and physician charges relating to the procurement of an organ, whether from a cadaver or a living donor, to the transplant facility using the appropriate revenue codes.

Source: 42 C.F.R. §§ 441.35; ~~42 CFR § 482.90 - 482.104~~; Miss. Code Ann. § 43-13-121.

History: Revised to correspond with SPA 15-018 (eff. 12/01/2015) eff. 01/01/2017; Revised - eff. 10/01/2012.

*Rule 4.5: Facility Criteria [Revised and moved to Rule 4.1.A.] Fundraising*

~~A. Medicaid requires organ transplant procedures to be performed in a Medicare approved transplant facility, unless otherwise authorized by Medicaid.~~

~~B. Bone marrow/peripheral stem cell transplant facilities must meet the following medical, experience and administrative criteria:~~

~~1. Medical Criteria~~

~~a) The facility must have written criteria for transplant candidate selection and a written implementation plan.~~

~~b) The facility must have a written transplant candidate management plan/protocol that includes both evaluative and therapeutic procedures for the waiting period, in-hospital period, and post-transplant phases of treatment.~~

~~c) The facility must make a sufficient commitment of resources and planning to the transplant program to demonstrate the importance of the program at all levels. Indications of this commitment must be broadly evident throughout the facility. The facility must use a multidisciplinary team that includes representatives with expertise~~

~~in the appropriate organ specialty (ex: hepatology, cardiology, or pulmonology) and the following general areas: transplant surgery, vascular surgery, anesthesiology, immunology, infectious diseases, pathology, radiology, nursing, blood banking, and social services.~~

## ~~2. Experience Criteria~~

- ~~a) The facility's volume of transplants and survival rates must demonstrate both experience and success with bone marrow and/or peripheral stem cell transplantation. The facility staff must have performed a reasonable number of successful transplants for each transplant type for which Medicaid approval is sought.~~
- ~~b) The facility must provide documentation to support the current competence of its transplant physicians and transplant surgeons, and, if requested, its transplant specific and general clinical staff. The qualifications and transplant experience of transplant physicians and surgeons specified by UNOS (UNOS bylaws Appendix B—III (2): Liver; (4): Heart; and (5): Lung and Heart Lung) will be considered appropriate for each specified transplant program.~~

## ~~3. Administrative Criteria~~

- ~~a) The facility must make an active member of the Organ Procurement and Transplant Network (OPTN) and abide by its approved rules. The facility must also have an agreement with an Organ Procurement Organization (OPO).~~
- ~~b) The facility must make available, either directly or by specified arrangements, all laboratory services needed to meet the needs of transplant candidates/recipients.~~
- ~~c) The facility must agree to maintain and, when requested, periodically submit clinical data, including pre-certification, concurrent review, and other requested information to Medicaid or to the UM/QIO.~~

A. The Division of Medicaid allows fundraisers to obtain funds needed for transplant costs not covered by the Medicaid program.

B. Fundraising criteria includes, but is not limited to, the following:

1. Prior to accepting donations, arrangements must be made with the Division of Medicaid to deposit donations in a trust fund/special account.
2. The trust fund/special account must be established and administered in compliance with all applicable federal and state rules and regulations.
3. The trust fund/special account must be managed and administered by someone other than the beneficiary or the beneficiary's guardian, legal representative or family member. The

beneficiary or the beneficiary's guardian, legal representative or family member cannot have direct access to the trust fund/special account.

4. Trust fund/special account must be maintained separately from personal monies belonging to the beneficiary or the beneficiary's guardian, legal representative or family member.
5. Legible documentation of income and expenditures made available to a Utilization Management/Quality Improvement Organization (UM/QIO), the Division of Medicaid, or designated entity upon request.
6. The beneficiary must report all sources of income to the Division of Medicaid. Donated funds for the purpose of payment of medical services are considered a third party source.
7. Transplant facilities/providers cannot participate in fundraising for beneficiaries to raise additional funds to pay for the transplant procedure and/or related services.

Source: 42 CFR §§ 121, 482.90—482.104, 482.12; 42 U.S.C. § 1396p; Miss. Code Ann. § 43-13-121.

History: Revised to correspond with SPA 15-018 (eff. 12/01/2015) eff. 01/01/2017; Revised eff.- 10/01/2012.

#### *Rule 4.6: Documentation Requirements*

Providers of transplant services must document and maintain records in accordance with requirements set forth in Miss. Admin. Code Part 200, Chapter 1, Rule 1.3: Medicaid requires at a minimum, transplant medical record documentation must contain the following on each beneficiary receiving a transplant and must include the following:

- A. Comprehensive history and physical.
- B. Treatments rendered that were unable to prevent progressive disability and/or death.
- C. Use of tobacco, alcohol, and/or illegal drugs ~~currently or~~ within the last six (6) months.
- D. Absence of severe and irreversible organ dysfunction in organ(s) other than the organ(s) being transplanted.
- E. Relevant diagnostic studies and results ~~(ex: including, but not limited to:~~
  1. X-rays,
  2. Lab reports,
  3. EKG reports,

- 4. ~~p~~Pulmonary function studies,
- 5. ~~p~~Psychosocial reports,
- 6. ~~n~~Nutritional evaluation, and
- 7. ~~p~~Performance status, ~~) and the results of the studies.~~

F. Reports, consults or other documentation to substantiate the transplant including documentation of transplant approval by the ~~center~~ facility's transplant review team.

G. Copy of ~~signed~~ informed consent form signed by the beneficiary and/or guardian or legal representative.

Source: 42 C.F.R. § 482.90 -104; Miss. Code Ann. §§ 43-13-1217; 43-13-1178; 43-13-14821.

History: Revised to correspond with SPA 15-018 (eff. 12/01/2015) eff. 01/01/2017.

*Rule 4.7: Reimbursement [Revised and moved to Miss. Admin. Code Part 202, Rule 4.4] Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)*

The Division of Medicaid pays for all medically necessary services for early and periodic screening, diagnosis, and treatment (EPSDT)-eligible beneficiaries in accordance with Miss. Admin. Code Part 223, without regard to service limitations and with prior authorization.

~~All transplants performed in the state of Mississippi are paid under the APR-DRG payment methodology including a policy adjustor.~~

~~B. For transplant services not available in Mississippi, payment for transplant services performed outside of Mississippi is made under the MS APR-DRG payment methodology including a policy adjustor. If access to quality services is unavailable under the MS APR-DRG payment methodology, a case rate may be set.~~

- ~~1. A case rate is set at forty percent (40%) of the sum of billed charges for transplant services as published in the most current *Milliman U.S. Organ and Tissue Transplant Cost Estimates and Discussion*.~~
- ~~2. The *Milliman* categories comprising the sum of billed charges include outpatient services received thirty (30) days pre-transplant, procurement, hospital transplant inpatient admission, physician services during transplant and one hundred eighty (180) days post (transplant) discharge. Outpatient immuno-suppressants and other prescriptions are not included in the case rate.~~
- ~~3. For beneficiaries enrolled in a Coordinated Care Organization (CCO), the CCO is responsible for reimbursement of outpatient services received thirty (30) days pre-~~

~~transplant and one hundred eighty (180) days post (transplant) discharge. These billed charges are not included in the case rate.~~

- ~~4. If the transplant stay exceeds the hospital length of stay published by *Milliman*, an outlier per diem payment will be made for each day that exceeds the hospital length of stay.~~
- ~~5. Reimbursement for transplant services cannot exceed one hundred percent (100%) of the sum of *Milliman's* billed charges for the categories listed in Rule 4.7, B.2 or B.3.~~
- ~~6. Provisions listed in Part 202, Chapter 4, Rule 4.7 apply to Transplant Services on or after October 1, 2012.~~
- ~~7. For transplant services not available in Mississippi and not listed in the most current *Milliman U.S. Organ and Tissue Transplant Cost Estimates and Discussion*, the Division of Medicaid will make payment using the MS APR-DRG payment methodology. If MS APR-DRG payment limits access to care, the Division will reimburse what the domicile state pays for the service. The Division of Medicaid is responsible for payment of transplant services listed in 4.7 B.2. with the CCO responsible for payment of transplant services listed in 4.7 B.3 for beneficiaries enrolled in a CCO.~~

Source: Miss. Code Ann. §§ 43-13-121~~17~~, 43-13-117~~21~~.-(A)(1)(d), 43-13-117 (A)(2)(c), 43-13-117 (A)(1)(e).

History: Renumbered rule eff. 01/01/2017; Revised eff. —01/01/2013; Revised eff. 10/01/2012.

~~*Rule 4.8: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)[Moved to Miss. Admin. Code Part 202, Rule 4.7]*~~

~~The Division of Medicaid pays for all medically necessary services for EPSDT eligible beneficiaries in accordance with Part 223 of this Title, without regard to service limitations and with prior authorization.~~

~~*Rule 4.9: Cornea Transplant [Revised and moved to Miss. Admin. Code Part 202, Rule 4.2]*~~

~~Medicaid covers cornea transplants for all beneficiaries and does not require prior authorization for medical necessity from the UM/QIO.~~

Source: ~~42 CFR § 482.90—104; Miss. Code Ann. § 43-13-121.~~

History: ~~Revised—10/01/2012~~

~~*Rule 4.10: Heart Transplant [Revised and moved to Miss. Admin. Code Part 202, Rule 4.2]*~~

~~A. Prior authorization is required.~~

~~B. Heart transplants are covered when all the following criteria are met:~~

- ~~1. Candidate is less than sixty-six (66) years of age.~~
- ~~2. New York Heart Association (NYHA) Class III or IV on maximal medical therapy.~~
- ~~3. Meets transplanting facility's blood and tissue type compatibility standards.~~
- ~~4. Infections are controlled for at least forty-eight (48) hours prior to transplant.~~
- ~~5. Pulmonary Functions studies of FEV1 of >1.5 liter, PVR of <3 Wood units (if >3, prior to vasodilators, <3 after), Pulmonary artery systolic pressure <65-70 mm Hg.~~
- ~~6. Absence of irreversible and severe end organ dysfunction, such as hepatic, renal, peripheral vascular, or cerebrovascular, as well as, refractory hypertension, or uncontrolled malignancy.~~
- ~~7. All other treatments have been attempted or considered and none will prevent progressive disability and/or death.~~
- ~~8. The candidate and/or legal representative understands the transplant risks and benefits, gives informed consent, and has the capacity and is willing to comply with needed care, including immunosuppressive therapy.~~
- ~~9. The candidate has been approved by the transplant review team.~~
- ~~10. Required serology studies have been completed for HIV, Hepatitis A, B, and C, Cytomegalovirus (CMV), and Varicella.~~
- ~~11. Immunizations have been administered as follows:
  - ~~a) All immunizations for children age two (2) to six (6) are up to date in accordance with the most current recommended childhood immunization schedule developed and endorsed by the Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP),~~
  - ~~b) Hepatitis A, if serology does not indicate immunity,~~
  - ~~c) Hepatitis B, if serology does not indicate immunity,~~
  - ~~d) Pneumococcal, and~~
  - ~~e) Influenza, annually.~~~~
- ~~12. A psychosocial evaluation has been performed for the adult candidate or, if the candidate is a child, for the family, with the following results:~~

- ~~a) Candidate's psychiatric disorders, if present, are being treated,~~
- ~~b) Candidate's social support system has been evaluated and found to be adequate, and~~
- ~~c) Candidate has no previous history of significant non-compliance to medical treatment.~~

~~13. Specific diagnostic inclusion criteria include the following conditions if expected to limit the candidate's survival rate to less than twelve (12) months:~~

- ~~a) Congestive, restrictive, or ischemic cardiomyopathy,~~
- ~~b) Valvular, congenital and other organic heart disease,~~
- ~~c) Recurrent and refractory life-threatening ventricular dysrhythmias, or~~
- ~~d) Refractory severe angina pectoris.~~

~~14. The facility is approved for heart transplants.~~

~~C. Transplants are not covered when the candidate has one (1) of the following:~~

- ~~1. Active chemical dependency, drugs or alcohol, within the preceding six (6) months.~~
- ~~2. Gastrointestinal hemorrhage.~~
- ~~3. Severe and irreversible pulmonary, for instance FEV1 < 1 liter, or other non-cardiac organ dysfunction.~~
- ~~4. Recent or unresolved pulmonary infarction, not embolism.~~
- ~~5. Uncorrectable absence of an essential psychosocial support system.~~
- ~~6. Unmanageable psychiatric disorder felt to significantly compromise compliance with the post-transplant regimen.~~
- ~~7. HIV.~~
- ~~8. Hepatitis B or Hepatitis C.~~
- ~~9. Systemic malignancy.~~

~~Source: 42 CFR § 482.90-104; 52 FR § 10935; Miss. Code Ann. § 43-13-121.~~

~~*Rule 4.11: Heart/Lung Transplant [Revised and moved to Miss. Admin. Code Part 202, Rule 4.2]*~~

~~A. Prior authorization is required.~~

~~B. Heart/lung transplants are covered when the following criteria are met:~~

- ~~1. Candidate is less than fifty six (56) years of age.~~
- ~~2. NYHA Class III or IV with rehabilitation potential.~~
- ~~3. Preserved nutritional state.~~
- ~~4. Meets facility's blood and tissue-type compatibility standards.~~
- ~~5. Infections controlled for at least forty eight (48) hours prior to transplant, unless the infection is limited to the lung to be removed.~~
- ~~6. Absence of irreversible and severe end organ dysfunction, including hepatic, gastrointestinal, renal, peripheral vascular, or cerebrovascular, or uncontrolled malignancy.~~
- ~~7. All other treatments have been attempted or considered and none will prevent progressive disability and/or death.~~
- ~~8. The candidate and/or legal representative understands the transplant risks and benefits, gives informed consent, and has the capacity and is willing to comply with needed care, including immunosuppressive therapy.~~
- ~~9. The candidate has been approved by the center's transplant review team.~~
- ~~10. Required serology studies have been completed for HIV, Hepatitis (A, B, and C), Cytomegalovirus (CMV), and Varicella.~~
- ~~11. Immunizations have been administered as follows:~~
  - ~~a) All immunizations for children age two (2) to six (6) are up to date in accordance with the most current recommended childhood immunization schedule developed and endorsed by the Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP).~~
  - ~~b) Hepatitis A, if serology does not indicate immunity.~~
  - ~~c) Hepatitis B, if serology does not indicate immunity.~~
  - ~~d) Pneumococcal.~~

~~e) Influenza, annually.~~

~~12. A psychosocial evaluation has been performed for the adult candidate or, if the candidate is a child, for the family, with the following results:~~

~~a) Candidate's psychiatric disorders, if present, are being treated.~~

~~b) Candidate's social support system has been evaluated and found to be adequate.~~

~~c) Candidate has no previous history of significant non-compliance to medical treatment.~~

~~13. Specific Diagnostic Inclusion Criteria~~

~~a) End stage fibrotic lung disease unresponsive to alternative therapy with FVC <65% of predicted.~~

~~b) End stage obstructive lung disease with FVC <25% of predicted.~~

~~c) End stage pulmonary hypertension, either primary or secondary—without significant right heart dysfunction, unless heart lung transplant planned.~~

~~d) Cystic fibrosis with FVC <40% and FEV1 <30% of predicted.~~

~~e) Bronchiectasis.~~

~~f) Bronchopulmonary dysplasia.~~

~~g) Obliterative bronchiolitis.~~

~~14. Facility must be approved for heart and lung transplants by Medicaid.~~

~~C. Heart/Lung transplants are not covered when the candidate has one (1) of the following:~~

~~1. Active chemical dependence, drugs or alcohol within the preceding six (6) months;~~

~~2. Steroid therapy >20mg/day, and must be off steroids or weanable from them;~~

~~3. Bone marrow failure of any stem line: RBC, WBC, platelets;~~

~~4. Severe osteoporosis;~~

~~5. Severe chest wall deformity~~

~~6. Cachexia, a body weight <70% of ideal for height, or obesity, body weight >120% of ideal for height, in candidates with Cystic Fibrosis;~~

- ~~7. Recent pulmonary embolism or current deep venous thrombosis,~~
- ~~8. Viral hepatitis, in candidates with Cystic Fibrosis,~~
- ~~9. HIV,~~
- ~~10. Uncorrectable absence of an essential psychosocial support system, or~~
- ~~11. Unmanageable psychiatric disorder felt to significantly compromise compliance with the post-transplant regimen.~~

~~Source: 42 CFR § 482.90—104; Miss. Code Ann. § 43-13-121.~~

~~*Rule 4.12: Kidney Transplant [Revised and moved to Miss. Admin. Code Part 202, Rule 4.2]*~~

~~Medicaid covers kidney transplants for all beneficiaries and does not require prior authorization for medical necessity from the UM/QIO.~~

~~Source: 42 CFR § 482.90—104; Miss. Code Ann. § 43-13-121.~~

~~History: Revised 10/01/2012~~

~~*Rule 4.13: Liver Transplant [Revised and moved to Miss. Admin. Code Part 202, Rule 4.2]*~~

~~A. Prior authorization is required.~~

~~B. Liver transplants are covered when the following criteria are met:~~

- ~~1. Candidate is less than sixty five (65) years of age.~~
- ~~2. Model for End Stage Liver Disease (MELD) score.~~
- ~~3. Pediatric End Stage Liver Disease (PELD) score.~~
- ~~4. Meets transplant facility's blood and tissue-type compatibility standards.~~
- ~~5. Infection controlled for at least forty eight (48) hours prior to transplant.~~
- ~~6. Absence of severe and irreversible end organ dysfunction, either cardiac, pulmonary, renal, peripheral vascular, or cerebrovascular, or uncontrolled extrahepatic malignancy.~~
- ~~7. All other treatments have been attempted or considered and none will prevent progressive disability and/or death.~~
- ~~8. The candidate and/or legal representative understands the transplant risks and benefits,~~

~~gives informed consent, and has the capacity and is willing to comply with needed care, including immunosuppressive therapy.~~

~~9. The candidate has been approved by the transplant review team.~~

~~10. Required serology studies have been completed for HIV, Hepatitis A, B, and C, Cytomegalovirus (CMV), and Varicella.~~

~~11. Immunizations have been administered as follows:~~

~~a) All immunizations for children age two (2) to six (6) are up to date in accordance with the most current recommended childhood immunization schedule developed and endorsed by the Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP);~~

~~b) Hepatitis A, if serology does not indicate immunity,~~

~~c) Hepatitis B, if serology does not indicate immunity,~~

~~d) Pneumococcal, and~~

~~e) Influenza, annually.~~

~~12. A psychosocial evaluation has been performed for the adult candidate or, if the candidate is a child, for the family, with the following results:~~

~~a) Candidate's psychiatric disorders, if present, are being treated.~~

~~b) Candidate's social support system has been evaluated and found to be adequate.~~

~~c) Candidate has no previous history of significant non-compliance to medical treatment.~~

~~13. Specific Diagnostic Inclusion Criteria~~

~~a) Chronic progressive liver disease, not otherwise correctable, including cirrhosis due to: alcoholism, if abstinent at least the prior six (6) months, chronic hepatitis C, primary or secondary biliary disease, sclerosing cholangitis, inborn error of metabolism, or other causes.~~

~~b) Non-cirrhotic liver failure due to: biliary atresia, fulminant liver failure, submassive hepatic necrosis, hepatoblastoma, Budd-Chiari syndrome, an obstruction of the hepatic veins if associated with a treatable disorder.~~

~~c) Hepatocellular carcinoma, in conjunction with chemotherapy, if there is no evidence~~

~~of extrahepatic metastases.~~

~~14. Facility is approved for liver transplants by the Division of Medicaid.~~

~~B. Liver transplants are not covered when the candidate has one (1) of the following.~~

~~1. Active chemical dependency, drugs or alcohol within the preceding six (6) months.~~

~~2. Acute alcoholic hepatitis.~~

~~3. Uncorrectable hemodynamic instability.~~

~~4. Extensive and uncorrectable portal vein thrombosis precluding portal inflow to graft.~~

~~5. Extrahepatic malignancy or hepatic malignancy with extrahepatic metastases.~~

~~6. Severe terminal diabetic and organ disease.~~

~~7. HIV.~~

~~8. Uncorrectable absence of an essential psychosocial support system.~~

~~9. Unmanageable psychiatric disorder felt to significantly compromise compliance with the post transplant regimen.~~

~~Source: 42 CFR § 482.90—104; 56 FR 15006; Miss. Code Ann. § 43-13-121.~~

~~*Rule 4.14: Single Lung Transplant [Revised and moved to Miss. Admin. Code Part 202, Rule 4.2]*~~

~~A. Prior authorization is required.~~

~~B. Single lung transplants are covered when the following criteria are met:~~

~~1. Candidate is less than sixty-six (66) years of age.~~

~~2. NYHA Class III or IV with rehabilitation potential.~~

~~3. Preserved nutritional state.~~

~~4. Meets facility's blood and tissue type compatibility standards.~~

~~5. Infections controlled for at least forty-eight (48) hours prior to transplant, unless the infection is limited to the lung to be removed.~~

~~6. Absence of irreversible and severe end organ dysfunction, either hepatic, gastrointestinal,~~

~~renal, peripheral vascular, or cerebrovascular, or uncontrolled malignancy~~

- ~~7. All other treatments have been attempted or considered and none will prevent progressive disability and/or death.~~
- ~~8. The candidate and/or legal representative understands the transplant risks and benefits, gives informed consent, and has the capacity and is willing to comply with needed care, including immunosuppressive therapy.~~
- ~~9. The candidate has been approved by the center's transplant review team.~~
- ~~10. Required serology studies have been completed for HIV, Hepatitis A, B, and C, Cytomegalovirus (CMV), and Varicella.~~
- ~~11. Immunizations have been administered as follows:
  - ~~a) All immunizations for children age two (2) to six (6) are up to date in accordance with the most current recommended childhood immunization schedule developed and endorsed by the Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP)~~
  - ~~b) Hepatitis A, if serology does not indicate immunity.~~
  - ~~c) Hepatitis B, if serology does not indicate immunity.~~
  - ~~d) Pneumococcal.~~
  - ~~e) Influenza, annually~~~~
- ~~12. A psychosocial evaluation has been performed for the adult candidate or, if the candidate is a child, for the family, with the following results:
  - ~~a) Candidate's psychiatric disorders, if present, are being treated.~~
  - ~~b) Candidate's social support system has been evaluated and found to be adequate.~~
  - ~~c) Candidate has no previous history of significant non-compliance to medical treatment.~~~~
- ~~13. Specific Diagnostic Inclusion Criteria
  - ~~a) End stage fibrotic lung disease unresponsive to alternative therapy with FVC <65% of predicted.~~
  - ~~b) End stage obstructive lung disease with FVC <25% of predicted.~~~~

~~e) End stage pulmonary hypertension, either primary or secondary — without significant right heart dysfunction, unless heart lung transplant planned.~~

~~d) Cystic fibrosis with FVC <40% and FEV1 <30% of predicted.~~

~~e) Bronchiectasis.~~

~~f) Bronchopulmonary dysplasia.~~

~~g) Obliterative bronchiolitis.~~

~~14. Facility must be approved for lung transplants by the Division of Medicaid.~~

~~C. Single lung transplants are not covered when the candidate has one (1) of the following:~~

~~1. Active chemical dependence, drugs or alcohol, within the preceding six (6) months.~~

~~2. Steroid therapy >20mg/day, must be off steroids or weanable from them.~~

~~3. Bone marrow failure of any stem line: RBC, WBC, platelets.~~

~~4. Severe osteoporosis.~~

~~5. Severe chest wall deformity.~~

~~6. Cachexia, body weight <70% of ideal for height, or obesity, body weight >120% of ideal for height, in candidates with Cystic Fibrosis~~

~~7. Recent pulmonary embolism or current deep venous thrombosis.~~

~~8. Viral hepatitis in candidates with Cystic Fibrosis.~~

~~9. HIV.~~

~~10. Uncorrectable absence of an essential psychosocial support system.~~

~~11. Unmanageable psychiatric disorder felt to significantly compromise compliance with the post transplant regimen.~~

~~Source: 42 CFR § 482.90 — 104; Miss. Code Ann. § 43-13-121.~~

~~*Rule 4.15: Bilateral Lung Transplant [Revised and moved to Miss. Admin. Code Part 202, Rule 4.2]*~~

~~A. Prior Authorization is required.~~

~~B. Bilateral lung transplants are covered when the following criteria are met:~~

- ~~1. Candidate is less than sixty one (61) years of age.~~
- ~~2. NYHA Class III or IV with rehabilitation potential.~~
- ~~3. Preserved nutritional state.~~
- ~~4. Meets facility's blood and tissue type compatibility standards.~~
- ~~5. Infections controlled for at least forty eight (48) hours prior to transplant, unless the infection is limited to the lung to be removed.~~
- ~~6. Absence of irreversible and severe end organ dysfunction, either hepatic, gastrointestinal, renal, peripheral vascular, or cerebrovascular), or uncontrolled malignancy.~~
- ~~7. All other treatments have been attempted or considered and none will prevent progressive disability and/or death.~~
- ~~8. The candidate and/or legal representative understands the transplant risks and benefits, gives informed consent, and has the capacity and is willing to comply with needed care, including immunosuppressive therapy.~~
- ~~9. The candidate has been approved by the center's transplant review team.~~
- ~~10. Required serology studies have been completed for HIV, Hepatitis (A, B, and C), Cytomegalovirus (CMV), and Varicella.~~
- ~~11. Immunizations have been administered as follows:~~
  - ~~a) All immunizations for children age two (2) to six (6) are up to date in accordance with the most current recommended childhood immunization schedule developed and endorsed by the Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP).~~
  - ~~b) Hepatitis A, if serology does not indicate immunity.~~
  - ~~c) Hepatitis B, if serology does not indicate immunity.~~
  - ~~d) Pneumococcal.~~
  - ~~e) Influenza, annually.~~
- ~~12. A psychosocial evaluation has been performed for the adult candidate or, if the candidate~~

is a child, for the family, with the following results:

- a) ~~Candidate's psychiatric disorders, if present, are being treated.~~
- b) ~~Candidate's social support system has been evaluated and found to be adequate.~~
- c) ~~Candidate has no previous history of significant non-compliance to medical treatment.~~

~~13. Specific Diagnostic Inclusion Criteria:~~

- a) ~~End stage fibrotic lung disease unresponsive to alternative therapy with FVC <65% of predicted.~~
- b) ~~End stage obstructive lung disease with FVC <25% of predicted.~~
- c) ~~End stage pulmonary hypertension, either primary or secondary without significant right heart dysfunction, unless heart lung transplant planned~~
- d) ~~Cystic fibrosis with FVC <40% and FEV1 <30% of predicted.~~
- e) ~~Bronchiectasis.~~
- f) ~~Bronchopulmonary dysplasia.~~
- g) ~~Obliterative bronchiolitis.~~

~~14. Facility is approved for lung transplants by Medicaid.~~

~~C. Bilateral lung transplants are not covered when the candidate has one of the following:~~

- 1. ~~Active chemical dependence, drugs or alcohol within the preceding six (6) months.~~
- 2. ~~Steroid therapy >20mg/day, must be off steroids or weanable from them.~~
- 3. ~~Bone marrow failure of any stem line: RBC, WBC, platelets.~~
- 4. ~~Severe osteoporosis.~~
- 5. ~~Severe chest wall deformity~~
- 6. ~~Cachexia, body weight <70% of ideal for height, or obesity, body weight >120% of ideal for height, in candidates with Cystic Fibrosis.~~
- 7. ~~Recent pulmonary embolism or current deep venous thrombosis.~~

~~8. Viral hepatitis in candidates with Cystic Fibrosis.~~

~~9. HIV.~~

~~10. Uncorrectable absence of an essential psychosocial support system.~~

~~11. Unmanageable psychiatric disorder felt to significantly compromise compliance with the post transplant regimen.~~

~~Source: 42 CFR 482.90-104; Miss. Code Ann. § 43-13-121.~~

~~*Rule 4.16: Bone Marrow Transplant [Revised and moved to Miss. Admin. Code Part 202, Rule 4.21]*~~

~~A. Medicaid covers bone marrow transplants as noted below and does not require prior authorization for medical necessity from the UM/QIO.~~

~~B. Bone marrow transplants (BMT), Autologous, Syngeneic, or Allogeneic, are covered for inpatient and outpatient when the following criteria are met:~~

~~1. Candidate is less than fifty-six (56) years of age for allogeneic, < sixty-six (66) if fully matched sibling donor.~~

~~2. Candidate is less than seventy (70) years of age for autologous.~~

~~3. Karnofsky >70 or ECOG <3.~~

~~4. Allogeneic HLA MLC match, 1 antigen mismatch accepted.~~

~~5. Infections controlled for forty-eight (48) hours prior to transplant.~~

~~6. Left ventricular ejection fraction >40%.~~

~~7. FEV1 of >50% of predicted.~~

~~8. Dlco >60% of predicted.~~

~~9. All other treatments have been attempted or considered and none will prevent progressive disability and/or death.~~

~~10. The candidate and/or legal representative understands the transplant risks and benefits, gives informed consent, and has the capacity and is willing to comply with needed care, including immunosuppressive therapy.~~

~~11. The candidate has been approved by the transplant review team.~~

- ~~12. The candidate's immunization history and HIV status has been obtained.~~
- ~~13. A psychosocial evaluation has been performed for the adult candidate or, if the candidate is a child, for the family, with the following results:~~
- ~~a) Candidate's psychiatric disorders, if present, are being treated.~~
  - ~~b) Candidate's social support system has been evaluated and found to be adequate.~~
  - ~~c) Candidate has no previous history of significant non-compliance to medical treatment.~~
- ~~14. Specific Diagnostic Inclusion Criteria (Allogeneic BMT or PSCT)~~
- ~~a) Severe aplastic anemia.~~
  - ~~b) Pure erythrocyte aplasia.~~
  - ~~c) Myelodysplasia.~~
  - ~~d) Severe hemoglobinopathy, including sickle cell, thalassemia.~~
  - ~~e) Selected immunodeficiency syndrome including SCID, Wiskott Aldrich, Chediak-Higashi~~
  - ~~f) Genetic storage disease, including Hurler's, Morquio's.~~
  - ~~g) Primary amyloidosis.~~
  - ~~h) Paroxysmal nocturnal hemoglobinuria.~~
  - ~~i) Severe platelet dysplasia.~~
  - ~~j) Acute lymphocytic leukemia, in first remission if high risk, at early relapse, or in second remission.~~
  - ~~k) Acute myelogenous leukemia, in same clinical states as listed for acute lymphocytic leukemia.~~
  - ~~l) Chronic lymphocytic leukemia.~~
  - ~~m) Chronic myelogenous leukemia.~~
  - ~~n) Hodgkin's lymphoma, failed first line therapy or failed at least one standard chemotherapy regimen.~~

- ~~o) Non-Hodgkin's lymphoma failed or responsive to first line therapy or high risk during first remission.~~
- ~~p) Familial hemophagocytic lymphohistiocytosis (FHL) also known as familial erythrophagocytic.~~
- ~~q) Lymphohistiocytosis (FEL).~~

~~15. Specific Diagnostic Inclusion Criteria (Autologous BMT or PSCT)~~

- ~~a) Acute lymphocytic leukemia in first remission if high risk, at early relapse, or in second remission.~~
- ~~b) Acute myelogenous leukemia in same clinical states as listed for acute lymphocytic leukemia.~~
- ~~c) Chronic lymphocytic leukemia.~~
- ~~d) Chronic myelogenous leukemia.~~
- ~~e) Hodgkin's lymphoma, for failed first line therapy or if failed at least one standard chemotherapy regimen.~~
- ~~f) Multiple Myeloma a single autologous BMT/SCT transplant will be considered for beneficiaries with Durie Salmon stage II or stage III disease if the following criteria is met. Newly diagnosed disease or responsive multiple myeloma. This includes beneficiaries with previously untreated disease, those with at least a partial response to prior chemotherapy, which is defined as 50% decrease in either measurable serum and/or urine paraprotein or in bone marrow infiltration, sustained for at least one (1) month, and those in responsive relapse with adequate renal, pulmonary, and hepatic function.~~

~~16. Tandem BMT/SCT for multiple myeloma is specifically excluded from coverage.~~

- ~~a) Non-Hodgkin's lymphoma, either failed or responsive to first line therapy or, if high risk, during first remission~~
- ~~b) Neuroblastoma.~~
- ~~c) Nephroblastoma.~~

~~17. Transplant facilities must meet Medicaid facility criteria.~~

~~C. Bone marrow transplants are not covered if the candidate has one (1) of the following:~~

- ~~1. Active chemical dependency, drugs or alcohol, within the preceding six (6) months~~

- ~~2. HIV.~~
- ~~3. Breast cancer.~~
- ~~4. Uncorrectable absence of an essential psychosocial support system.~~
- ~~5. Unmanageable psychiatric disorder felt to significantly compromise the candidate's compliance with the post transplant regimen.~~

~~Source: 42 CFR § 482.90-104; Miss. Code Ann. § 43-13-121.~~

~~History: Revised 10/01/2012~~

~~*Rule 4.17: Peripheral Stem Cell Transplant [Revised and moved to Miss. Admin. Code Part 202, Rule 4.2]*~~

~~A. No prior authorization is required.~~

~~B. Peripheral Hematopoietic Stem Cell Transplants (PSCT), Autologous, Syngeneic, or Allogeneic, are covered for inpatient and outpatient when the following criteria are met:~~

- ~~1. Candidate is less than fifty six (56) years of age for allogeneic, < sixty six (66) if fully matched sibling donor.~~
- ~~2. Candidate is less than seventy (70) years of age for autologous.~~
- ~~3. Karnofsky >70 or ECOG <3.~~
- ~~4. Allogeneic HLA-MLC match, 1 antigen mismatch accepted.~~
- ~~5. Infections controlled for forty eight (48) hours prior to transplant.~~
- ~~6. Left ventricular ejection fraction >40%.~~
- ~~7. FEV1 of >50% of predicted.~~
- ~~8. Dleo >60% of predicted.~~
- ~~9. All other treatments have been attempted or considered and none will prevent progressive disability and/or death.~~
- ~~10. The candidate and/or legal representative understands the transplant risks and benefits, gives informed consent, and has the capacity and is willing to comply with needed care, including immunosuppressive therapy.~~

- ~~11. The candidate has been approved by the transplant review team.~~
- ~~12. The candidate's immunization history and HIV status has been obtained.~~
- ~~13. A psychosocial evaluation has been performed for the adult candidate or, if the candidate is a child, for the family, with the following results:
  - ~~a) Candidate's psychiatric disorders, if present, are being treated.~~
  - ~~b) Candidate's social support system has been evaluated and found to be adequate.~~
  - ~~c) Candidate has no previous history of significant non-compliance to medical treatment.~~~~
- ~~14. Specific Diagnostic Inclusion Criteria (Allogeneic PSCT)
  - ~~a) Severe aplastic anemia.~~
  - ~~b) Pure erythrocyte aplasia.~~
  - ~~c) Myelodysplasia.~~
  - ~~d) Severe hemoglobinopathy, including sickle cell, thalassemia.~~
  - ~~e) Selected immunodeficiency syndrome, including SCID, Wiskott-Aldrich, Chediak-Higashi.~~
  - ~~f) Genetic storage disease, including Hurler's, Morquio's.~~
  - ~~g) Primary amyloidosis.~~
  - ~~h) Paroxysmal nocturnal hemoglobinuria.~~
  - ~~i) Severe platelet dysplasia.~~
  - ~~j) Acute lymphocytic leukemia, in first remission if high risk, at early relapse, or in second remission.~~
  - ~~k) Acute myelogenous leukemia, in same clinical states as listed for acute lymphocytic leukemia.~~
  - ~~l) Chronic lymphocytic leukemia.~~
  - ~~m) Chronic myelogenous leukemia.~~
  - ~~n) Hodgkin's lymphoma, failed first line therapy or failed at least one standard~~~~

~~chemotherapy regimen.~~

- ~~o) Non Hodgkin's lymphoma, failed or responsive to first line therapy or high risk during first remission.~~
- ~~p) Familial hemophagocytic lymphohistiocytosis (FHL) also known as familial erythrophagocytic.~~
- ~~q) Lymphohistiocytosis (FEL).~~

~~15. Specific Diagnostic Inclusion Criteria (Autologous PSCT).~~

- ~~a) Acute lymphocytic leukemia, in first remission if high risk, at early relapse, or in second remission.~~
- ~~b) Acute myelogenous leukemia, in same clinical states as listed for acute lymphocytic leukemia.~~
- ~~c) Chronic lymphocytic leukemia.~~
- ~~d) Chronic myelogenous leukemia.~~
- ~~e) Hodgkin's lymphoma, for failed first line therapy or if failed at least one standard chemotherapy regimen.~~
- ~~f) Multiple Myeloma single autologous BMT/SCT transplant will be considered for beneficiaries with Durie Salmon stage II or stage III disease if this is a newly diagnosed disease or responsive multiple myeloma. This includes beneficiaries with previously untreated disease, those with at least a partial response to prior chemotherapy which is defined as 50% decrease in either measurable serum and/or urine paraprotein or in bone marrow infiltration, sustained for at least one (1) month, and those in responsive relapse with adequate renal, pulmonary, and hepatic function.~~
- ~~g) Recurrent solid tumors.~~

~~16. Tandem BMT/SCT for multiple myeloma is specifically excluded from coverage.~~

- ~~a) Non Hodgkin's lymphoma, either failed or responsive to first line therapy or, if high risk, during first remission.~~
- ~~b) Neuroblastoma.~~
- ~~c) Nephroblastoma.~~

~~17. Transplant facilities must meet Medicaid facility criteria.~~

~~C. Peripheral stem cell transplants are not covered when the candidate has one of the following:~~

- ~~1. Active chemical dependency, drugs or alcohol, within the preceding six (6) months.~~
- ~~2. HIV.~~
- ~~3. Breast cancer.~~
- ~~4. Uncorrectable absence of an essential psychosocial support system.~~
- ~~5. Unmanageable psychiatric disorder felt to significantly compromise the candidate's compliance with the post-transplant regimen.~~

~~Source: 42 CFR § 482.90-104; Miss. Code Ann. § 43-13-121.~~

~~History: Revised 04/01/2013, 10/01/2012~~

~~*Rule 4.18: Small Bowel Transplant [Revised and moved to Miss. Admin. Code Part 202, Rule 4.2]*~~

~~A. Prior authorization is required.~~

~~B. Medicaid covers small bowel transplants meeting the following criteria for small bowel (or intestinal) transplantation, whether performed as a solitary procedure (SBT); or performed in conjunction with liver (SB/LT); or with stomach, duodenum, and pancreas, with or without liver (SB/MVT) transplantation:~~

- ~~1. The loss or absence of sufficient absorptive capacity of the intestinal tract to support life; and~~
- ~~2. The demonstrated failure of total parenteral nutrition (TPN).~~

~~C. Concomitant liver or multivisceral transplantation can only be medically justified by documentation of severe and irreversible damage to the individual organ(s) to be replaced. Concomitant live or multivisceral transplants must meet the following criteria:~~

- ~~1. Candidate is less than sixty five (65) years of age.~~
- ~~2. Meets transplanting facility blood and tissue type compatibility standards.~~
- ~~3. Infections controlled for at least forty eight (48) hours prior to transplant~~
- ~~4. Absence of severe and irreversible end organ dysfunction, to include cardiac, central nervous system, pulmonary, renal, peripheral vascular or cerebrovascular.~~
- ~~5. All other treatments have been attempted or considered and none will prevent progressive~~

~~disability and/or death.~~

- ~~6. The candidate and/or legal representative understands the transplant risks and benefits, gives informed consent, and has the capacity and is willing to comply with needed care, including immunosuppressive therapy.~~
- ~~7. The candidate has been approved by the transplant review team.~~
- ~~8. Required serology studies have been completed for HIV, Hepatitis A, B, and C, Cytomegalovirus (CMV), and Varicella.~~
- ~~9. Immunizations have been administered as follows:
  - ~~a) All immunizations for children age two (2) to six (6) are up to date in accordance with the most current recommended childhood immunization schedule developed and endorsed by the Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP).~~
  - ~~b) Hepatitis A, if serology does not indicate immunity.~~
  - ~~c) Hepatitis B, if serology does not indicate immunity.~~
  - ~~d) Pneumococcal.~~
  - ~~e) Influenza, annually.~~~~
- ~~10. A psychosocial evaluation has been performed for the adult candidate or, if the candidate is a child, for the family, with the following results:
  - ~~a) Candidate's psychiatric disorders, if present, are being treated.~~
  - ~~b) Candidate's social support system has been evaluated and found to be adequate.~~
  - ~~c) Candidate has no previous history of significant non-compliance to medical treatment.~~~~
- ~~11. Specific Diagnostic Inclusion Criteria
  - ~~a) Severe and irreversible intestinal insufficiency, congenital or acquired, including, but not limited to the following causes:
    - ~~1) Intestinal atresia.~~
    - ~~2) Splanchnic vascular occlusive disease.~~~~~~

- ~~3) Gastroschisis.~~
- ~~4) Inflammatory bowel disease.~~
- ~~5) Microvillus involution disease, intractable diarrhea of infancy.~~
- ~~6) Post-traumatic, including surgical short bowel syndrome.~~
- ~~7) Volvulus.~~
- ~~8) Necrotizing enterocolitis.~~
- ~~9) Chronic intestinal pseudo-obstruction.~~
- ~~10) Radiation enteritis.~~

~~b) Failure of Total Parenteral Nutrition (TPN) as documented by:~~

- ~~1) Overt or impending liver failure due to TPN induced hepatic injury,~~
- ~~2) Thrombosis of two or more central venous channels: jugular, subclavian, femoral,~~
- ~~3) Two or more episodes of TPN catheter induced sepsis in a year or a single episode of line related fungemia, or~~
- ~~4) Frequent episodes of dehydration due to uncontrollable and high volume loss of fluids through the gastrointestinal tract.~~

~~12. Facility is approved for small bowel transplants by Medicaid.~~

~~D. Small bowel transplants are not covered when the candidate has one (1) of the following:~~

- ~~1. Active chemical dependency, drugs or alcohol within the preceding six (6) months.~~
- ~~2. Profound and progressive neurological dysfunction, like Tay Sachs.~~
- ~~3. Non-correctable non-gastrointestinal disease with a lethal prognosis.~~
- ~~4. Congenital immunodeficiency syndrome.~~
- ~~5. Active tuberculosis or active sepsis.~~
- ~~6. Uncorrectable absence of an essential psychosocial support system.~~
- ~~7. Unmanageable psychiatric disorder felt to significantly compromise compliance with the post-transplant regimen.~~

~~8. HIV.~~

~~9. Systemic malignancy.~~

~~Source: 42 CFR § 482.90-104; Miss. Code Ann. § 43-13-121.~~