KIDNEY TRANSPLANT
SUR703.007
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COVERAGE:

Kidney transplants are considered medically necessary when satisfactory documentation to support medical necessity is provided for selected candidates. These candidates include, but are not limited to, patients with any one of the following conditions:

- Acute Tubular Necrosis;
- Amyloid Disease;
- Analgesic Nephropathy;
- Anti-Glomerular Base-Membrane Disease;
- Chronic Pyelonephritis;
- Cortical Necrosis;
- Cystinosis;
- Diabetes Mellitus;
- Fabry’s Disease;
- Focal Glomerulonephritis;
- Gout Nephritis;
- Heavy Metal Poisoning;
- Hemolytic Uremic Syndrome;
- Henoch-Schönlein Purpura;
- Horseshoe Kidney;
- Hypertensive Nephrosclerosis;
- Immunoglobulin A (IGA) Nephropathy;
- Medullary Cystic Disease;
- Myeloma;
- Nephritis;
- Nephrocalcinosis;
- Obstructive Uropathy;
- Oxalosis;
- Polyarteritis;
- Polycystic Kidney Disease;
- Renal Aplasia or Hyperplasia;
- Renal Artery or Vein Occlusion;
- Renal Cell Carcinoma;
- Systemic Lupus Erythematosus;
- Trauma leading to Nephrectomy;
- Tubular Sclerosis;
- Wegener’s Granulomatosis; OR
- Wilm’s Tumor.

Kidney transplantation is an appropriate treatment for patients with the above disease conditions and who:

- Are free of active alcohol or narcotic abuse; AND
- Can deal with post operative and a life long medical regimen on a physical and psychological basis; AND
- Are free of comorbid conditions such as active systemic infection and malignancy.

Supportive Documentation for a kidney transplant must accompany the request or claim for coverage allowance. Examples of documentation include but are not limited to AT LEAST TWO of the following:
Consultation reports;
Letters with pertinent information from providers AND/OR patient;
Office records;
Operative reports;
Pathology reports; OR
Applicable hospital records.

DESCRIPTION:

A kidney transplant involves the surgical removal of a kidney from a healthy, related/unrelated donor or cadaver donor with later transplantation in a recipient. A donor kidney is usually transplanted retroperitoneally in the iliac fossa area. Vascular reanastomosis occurs with the iliac vessels to the renal vein. Ureteral permanence is completed by implanting the ureter (from the donor kidney) into the bladder or attaching to the ureter of the recipient kidney.

Dual kidney transplants (DKT) can be described as both donor kidneys are transplanted into a single recipient. The idea being, if a single, optimally functioning kidney is unavailable, then using two reduced function kidney’s will equal one full functioning kidney.

RATIONALE:

Kidney transplants are the most common form of transplanted organs. This surgery is an accepted treatment for end stage renal disease (ESRD) caused by numerous etiologies.

According to The Organ Procurement and Transplantation Network (OPTN), as of June 26, 2003, 54,967 candidates are in need of a kidney transplant. With a shrinking donor pool and increasing candidate list, a disparity exists between the number of available donors and potential recipients. DKT is seen as a way of meeting the recipients need for a kidney transplant. One 1999 study (Lee and associates), retrospectively compared the data of donor and recipients using DKT versus single cadaveric transplants (SKT). The one year survival rates for patient and graft was 97% and 90%. The DKT rate was 98% and 89%. More recently in 2003, a clinical study (Alfrey and colleagues) evaluated the results of 287 patients from a relational database and reported an overall 5 year graft survival rate for DKT at 69% versus a 61% for SKT. In comparing recipients with SKT (obtained from donors 50 years or 64 years old) with recipients of DKT (obtained from donors 50 and older) both groups had similar 1 year graft survival rates, 85% for single versus 84 % DKT. The 5 year graft survival rate reported a slightly better rate for DKT at 64% versus a 50 % for SKT.
Because of the expansion of donor criteria by the United Network for Organ Sharing (UNOS) in 2002, DKT has become an accepted standard in kidney transplantation.

PRICING:

None

REFERENCES:


DISCLAIMER:

State and federal law, as well as contract language, including definitions and specific inclusions/exclusions, takes precedence over Medical Policy and must be considered first in determining coverage. The member’s contract benefits in effect on the date that services are rendered must be used. Any benefits are subject to the payment of premiums for the date on which services are rendered. Medical technology is constantly evolving, and we reserve the right to review
and update Medical Policy periodically.
HMO Blue Texas physicians who are contracted/affiliated with a capitated IPA/medical group must contact the IPA/medical group for information regarding HMO claims/reimbursement information and other general policies and procedures.