MEDICAL POLICY

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Medical Policy Title	**Liver Transplantation**
Policy Number	**7.02.07**
Current Effective Date	**November 20, 2025**
Next Review Date	**November 2026**

Our medical policies are based on the assessment of evidence based, peer-reviewed literature, and professional guidelines. Eligibility for reimbursement is based upon the benefits set forth in the member's subscriber contract. (Link to Product Disclaimer)

POLICY STATEMENT(S)

I. Liver transplantation for selected individuals with end-stage liver disease is considered **medically appropriate** for **ANY** of the following indications when criteria are met:

A. Hepatocellular diseases:

1. Alcoholic cirrhosis;
2. Viral hepatitis;
3. Autoimmune hepatitis;
4. Alpha-1 antitrypsin deficiency;
5. Hemochromatosis;
6. Non-alcoholic steatohepatitis cirrhosis/ metabolic dysfunction-associated steatohepatitis (MASH);
7. Protoporphyria; or
8. Wilson's disease;

B. Cholestatic liver diseases:

1. Primary biliary cirrhosis;
2. Primary sclerosing cholangitis with development of secondary biliary cirrhosis; or
3. Biliary atresia;

C. Vascular disease:

1. Budd-Chiari syndrome;

D. Primary hepatocellular carcinoma when:

1. Disease is organ confined, and the patient is not a candidate for subtotal liver resection;

E. Inborn errors of metabolism;

F. Trauma and toxic reactions;

G. Nonresectable hilar (extrahepatic) cholangiocarcinoma and as part of a neoadjuvant chemoradiation protocol when:

1. Absence of metastatic disease, **and**
2. For localized hilar tumors Stage I or II;

H. Nonresectable intrahepatic cholangiocarcinoma when:

1. Absence of metastatic disease confirmed by a staging laparoscopy or laparotomy; **and**
2. When combined with neoadjuvant chemoradiation;

I. Hepatoblastoma (non-metastatic):

J. Polycystic disease of the liver; **or**

K. Familial amyloid polyneuropathy.

II. Recipient Selection Guidelines

A. Cadaver Liver Recipient:

1. Model for End-stage Liver Disease (MELD) score equal to or greater than 9 (UNOS adjusts the MELD score for patients with hepatocellular cancer by adding points to their scores).
2. Patients with polycystic disease of the liver do not always develop progressive liver failure but may require transplantation due to the anatomic complications of a hugely enlarged liver. The MELD/PELD score may not apply to these cases. One of the following complications should be present:
   a. Enlargement of liver impinging on respiratory function;
   b. Extremely painful enlargement of liver; **or**
   c. Enlargement of liver significantly compressing and interfering with function of other abdominal organs.
3. The MELD/ Pediatric End-stage Liver Disease (PELD) score may apply to patients with amyloid polyneuropathy. Candidacy for liver transplant is an individual consideration based on the morbidity of the polyneuropathy. Many patients may not be candidates for liver transplant alone due to coexisting cardiac disease.

B. Living Donor Recipient:

1. MELD score equal to or greater than 9 and less than or equal to 25; and
2. Listed on the cadaveric liver transplant waiting list; **and**
3. Has suffered at least one (1) significant complication related to liver disease (e.g., variceal hemorrhage, spontaneous bacterial peritonitis, encephalopathy, or severe impairment to his or her quality of life due to, for example, fatigue, pruritis).

III. Contraindications to Liver Transplantation

A. Cadaveric Organ Recipient:

1. Relative contraindications include:

a. Major co-morbid illnesses such as ischemic heart disease, severe peripheral vascular disease, congestive cardiomyopathy, moderately severe COPD;

b. HIV infection unless **ALL** of the following criteria are met:

i. CD4 count greater than 100 cells/mm^3 for non-hepatitis C patients, greater than 200 cells/mm^3 for patients with hepatitis C;

ii. HIV-1RNA undetectable;

iii. On stable anti-retroviral therapy greater than 3 months;

iv. No other complications from AIDS (e.g., opportunistic infection, including aspergillus, tuberculosis, coccidioidomycosis; resistant fungal infections, Kaposi's sarcoma, or other neoplasm); **and**

v. Meets all other criteria for transplantation;

c. Presence of malignancy within 5 years of transplantation (other than non-melanoma skin cancers), or unless malignancy has been completely resected, or unless (upon medical review) it is determined that malignancy has been treated with small likelihood of recurrence and acceptable future risks;

d. Ongoing or recurring infections that are not effectively treated;

2. Absolute contraindications: uncontrolled behavioral health disorder that manifests in behaviors that that interfere with the patient's capacity to comply with surgical and follow-up management including but not limited to alcohol or substance abuse and major thought disorder.

B. Living Donor Organ Recipient:

1. Hepatocellular carcinoma if:

a. There is evidence of metastatic disease;

b. The recipient can expect less than a one-year disease-free outcome;

2. Simultaneous combined liver/kidney transplantation (however, in cases involving hyperoxalosis or other specific metabolic disorders, special consideration should be given to allowing simultaneous liver/kidney transplantation from two different donors).

IV. Living Donation Guidelines

A. Donor selection must be consistent with the New York State Department of Health, updates to that report, and relevant regulatory requirements.

B. Donor should be "emotionally related" to recipient (e.g., relative, previous known or current acquaintance).

RELATED POLICIES

Corporate Medical Policy

7.02.05 Small Bowel and Multvisceral Transplants in Adults and Children

POLICY GUIDELINE(S)

I. Prior authorization is contract dependent. Approvals for all transplants, including arrangements with an approved transplant center, may be required.

II. Pre-transplant evaluation documentation could include the following clinical information. If testing is unable to be performed, the rationale for not performing the testing must be included in the documentation.

   A. Clinical Evaluation:

      1. Confirmation of diagnosis;
      2. Identification of comorbidities;
      3. Treatment of co-morbidities;
      4. Current assessment of co-morbidities;
      5. Consult notes (if applicable).

   B. Psycho-Social Evaluation:

      1. Karnofsky performance score or Palliative Performance Scale (PPS) score.
      2. Identification of stressors (family support, noncompliance issues, motivational issues, alcohol, or substance abuse).

   C. Oral Health Evaluation

   D. Lab Tests:

      1. CBC, metabolic profile;
      2. Serologies: CMV, Hepatitis B and C;
      3. HIV Testing.

   E. Cardiac Assessment:

      1. 12 Lead EKG;
      2. Stress (exercise, nuclear, or dobutamine);
      3. Echo or Muga Scan.

   F. Pulmonary Assessment:

      1. Chest x-ray;
      2. Pulmonary function tests (PFTs) for high-risk for respiratory failure (COPD, emphysema, a-1-antritrypsin deficiency, hepatopulmonary syndrome, or significant smoking history);
      3. Low dose screening CT for individuals considered high-risk for lung cancer (e.g., 20-30 pack history of smoking).

G. Age-Appropriate Screening Tests: Please refer to the U.S Preventive Services Task Force (USPSTF) website for list of age-appropriate screening guidelines. Available from: https://uspreventiveservicestaskforce.org/uspstf/ [accessed 2025 Oct 24]

III. Re-authorization

Transplant re-authorization must be completed annually while actively waiting for a transplant. Re-authorization documentation must be within the past 11 months (unless specified) and include the following clinical information (if testing is unable to be performed, the rationale must be included in the documentation). If your health condition has not changed from the previous year some testing would not be applicable.

A. Clinical Evaluation:
   1. Updated list of diagnoses to include identification of comorbidities, current assessment, and treatment plan.
   2. Specialty consultation notes (if applicable).

B. Current functional ability as evidence by current Karnofsky performance score (KPS); or Palliative Performance Scale (PPS) score.

C. Follow-up Oral Health Evaluation.

D. Lab Tests:
   1. CBC, metabolic profile;
   2. Serologies: CMV Hepatitis B and C; and
   3. HIV testing (If applicable).

E. E. Cardiac Assessment:
   1. 12 Lead EKG (If applicable); and
   2. Stress (exercise, nuclear, or dobutamine) (If applicable),
   3. Echo or Muga scan (If applicable).

F. Pulmonary Assessment:
   1. Chest x-ray (If applicable);
   2. Pulmonary function tests (PFTs) for high-risk for respiratory failure (COPD, emphysema, a-1-antritrypsin deficiency, hepatopulmonary syndrome, or significant smoking history) (If applicable);
   3. Low-dose screening CT for individuals considered high-risk for lung cancer (e.g., 20- to 30-pack history of smoking.

G. Age-appropriate Screening Tests: Please refer to the U.S Preventive Services Task Force (USPSTF) website for list of age-appropriate screening guidelines. Available from: https://www.uspreventiveservicestaskforce.org/uspstf/ [accessed 2025 Oct 24]

IV. Candidates who have end stage disease related to or impacted by alcohol consumption, including viral hepatitis, must demonstrate a period of abstinence through clinical treatment records (e.g., PCP, alcohol treatment programs). If the patient has been abstinent less than one month, a medical director consultation with the transplant center behavioral health team is required which includes an assessment by a trained Alcohol and Addiction Professional. The assessment should include history of addiction, harmful drinking patterns, awareness of harmful drinking by the patient, social environment along with family support, any identifiable psychiatric issues, and post-transplantation rehabilitation planning.

V. Candidates may be waitlisted at more than one transplant center. Since waiting time priority is first calculated among candidates at all hospitals within the local donation area, listing at transplant centers in different local allocation areas is recommended. Requirements for multiple-listed candidates may vary among transplant centers. When possible, results of tests used in the evaluation for the transplant at one center should be used at subsequent centers where the patient is listed.

DESCRIPTION

A liver transplant consists of replacing a diseased liver with a healthy liver or a segment of a healthy liver. Transplanted organs are harvested from either a cadaver (brain-dead donor) or from a living donor. In a living donor liver transplantation (LDLT) a portion of the liver is surgically removed from a healthy living person and placed into an individual whose liver is no longer working properly. The donor's remaining liver regrows and returns to its normal size, volume, and capacity within a couple of months after the surgery. At the same time, the transplanted liver portion grows and restores normal liver function in the recipient. Liver transplantation is currently the treatment of last resort for patients with end-stage liver disease.

The United Network for Organ Sharing (UNOS) uses the Model for End-stage Liver Disease (MELD) and Pediatric End-stage Liver Disease (PELD) criteria. Candidates who are less than 12 years old receive a PELD score, while candidates who are at least 12 years old receive a MELD score. These are calculated using a combination of the candidate's clinical lab values and reflect the probability of death on the waitlist within a 90-day period. Higher scores indicate a higher probability of mortality and increased urgency for transplant. Candidates that are considered urgent are assigned status 1A or 1B. MELD and PELD score ranges from six (6) to 40.

MELD calculator available from: https://optn.transplant.hrsa.gov/resources/allocation-calculators/meld-calculator/ [accessed 2025 Oct 24]

PELD calculator available from: https://optn.transplant.hrsa.gov/resources/allocation-calculators/peld-calculator/ [accessed 2025 Oct 24]

Donor morbidity and mortality are prime concerns in adult donors undergoing partial hepatectomy. Subjecting healthy donors to the risks of surgery, especially considering uncertain long-term outcomes, can be justified only in clinical circumstances in which the potential recipient has a compelling need for a living donor transplant; such as when a liver transplantation is the only therapeutic option, and a cadaveric transplantation is impossible or problematic for reasons such as

anticipated waiting times. Due to the scarcity of donor organs and the success of living donation between parent and child, adult-to-adult living donor liver transplantation offers an option for appropriately screened recipients and donors.

SUPPORTIVE LITERATURE

Mazzaferro et al (1996) developed criteria to better determine which patients with hepatocellular carcinomas and cirrhosis were more likely to have better outcomes after liver transplant. They studied 48 patients with cirrhosis who had small, unresectable hepatocellular carcinomas and underwent treatment with liver transplant. The criteria for eligibility for transplantation were the presence of a tumor 5 cm or less in diameter in patients with single hepatocellular carcinomas and no more than three tumor nodules, each 3 cm or less in diameter, in patients with multiple tumors, with no evidence of macrovascular invasion or metastasis. They found that liver transplantation was an effective treatment for small, unresectable hepatocellular carcinomas in patients with cirrhosis, as their cohort demonstrated excellent long-term outcomes. Their protocol became known as the Milan Criteria and have been adopted by the American Association for the Study of Liver Diseases (AASLD).

Li et al (2025) published a meta-analysis which aimed to analyze liver transplant (LT) selection criteria through overall survival outcomes from post-operative data of patients with differing severity levels of acute-on-chronic liver failure (ACLF). They classified the severity grades according to the European Association for the Study of the Liver criteria. A total of 28,025 participants were included and the ACLF grades analysis showed that 33.7% of the patients were classified as ACLF-1, 35.1% as ACLF-2, and 31.2% as ACLF-3. Patients with ACLF-1 and ACLF-2 demonstrated favorable survival outcomes within one year, with survival rates reaching 87% [95% confidence interval (CI): 84%-91%] and 86% (95%CI: 81%-91%), respectively. Despite the relatively lower survival (73%, 95%CI: 66%-80%) and higher incidence of infection (48%, 95%CI: 29%-67%) observed in ACLF-3 patients, their survival exceeds those who do not undergo LT. Post-transplant survival was highest in North America across all ACLF grades.

PROFESSIONAL GUIDELINE(S)

The American Association for the Study of Liver Diseases (AASLD) and the American Society of Transplantation (AST) issued joint guidelines for evaluation for liver transplantation in adults (Martin 2014). "Liver transplant (LT) is indicated for severe acute or advanced chronic liver disease when the limits of medical therapy have been reached" and they make the following recommendations:

- "Evaluation for LT should be considered once a patient with cirrhosis has experienced an index complication such as ascites, hepatic encephalopathy, or variceal hemorrhage or hepatocellular dysfunction results in a MELD Score ≥15".
- "In a liver transplant candidate potentially treatable etiologies and components of hepatic decompensation such as ascites, hepatic encephalopathy, or variceal hemorrhage should be treated."
- "Potential liver transplant candidates with worsening renal dysfunction or other evidence of rapid hepatic decompensation should have prompt evaluation for liver transplant."

- Medical Comorbidities
    - "Obese patients (WHO class 1 and greater) require dietary counseling prior to LT."
    - "Class 3 obesity (BMI ≥40) is a relative contraindication to LT."
    - "Cardiac evaluation needs to include assessment of cardiac risk factors with stress echocardiography as an initial screening test with cardiac catheterization as clinically indicated."
    - "In the absence of significant comorbidities, older recipient age (>70 years) is not a contraindication to LT."
    - "Portopulmonary hypertension (POPH) should be excluded in LT candidates by routine echocardiography. For RVSP ≥45 mm Hg right heart cardiac catheterization is indicated."
    - "LT can be offered to potential recipients with POPH, which responds to medical therapy with an MPAP ≤35 mmHg."
    - "The presence of severe hepatopulmonary syndrome (HPS) is associated with increased mortality and affected individuals should undergo expedited LT evaluation."
    - "Simultaneous liver-kidney transplantation is indicated for LT candidates in whom renal failure reflects CKD with GFR <30 mL/min or acute kidney injury with dialysis >8 weeks or if extensive glomerulosclerosis is present."
- Tobacco use
    - "Tobacco consumption should be prohibited in LT candidates."
- Malignancy
    - "LT candidates with a prior extrahepatic malignancy should have received definitive treatment with adequate tumor-free survival prior to listing for LT."
    - "Candidates should undergo age and risk factor-appropriate cancer screening, e.g., colonoscopy, mammography, Papanicolaou smear."
- Infectious Diseases
    - "LT candidates should be screened for bacterial, viral, and fungal infections prior to LT."
    - "Treatment for latent TB should be initiated pre-LT."
    - "Vaccination should be encouraged against pneumococcus, influenza, diphtheria, pertussis, and tetanus."
    - "Live vaccines (mumps, measles, rubella, and varicella), if indicated, should be administered early in the evaluation process."
    - "Patients with HIV infection are candidates for LT if immune function is adequate and the virus is expected to be undetectable by the time of LT."

  - "LT transplant candidates with HCV have the same indications for LT as for other etiologies of cirrhosis."
  - "Patients with HBV liver disease should receive antiviral therapy to suppress HBV replication pretransplant and continued surveillance for HCC."
  - "LT should be considered in patients with decompensated autoimmune hepatitis who do not respond to or are not appropriate candidates for medical therapies."
- Psychosocial Evaluation
  - "Patients should be evaluated for and meet reasonable expectations for adherence to medical directives and mental health stability as determined by the psychosocial evaluation."
  - "Methadone-maintained patients should not be denied transplantation based on methadone use alone, and expectations of methadone reduction or discontinuation should not be a requirement for transplant listing."
  - "Patients should have adequate social/caregiver support to provide the necessary assistance both while waitlisted and until independently functioning in the postoperative period."
- Primary Biliary Cirrhosis (PBC)
  - "LT is indicated for decompensated PBC."
  - "Severe pruritus, refractory to medical therapy, may also be an indication for LT."
- Primary Sclerosing Cholangitis (PSC)
  - "LT is an effective therapy for decompensated liver disease due to PSC, including bouts of recurrent cholangitis and sepsis."
- Alcoholic Liver Disease
  - "Early referral of ALD patients for initiation of LT evaluation facilitates psychosocial assessment and setting addiction treatment goals."
  - "Given the chronic nature of alcohol dependence, ongoing monitoring is an important part of a comprehensive treatment plan."
- Acute Liver Failure (ALF)
  - "Patients with ALF require immediate referral to a liver transplant center."
  - "Patients with acetaminophen overdose should be evaluated for and meet reasonable expectations for adherence to medical directives and mental health stability as determined by the psychosocial evaluation."
- Hepatocellular Carcinoma
  - "LT is an effective therapy for HCC within the Milan criteria."

- "LT may be an option for HCC in excess of the Milan criteria in combination with tumor downstaging to Milan."

- Cholangiocarcinoma
  - "Patients diagnosed with early-stage cholangiocarcinoma and deemed unresectable due to parenchymal liver disease or anatomic location may be considered for LT in combination with neoadjuvant chemoradiation."
- Metabolic Diseases
  - Nonalcoholic steatohepatitis (NASH)
    - "LT is an effective therapy for decompensated liver disease due to NASH or cryptogenic cirrhosis."
  - α-1-Antritrypsin Deficiency
    - "LT is indicated for decompensated cirrhosis due to α-1-antritrypsin deficiency."
  - Hereditary Hemochromatosis
    - "LT is indicated for decompensated cirrhosis due to hemochromatosis."
  - Wilson's Disease
    - "Urgent LT is indicated for Wilsonian acute liver failure."
    - "LT is indicated in decompensated cirrhosis due to Wilson's disease unresponsive to medical therapy."
    - "LT is not recommended as therapy for neuropsychological Wilson's disease, as LT does not reliably improve neurologic outcomes."
- Hereditary Amyloidosis
  - "LT should be considered in familial amyloid polyneuropathy (FAP) to eliminate hepatic amyloid production early in the course of disease and particularly prior to the development of cardiac and ocular complications, as these complications are not reliably improved by LT."
- Primary Hyperoxaluria
  - "Preemptive LT (prior to the development of advanced renal disease) or combined liver and kidney transplantation in the setting of end stage renal disease (ESRD) are curative for primary hyperoxaluria and should be considered for patients who do not respond to medical therapy."
- MELD Exceptions
  - "For an LT candidate whose MELD score does not adequately reflect the severity of their liver disease, an appeal for MELD exception points should be made to the Regional Review Boards (RRB)."

The AASLD practice guidelines on diagnosis and treatment of alcohol-associated liver disease (Crabb 2020) recommend the following:

- "Patients without liver disease should be educated about safe levels of alcohol use for men (no more than two standard drinks per 24 hours) and women (no more than one standard drink per 24 hours)."
- "Patients with Alcohol-associated liver disease (ALD) or other liver diseases, in particular non-alcoholic fatty liver disease [NAFLD], NASH, viral hepatitis, and hemochromatosis, should be counseled that there is no safe level of drinking, and that they should abstain."
- "Potential LT candidates with ALD undergo evaluation by a mental health provider for full psychiatric diagnosis and adequate treatment planning."
- "Patients with decompensated alcohol-associated cirrhosis, CPT class C or MELD-Na of at least 21 should be referred and considered for liver transplantation."
- "Candidate selection for liver transplantation in alcohol-associated cirrhosis should not be based solely on a fixed interval of abstinence."
- "Liver transplantation may be considered in carefully selected patients with favorable psychosocial profiles in severe alcoholic hepatitis [AH] not responding to medical therapy."

The AASLD released a practice guideline for the prevention, diagnosis, and treatment of hepatocellular carcinoma (HCC) (Singal 2023). They state:

- "For patients with early-stage HCC who are ineligible for resection because of liver dysfunction or tumor multi-focality, LT is an optimal treatment strategy because it provides a cure for both HCC and the underlying liver disease… The Milan criteria (one lesion between 1 and 5 cm or two to three lesions between 1 and 3 cm) has been well established as the standard for optimal patient selection."
- "Liver transplantation should be the treatment of choice for transplant-eligible patients with early-stage HCC occurring in the setting of clinically significant portal hypertension and/or decompensated cirrhosis."
- "Liver transplantation should be the treatment of choice for transplant-eligible patients with HCC that recur within Milan criteria after surgical resection."

The National Comprehensive Cancer Network (NCCN) guidelines on hepatocellular carcinoma (V. 2.2025) recommend patients meeting the UNOS criteria should be considered for transplantation (cadaveric or living donation). Additionally, patients with tumor characteristics that are just outside of the UNOS guidelines may be considered for transplantation based on the institution. For those who have had successful downstaging therapy, transplantation can also be considered.

REGULATORY STATUS

The U.S. Food and Drug Administration (FDA) does not regulate the transplantation of vascularized human organ transplants such as kidney, liver, heart, lung, or pancreas. The Health Resources Services Administration (HRSA) oversees the transplantation of vascularized human organs. More

information available from: https://www.fda.gov/vaccines-blood-biologics/tissue-tissue-products/tissue-and-tissue-product-questions-and-answers [accessed 2025 Oct 24]

HRSA information available from: https://data.hrsa.gov/topics/health-systems/organ-donation/ [accessed 2025 Oct 24]

CODE(S)

- Codes may not be covered under all circumstances.
- Code list may not be all inclusive (AMA and CMS code updates may occur more frequently than policy updates).
- (E/I)=Experimental/Investigational
- (NMN)=Not medically necessary/appropriate

CPT Codes

Code	Description
47133	Donor hepatectomy (including cold preservation), from cadaver donor
47135	Liver allotransplantation; orthotopic, partial or whole, from cadaver or living donor, any age
47140	Donor hepatectomy (including cold preservation), from living donor; left lateral segment only (segments II and III)
47141	Donor hepatectomy (including cold preservation), from living donor; total left lobectomy (segments II, III and IV)
47142	Donor hepatectomy (including cold preservation), from living donor; total right lobectomy (segments V, VI, VII and VIII)
47143	Backbench standard preparation of cadaver donor whole liver graft prior to allotransplantation, including cholecystectomy, if necessary, and dissection and removal of surrounding soft tissues to prepare the vena cava, portal vein, hepatic artery, and common bile duct for implantation; without trisegment or lobe split
47144	Backbench standard preparation of cadaver donor whole liver graft prior to allotransplantation, including cholecystectomy, if necessary, and dissection and removal of surrounding soft tissues to prepare the vena cava, portal vein, hepatic artery, and common bile duct for implantation; with trisegment split of whole liver graft into 2 partial liver grafts (i.e., left lateral segment [segments II and III] and right trisegment [segments I and IV through VIII])

Code	Description
47145	Backbench standard preparation of cadaver donor whole liver graft prior to allotransplantation, including cholecystectomy, if necessary, and dissection and removal of surrounding soft tissues to prepare the vena cava, portal vein, hepatic artery, and common bile duct for implantation; with lobe split of whole liver graft into 2 partial liver grafts (i.e., left lobe [segments II, III, and IV] and right lobe [segments I and V through VIII])
47146	Backbench reconstruction of cadaver or living donor liver graft prior to allotransplantation; venous anastomosis, each
47147	Backbench reconstruction of cadaver or living donor liver graft prior to allotransplantation; arterial anastomosis, each

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HCPCS Codes

Code	Description
Not Applicable	

ICD10 Codes

Code	Description
A52.15	Late syphilitic neuropathy
B15.0-B15.9	Acute hepatitis A (code range)
B16.0-B16.9	Acute hepatitis B (code range)
B17.10-B17.11	Acute hepatitis C (code range)
B17.8-B19.9	Other acute viral hepatitis (code range)
B25.1	Cytomegaloviral hepatitis
B66.1	Clonorchiasis
B66.3	Fascioliasis
C22.0	Liver cell carcinoma
C22.2-C22.9	Malignant neoplasm of liver and intrahepatic bile ducts (code range) (includes hepatoblastoma)
D64.0-D64.3	Sideroblastic anemia (code range)

Code	Description
D81.810	Biotinidase deficiency
D84.1	Defects in the complement system
E70.0-E71.30	Disorders of aromatic amino-acid metabolism (code range)
E72.00-E73.1	Other disorders of amino-acid metabolism (code range)
E74.39	Other disorders of intestinal carbohydrate absorption ~~(code range)~~
E74.4-E74.9	Other disorders of carbohydrate metabolism (code range)
E75.21-E75.3	Disorders of sphingolipid metabolism and other lipid storage disorders (code range)
E75.5-E75.6	Lipid storage disorders (code range)
E77.0-E77.9	Disorders of glycoprotein metabolism (code range)
E78.0-E78.9	Pure hypercholesterolemia (code range)
E80.0-E80.29	Disorders of porphyrin and bilirubin metabolism (code range)
E83.00-E83.19	Disorders of mineral metabolism (code range)
E88.89	Other specified metabolic disorders
E88.9	Metabolic disorder, unspecified
G60.0	Hereditary motor and sensory neuropathy
G60.2	Neuropathy in association with hereditary ataxia
G63	Polyneuropathy in diseases classified elsewhere
G65.0-G65.2	Sequelae of inflammatory and toxic polyneuropathies (code range)
G80.1-G80.9	Cerebral palsy (code range)
I82.0	Budd-Chiari syndrome
I99.9	Unspecified disorder of circulatory system
K71.0-K71.9	Toxic liver disease (code range)
K74.0	Hepatic fibrosis
K74.3-K74.69	Fibrosis and cirrhosis of liver (code range)

Code	Description
K75.2-K75.3	Other inflammatory liver diseases (code range)
K75.81-K75.89	Other specified inflammatory liver diseases (code range)
K75.9	Inflammatory liver disease, unspecified
K76.4	Peliosis hepatitis
K77	Liver disorders in diseases classified elsewhere
K80.30-K80.37	Calculus of bile duct with cholangitis (code range)
K83.0-K83.8	Other diseases of biliary tract (code range)
K87	Disorders of gallbladder, biliary tract and pancreas in diseases classified elsewhere
M34.83	Systemic sclerosis with polyneuropathy
Q44.2-Q44.3	Congenital malformations of gallbladder, bile ducts and liver (code range)
Q44.6	Cystic disease of liver
S31.609A	Unspecified open wound of abdominal wall, unspecified quadrant with penetration into peritoneal cavity, initial encounter
S36.112A	Contusion of liver, initial encounter

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SEARCH TERMS

Hepatic transplant, Liver Transplant, Living donor liver transplant.

CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)

Adult Liver Transplantation (NCD 260.1) [accessed 2025 Oct 23]

Pediatric Liver Transplantation (NCD 260.2) [accessed 2025 Oct 23]

PRODUCT DISCLAIMER

- Services are contract dependent; if a product does not cover a service, medical policy criteria do not apply.
- If a commercial product (including an Essential Plan or Child Health Plus product) covers a specific service, medical policy criteria apply to the benefit.
- If a Medicaid product covers a specific service, and there are no New York State Medicaid guidelines (eMedNY) criteria, medical policy criteria apply to the benefit.
- If a Medicare product (including Medicare HMO-Dual Special Needs Program (DSNP) product) covers a specific service, and there is no national or local Medicare coverage decision for the service, medical policy criteria apply to the benefit.
- If a Medicare HMO-Dual Special Needs Program (DSNP) product DOES NOT cover a specific service, please refer to the Medicaid Product coverage line.

POLICY HISTORY/REVISION

Committee Approval Dates

07/02/99, 12/21/00, 02/21/02, 05/21/03, 07/15/04, 06/16/05, 08/17/06, 07/19/07, 10/23/08, 08/20/09, 10/28/10, 10/20/11, 10/18/12, 01/16/14, 01/22/15, 01/21/16, 01/19/17, 01/18/18, 01/17/19, 01/16/20, 01/21/21, 08/19/21, 08/18/22, 10/19/23, 10/17/24, 11/20/25

Date	Summary of Changes
11/20/25	• Annual review, policy intent unchanged.
01/01/25	• Summary of changes tracking implemented.
07/02/99	• Original effective date