Molina Clinical Policy
Kidney Transplantation
Policy No. 045

Last Approval: 06/10/2026
Next Review Due By: June 2027

DISCLAIMER

This Molina Clinical Policy (MCP) is intended to facilitate the Utilization Management process. Policies are not a supplementation or recommendation for treatment; Providers are solely responsible for the diagnosis, treatment, and clinical recommendations for the Member. It expresses Molina's determination as to whether certain services or supplies are medically necessary, experimental, investigational, or cosmetic for purposes of determining appropriateness of payment. The conclusion that a particular service or supply is medically necessary does not constitute a representation or warranty that this service or supply is covered (e.g., will be paid for by Molina) for a particular Member. The Member's benefit plan determines coverage – each benefit plan defines which services are covered, which are excluded, and which are subject to dollar caps or other limits. Members and their Providers will need to consult the Member's benefit plan to determine if there are any exclusion(s) or other benefit limitations applicable to this service or supply. If there is a discrepancy between this policy and a Member's plan of benefits, the benefits plan will govern. In addition, coverage may be mandated by applicable legal requirements of a State, the Federal government or CMS for Medicare and Medicaid Members. CMS's Coverage Database can be found on the CMS website. The coverage directive(s) and criteria from an existing National Coverage Determination (NCD) or Local Coverage Determination (LCD) will supersede the contents of this MCP and provide the directive for all Medicare members. References included were accurate at the time of policy approval and publication.

OVERVIEW

End Stage Renal Disease (ESRD) is the irreversible final stage of chronic kidney disease (CKD), characterized by the kidney's inability to function adequately (Hashmi et al. 2025). Chronic kidney disease (CKD) is defined as abnormalities of kidney structure or function, present for at least three months, with implications for health. . The most common causes of CKD in adults include diabetes mellitus, hypertension, and glomerulonephritis. In children, congenital abnormalities of the kidney and urinary tract and glomerular disease are predominant causes. Children with CKD have an increased lifetime risk of disease progression and experience significant morbidity, particularly when CKD is advanced at presentation. CKD is staged based on estimated glomerular filtration rate (GFR) and urinary albumin to creatinine ratio. CKD and ESRD are accompanied by many complications that severely impact quality of life and lead to premature mortality. Treatments of CKD and ESRD include medications, dietary modifications, dialysis, and solid organ transplant (KDIGO 2024).

Kidney Transplant is the preferred treatment for ESRD, offering improved survival and quality of life compared to dialysis. In 2023, there were 28,142 kidney transplants performed in the United States. During that same year, 36.661 adults were actively listed for kidney transplant while more than 141,886 adults were on the waitlist at any point during the year. (Lentine et al. 2025). Five-year graft survival varies by donor type and recipient characteristics. For example, among adults aged 63 or older, 5-year graft survival was 80.2% for living donor kidney transplants and 66.1% for deceased donor kidney transplants. Five-year graft survival rates were 90.0% for live donor kidney transplants and 82.2% for deceased donor kidney transplants in recipients aged 18-24 years. Transplant candidates who have no known contraindications should be referred to a transplantation program when the estimated GFR is <30 mL / min /1.73 m^2, as an early referral allows time for assessment and preparation. (Lentine et al. 2025).

Kidney Transplant Allocation Process

Currently transplant candidates are assessed via a complex system of scores that signal health status, estimated medical urgency, time to hospital, registry waiting time, and more. All registrants are assigned a kidney allocation score which signals health condition and medical need based on a variety of factors, such as GFR, dialysis duration, co-morbidities, and more. Adults are assigned an Estimated Post Transplant Survival score ([1]OPTN 2025).

The United Network for Organ Sharing (UNOS) is currently transitioning to a continuous distribution framework, which assigns a composite allocation score based on multiple attributes, including medical urgency, post-transplant survival, biological disadvantages, patient access, and placement efficiency. This approach aims to enhance equity and efficiency in organ allocation ([2]OPTN 2025).

RELATED POLICIES

MCP-459: Pre-Transplant and Transplant Evaluation
MCP-017: Pancreas Transplantation
MCP-114: Liver Transplantation

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COVERAGE POLICY

All transplants require prior authorization from the Corporate Transplant Department. Solid organ transplant requests will be reviewed by the Corporate Senior Medical Director or qualified clinical designee. All other transplants will be reviewed by the Corporate Senior Medical Director or covering Medical Director. If the criteria are met using appropriate NCD and/or LCD guidelines, State regulations, and/or MCP policies the Corporate Senior Medical Director's designee can approve the requested transplant.

Office visits with participating Providers do NOT require prior authorization. Providers should see the Member in office visits as soon as possible and without delay. Failure to see the Member in office visits may be considered a serious quality of care concern.

Please see *MCP-459 Pre-Transplant and Transplant Evaluations* for pre-transplant criteria and transplant evaluation criteria that must be met prior to solid organ transplant.

Adult and Pediatric Criteria for Kidney Transplantation

Kidney organ transplantation from a deceased or a living donor is **considered medically necessary** in adult and pediatric Members that have met ALL the following criteria:

1. ALL MCP 459 pre-transplant and transplant evaluation criteria are met

2. Renal insufficiency with uremia or impending/current End Stage Renal Disease (ESRD) with poor renal function documented by progressive and irreversible deterioration in renal function over the previous 6–12 months and ONE of the following:
   a. Currently on dialysis
   b. In adults 18 years and older: The measured or calculated GFR is < 20 mL/min
   c. In children less than 18 years old: The measured or calculated GFR is < 30 mL/min

3. The requesting transplant recipient is carefully evaluated and potentially treated for any of the following organ-specific contraindications that apply *in addition* to the contraindications found in MCP 459:
   a. ESRD caused by congenital malformations (e.g., spina bifida, prune belly, vesicoureteral reflux), acquired malformations (e.g., chronic genitourinary tuberculosis, repeated surgery for vesicoureteral reflux), or functional disorders of the lower urinary tract requires evaluation, treatment when applicable, and clearance by urologist prior to transplantation
   b. Bladder or sphincter insufficiency (e.g., iatrogenic, neurogenic), requires evaluation, treatment when applicable (e.g., supravesical urinary diversion being performed at least 10-12 weeks prior to consideration of transplantation) and clearance by a urologist prior to transplantation
   c. Genitourinary disease (e.g., recurrent UTIs, structural anomalies) requires evaluation, treatment when applicable, and clearance by a urologist prior to transplantation

Adult and Pediatric Criteria for Simultaneous Liver-Kidney Transplantation

A simultaneous liver and kidney transplant may be **considered medically necessary** when ANY of the following criteria are met in addition to the criteria in MCP-114 Liver Transplantation and the above kidney transplantation indications:

1. Chronic kidney disease with a measured or calculated GFR less than or equal to 60 mL/min for greater than 90 consecutive days and ONE of the following:
   a. Member has begun regularly administered dialysis as an ESRD patient
   b. At the time of registration on the kidney waiting list, the Member's most recent measured or calculated creatinine clearance (CrCl) or GFR is less than or equal to 30 mL/min

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c. On a date after registration on the kidney waiting list, the Member's measured or calculated CrCl or GFR is less than or equal to 30 mL/min

2. Members with sustained acute kidney injury and at least ONE of the following for the last 6 weeks:
   a. Has been on dialysis at least once every 7 days
   b. Has a measured or calculated CrCl or GFR less than or equal to 25 mL/min at least once every 7 days

3. Metabolic disease and a diagnosis of at least ONE of the following:
   a. Hyperoxaluria
   b. Atypical hemolytic uremic syndrome (HUS) from mutations in factor H or factor I
   c. Familial non-neuropathic systemic amyloidosis
   d. Methylmalonic aciduria

Robotically Assisted Kidney Transplant (RAKT)

Robotically assisted kidney transplantation is considered **experimental, investigational, and unproven** due to insufficient evidence in the peer-reviewed medical literature to establish long-term safety, efficacy, and effect on net health outcomes.

DOCUMENTATION REQUIREMENTS: Molina Healthcare reserves the right to require that additional documentation be made available as part of its coverage determination; quality improvement; and fraud; waste and abuse prevention processes. Documentation required may include, but is not limited to, patient records, test results and credentials of the provider ordering or performing a drug or service. Molina Healthcare may deny reimbursement or take additional appropriate action if the documentation provided does not support the initial determination that the drugs or services were medically necessary, not investigational, or experimental, and otherwise within the scope of benefits afforded to the member, and/or the documentation demonstrates a pattern of billing or other practice that is inappropriate or excessive.

SUMMARY OF MEDICAL EVIDENCE

Systematic Reviews and Meta-Analyses

Chaudhry et al. (2022) performed a systematic review and meta-analysis to study the survival benefit of transplantation versus dialysis for waitlisted kidney failure patients with a priori stratification. Online databases were used (e.g., MEDLINE, Ovid Embase, Web of Science, Cochrane Collection, and ClinicalTrials.gov) and included results between database inception and March 1, 2021. This included comparative studies that assessed all-cause mortality for transplantation versus dialysis in patients with kidney failure waitlisted for transplant surgery. In total, 48 observational studies with no randomized controlled trials (n=1,245,850 patients) were used. Overall, 92% of the studies reported a long term (> 1 year) survival benefit related with transplantation compared with dialysis. Eleven studies identified stratums in which transplantation offered no statistically significant benefit over remaining on dialysis. Eighteen studies were suitable for meta-analysis with kidney transplantation showing a strong survival benefit. Kidney transplantation remains the standard treatment modality for many patients with kidney failure in an effort to reduce all-cause mortality. However, some subgroups may lack a survival benefit.

Non-Randomized Studies, Retrospective Reviews, and Other Evidence

Dharia et al. (2022) conducted a single center observational retrospective cohort study of kidney transplant recipients between 2006 – 2018. The clinicians compared outcomes in transplant recipients with deceased donor recipients with potential but non-actualized living donors to those recipients with actualized living donors, and to deceased donor recipients without potential living donors. A total of 453 kidney transplant recipients were analyzed. Deceased donor recipients without potential living donors and non-actualized living donors did not differ in key donor organ characteristics. The 5-year death censored graft survival of non-actualized living donors was similar to actualized living donors ($p = 0.19$). Deceased donor recipients without potential living donors graft survival were inferior to actualized living donors ($p = 0.005$) but also trended inferior to non-actualized living donors ($p = 0.052$). By multivariate Cox regression analysis, living donor demonstrated similar 5-year graft survival to non-actualized living donors (HR for graft loss 0.8 [95% CI 0.25–2.6], $p = 0.72$) but actualized living donors graft survival was superior to deceased donor recipients without potential living donors (HR 0.34 [0.16–0.72], $p = 0.005$). The authors summarized that deceased donor recipients with potential but non-actualized living donors exhibit similar mid-term graft and patient survival compared to living donor recipients, thus having an identified living donor at the time of pre-transplant assessment portends a favorable prognosis for the recipient.

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Hariharan et al. (2021) published a comprehensive review on long term survival after kidney transplantation. The review analyzed from 1996 to 2019, and highlighted the increase in survival rates since 2008 compared to the 90's and early 00's. The article points out that the opioid epidemic contributed to a rise in deceased donor kidneys, but that demand for kidneys has outpaced any increase in supply over the last couple of decades. The leading causes of transplant graft failure in the first year are due to technical issues/vascular complications (41%), acute rejection (17%), and glomerulonephritis (3%); after the first year the leading causes of graft failure are chronic rejection (63%) and glomerulonephritis (6%). The primary causes of death in recipients with functional grafts were cardiovascular disease (31% of deaths), infection (31%), and cancer (7%) in the first-year post-transplant; and cancer (29%), cardiovascular disease (23%), and infection (12%) after the first year. The United States reports lower 5-year survival rates than other countries. Five-year graft survival rates in 2014 for primary kidney transplants from deceased donors and living donors in the United States were 72% and 85%, respectively, as compared with 81% and 90% in Australia and New Zealand, 79% and 87% in Europe, and 81 and 91% in Canada. The article points out that this may be in part due to United States insurance coverage issues for long term immunosuppressive medications, which will hopefully improve after the passage of the Immunosuppressive Drug Coverage for Kidney Transplant Patients Act (Immuno Bill, H.R. 5534) in 2020, which stipulates lifelong coverage for transplant recipients. The article summarized that kidneys from deceased donors with high scores on the Kidney Donor Profile Index have been associated with an increased incidence of delayed graft function, which can be improved by reducing the severity of perfusion injury with a shorter cold ischemia time, as these organs are still vital for recipients with anticipated shorter life spans. The article continues to analyze acute rejection and summarizes that acute rejection is the result of suboptimal immunosuppressive therapy, particularly in transplant recipients at high immunologic risk, nonadherence to immunosuppressive therapy, or a reduction in immunosuppressive medications. The authors emphasize that prevention of acute rejection with comprehensive screening and care plans is pivotal, as well as infection prevention via vaccinations and patient education. The authors emphasized that efforts to improve graft survival rates will be due to comprehensive care by trained professionals that focus on organ quality and the prevention and treatment of acute rejection, cardiovascular disease, infection, and cancer.

Francis et al. (2020) report that survival among pediatric kidney transplant recipients has improved over the past five decades however, changes in cause-specific mortality remain uncertain. The authors performed a retrospective cohort study to estimate the link between transplant era and overall and cause-specific mortality for the child and adolescent population. Data included those under age 20 and who received the first kidney transplant between 1970 and 2015 from the Australian and New Zealand Dialysis and Transplant Registry. A total of 1810 recipients were included. The median age at transplantation was 14 years. Approximately 58% of recipients were male, and 52% received a kidney from a living donor. Recipients were followed for a median of 13.4 years. Twenty-four percent of the recipients followed died (431) with 174 from cardiovascular causes, 74 from infection, 50 from cancer, and 133 from other causes. Survival rates increased over time with 5-year survival rates rising from 85% for those first transplanted in 1970-1985 to 99% between 2005-2015. Increased survival was primarily contributed to a decrease in deaths from cardiovascular causes and infections. In comparison with patients transplanted between 1970-1985, mortality risk was 72% lower among those transplanted 2005-2015.

Robotically Assisted Kidney Transplant (RAKT)

Systematic Reviews and Meta-Analyses

Kourounis et al. (2024) published an updated Cochrane systematic review evaluating randomized controlled trials comparing open donor nephrectomy (ODN), laparoscopic donor nephrectomy (LDN), hand-assisted laparoscopic donor nephrectomy (HALDN), and robotic assisted donor nephrectomy (RADN) for live kidney donors. Thirteen trials involving 1280 donors were included, with most studies comparing LDN to ODN or HALDN, and only one small trial (n=45) comparing LDN with RADN. Compared with ODN, LDN was associated with reduced analgesia requirements and shorter hospital stay, although operative duration and warm ischemia time were longer. No significant differences were found between LDN and ODN in blood loss, perioperative complications, or reoperations, but the certainty of evidence for these outcomes was low to very low due to heterogeneity and methodologic limitations. Across three trials comparing LDN and HALDN, no differences were observed in analgesia use, hospital stay, operative duration, blood loss, perioperative complications, or reoperations, but the evidence for warm ischemia time was very uncertain due to high heterogeneity. The single RDN trial reported a longer warm ischemia time with robotic surgery (5.4 versus 4.4 minutes), but no differences in analgesia requirement operative duration, blood loss, perioperative complications, reoperations or hospital stay compared with LDN. Conversion to open surgery was rare across minimally invasive procedures, with reported rates of 1.02% for LDN, 0.63% for HALDN, and 0% for RADN. Graft outcomes were inconsistently reported, and no significant differences were identified between LDN and ODN for early graft loss,

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delayed graft function, acute rejection, ureteric complications, kidney function, a one-year graft loss. The authors noted substantial heterogeneity, limited reporting of graft outcomes and variable surgeon experience, all of which reduced confidence in the evidence. Evidence for RADN was limited to a single small trial with short term follow up, providing insufficient information on longer term donor or recipient outcomes.

Non-Randomized Studies, Retrospective Reviews, and Other Evidence

Christou et al. (2026) conducted an observational, retrospective, cohort study comparing robot assisted donor nephrectomy (RADN) with hand-assisted laparoscopic donor nephrectomy (HALDN) in a single United Kingdom transplant center, evaluating 70 donors in each group after matching. Donor demographics and baseline characteristics were similar between groups, and operative duration did not differ significantly. RADN was associated with a longer warm ischemia time (3.53 minutes vs 2.76 minutes, P < 0.001) and a longer median hospital stay (4.21 days vs 3.17 days, P < 0.001), although these differences did not translate into adverse donor or recipient outcomes. One intraoperative complication occurred in the RADN group due to a vascular stapler misfire, resulting in conversion to open surgery. The authors noted that procedural modifications were implemented thereafter with no further conversions reported. Postoperative complication rates, readmissions, reoperations, and donor renal function at 30 days and one year were comparable between groups, and recipient renal function at 3, 6, and 12 months did not differ. Follow-up was limited to one year, and donor outcomes beyond this period were not assessed, resulting in incomplete information on longer-tern safety and functional results. The authors concluded that RADN is safe and feasible within an experienced center, but acknowledged limitations including retrospective design, single-center experience, and early learning curve effects.

Musquera et al. (2025) conducted a retrospective cohort study comparing outcomes in 400 living donor kidney transplant recipients, including 200 who underwent robotic assisted transplantation (RAKT) and 200 who received the conventional open technique (OKT). All OKT recipients met eligibility criteria for RAKT, although the authors noted that the non-randomized, single centered design introduces potential selection bias and limits generalizability. Operative time was significantly longer in the RAKT group (185.5 versus 120 minutes, < 0.0001), while intraoperative complication rates were similar between groups. Post operative surgical complications occurred more frequently in the OKT cohort, including higher rates of hematuria, wound infection, and urinary leakage, and the median length of hospitalization was shorter with RAKT (7.0 versus 9.0 days, p < 0.0001). However, all 7 early graft nephrectomies occurred in the RAKT group, primarily due to vascular thrombosis or rejection, and several were attributed to the early learning curve of the robotic program. Despite these perioperative differences, there were no significant differences in delayed graft function, serum creatinine, eGFR, or patient and graft survival at 1, 3, or 5 years. The authors concluded that RAKT is feasible and may reduce postoperative morbidity, but emphasized the evidence remains limited by retrospective design and single-institution experience, and that multicenter randomized control trials are needed to confirm these findings.

Idu et al. (2022) conducted a retrospective single-center study comparing RADN versus HALDN, with all procedures performed by the same surgeon. Baseline donor characteristics were similar between groups, although the RADN cohort had more left- sided nephrectomies and a lower median BMI. RADN was associated with a longer operative time (173 vs 137 minutes) and longer first warm ischemia time (2.60 vs 2.15 minutes), while blood loss was lower (33 vs 64 mL). Postoperative pain, length of stay, and overall complication rates did not differ significantly. One conversion to open surgery occurred in the HALDN group, and none occurred in the RADN group. A stapler malfunction occurred in one RADN case, but the renal artery stump was controlled robotically, and the kidney was immediately extracted without reported sequelae. Recipient outcomes were largely comparable. Serum creatinine at one week and one month did not differ significantly. Estimated GFR one week was higher in the RADN group (47 vs 41 ml/min/1.73m2), but this difference was not present at one month. One graft loss occurred in the RADN group due to biopsy proven humoral rejection. The authors concluded that our RADN is safe and feasible, with donor and graft outcomes comparable to HALDN while noting limitations including the retrospective design, single-center and single-surgeon experience and lack of cost analysis.

Windisch et al. (2021) conducted a retrospective comparative study of 176 living kidney donors who underwent either RADN (n = 72) or HALDN (n = 104) within a Swiss transplant network. Baseline donor characteristics were similar between groups, although left sided nephrectomy was more frequently performed in the robotic cohort (82% vs 52%, p<0.01). Total operative time was significantly longer with RADN (287 vs 160 min; p<0.01), while warm ischemia time did not differ between techniques (221 vs 213 secs, p=0.446). All donors in both groups were operated on without the need for conversion to open surgery, and postoperative complication rates were low and comparable. The RADN cohort experienced a shorter median hospital stay (3.9 vs 5.7 days, p<0.01). Donor renal function at discharge and

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one month showed a small but statistically significantly higher creatinine ratio in the Rd. and group, (1.56 vs 1.44 at 1-month checkup, p<0.01). Follow up was limited to one month for renal function, and outcomes beyond this early postoperative period were not assessed, resulting in incomplete information on longer term donor safety and functional recovery. The authors concluded that RADN is safe and feasible, but acknowledged limitations including retrospective design, differences between the surgical teams, and the absence of long-term donor or recipient outcome assessment.

National and Specialty Organizations

The **European Association of Urology (EAU)** (2024) published updated guidelines for renal transplantation. EAU recommendations include organ retrieval and preservation prior to transplantation, living and deceased donor implantation surgery, including anesthetic, pre-, intra-, and post-operative management, surgical approaches for first, second, third, and further transplants, donor and recipient complications, immunosuppression, and follow-up after transplantation. Each recommendation is assigned a “strong” or “weak” rating based on available evidence. The 2024 version is described as a limited text update to align the guideline with more recent literature. .

KDIGO (Kidney Disease: Improving Global Outcomes) published *Clinical Practice Guideline on the Evaluation and Management of Candidates for Kidney Transplantation.* Recommendations are outlined for immunosuppression, graft monitoring, as well as prevention and treatment of infection, cardiovascular disease, malignancy, and other complications that are common in kidney transplant recipients, including hematological and bone disorders. There are also pediatric-specific guidelines. The KDIGO guideline also outlines prevention and treatment of complications that may follow kidney transplantation (KDIGO 2020).

The **Organ Procurement and Transplantation Network (OPTN)** published *Policy 8: Allocation of Kidneys* which includes adult and pediatric scoring tools, updated requirements, adult and pediatric status exceptions, and additional information pertaining to the allocation of kidneys. OPTN policy 9.9 also includes kidney-liver transplantation, outlining eligibility criteria, medical urgency considerations, and prioritization rules for candidates who qualify for simultaneous liver-kidney transplantation. ([1]OPTN 2025).

CODING & BILLING INFORMATION

CPT (Current Procedural Terminology)

Code	Description
50300	Donor nephrectomy (including cold preservation); from cadaver donor, unilateral or bilateral
50320	Donor nephrectomy (including cold preservation); open, from living donor
50323	Backbench standard preparation of cadaver donor renal allograft prior to transplantation, including dissection and removal of perinephric fat, diaphragmatic and retroperitoneal attachments, excision of adrenal gland, and preparation of ureter(s), renal vein(s), and renal artery(s), ligating branches, as necessary
50325	Backbench standard preparation of living donor renal allograft (open or laparoscopic) prior to transplantation, including dissection and removal of perinephric fat and preparation of ureter(s), renal vein(s), and renal artery(s), ligating branches, as necessary
50327	Backbench reconstruction of cadaver or living donor renal allograft prior to transplantation; venous anastomosis, each
50328	Backbench reconstruction of cadaver or living donor renal allograft prior to transplantation; arterial anastomosis, each
50329	Backbench reconstruction of cadaver or living donor renal allograft prior to transplantation; ureteral anastomosis, each
50340	Recipient nephrectomy (separate procedure)
50360	Renal allotransplantation, implantation of graft; without recipient nephrectomy
50365	Renal allotransplantation, implantation of graft; with recipient nephrectomy
50370	Removal of transplanted renal allograft
50380	Renal autotransplantation, reimplantation of kidney
50547	Laparoscopy, surgical; donor nephrectomy (including cold preservation), from living donor

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HCPCS (Healthcare Common Procedure Coding System)

Code	Description
S2152	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 post-transplant care in the global definition
S2900	Surgical techniques requiring use of robotic surgical system (list separately in addition to code for primary procedure)

CODING DISCLAIMER: Codes listed in this policy are for reference purposes only and may not be all-inclusive. Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement. Listing of a service or device code in this policy does not guarantee coverage. Coverage is determined by the benefit document. Molina adheres to Current Procedural Terminology (CPT®), a registered trademark of the American Medical Association (AMA). All CPT codes and descriptions are copyrighted by the AMA; this information is included for informational purposes only. Providers and facilities are expected to utilize industry standard coding practices for all submissions. When improper billing and coding is not followed, Molina has the right to reject/deny the claim and recover claim payment(s). Due to changing industry practices, Molina reserves the right to revise this policy as needed.

APPROVAL HISTORY

06/10/2026	Policy reviewed. Added E/I/U criteria for robotically-assisted kidney transplant. IRO peer reviewed on May 27, 2026 by a practicing physician board certified in Nephrology and Internal Medicine.
06/11/2025	Policy reviewed. No changes to coverage criteria. Updated Summary of Medical Evidence and References.
06/12/2024	Policy reviewed. Coverage criteria revised with removal of transplant evaluation, continuation of therapy, and general contraindication coverage criteria as it is now stipulated in MCP 459 Pre-Transplant and General Transplant Evaluation. IRO Peer Reviewed on May 1, 2024, by a practicing physician board certified in Nephrology and Internal Medicine. Specialty society guidelines updated.
04/10/2024	Removed requirement of dialysis center documentation for dialysis compliance. Annual review scheduled for June 2024.
06/14/2023	Policy reviews, changes to criteria include: "Pre-Transplant Evaluation" changed to "Transplant Evaluation,". Changes to criteria include age for colonoscopy reduced to 45 years, addition of non-life limiting neurological impairment criteria and additional disease processes to criteria, removal of abnormal serology criteria and daily cannabis use section, and addition of asterisk added to pre-transplant criteria to denote it may be waived by a Center of Excellence. "Marijuana" changed to "cannabis." IRO Peer Review on May 24, 2023, by a practicing, board-certified physician with a specialty in Surgery Transplant.
06/08/2022	Policy reviewed, no changes to coverage criteria; included section on marijuana use.
06/09/2021	Policy reviewed, no changes, updated references.
04/23/2020	Policy reviewed, updated criteria for simultaneous liver and kidney transplant based on OPTN Policy 9.9. Guidelines and references updated. Removed the CPT code 50380.
09/18/2019	Policy reviewed, no changes.
09/13/2018	Policy reviewed, no changes.
12/13/2017	Policy reviewed, changed the age for pediatric criteria from 12 to younger than 18 years of age.
09/15/2016	Policy reviewed, no changes.
12/16/2015	Policy reviewed, no changes.
11/20/2014	Policy reviewed; updated the pretransplant and transplant criteria.
01/14/2013	Policy reviewed, no changes.
08/20/2012	Pretransplant evaluation criteria added; adult and pediatric criteria changed; contraindications section changed, added criteria for simultaneous liver-kidney transplantation, professional guidelines updated.
10/26/2011	Policy reviewed, no changes.
02/28/2008	New policy.

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