Clinical Review Criteria
Kidney/Pancreas Transplant

NOTICE: Kaiser Foundation Health Plan of Washington and Kaiser Foundation Health Plan of Washington Options, Inc., provide these Clinical Review Criteria for internal use by their members and health care providers. The Clinical Review Criteria only apply to Kaiser Foundation Health Plan of Washington and Kaiser Foundation Health Plan of Washington Options, Inc. Use of the Clinical Review Criteria or any Kaiser Permanente entity name, logo, trade name, trademark, or service mark for marketing or publicity purposes, including on any website, or in any press release or promotional material, is strictly prohibited.

Kaiser Permanente Clinical Review Criteria are developed to assist in administering plan benefits. These criteria neither offer medical advice nor guarantee coverage. Kaiser Permanente reserves the exclusive right to modify, revoke, suspend or change any or all of these Review Criteria, at Kaiser Permanente’s sole discretion, at any time, with or without notice. Member contracts differ in their benefits. Always consult the patient’s Medical Coverage Agreement or call Kaiser Permanente Customer Service to determine coverage for a specific medical service.

Criteria
For Medicare Members

<table>
<thead>
<tr>
<th>Source</th>
<th>Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Coverage Determinations (NCD)</td>
<td>Pancreas Transplants (260.3)</td>
</tr>
<tr>
<td>Local Coverage Determinations (LCD)</td>
<td>None</td>
</tr>
</tbody>
</table>

For Non-Medicare Members
Kaiser Permanente has elected to use the Renal Transplant (S-1015) MCG* for medical necessity determinations.

* MCG are proprietary and cannot be published and/or distributed. However, on an individual member basis, Kaiser Permanente can share a copy of the specific criteria document used to make a utilization management decision. If one of your patients is being reviewed using these criteria, you may request a copy of the criteria by calling the Kaiser Permanente Clinical Review staff at 1-800-289-1363.

If requesting this service, please send the following documentation to support medical necessity:
• Copy of final summary report from multidisciplinary transplant team

The following information was used in the development of this document and is provided as background only. It is not to be used as coverage criteria. Please only refer to the criteria listed above for coverage determinations.

Background
This service is covered when it is medically necessary and identified as a benefit in the consumer’s coverage contract. The Kaiser Permanente Nephrologists in collaboration with the GHC Transplant Committee and the Transplant Centers define the Kaiser Permanente patient selection criteria.

Evidence and Source Documents
Kaiser Permanente Committee on Emerging Technology
Transplant, simultaneous Pancreas/Kidney (SPK) - 7/11/1990
Simultaneous pancreas/kidney transplantation is approved for diabetic patients who otherwise would be candidates for a kidney transplant, subject to review in six months.

The University of Washington transplant criteria set are used as a source document and updated when new efficacy data becomes available by the GHC Nephrology section with approval by the GHC Transplant Committee.
**Codes**

**CPT**

Kidney: 50300, 50320, 50323, 50325, 50327, 50328, 50329, 50340, 50360, 50365, 50370, 50547

Pancreas: 48550, 48551, 48552, 48554, 48556, 48550, 48551, 48552, S2065