

# Clinical Policy: Lung Transplantation

Reference Number: LA.CP.MP.57

[Coding  
Implications](#)

Date of Last Revision: 409/23

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

## Description

~~Medical~~ This policy describes the medical necessity criteria for the review of lung transplantation requests.

The below criteria are sourced from the International Society for Heart and Lung Transplantation (ISHLT) 2021 Consensus Document for the Selection of Lung Transplant Candidates.<sup>19</sup>

The ISHLT consensus document that the below criteria are derived from provides guidelines based on expert synthesis of the current literature with a goal of improving survival and quality of life in transplant candidates. ISHLT recognizes that donor lungs are a limited societal resource, requiring that guidance on candidate selection be based on survival benefit. Given the rigor of the guidelines on which this policy is based, the benefits of receiving a lung transplant in individuals meeting the criteria below outweighs the potential risk of adverse outcomes related to receiving a transplant that is not indicated or not receiving a transplant that is indicated.

## Policy/Criteria

- I. It is the policy of Louisiana Healthcare Connections that lung transplantation for members/enrollees with chronic, end-stage lung disease who have failed maximal medical (including pulmonary rehabilitation, as applicable) or surgical therapy is **medically necessary** when all the following criteria are met:
  - A. High (> 50%) risk of death from lung disease within two years if lung transplantation is not ~~performed~~performed<sup>19</sup>;
  - B. High (> 80%) likelihood of five-year post-transplant survival from a general medical perspective provided there is adequate graft ~~function~~function<sup>19</sup>;
  - C. Does not have ANY of the following absolute ~~contraindications~~<sup>19</sup>contraindications<sup>19</sup>:
    1. Malignancy with high risk of recurrence or death related to cancer;
    2. Glomerular filtration rate < 40 mL/min/1.73m<sup>2</sup> unless being considered for multi-organ transplant;
    3. Acute renal failure with rising creatinine or on dialysis and low likelihood of recovery;
    4. Acute liver failure, or cirrhosis with portal hypertension or synthetic dysfunction unless being considered for multi-organ transplant;
    5. Stroke, acute coronary syndrome, or myocardial infarction (excluding demand ischemia) within 30 days;
    6. Septic shock;
    7. Active extrapulmonary or disseminated infection;
    8. Active *tuberculosis* infection;
    9. HIV infection with detectable viral load;

## CLINICAL POLICY

### Lung Transplantation

10. Progressive cognitive impairment;
  11. Inability to adhere to the regimen necessary to preserve the transplant, even with caregiver support;-
  12. Other severe, uncontrolled medical condition expected to limit survival after transplant;-
  13. Active substance use or dependence ~~(including current tobacco use, vaping, marijuana use (unless prescribed by a licensed practitioner), smoking, or IV drug use without convincing evidence of risk reduction behaviors (unless urgent transplant timelines are present, in which case a commitment to reducing behaviors is acceptable). Serial blood and urine testing may be used to verify abstinence from substances that are of concern.;~~  
    - a. ~~If there is a history of nicotine or tobacco use, documentation notes abstinence from all tobacco and nicotine products (including nicotine replacement therapy) for ≥ six months prior to transplant.~~
- D. Has one of the following disease states (not an all- inclusive list):
1. *Adult members/enrollees, age ≥ 18:*
    - a. Interstitial lung disease and any of the ~~following~~following<sup>19</sup>.\*:
      - i. Absolute decline in forced vital capacity (FVC)  $\geq 10\%$  in the past six months despite appropriate treatment;
      - ii. Absolute decline in diffusing capacity of the lung for carbon monoxide (DLCO)  $\geq 10\%$  in the past six months despite appropriate treatment;
      - iii. Absolute decline in forced vital capacity (FVC)  $\geq 5\%$  with radiographic progression in the past ~~six~~ months despite appropriate treatment;
      - iv. Desaturation to  $< 88\%$  on six-minute-walk test (6MWT) or  $> 50$  m decline in 6MWT distance in the past ~~six~~ months;
      - v. Pulmonary hypertension on right heart catheterization or two-dimensional echocardiography (in the absence of diastolic dysfunction);
      - vi. Hospitalization because of respiratory decline, pneumothorax, or acute exacerbation;
    - b. Cystic fibrosis (CF) or other causes of bronchiectasis and any of the ~~following~~following<sup>19</sup>:
      - i.  $FEV_1 < 25\%$  predicted despite optimal medical management including a trial of elexacaftor/tezacaftor/ivacaftor if eligible;
      - ii. Both of the following:
        - a) Any of the following despite optimal medical management including a trial of elexacaftor/tezacaftor/ivacaftor if eligible:
          - 1)  $FEV_1 < 30\%$  predicted;
          - 2)  $FEV_1 < 40\%$  predicted and any of the following:
            - ~~(a)i)~~          Six-minute walk distance  $< 400$  meters;
            - ~~(b)ii)~~           $P_aCO_2 > 50$  mmHg 50 mmHg;
            - ~~(c)iii)~~          Hypoxemia at rest or with exertion;
            - ~~(d)iv)~~          Pulmonary hypertension (PA systolic pressure  $> 50$  mmHg 50 mmHg on echocardiogram or evidence of right ventricular dysfunction);
            - ~~(e)v)~~          Worsening nutritional status despite supplementation;
            - ~~(f)vi)~~          Two exacerbations per year requiring intravenous antibiotics;
            - ~~(g)vii)~~          Massive hemoptysis ( $> 240$  mL) requiring bronchial artery embolization;

## CLINICAL POLICY

### Lung Transplantation

- (h)viii) Pneumothorax;
- 3) FEV<sub>1</sub> <50% predicted and rapidly declining based on pulmonary function testing or progressive symptoms;
- 4) Any exacerbation requiring positive pressure ventilation;
- b) Any of the ~~following~~<sup>following</sup><sup>19</sup>:
  - 1) Rapid decline in lung function or progressive symptoms (>30% relative decline in FEV<sub>1</sub> over 12 months);
  - 2) Frequent hospitalization, particularly if >28 days hospitalized in the preceding year;
  - 3) Any exacerbation requiring mechanical ventilation;
  - 4) Chronic respiratory failure with hypoxemia or hypercapnia, particularly for those with increasing oxygen requirements or needing long-term non-invasive ventilation therapy;
  - 5) Pulmonary hypertension (Pulmonary arterial systolic pressure >50 mmHg on echocardiogram or evidence of right ventricular dysfunction);
  - 6) Worsening nutritional status particularly with body mass index (BMI) <18 kg/m<sup>2</sup> despite nutritional interventions;
  - 7) Recurrent massive hemoptysis despite bronchial artery embolization;
  - 8) World Health Organization (WHO) Functional Class IV;
- c. Chronic obstructive pulmonary disease (COPD), and any of the ~~following~~<sup>following</sup><sup>19</sup>:
  - i. BODE score (includes BMI, degree of airflow obstruction, degree of dyspnea, and exercise capacity) of 7 to 10;
  - ii. FEV<sub>1</sub> (forced expiratory volume in one second) < 20% predicted;
  - iii. History of severe exacerbations;
  - iv. Chronic hypercapnia;
  - v. Moderate to severe pulmonary hypertension;
- d. Pulmonary vascular diseases and any of the ~~following~~<sup>following</sup><sup>19</sup>:
  - i. European Society of Cardiology/European Respiratory Society (ESC/ERS) high risk or Registry to Evaluate Early and Long-term Pulmonary Arterial Hypertension Disease Management (REVEAL) risk score >10 on appropriate pulmonary arterial hypertension (PAH) therapy, including intravenous (IV) or subcutaneous (SC) prostacyclin analogues;
  - ii. Progressive hypoxemia;
  - iii. Progressive, but not end stage, liver, or kidney dysfunction due to PAH
  - iv. Life-threatening hemoptysis;
- ~~e. Eisenmenger syndrome with pulmonary hypertension despite therapy aimed at avoiding polycythemia, iron deficiency and dehydration, and the associated profound hypoxemia and impaired quality of life;~~
- ~~f.e.~~ Lymphangioleiomyomatosis (LAM) with evidence of disease progression despite mTOR inhibitor therapy and any of the ~~following~~<sup>following</sup><sup>19</sup>:
  - i. Severely abnormal lung function (e.g. FEV<sub>1</sub> <30% predicted);
  - ii. Exertional dyspnea (NYHA class III or IV);
  - iii. Hypoxemia at rest;
  - iv. Pulmonary hypertension;
  - v. Refractory pneumothorax;
- ~~g.f.~~ Primary lung graft failure ~~or bronchiolitis obliterans;~~
- g. Acute respiratory distress syndrome (ARDS) with a persistent requirement for mechanical ventilatory support and /or extracorporeal life support (ECLS) without

## CLINICAL POLICY

### Lung Transplantation

- expectation of clinical recovery and with evidence of irreversible lung destruction<sup>19</sup>:
2. *Pediatric members/enrollees, age < 18<sup>19</sup>:*
    - a. Cystic fibrosis, and any of the following<sup>19</sup>:
      - i. ~~Progressive lung disease and disability~~ FEV<sub>1</sub> < 25% predicted despite optimal medical therapy management including a trial of elexacaftor/tezacaftor/ivacaftor if eligible<sup>19</sup>:
      - ii. Both of the following<sup>19</sup>:
        - a) Any of the following despite optimal medical management including a trial of elexacaftor/tezacaftor/ivacaftor if eligible:
          - ii.1) FEV<sub>1</sub> < 30% predicted; < 40% predicted<sup>19</sup>:
          - iii. Increasingly frequent hospitalizations;
          - iv. Hypoxemia, ( PaO<sub>2</sub> < 8 kPa or < 60 mm Hg);
          - v. Hypercapnia, (PaCO<sub>2</sub> > 6.6 kPa or > FEV<sub>1</sub> < 50 mmHg);
          - b.2) Idiopathic pulmonary arterial hypertension, % predicted and any of the following<sup>19</sup>:
            - i) Six-minute walk distance < 400 meters;
            - ii) P<sub>a</sub>CO<sub>2</sub> > 50 mmHg;
            - iii) Hypoxemia at rest or with exertion;
            - iv) Pulmonary hypertension (PA systolic pressure > 50 mmHg on echocardiogram or evidence of right ventricular dysfunction;
            - v) Worsening nutritional status despite supplementation;
            - vi) Two exacerbations per year requiring intravenous antibiotics;
            - vii) Massive hemoptysis (>240 mL) requiring bronchial artery embolization;
            - viii) Pneumothorax.
          - 3) FEV<sub>1</sub> < 50% predicted and rapidly declining based on pulmonary function testing or progressive symptoms;
          - 4) Any exacerbation requiring positive pressure ventilation;
        - b) Any of the following<sup>19</sup>:
          - 1) Rapid decline in lung function or progressive symptoms (>30% relative decline in FEV<sub>1</sub> over 12 months);
          - 2) Frequent hospitalization, particularly if > 28 days hospitalized in the preceding year;
          - 3) Any exacerbation requiring mechanical ventilation;
          - 4) Chronic respiratory failure with hypoxemia or hypercapnia, particularly for those with increasing oxygen requirements or needing long-term non-invasive ventilation therapy;
          - 5) Pulmonary hypertension (Pulmonary arterial systolic pressure > 50 mmHg on echocardiogram or evidence of right ventricular dysfunction);
          - 6) Worsening nutritional status particularly with BMI < 18 kg/m<sup>2</sup> despite nutritional interventions;
          - 7) Recurrent massive hemoptysis despite bronchial artery embolization;
          - 8) WHO Functional Class IV.
      - b. Pulmonary vascular disease and any of the following<sup>19</sup>:
        - i. ESC/ERS high risk or Registry to Evaluate Early and Long-term Pulmonary Arterial Hypertension Disease Management (REVEAL) risk score > 10 on appropriate PAH therapy, including IV or SC prostacyclin analogues;
        - ii. Progressive hypoxemia;

## CLINICAL POLICY

### Lung Transplantation

- ~~iii. Progressive, but not end stage, liver, or kidney dysfunction due to PAH;~~
- ~~iv. Life-threatening hemoptysis;~~
- ~~i.v. PAH in the European Pediatric Pulmonary Vascular Disease Network (EPPVDN) high risk category and on optimal therapy without improvement;<sup>19</sup>~~
- ~~ii. Low exercise tolerance with 6MWT < 350 meters;~~
- ~~iii. Uncontrolled syncope;~~
- ~~iv. Hemoptysis;~~
- ~~v. Right sided heart failure;~~
- ~~vi. Failure to respond to vasodilator therapy;~~
- ~~c. Pulmonary vascular disease and failure to respond to medical management;~~
- ~~d. Eisenmenger syndrome with pulmonary hypertension despite therapy aimed at avoiding polycythemia, iron deficiency and dehydration, and the associated profound hypoxemia and impaired quality of life;~~
- ~~e. Surfactant dysfunction disorders with unrelenting respiratory failure, or progressive interstitial lung disease with respiratory insufficiency, unresponsive to medical interventions;~~
- ~~f.c. Bronchopulmonary dysplasia, and any of the following<sup>19</sup>:~~
  - ~~i. Extended time requiring ventilator support without clinical improvement;~~
  - ~~ii. Pulmonary hypertension unresponsive to oxygen therapy;~~
  - ~~iii. Repeated episodes of respiratory failure without improvement in clinical trajectory over time, despite good medical support;~~
  - ~~iv. Progressive pulmonary hypertension;~~
- ~~g. Diffuse parenchymal lung disease, and any of the following:~~
  - ~~i. Absolute decline in FVC > 10% in the past six months despite appropriate treatment;~~
  - ~~ii. Absolute decline in DLCO > 10% in the past six months despite appropriate treatment;~~
  - ~~i.iii. Absolute decline in FVC > 5% with radiographic progression in the past six months despite optimal management appropriate treatment;~~
  - ~~ii. Poor quality of life;~~
  - ~~iv. Desaturation to < 88% on 6MWT or > 50 m decline in 6MWT distance in the past six months;~~
  - ~~v. Pulmonary hypertension on right heart catheterization or two dimensional echocardiography (in the absence of diastolic dysfunction);~~
  - ~~vi. Hospitalization because of respiratory decline, pneumothorax, or acute exacerbation.~~
- ~~d. COPD, and any of the following<sup>19</sup>:~~
  - ~~i. BODE score (includes BMI, degree of airflow obstruction, degree of dyspnea, and exercise capacity) of seven to 10;~~
  - ~~ii. FEV<sub>1</sub> < 20% predicted;~~
  - ~~iii. History of severe exacerbations;~~
  - ~~iv. Chronic hypercapnia;~~
  - ~~v. Moderate to severe pulmonary hypertension.~~
- ~~h.e. Primary lung graft failure or bronchiolitis obliterans failure<sup>19</sup>;~~
- ~~i. End stage emphysema due to alpha-1 trypsin deficiency.~~
- ~~f. LAM with evidence of disease progression despite mTOR inhibitor therapy and any of the following<sup>19</sup>:~~

## CLINICAL POLICY

### Lung Transplantation

- i. Several abnormal lung function (e.g. FEV1 <30% predicted);
- ii. Exertional dyspnea (NYHA class III or IV);
- iii. Hypoxemia at rest;
- iv. Pulmonary hypertension;
- v. Refractory pneumothorax.
- g. ARDS with a persistent requirement for mechanical ventilatory support and /or ECLS without expectation of clinical recovery and with evidence of irreversible lung destruction<sup>19</sup>.

\*Note: FVC may be a less reliable parameter for those with concomitant ~~emphysema~~emphysema<sup>19</sup>.

### Background

Lung transplantation is an accepted therapy for the management of a range of severe lung disorders. Single, double, and lobar-lung transplants have all been successful for carefully selected patients with end-stage pulmonary disease. The most common disease processes for which lung transplants are performed include COPD, idiopathic pulmonary fibrosis, cystic fibrosis, pulmonary arterial hypertension, and sarcoidosis.

COPD is one of the most common lung diseases and is the most common indication for lung transplantation in adults. Chronic bronchitis and emphysema are the two main forms of COPD, both most commonly caused from smoking. Non-smokers with an alpha-1 antitrypsin deficiency can also develop emphysema. These conditions are the most common indications for single lung transplants. Cystic fibrosis, emphysema, and alpha-1 antitrypsin deficiency are the most common indications for double lung transplant, or sequential replacement of both lungs.

The most common indications for pediatric lung transplants include pulmonary vascular disease, bronchiolitis obliterans, bronchopulmonary dysplasia, graft failure due to viral pneumonitis, and cystic ~~fibrosis~~fibrosis.

### 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 2022, 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 and may not support medical necessity and may not support medical necessity. 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.

NOTE: Coverage is subject to each requested code's inclusion on the corresponding LDH fee schedule. Non-covered codes are denoted (\*) and are reviewed for Medical Necessity for members under 21 years of age on a per case basis.

CPT® Codes	Description
<del>32850</del> <u>328</u>	Donor pneumonectomy(s) (including cold preservation), from cadaver donor
32851	Lung transplant, single; without cardiopulmonary bypass



## CLINICAL POLICY

### Lung Transplantation

CPT® Codes	Description
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

HCPCS Codes	Description
S2060*	Lobar lung transplantation
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

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Converted corporate to local policy.	08/15/2020	
References reviewed and updated. Replaced “members” with “members/enrollees” in all instances. Replaced contraindications of “severely limited functional status with poor rehabilitation potential” and those regarding past or current nonadherence to medical therapy, and psychological condition associated with the inability to comply with medical therapy with “Inability to adhere to the regimen necessary to preserve the transplant, even with caregiver support.” Changed “review date” in header to “Date of Last Revision” and “Date” in the revision log header to “Revision Date.” Added “and may not support medical necessity” in coding implications. Annual review. References reviewed and updated. Reviewed by specialist.	2/22	
Annual review. Added “or surgical therapy” to I and noted that maximal medical therapy includes pulmonary rehab when applicable. Updated the following based on ISHLT 2021 guidelines; removed criteria “High (> 80%) likelihood of surviving at least 90 days after lung transplantation.”, updated	5/22	8/13/22

## CLINICAL POLICY

### Lung Transplantation

Reviews, Revisions, and Approvals	Revision Date	Approval Date
I.C., I.D.1.a, I.D.1.b., I.D.1.c., I.D.1.d., I.D.1.f., I.D.2.a, I.D.2.b. Clarified nicotine and tobacco abstinence contraindication. Added CPT codes 32850, 32855, and 32856. References reviewed, updated, and reformatted. Reviewed by specialist. Added “and may not support medical necessity” to Coding Implications section		
Annual review. Criteria I.C.13. updated to exclude marijuana use when prescribed by a licensed practitioner and include required commitment to reducing substance use behaviors if urgent transplant timelines are present. Added pediatric indication for end-stage emphysema due to alpha-1 trypsin deficiency. References reviewed and updated.	4/23	7/21/23
<u>Revised adult and pediatric criteria to align with ISHLT 2021 consensus document. References reviewed and updated. Note for non-covered codes added.</u>	<u>09/23</u>	

## References

1. MedlinePlus. Chronic obstructive pulmonary disease (COPD). <https://medlineplus.gov/ency/article/000091.htm>. Accessed January 20, 2023.
2. Rabe KF, Watz H. Chronic obstructive pulmonary disease. *Lancet*. 2017;389(10082):1931-1940. doi:10.1016/S0140-6736(17)31222-9
3. Biswas Roy S, Panchanathan R, Walia R, et al. Lung Retransplantation for Chronic Rejection: A Single-Center Experience. *Ann Thorac Surg*. 2018;105(1):221-227. doi:10.1016/j.athoracsur.2017.07.025
4. Christie JD, Edwards LB, Kucheryavaya AY, et al. The Registry of the International Society for Heart and Lung Transplantation: Twenty-eighth Adult Lung and Heart-Lung Transplant Report--2011. *J Heart Lung Transplant*. 2011;30(10):1104-1122. doi:10.1016/j.healun.2011.08.004
5. Faro A, Mallory GB, Visner GA, et al. American Society of Transplantation executive summary on pediatric lung transplantation. *Am J Transplant*. 2007;7(2):285-~~to~~ 292. doi:10.1111/j.1600-6143.2006.01612.x
6. Yusen RD, Edwards LB, Kucheryavaya AY, et al. The Registry of the International Society for Heart and Lung Transplantation: Thirty-second Official Adult Lung and Heart-Lung Transplantation Report--2015; Focus Theme: Early Graft Failure. *J Heart Lung Transplant*. 2015;34(10):1264-1277. doi:10.1016/j.healun.2015.08.014
7. Hachem RR. Lung transplantation: an overview. UpToDate. [www.uptodate.com](http://www.uptodate.com). Published September 6, 2022. Accessed January 20, 2023.
8. Hachem RR. Lung transplantation: disease-based choice of procedure. UpToDate. [www.uptodate.com](http://www.uptodate.com). Published December 7, 2022. Accessed January 20, 2023.
9. Hachem RR. Lung transplantation: general guidelines for recipient selection. UpToDate. [www.uptodate.com](http://www.uptodate.com). Published ~~January 18~~ July 12, 2023. Accessed ~~January 20~~ July 24, 2023.
10. Hall DJ, Belli EV, Gregg JA, et al. Two Decades of Lung Retransplantation: A Single-Center Experience. *Ann Thorac Surg*. 2017;103(4):1076-1083. doi:10.1016/j.athoracsur.2016.09.107



## CLINICAL POLICY

### Lung Transplantation

11. Kirkby S, Hayes D Jr. Pediatric lung transplantation: indications and outcomes. *J Thorac Dis.* 2014;6(8):1024-1031. doi:10.3978/j.issn.2072-1439.2014.04.27
12. Kotloff RM, Thabut G. Lung transplantation. *Am J Respir Crit Care Med.* 2011;184(2):159-171. doi:10.1164/rccm.201101-0134CI
13. Meyer KC. Recent advances in lung transplantation. *F1000Res.* 2018;7:F1000 Faculty Rev-1684. Published 2018 Oct 23. doi:10.12688/f1000research.15393.1
14. Whitson, BA. Lung transplantation. Medscape.  
<https://emedicine.medscape.com/article/429499-overview>. Published August 19, 2019.
15. National Institute for Health and Clinical Excellence. Living-donor lung transplantation for end-stage lung disease. <https://www.nice.org.uk/guidance/ipg170>. Published May 24, 2006. Accessed January 20, 2023.
16. Organ Procurement and Transplantation Network. Policies.  
<https://optn.transplant.hrsa.gov/policies-bylaws/policies/>. Updated December 6, 2021. Accessed January 20, 2023.
17. Weill D, Benden C, Corris PA, et al. A consensus document for the selection of lung transplant candidates: 2014--an update from the Pulmonary Transplantation Council of the International Society for Heart and Lung Transplantation. *J Heart Lung Transplant.* 2015;34(1):1-15. doi:10.1016/j.healun.2014.06.014
18. Simon, RH. Cystic fibrosis: management of advanced lung disease. UpToDate.  
[www.uptodate.com](http://www.uptodate.com). Published October 18, 2022. Accessed January 20, 2023.
19. Leard LE, Holm AM, Valapour M, et al. Consensus document for the selection of lung transplant candidates: An update from the International Society for Heart and Lung Transplantation. *J Heart Lung Transplant.* 2021;40(11):1349-~~to~~ 1379. doi:10.1016/j.healun.2021.07.005
20. Stone HM, Edgar RG, Thompson RD, Stockley RA. Lung Transplantation in Alpha-1-Antitrypsin Deficiency. *COPD.* 2016;13(2):146-152. doi:10.3109/15412555.2015.1048850.
21. Stoller JK. Clinical manifestations, diagnosis, and natural history of alpha-1 antitrypsin deficiency. UpToDate. [www.uptodate.com](http://www.uptodate.com). Published September 13, 2022. Accessed February 16, 2023.
22. Stoller JK. Treatment of alpha-1 antitrypsin deficiency. UpToDate. [www.uptodate.com](http://www.uptodate.com). Published November 4, 2021. Accessed February 16, 2023.

### **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. LHCC 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.

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

## CLINICAL POLICY

### Lung Transplantation

insurance, etc.), as well as to state and federal requirements and applicable LHCC -administrative policies and procedures.—

This clinical policy is effective as of the date determined by LHCC. 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. LHCC 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 LHCC has no control or right of control. —Providers are not agents or employees of LHCC.

This clinical policy is the property of LHCC. 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.—

©2023 Louisiana Healthcare Connections. All rights reserved. —All materials are exclusively owned by Louisiana Healthcare Connections and are protected by United States copyright law and international copyright law.— No part of this publication may be reproduced, copied, modified, distributed, displayed, stored in a retrieval system, transmitted in any form or by any means, or otherwise published without the prior written permission of Louisiana Healthcare Connections. You may not alter or remove any trademark, copyright or other notice contained herein. Louisiana Healthcare Connections is a registered trademark exclusively owned by Louisiana Healthcare Connections.