Islet Cell Transplantation

Description of Procedure or Service

Autologous islet transplantation, performed in conjunction with pancreatectomy, is proposed to reduce the likelihood of insulin-dependent diabetes. Moreover, allogeneic islet cell transplantation is being investigated as a treatment or cure for patients with type 1 diabetes.

In autologous islet transplantation, during the pancreatectomy procedure, islet cells are isolated from the resected pancreas using enzymes, and a suspension of the cells is injected into the portal vein of the patient’s liver. Once implanted, the beta cells in these islets begin to make and release insulin. In the case of allogeneic islet cell transplantation, cells are harvested from the deceased donor’s pancreas, processed, and injected into the recipient’s portal vein. Up to 3 donor pancreas transplants may be required to achieve insulin independence. Allogeneic transplantation may be performed in the radiology department.

Primary risk factors for chronic pancreatitis include toxic-metabolic, idiopathic, genetic, autoimmune, recurrent and severe acute pancreatitis, or obstructive (the TIGAR-O classification system). Patients with chronic pancreatitis may experience intractable pain that can only be relieved with a total or near total pancreatectomy. The pain relief must be balanced against the certainty that the patient will become an insulin dependent diabetic if a pancreatectomy is performed. Autologous islet cell transplantation has been investigated as a technique to prevent this serious morbidity.

Allogeneic islet transplantation has been used for type 1 diabetes to restore normoglycemia and, ultimately, reduce or eliminate the long-term complications of diabetes such as retinopathy, neuropathy, nephropathy, and cardiovascular disease. Islet transplantation offers an alternative to whole-organ pancreas transplantation. However, a limitation of islet transplantation is that 2 or more donor organs are usually required for successful transplantation, although experimentation with single-donor transplantation is occurring. A pancreas that is rejected for whole organ transplant is typically used for islet transplantation. Islet transplantation is recommended only for those with frequent and severe metabolic complications who have consistently failed to achieve control with insulin-based management.

In 2000, a modified immunosuppression regimen increased the success of allogeneic islet transplantation. This regimen was developed in Edmonton, Canada and is known as the “Edmonton protocol.”

Islet cells are regulated by the U.S. Food and Drug Administration (FDA) which classifies allogeneic islet cell transplantation as somatic cell therapy, requiring premarket approval. Islet cells also meet the definition of a drug under the federal Food, Drug, and Cosmetic Act. Clinical studies to determine the safety and effectiveness outcomes of allogeneic islet transplantation must be conducted under FDA investigational new drug (IND) regulation. While at least 35
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Investigational new drug applications have been submitted to the FDA, no center has submitted a biologics license application.

Related Policy
Insulin Therapy, Chronic Intermittent Intravenous (CIIT) Pancreas Transplant

***Note: This Medical Policy is complex and technical. For questions concerning the technical language and/or specific clinical indications for its use, please consult your physician.

Policy

BCBSNC will provide coverage for Autologous Islet Cell Transplantation when it is determined to be medically necessary because the medical criteria and guidelines shown below are met.

Allogeneic islet transplantation is considered investigational for the treatment of type 1 diabetes. BCBSNC does not provide coverage for investigational services or procedures.

Benefits Application

This medical policy relates only to the services or supplies described herein. Please refer to the Member's Benefit Booklet for availability of benefits. Member's benefits may vary according to benefit design; therefore member benefit language should be reviewed before applying the terms of this medical policy.

When Islet Cell Transplantation is covered

Autologous pancreas islet cell transplantation may be considered medically necessary as an adjunct to a total or near total pancreatectomy in patients with chronic pancreatitis.

When Islet Cell Transplantation is not covered

When the criteria listed above are not met.

Allogeneic islet transplantation is considered investigational for the treatment of type 1 diabetes.

Islet transplantation is considered investigational in all other situations.

Policy Guidelines

Although the published experience with autologous islet cell transplantation is limited, the procedure appears to significantly decrease the incidence of diabetes after total or near total pancreatectomy in patients with chronic pancreatitis. In addition, this procedure is not associated with serious complications itself and is performed as an adjunct to the pancreatectomy procedure.

With the expansion of clinical trials regarding treatment of type 1 diabetes, the number of new allogeneic islet cell recipients will continue to rise. The current data suggests that the best candidates for islet transplantation are those with better glycemic control to start with. Close relationships between procurement, processing, and transplant teams are associated with favorable outcomes. However, more extensive follow-up is needed to evaluate the long-term safety of allogeneic islet transplantation and its impact on complications of diabetes mellitus. Thus, while the techniques for allogeneic islet cell transplants are evolving, the impact on net health outcomes for patients with Type I diabetes, not otherwise undergoing surgery, is still uncertain.

Billing/Coding/Physician Documentation Information
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This policy may apply to the following codes. Inclusion of a code in this section does not guarantee that it will be reimbursed. For further information on reimbursement guidelines, please see Administrative Policies on the Blue Cross Blue Shield of North Carolina web site at www.bcbsnc.com. They are listed in the Category Search on the Medical Policy search page.

Applicable service codes: 48160, 48999, G0341, G0342, G0343, S2102

BCBSNC may request medical records for determination of medical necessity. When medical records are requested, letters of support and/or explanation are often useful, but are not sufficient documentation unless all specific information needed to make a medical necessity determination is included.

Scientific Background and Reference Sources


BCBSA Medical Policy Reference Manual [Electronic Version]. 7.03.12, 12/14/08


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Policy Implementation/Update Information

10/01 Original policy issued.


6/24/04 Specialty Matched Consultant Advisory Panel review. No changes to criteria. Benefit Application and Billing/Coding section updated for consistency. Added CPT code 48160 which is specific to this policy and removed 48146. References added.

10/14/04 Codes G0341, G0342 and G0343 added to the Billing/Coding section.

6/19/06 Specialty Matched Consultant Advisory Panel review 5/18/2006. Name changed from "Islet Cell Transplantation, Autologous" to "Islet Transplantation". Information added to "Description of Procedure or Service" section related to allogeneic use and FDA regulation. Additional policy statement added to indicate "Allogeneic islet transplantation is considered investigational for the treatment of type 1 diabetes. Statement added to "When Not Covered" section also. Rationale added to "Policy Guidelines" section. CPT codes 0141T, 0142T, 0143T and HCPCS code S2102 added to "Billing/Coding" section. References added.

6/30/08 Specialty Matched Consultant Advisory Panel review 5/29/08. No change to policy statement. References added. (btw)

6/22/10 Policy Number(s) removed (amw)


8/30/11 Description section and Policy Guidelines section updated. No change in medical coverage criteria. Specialty Matched Consultant Advisory Panel review 7/27/11. Policy accepted as written. (adn)

1/1/12 Coding update. CPT Codes 0141T, 0142T, 0143T deleted. (adn)

8/7/12 Added Related Policy. Policy Guidelines Section revised. Specialty Matched Consultant Advisory Panel Review 7/18/12. No change to policy statement. (sk)
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7/30/13 Medical Director review. CPT code 48999 added to Policy Guidelines. References updated. Specialty Matched Consultant Advisory Panel Review 7/17/12. No changes to policy statement. (sk)


7/1/15 Reference added. (sk)


8/30/16 Specialty Matched Consultant Advisory Panel review meeting 7/27/2016. No change to policy. (an)

8/11/17 Description section updated. Specialty Matched Consultant Advisory Panel review meeting 7/26/2017. No change to policy statement. (an)

Medical policy is not an authorization, certification, explanation of benefits or a contract. Benefits and eligibility are determined before medical guidelines and payment guidelines are applied. Benefits are determined by the group contract and subscriber certificate that is in effect at the time services are rendered. This document is solely provided for informational purposes only and is based on research of current medical literature and review of common medical practices in the treatment and diagnosis of disease. Medical practices and knowledge are constantly changing and BCBSNC reserves the right to review and revise its medical policies periodically.