# Clinical Policy: Kidney (Renal) Transplantation

Reference Number: WNC.CP.203
Last Review Date: 02/2025

Coding Implications
Revision Log

**See Important Reminder at the end of this policy for important regulatory and legal information.**

**Note:** When state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

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## Description[1]

Kidney (renal) transplantation is a surgical procedure to implant a healthy kidney into a Member with kidney disease or kidney failure. Sources for donated kidneys include living donors (may be a blood relative or an unrelated donor) or from a donor that has recently died, but has not suffered kidney injury (cadaver donor). However, a kidney from a living donor is preferable to a cadaver organ because the waiting period is dramatically shorter and because the organ can be tested before transplant, usually function immediately after transplant, and last longer. Blood-group matched (ABO compatible) living-donor kidney transplantation is the gold standard.

## Policy/Criteria[1]

**I.** WellCare of North Carolina® shall cover kidney transplantation (deceased or living donor) for a member who meets **ALL** the following criteria:

- **A.** Renal insufficiency with uremia or current end stage renal disease (ESRD) with poor renal function documented by progressive and irreversible deterioration in renal function over the previous six (6) consecutive months and **ONE** of the following:
  1. Currently on dialysis;
  2. In members eighteen (18) years and older, the measured or calculated glomerular filtration rate (GFR) is < 20 mL/min; **OR**
  3. In members seventeen (17) years and younger, the measured or calculated GFR is < 30 mL/min.
- **B.** The member has completed an evaluation and meets the eligibility criteria for the transplant center performing the procedure;
- **C.** The member and caregiver are willing and capable of following the posttransplant treatment plan;
- **D.** Kidney re-transplant after a failed primary kidney transplant may be considered medically necessary if a member meets the criteria for kidney transplantation.
- **E.** If the member is human immunodeficiency virus (HIV)-positive, **ALL** the following additional criteria must be met:
  1. Cluster Differentiation 4 (CD4) count greater than 200 cells/mm-3 for more than six (6) consecutive months;
  2. HIV-1 Ribonucleic acid (RNA) undetectable;
  3. On stable anti-retroviral therapy more than three (3) consecutive months;

4. No other complications from HIV (opportunistic infection, such as aspergillus, tuberculosis, coccidiosis mycosis, resistant fungal infections, Kaposi's sarcoma, or other neoplasm); **and**
5. Meets **ALL** other criteria listed for transplantation.

**II.** WellCare of North Carolina® **does not** cover kidney transplantation for a member who has any **ONE** of the contraindications listed below:
- **A.** Clinical indications other than listed above.
- **B.** If the procedure is expected to be futile due to co-morbid disease or if post transplantation care is expected to significantly worsen co-morbid conditions;
- **C.** Serious cardiac or other ongoing insufficiencies that create an inability to tolerate transplant surgery;
- **D.** Active drug or alcohol use;
- **E.** Active tobacco use;
- **F.** Active, potentially life-threatening, malignancy;
- **G.** Life threatening extra-renal congenital abnormalities;
- **H.** Active infection;
- **I.** Active vasculitis;
- **J.** Untreated or irreversible end-stage illnesses;
- **K.** Untreated coagulation disorder;
- **L.** Inability to comply with post-transplant regimen;
- **M.** Organs sold rather than donated to a Member; **or**
- **N.** Artificial organs or human organ transplant service for which the cost is covered or funded by governmental, foundation, or charitable grants.

## Background[1]

**I.** WellCare of North Carolina® shall require prior approval for cadaveric or living donor kidney transplantation.

**II.** The renal diseases responsible for chronic kidney disease (CKD) in children are different from those observed in adults. Congenital renal and urologic anomalies are the most common cause of CKD in children. Although there have been many advances in conservative renal replacement therapy, renal transplantation is the best treatment for children with end-stage renal disease (ESRD). For these reasons, children frequently undergo primary or preemptive transplantation, in which transplantation is the first mode of treatment for ESRD. When performed, this procedure most commonly involves a living donor who is related to the member.

**III. Definitions**
- **A. Glomerular Filtration Rate (GFR)** - GFR is a blood test used to check how well the kidneys are working. Specifically, it estimates how much blood passes through the

glomeruli each minute. Glomeruli are the tiny filters in the kidneys that filter waste from the blood.

**B. Chronic Kidney Disease (CKD)** - Chronic kidney disease is defined according to the presence or absence of kidney damage and level of kidney function—irrespective of the type of kidney disease (diagnosis).

**C. End Stage Renal Disease (ESRD)** - End stage renal disease (ESRD) is the last stage (stage five) of chronic kidney disease (CKD). When CKD, polycystic kidney disease (PKD) or other kidney diseases develop into ESRD, dialysis or a kidney transplant is necessary to live.

**Coding Implications**

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2025, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

| CPT®* Codes | Description |
|---|---|
| 50300 | Donor nephrectomy (including cold preservation); from cadaver donor, unilateral or bilateral |
| 50320 | Donor nephrectomy (including cold preservation); open, from living donor |
| 50340 | Recipient nephrectomy |
| 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 auto transplantation, reimplantation of kidney |

| Reviews, Revisions, and Approvals | Reviewed Date | Approval Date |
|---|---|---|
| Original approval date | 04/21 | 06/21 |
| Reviewed CPT codes. | 04/22 | 05/22 |
| Annual Review. NCHC verbiage removed from NC Guidance Verbiage. | 05/23 | 05/23 |
| Annual Review. ICD-10-CM code & HCPCS tables removed. | 02/24 | 02/24 |
| Annual Review. Removed “Medicaid and health choice” verbiage from References. | 02/25 | 02/25 |

**References**

1. State of North Carolina Medicaid Clinical Coverage Policy No: 11B-4 Kidney (Renal) Transplantation. Program Specific Clinical Coverage Policies NC Medicaid (ncdhhs.gov). Published August 15, 2023. Accessed November 5, 2024.

**North Carolina Guidance**

*Eligibility Requirements*

a. An eligible beneficiary shall be enrolled in the NC Medicaid Program (Medicaid is NC Medicaid program, unless context clearly indicates otherwise);
b. Provider(s) shall verify each Medicaid beneficiary's eligibility each time a service is rendered.
c. The Medicaid beneficiary may have service restrictions due to their eligibility category that would make them ineligible for this service.

*EPSDT Special Provision: Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age*

a. 42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid beneficiary under 21 years of age if the service is medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed practitioner).

This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his or her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the beneficiary's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the beneficiary's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product or procedure:

1. that is unsafe, ineffective, or experimental or investigational.
2. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary

"to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure meets all EPSDT criteria, including to correct or improve or maintain the beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

**EPSDT and Prior Approval Requirements**

1. If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does NOT eliminate the requirement for prior approval.
2. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *NCTracks Provider Claims and Billing Assistance Guide*, and on the EPSDT provider page. The Web addresses are specified below:
   *NCTracks Provider Claims and Billing Assistance Guide*:
   https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html
   *EPSDT provider page*: https://medicaid.ncdhhs.gov/

*Provider(s) Eligible to Bill for the Procedure, Product, or Service*
To be eligible to bill for the procedure, product, or service related to this policy, the provider(s) shall:

a. meet Medicaid qualifications for participation;
b. have a current and signed Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement; and
c. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

*Compliance*
Provider(s) shall comply with the following in effect at the time the service is rendered:

a. All applicable agreements, federal, state and local laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements; and
b. All NC Medicaid's clinical (medical) coverage policies, guidelines, policies, provider manuals, implementation updates, and bulletins published by the Centers for Medicare and Medicaid Services (CMS), DHHS, DHHS division(s) or fiscal contractor(s).

*Claims-Related Information*
Provider(s) shall comply with the NC Tracks Provider Claims and Billing Assistance Guide, Medicaid bulletins, fee schedules, NC Medicaid's clinical coverage policies and any other relevant documents for specific coverage and reimbursement for Medicaid:

a. Claim Type - as applicable to the service provided:
   Professional (CMS-1500/837P transaction)
   Institutional (UB-04/837I transaction)
   Unless directed otherwise, Institutional Claims must be billed according to the National Uniform Billing Guidelines. All claims must comply with National Coding Guidelines.
b. International Classification of Diseases and Related Health Problems, Tenth Revisions, Clinical Modification (ICD-10-CM) and Procedural Coding System (PCS) - Provider(s)

shall report the ICD-10-CM and Procedural Coding System (PCS) to the highest level of specificity that supports medical necessity. Provider(s) shall use the current ICD-10 edition and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for code description, as it is no longer documented in the policy.

c. Code(s) - Provider(s) shall report the most specific billing code that accurately and completely describes the procedure, product or service provided. Provider(s) shall use the Current Procedural Terminology (CPT), Health Care Procedure Coding System (HCPCS), and UB-04 Data Specifications Manual (for a complete listing of valid revenue codes) and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for the code description, as it is no longer documented in the policy. If no such specific CPT or HCPCS code exists, then the provider(s) shall report the procedure, product or service using the appropriate unlisted procedure or service code.
   *Unlisted Procedure or Service*
   CPT: The provider(s) shall refer to and comply with the Instructions for Use of the CPT Codebook, Unlisted Procedure or Service, and Special Report as documented in the current CPT in effect at the time of service.
   HCPCS: The provider(s) shall refer to and comply with the Instructions For Use of HCPCS National Level II codes, Unlisted Procedure or Service and Special Report as documented in the current HCPCS edition in effect at the time of service.
d. Modifiers - Providers shall follow applicable modifier guidelines.
e. Billing Units - Provider(s) shall report the appropriate code(s) used which determines the billing unit(s).
f. Co-payments -
   For Medicaid refer to Medicaid State Plan:
   https://medicaid.ncdhhs.gov/get-involved/nc-health-choice-state-plan

g. Reimbursement - Provider(s) shall bill their usual and customary charges. For a schedule of rates, refer to: https://medicaid.ncdhhs.gov/.

**Important Reminder**

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members/enrollees and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members/enrollees and their representatives agree to be bound by such terms and conditions by providing services to members/enrollees and/or submitting claims for payment for such services.