



## Lung Transplantation Clinical Coverage Criteria

### Description

Lung transplantation involves the surgical replacement of one or both lungs in patients with end-stage lung diseases. Lung transplantation is typically preceded by medical interventions such as surgery or oxygen therapy. The type of lung transplantation (lobar, single, double) is based upon the candidate's condition and indication for transplantation in addition to the availability of viable donor organs. Donor organs are often scarce or unsuitable for transplantation.

It is important to note that referral and listing for lung transplant are two different entities. The International Society for Heart and Lung Transplantation (ISHLT) recommends early referral to a transplant center for progressive lung diseases that have a projected poor prognosis. Early referral may allow time for candidates to address modifiable barriers to transplant, such as obesity, malnutrition, medical comorbidities, or inadequate social support. Referral means that a patient has met the minimal clinical criteria and further consideration towards lung transplant should be considered in the absence of any absolute contraindications. Listing, on the other hand, requires a thorough evaluation and careful risk-to-benefit assessment. In general, listing a patient for lung transplant is thought to be an explicit acknowledgment that a patient has limited life expectancy without lung transplant and the odds of survival are better with lung transplant (Shweish and Dronavalli, 2019).

### Policy

This Policy applies to the following Fallon Health products:

- Fallon Medicare Plus
- MassHealth ACO
- NaviCare HMO SNP
- PACE (Summit Eldercare PACE, Fallon Health Weinberg PACE)
- Community Care

Lung transplantation requires prior authorization.

### Fallon Health Clinical Coverage Criteria

Fallon Health Clinical Coverage Criteria apply to Community Care members.

Effective May 1, 2025, Fallon Health will use InterQual Criteria when making medical necessity determinations for single or bilateral primary lung transplantation for Community Care members 18 years of age and older.

For coverage criteria for single or bilateral primary lung transplantation, refer to the InterQual criteria in effect on the date of service:

- InterQual® CP:Procedures, Transplantation, Lung

Fallon Health makes InterQual criteria available to the public through the transparency tool on our website, effective January 1, 2024.

### Indications for Lung Transplant in Children

The etiology of lung disease among pediatric candidates has changed over time, with a decrease in the proportion of candidates with cystic fibrosis from 40.0% in 2017 to 9.7% in 2022. Cystic Fibrosis remains the leading indication for lung transplant in children aged 6–17 years; however,

the number of candidates with idiopathic pulmonary arterial hypertension (IPAH) is increasing, and it is currently the most common indication for those 1–5 years of age. For infants (< 1 year) surfactant protein B deficiency and pulmonary hypertension (which is usually due to congenital heart disease, not IPAH) are the primary indications for lung transplant. Other infant and childhood indications include adenosine triphosphate binding cassette protein member A3 deficiency, alveolar capillary dysplasia with misalignment of pulmonary veins, childhood interstitial lung disease, and bronchiolitis obliterans (Leard et al., 2021).

#### Timing of Listing

In addition to the general criteria for adults, considerations for listing children for lung transplant include the following:

- Children with Cystic Fibrosis (CF) < 18 years of age should be listed when FEV<sub>1</sub> < 30% predicted.
- Patients with pulmonary arterial hypertension (PAH) <18 years of age should be listed when they are in the European Pediatric Pulmonary Vascular Disease Network (EPPVDN) high risk category<sup>1</sup> and on optimal therapy without improvement.

#### **Lobar lung transplantation**

Potential candidates with small chest size may be candidates for lobar lung transplant. While early complications may be higher, the 1- and 3- year survival may be comparable to conventional transplant, suggesting lobar lung transplant may be an acceptable option (Leard et al., 2021).

#### **Heart-Lung Transplantation**

Refer to Fallon Health's policy for [Transplants, Solid Organ](#) for coverage criteria for heart-lung transplants.

#### **Lung Re-Transplantation**

Lung re-transplantation will be considered on an individual case-by-case basis. The outcomes after re-transplants are inferior compared to first lung transplants, particularly if the re-transplant is done within the first year after the original transplant or for patients with restrictive allograft syndrome. Studies, however, have found acceptable results for carefully selected recipients. In the pre-transplant evaluation of such patients, particular emphasis should be focused on understanding the possible reasons for the graft failure, such as alloimmunization, poor compliance, GER, or repeated infections (Leard et al., 2021).

- The timing of re-transplant is a complex issue and requires consideration of the rate of deterioration, time since initial transplant, the need for supportive therapies and donor lung availability, which may be limiting in some cases.
- Survival after re-transplant is inferior to that seen with the primary operation and should only be undertaken in carefully selected candidates.
- In the evaluation of patients being considered for lung re-transplant, particular emphasis should be focused on understanding the possible reasons for the graft failure, such as alloimmunization, poor adherence, gastroesophageal reflux, or repeated infections.

### **Medicare Variation**

Medicare statutes and regulations do not have criteria for lung transplantation. Medicare does not have an NCD for lung transplantation. National Government Services, Inc., the Part A/B Medicare Administrative Contractor (MAC) with jurisdiction in our service area, does not have an LCD for lung transplantation (Medicare Coverage Database search 03/19/2026).

To date, the Medicare program has not issued an NCD on lung or heart-lung transplantation. However, CMS established a national coverage policy for lung transplants in [Federal Register / Vol. 60, No. 22 / Thursday, February 2, 1995 / Notices, Medicare Program; Criteria for Medicare Coverage of Lung Transplants](#).

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<sup>1</sup> Hansmann G, Koestenberger M, Alastalo TP, et al. 2019 updated consensus statement on the diagnosis and treatment of pediatric pulmonary hypertension: The European Pediatric Pulmonary Vascular Disease Network (EPPVDN), endorsed by AEPC, ESPR and ISHLT. *J Heart Lung Transplant*. 2019 Sep;38(9):879-901.

Medicare will cover lung transplants only for those beneficiaries who are diagnosed as having progressive end-stage pulmonary disease and when performed by a facility that has received approval from CMS for a lung transplant program. Medicare will also cover lung transplantation for end-stage cardiopulmonary disease when it is expected that transplant of the lung will result in improved cardiac function. Coverage criteria for lung transplantation are fully established by Medicare; therefore, the Plan's coverage criteria are not applicable.

Careful patient selection for lung transplants is essential to achieve optimal results. CMS requires that facilities have written patient selection criteria that they follow in determining suitable candidates for lung transplants, such as the following:

- a. A patient is selected based upon both a critical medical need for transplantation and a strong likelihood of successful clinical outcome.
- b. A patient who is selected for a lung transplant has irreversible, progressively disabling, end-stage pulmonary disease (or, in some instances, end-stage cardiopulmonary disease).
- c. The facility has tried or considered all other medically appropriate medical and surgical therapies that might be expected to yield both short- and long-term survival comparable to that of transplantation.
- d. Plans for long-term adherence to a disciplined medical regimen are feasible and realistic for the individual patient.

Many factors must be recognized as exerting an adverse influence upon the patient's outcome after transplantation. The following adverse factors are among those that should be considered in selecting patients for transplantation:

- Primary or metastatic malignancies of the lung.
- Current significant acute illness that is likely to contribute to a poor outcome if the patient receives a lung transplant or current use of mechanical ventilation for more than a very brief period.
- Significant or advanced heart, liver, kidney, gastrointestinal or other systemic or multi-system disease that is likely to contribute to a poor outcome after lung transplantation.
- Significant extra-pulmonary infection.
- Chronic pulmonary infection in candidates for single lung transplantation.
- Continued cigarette smoking or failure to have abstained for long enough to indicate low likelihood of recidivism.
- Systemic hypertension that requires more than two drugs for adequate control.
- Cachexia, even in the absence of major end-organ failure.
- Obesity.
- Previous thoracic or cardiac surgery or other bases for pleural adhesions.
- Age beyond that at which there has been substantial favorable experience.
- Chronic corticoid therapy that cannot be tapered to a low dose (10 mg prednisone per day) or discontinued prior to transplantation.
- A history of behavior pattern or psychiatric illness considered likely to interfere significantly with a disciplined medical regimen.

The transplant must be performed by a facility that has received approval from CMS for an organ transplant program. The List of CMS-Approved Organ Transplant Programs is currently available on the [Quality, Certification and Oversight Reports \(QCOR\)](#) web site. The Approved Transplant Program List may be downloaded in Microsoft Excel format. In the side navigation bar, under Providers & Suppliers, click "Hospitals," then under Provider Reports, click "Approved Transplant Program List."

## MassHealth Variation

MassHealth has Guidelines for Medical Necessity Determination for Organ Transplant Procedures. These Guidelines apply to the following single- or double-organ transplants: liver, heart, lung, pancreas, and small bowel (MassHealth website search 03/19/2026), therefore, Fallon Health Clinical Coverage Criteria for lung transplantation are not applicable.

## Exclusions

- Lung transplants that do not meet the above criteria.
- Lung transplant where the member has an absolute contraindication.

## Evidence Summary

Lung transplantation is now a generally accepted treatment for the management of a wide range of severe lung disorders, with evidence supporting quality of life and survival benefit for lung transplant recipients. However, the number of donor organs available remains far fewer than the number of patients with end-stage lung disease who might potentially benefit from the procedure. It is of primary importance, therefore, to optimize the use of this resource, such that the selection of patients who receive a transplant represents those with realistic prospects of favorable long-term outcomes. There is a clear ethical responsibility to respect these altruistic gifts from all donor families and to balance the medical resource requirements of one potential recipient against those of others in their society (Orens et al., 2006).

It is important to recognize that few data exist from randomized controlled trials upon which to support coverage criteria for lung transplantation. Guidelines are based primarily on consensus of opinion rendered by experts in the field and on analysis of retrospective single-center and multicenter studies and registries. The definitive work addressing criteria for selecting lung transplant patients, and contraindications against performing surgery, are written by the Pulmonary Scientific Council of the International Society for Heart and Lung Transplantation (ISHLT), which published versions in 1998 (Maurer et al., 1998), 2006 (Orens et al., 2006), and 2014 (Weill et al., 2015). In 2021, the ISHLT updated its consensus document on selection of lung transplant candidates (Leard, 2021). While lung transplantation aims to improve both survival and quality of life, the expert consensus acknowledges that when making recommendations about allocating a scarce resource, survival benefit is prioritized based on an ethical framework. The worldwide scarcity of donor lungs requires rationing of this lifesaving but limited societal resource. This makes the selection of transplant candidates an ethical choice as well as a medical one. The fundamental ethical principles of “utility”, “justice”, and “respect for persons” must, therefore, provide the framework for candidate selection and organ allocation systems (Leard et al., 2021).

Over the last 3 decades, there has been a significant increase in the number of lung transplants performed, with the main trend seen in adult bilateral lung transplant. A recent report by the registry of ISHLT listed all lung transplants performed between 1995 and 2015. The most common indications consisted of COPD (36.5%), interstitial lung disease (ILD) (29.7%), and bronchiectasis (18.5%) (Yusen et al., 2016). Of these three broad categories, COPD without alpha-1 antitrypsin deficiency, idiopathic interstitial pneumonia (IIP), and CF comprised the bulk of lung transplant, respectively (Shweish and Dronavalli, 2019).

Given the high risk and complexity of lung transplant, careful assessment of potential contraindications should be made. The most recent ISHLT consensus cites several absolute contraindications for lung transplant (Leard, 2021). Candidates with these conditions are considered too high risk to achieve successful outcomes post lung transplantation. Contraindications can change over time and may not be a contraindication for referral, but when present at the time of listing or while listed for lung transplantation may increase risk for poor transplant outcomes. In addition to Absolute Contraindications, the ISHLT consensus includes risk factors with high or substantially increased risk and risk factors. Modifiable conditions should be optimized when possible.

Consideration of an upper age limit for lung transplant candidacy remains a controversial subject. In the 2006 and 2014 ISHLT guidelines, age greater than 65 years in association with low physiologic reserve and/or other relative contraindications was considered a relative contraindication. There has been no endorsement of an upper age limit as an absolute contraindication, but older individuals have worse long-term survival following lung transplant. The age of lung transplant recipients has increased over the past decade. In the United States, candidates greater than 65 years of age now comprise more than 30% of the waiting list and are

the age group with the highest transplant rate. With increasing experience in older recipients, several studies have shown that carefully selected older recipients may have the same short-term survival as younger recipients. However, the results are skewed by selection bias, reflecting the fact that most recipients over the age of 65 years undergoing lung transplant are highly selected with very few comorbidities such as coronary artery disease and diabetes. Despite this selection bias and acceptable short-term outcomes, lung transplant recipients over the age of 70 years have decreased longer term survival (Hayanga et al., 2015).

Lung diseases are characterized by the Organ Procurement and Transplantation Network (OPTN) into four main diagnosis groups: group A, obstructive lung disease; group B, pulmonary vascular disease; group C, cystic fibrosis and immunodeficiency disorders; and group D, restrictive lung diseases (OPTN, 2023).

Group A, obstructive lung disease includes COPD, Alpha-1 antitrypsin deficiency, Lymphangioliomyomatosis (LAM), Sarcoidosis with mean pulmonary artery pressure  $\leq 30$  mmHg, and bronchiectasis including primary ciliary dyskinesia.

COPD is the most common indication for lung transplant worldwide, accounting for more than one third of all lung transplants between 1995 and 2013 (Yusen et al., 2016). Several factors play into the decision to refer COPD patients for lung transplant, the most important of which are indicators of worsening functional status and spirometry. Compared to other chronic lung diseases, COPD poses a unique challenge for lung transplant. The goal in every candidate is to identify a time in the course of the disease when the patient is most likely to have a net survival benefit from lung transplant. This proves to be more challenging in COPD for several reasons. First, due to the chronicity and protracted course of COPD, patients may tend to live beyond the median post-transplant survival. Second, the lung allocation score (LAS) is designed to identify and prioritize patients with shorter survival. This means that COPD patients listed for lung transplant will end up having lower LAS and longer waitlist times. This, in turn, will lead to disease progression, physical deconditioning and ultimately, higher risk for worse post-transplant outcomes (Shweish and Dronavalli, 2019).

Group B, pulmonary vascular disease, includes idiopathic or primary pulmonary arterial hypertension, Eisenmenger's syndrome, chronic thromboembolic disease related pulmonary hypertension, and pulmonary veno-occlusive disease.

The number of lung transplants for pulmonary arterial hypertension (PAH) has seen a decrease over the last two decades, and this is largely due to the improved survival with medical therapy for PAH. Lung transplant is indicated for patients who show evidence of persistent deterioration despite aggressive and optimized medical treatment. Despite improvements in targeted medical therapy, PAH still has a relatively poor prognosis. The timing for referral in PAH patients remains a challenge, and the window of transplant can be narrow. In addition, patients with pulmonary hypertension have higher rates of perioperative complications, manifested by higher rates of primary graft dysfunction and right ventricular failure (Shweish and Dronavalli, 2019). The Registry to Evaluate Early and Long-term PAH Disease Management (REVEAL) report identified and confirmed several risk factors associated with higher mortality (Benza et al., 2010).

Group C, infectious lung disease, includes Cystic Fibrosis (CF) and immune deficiency syndromes like IgG deficiency.

Despite the significantly improved survival in CF over the last decades, many patients continue to have progressive disease and require lung transplant. Compared to other indications for lung transplant, the 5-year lung transplant survival rates in CF are significantly better. This is largely due to the younger age of CF patients at the time of transplant. In addition, studies report improved quality of life among transplant recipients for CF. In patients who meet criteria for referral, a careful assessment should be made to determine their predicted survival and timing of transplant, which is not clearly demarcated. Several factors have been associated with increased mortality in CF patients, the most useful of which has been the FEV<sub>1</sub> as a surrogate for disease progression and mortality (Shweish and Dronavalli, 2019). There have been many studies that have developed predictive models for CF mortality; however, forced expiratory volume in 1

second (FEV<sub>1</sub>) <30% predicted remains the most commonly used indicator of 2-year survival, and CF clinicians generally use the 30% FEV<sub>1</sub> threshold to guide patient referrals for lung transplantation assessment (Stanojevic et al., 2019).

Group D, restrictive lung disease, includes Idiopathic pulmonary fibrosis (IPF), Eosinophilic granulomatosis, Sarcoidosis with mean pulmonary artery pressure ≥30 mmHg, Scleroderma/CREST syndrome, Bronchoalveolar carcinoma, Bronchiolitis obliterans syndrome (BOS) following lung transplant, and primary graft failure following lung transplant.

IPF is a rapidly progressive disease with a median survival of 2–3 years from the time of diagnosis and a 5-year survival of about 25%. IPF is the most common subtype of interstitial lung disease (ILD) and has been associated with worse outcomes when compared to other forms of ILD. Other ILD that may carry a similar course as IPF include fibrotic non-specific interstitial pneumonia (NSIP), progressive ILDs refractory to immunomodulation therapy. The high mortality in IPF, along with the implementation of the LAS has been responsible for the dramatic increase in the number of lung transplant recipients with IPF over the last two decades and warrants earlier referral for lung transplant evaluation. Despite FDA approval of the anti-fibrotic agents nintedanib and pirfenidone, no medical therapy has been shown to have a clearly established impact on mortality. Mortality predictors in IPF have been well studied, however, these variables do not reliably predict the risk of disease progression. As of now, there are no biomarkers that have been conclusively shown to have a correlation with disease progression or mortality (Shweish and Dronavalli, 2019).

### Analysis of Evidence (Rationale for Determination)

Few data exist from randomized controlled trials upon which to support coverage criteria for lung transplantation. Despite that, lung transplantation is now a generally accepted treatment for the management of a range of chronic, end-stage lung diseases, with evidence supporting quality of life and survival benefit for lung transplant recipients. Guidelines are based primarily on consensus of opinion rendered by experts in the field and on analysis of retrospective single-center and multicenter studies and registries.

The definitive work addressing criteria for selecting lung transplant patients, and contraindications against performing surgery, are written by the Pulmonary Scientific Council of the International Society for Heart and Lung Transplantation (ISHLT). The ISHLT updated its consensus document on selection of lung transplant candidates in 2021 (Leard, 2021).

### Coding

The following codes are included below for informational purposes only; inclusion of a code does not constitute or imply coverage or reimbursement.

Code	Description
32850	Donor pneumonectomy(s) (including cold preservation), from cadaver donor
32851	Lung transplant, single; without cardiopulmonary bypass
32852	Lung transplant, single; with cardiopulmonary bypass
32853	Lung transplant, double (bilateral sequential or en bloc); without cardiopulmonary bypass
32854	Lung transplant, double (bilateral sequential or en bloc); with cardiopulmonary bypass
32855	Backbench standard preparation of cadaver donor lung allograft prior to transplantation, including dissection of allograft from surrounding soft tissues to prepare pulmonary venous/atrial cuff, pulmonary artery, and bronchus; unilateral
32856	Backbench standard preparation of cadaver donor lung allograft prior to transplantation, including dissection of allograft from surrounding soft tissues to prepare pulmonary venous/atrial cuff, pulmonary artery, and bronchus; bilateral

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## Policy history

Origination date:	01/01/2016
Review/Approval(s):	Technology Assessment Committee: 1/27/2016 (policy origination), 01/25/2017 (removed codes 32855-32856 as they are not separately reimbursable, updated references), 05/24/2017 (added criteria based on substance abuse), 05/15/2018 (updated references, added language regarding non-smoking and compliance to care), 06/25/2021 (Added clarifying language related to Medicare Advantage, NaviCare and PACE under policy section), 05/22/2019 (updated references), 03/26/2024 (annual review; updated Clinical Coverage Criteria and Absolute Contraindications consistent with 2021 ISHLT Consensus document; updated references), 03/25/2025 (annual review; adopted InterQual Criteria for adult lung transplantation for Community Care members, added new sections for Medicare

Variation and MassHealth Variation), 03/24/2026 (annual review; no changes to coverage criteria).  
Utilization Management Committee: 04/15/2025 (annual review; approved), 04/21/2026 (annual review; approved with no changes to coverage criteria).

## Instructions for Use

Fallon Health complies with CMS's national coverage determinations (NCDs), local coverage determinations (LCDs) of Medicare Contractors with jurisdiction for claims in the Plan's service area, and applicable Medicare statutes and regulations when making medical necessity determinations for Medicare Advantage members. When coverage criteria are not fully established in applicable Medicare statutes, regulations, NCDs or LCDs, Fallon Health may create internal coverage criteria under specific circumstances described at § 422.101(b)(6)(i) and (ii).

Fallon Health generally follows Medical Necessity Guidelines published by MassHealth when making medical necessity determinations for MassHealth members. In the absence of Medical Necessity Guidelines published by MassHealth, Fallon Health may create clinical coverage criteria in accordance with the definition of Medical Necessity in 130 CMR 450.204.

For plan members enrolled in NaviCare, Fallon Health first follows CMS's national coverage determinations (NCDs), local coverage determinations (LCDs) of Medicare Contractors with jurisdiction for claims in the Plan's service area, and applicable Medicare statutes and regulations when making medical necessity determinations. When coverage criteria are not fully established in applicable Medicare statutes, regulations, NCDs or LCDs, or if the NaviCare member does not meet coverage criteria in applicable Medicare statutes, regulations, NCDs or LCDs, Fallon Health then follows Medical Necessity Guidelines published by MassHealth when making necessity determinations for NaviCare members.

Each PACE plan member is assigned to an Interdisciplinary Team. PACE provides participants with all the care and services covered by Medicare and Medicaid, as authorized by the interdisciplinary team, as well as additional medically necessary care and services not covered by Medicare and Medicaid. With the exception of emergency care and out-of-area urgently needed care, all care and services provided to PACE plan members must be authorized by the interdisciplinary team.

Not all services mentioned in this policy are covered for all products or employer groups. Coverage is based upon the terms of a member's particular benefit plan which may contain its own specific provisions for coverage and exclusions regardless of medical necessity. Please consult the product's Evidence of Coverage for exclusions or other benefit limitations applicable to this service or supply. If there is any discrepancy between this policy and a member's benefit plan, the provisions of the benefit plan will govern. However, applicable state mandates take precedence with respect to fully-insured plans and self-funded non-ERISA (e.g., government, school boards, church) plans. Unless otherwise specifically excluded, federal mandates will apply to all plans.