



CIGNA MEDICAL COVERAGE POLICY

The following Coverage Policy applies to all health benefit plans administered by CIGNA Companies including plans formerly administered by Great-West Healthcare, which is now a part of CIGNA.

Subject **Lung and Heart-Lung Transplantation**

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Heart Transplantation
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INSTRUCTIONS FOR USE

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Coverage Policy

CIGNA covers lung transplantation as medically necessary when ALL of the following criteria are met:

- end-stage disease of lung parenchyma, airway and pulmonary vasculature that is not amenable to maximum alternative medical or surgical therapies
- severe, progressive symptoms with a functional status of New York Heart Association class III or IV despite optimal medical management, resulting in an unacceptable quality of life
- projected life span of less than two years without lung transplantation

CIGNA covers heart-lung transplantation as medically necessary when ALL of the following criteria are met:

- end-stage cardiopulmonary disease where the replacement of either organ alone is unlikely to improve survival or quality of life
- projected life span < two years without heart-lung transplantation
- the individual remains at a New York Heart Association functional class III or IV despite maximal medical and surgical management

CIGNA does not cover lung or heart-lung transplantation for an individual with ANY of the following contraindications to transplant surgery because it is considered not medically necessary (this list may not be all-inclusive):

- malignancy that is expected to significantly limit future survival

- persistent, recurrent or unsuccessfully treated major or systemic infection
- systemic illness or comorbidity that would be expected to substantially negatively impact the successful completion and/or outcome of transplant surgery
- untreatable advanced dysfunction of another organ system
- coronary artery disease not amenable to percutaneous intervention or bypass grafting, or associated with significant impairment of left ventricular function
- chest wall/spinal deformity that would pose a contraindication to transplantation
- a pattern of demonstrated noncompliance which would place a transplanted organ at serious risk of failure
- human immunodeficiency virus (HIV) disease unless ALL of the following are noted:
 - CD4 count greater than 200 cells/mm³
 - HIV-1 ribonucleic acid (RNA) undetectable
 - stable anti-retroviral therapy for more than three months
 - absence of serious complications associated with HIV disease (e.g., opportunistic infection, including aspergillus, tuberculosis, coccidioidomycosis, or resistant fungal infections; or Kaposi's sarcoma or other neoplasm)

Note: Selected candidates may be eligible for multi-organ transplantation. In each case, the candidate should meet all of the criteria for selection for the individual transplant being considered.

General Background

Lung Transplantation

Lung transplantation is the surgical replacement of the lung (s) of an individual with end-stage pulmonary disease with the partial (lobar) or whole lung or lungs of a living or deceased donor. The primary goal is the projected survival benefit. For most recipients, lung transplantation is a palliative, rather than curative treatment. It is an accepted treatment of last resort for persons with end-stage lung disease who do not respond to alternative medical or surgical treatment. Improvements in quality of life, in addition to survival, should be used to assess the effectiveness of the procedure (Orens, 2006). Broad application of this therapy is hampered primarily by the limited availability of suitable donor organs (Chang, 2007).

Lung transplantation recipients represent a heterogeneous population, with different diagnostic groups having different survival rates; however, in a cohort study of 1997 patients, 1143 of whom received lung transplantation, improved survival was noted for all diagnosis groups (Titman, 2009). Although there are no randomized controlled clinical trials demonstrating the safety and effectiveness of lung transplantation, several registry analyses and retrospective cohort studies note improved overall survival with transplantation compared with other medical and surgical therapies (Organ Procurement Transplant Network [OPTN]/Scientific Registry of Transplant Recipients [SRTR], 2009; Christie, 2009; Titman, 2009).

The type of lung transplantation procedure used (i.e., lobar, single, or double) and donor type (i.e., deceased or living) are based upon the candidate's condition and indication for transplantation, and the availability of donor organs. As donor organs are scarce relative to the number of candidates needing transplantation, conservation of acceptable donor organs is also taken into consideration.

Deceased Donor Lung Transplantation: Deceased donor lung transplantation (DDLTL), also known as cadaveric donor lung transplantation, is most commonly performed. In 1995, the United Network for Organ Sharing (UNOS) changed the method for allocating donated cadaver lungs for individuals >age 12 by assigning each candidate a Lung Allocation Score based on survival benefit and urgency rather than waiting time (Mulligan, 2008). In contrast, allocation to children under age 12 continues to be based on waiting time. Preferential transplantation of sicker patients has not resulted in an increase in early mortality following transplantation (Kotloff, 2010).

According to the Organ Procurement and Transplantation Network (OPTN)/Scientific Registry of Transplant Recipients (SRTR) 2009 Annual Report, unadjusted patient survival rates for recipients receiving single lung transplantation between 1999 and 2008 were 83.1%, 51.3%, and 21.2%, respectively, at three-, five- and ten

years. Unadjusted patient survival rates for double lung transplantation were 83.4%, 57.1%, and .3%, respectively at three-, five-, and ten years (2009). Long-term survival is compromised by the frequent development of chronic lung allograft rejection (e.g., bronchiolitis obliterans syndrome) which develops in approximately 50% of all long-term lung transplantation survivors (OPTN/SRTR, 2009).

Living Donor Lung Transplantation: Initiated in 1993 due to the higher demand than supply for patients waiting for lung transplantation, along with a scarcity of deceased donor organs (Solomon, 2010), living donor lung transplantation (LDLT) is now rarely performed. This procedure requires the donation of one lung lobe from each of two living donors. Major complications have included pleural effusion, bronchial stump fistula, bi-lobectomy, hemorrhage phrenic nerve injury, pulmonary artery thrombosis, bronchial stricture, and persistent air leak. Minor complications include persistent air leak, arrhythmia, and pneumonia (Solomon, 2010). Although deceased donor lung transplantation is preferred to avoid risk to two healthy donors, LDLT may be an acceptable alternative when the recipient is not likely to survive long enough to receive deceased donor organs (Solomon, 2010).

According to the (OPTN)/ (SRTR) 2009 Annual Report, “Lobar lung transplantation from living donors decreased steadily over the past decade. The number of living donors peaked at 58 (representing 7 percent of all lung donors) in 1999, and decreased to 6 cases in 2007 and zero cases in 2008.” Survival data for LDLT were not published in the OPTN/SRTR 2009 Annual Report. One-, three, and five-year Kaplan-Meier patient survival rates for living donor lung transplantation (LDLT) performed 1997-2004 are 85.8%, 55.3%, and 35.8%, respectively (based on OPTN data as of July 1, 2011). These outcomes compare to Kaplan-Meier patient survival rates for deceased donor lung transplantation (DDLT) of 83.3%, 62.8%, and 47.3%, respectively, for the same time ranges (based on OPTN data as of July 1, 2011).

Indications for Lung Transplantation: Four primary diagnostic groupings of lung disease for which transplantation may be indicated have been identified. Along with examples of each category, these include:

- chronic obstructive lung disease (COPD) (e.g., emphysema, alpha-1 antitrypsin deficiency)
- pulmonary vascular disease (e.g., primary pulmonary hypertension, Eisenmenger syndrome)
- cystic fibrosis or immunodeficiency disorders (e.g., cystic fibrosis, bronchiectasis, hypogammaglobulinemia)
- restrictive lung disease (e.g., idiopathic pulmonary fibrosis (IPF), also called cryptogenic fibrosing alveolitis, pulmonary fibrosis from other causes (e.g., fibrogenic dust, drug toxicity, or severe pulmonary hypertension, interstitial lung disease)

The selection of candidates requires an appreciation of the natural history of advanced lung disease as well as the impact of pretransplantation patient characteristics on post-transplantation outcomes (Kreider, 2009). Disease-specific parameters used to determine appropriateness for lung transplantation have been suggested by the International Society for Heart and Lung Transplantation ([ISHLT]) (Orens, 2006), the American Society of Transplantation (Steinman, 2001; Faro, 2007), the American Society of Transplant Surgeons (Faro, 2007), and other published scientific literature (Kotloff, 2010; Lynch, 2006; Maurer, 2005; Trulock, 2004; Maurer, 2001) include the following:

Chronic Obstructive Airway Disease (e.g., emphysema, chronic bronchitis and bronchiolitis obliterans):

- BODE (i.e., body mass index [B], degree of obstruction [O], dyspnea [D], exercise capacity [E]), score of 7–10 measured by a six-minute walk test.
- FEV1 (i.e., forced expiratory volume in the first second) less than 20%–25% of predicted, without reversibility
- history of hospitalization for exacerbation of COPD associated with acute hypercapnia (e.g. PCO_2 (i.e., partial pressure (tension) of carbon dioxide, artery) ≥ 50 mmHg)
- pulmonary hypertension and/or cor pulmonale, despite oxygen therapy
- elevated $PaCO_2$ (i.e., partial pressure (tension) of carbon dioxide, alveolar) with progressive deterioration requiring long-term oxygen therapy

Cystic Fibrosis and Other Bronchiectatic Diseases:

- FEV1 \leq 30% of the predicted value
- rapidly declining lung function with FEV1 $>$ 30% predicted as evidenced by increasing numbers of hospitalizations, rapid fall in FEV1, or massive hemoptysis or increasing cachexia, despite medical management
- increasing frequency of exacerbations requiring antibiotic therapy
- refractory and/or recurrent pneumothorax
- oxygen-dependent respiratory failure
- hypercapnia
- pulmonary hypertension

Idiopathic Pulmonary Fibrosis (IPF): Histologic or radiographic evidence of IPF and any of the following:

- symptomatic (e.g., oxygen desaturation with rest or exercise), progressive disease with failure to improve or maintain lung function while being treated with steroids or other immunosuppressive drug therapy
- a 10% or greater decrease in FVC (i.e., forced vital capacity) during six months of follow-up
- diffusion capacity (corrected for alveolar volume) less than 39% predicted
- honeycombing on computerized tomography
- decrease in pulse oximetry $<$ 88% during a six-minute walk test

Sarcoidosis: These individuals have poor outcomes in the following clinical scenarios:

Impairment of exercise tolerance as evidenced by New York Heart Association (NYHA) functional class III or IV and any of the following:

- pulmonary hypertension
- hypoxemia at rest
- elevated right atrial pressure exceeding 15 mmHG (millimeters of mercury)

Pulmonary Arterial Hypertension:

- persistent NYHA functional class III or IV
- low, or declining six-minute walk test
- cardiac index of less than two liters per minute per square meter
- right atrial pressure of more than 15 mmHg
- mean pulmonary artery pressure greater than 55 mmHg

Primary Pulmonary Hypertension Secondary to Congenital Heart Disease (e.g., Eisenmenger syndrome):

- severe progression of symptoms with function at NYHA functional class III or IV, despite optimal medical management

Lymphangioliomyomatosis and Eosinophilic Granuloma:

- NYHA functional class III or IV
- severe impairment in lung function and exercise capacity
- hypoxemia at rest

Cardiopulmonary Vascular Disease in Children:

- disease no longer responding to maximum medical and/or surgical treatment
- moderately severe or severe functional impairment (i.e., NYHA functional class III or IV)
- right ventricular failure
- severe cyanosis
- low cardiac output

Other Diseases in Children Presenting in Advanced Stages (e.g., bronchiolitis obliterans syndrome, pulmonary fibrosis and bronchopulmonary dysplasia):

- progressive disability (i.e., NYHA functional class III or IV) despite optimal medical therapy

A significant incidence of coronary artery disease is found in individuals with lung disease (Choong, 2006). Cardiac revascularization is a therapeutic option which may be used with lung transplantation for individuals with coronary artery disease that is amenable to percutaneous intervention or bypass grafting (Orens, 2006).

Summary for Lung Transplantation

Although data are not robust, lung transplantation is considered an acceptable treatment option for selected individuals with end-stage lung disease that does not respond to alternative medical or surgical treatment.

Heart-Lung Transplantation

Heart-lung transplantation is the surgical replacement of the heart and lungs of an individual who has end-stage cardiopulmonary disease with the healthy heart and lungs of a donor. It is an accepted therapy for individuals whose disease is refractory to standard optimal medical or surgical treatment when no contraindications are present. Combined heart-lung transplantation is reserved for candidates in whom either heart transplantation or lung transplantation alone would not improve the recipient's condition. There are no randomized clinical trials that compare heart-lung transplantation to optimal medical treatment.

Indications for Heart-Lung Transplantation: Congenital heart disease remains the most common indication for persons receiving heart-lung transplantation, followed by PPH. Other indications include, but are not limited to complex congenital disease with pulmonary hypoplasia, Eisenmenger syndrome, primary pulmonary hypertension, congenital lung abnormalities, alpha-antitrypsin deficiency, and end-stage parenchymal lung disease (Bernstein, 2007; Gammie, 2001; Maurer, 2001).

Patient Survival Rates: According to the Organ Procurement Transplant Network (OPTN)/Scientific Registry of Transplant Recipients (SRTR), patient survival rates for primary heart transplantation between 1997 and 2004 were 67.5%, 49.6%, and 40.1%, respectively, at one-, three-, and five-years (based on OPTN data as of July 1, 2011). Although outcomes of combined heart and lung transplantation have remained unchanged over the past decade, they are inferior to those of isolated heart or lung transplantation (OPTN/SRTR, 2009).

Summary for Heart-Lung Transplantation

Although there are no randomized controlled clinical trials demonstrating the safety and effectiveness of heart-lung transplantation; however, it is considered an acceptable treatment option for selected individuals with end-stage cardiopulmonary disease that does not respond to alternative medical or surgical treatment.

Contraindications to Lung and Heart-Lung Transplantation: Appropriate selection is the first step in attaining the best result for each recipient. Transplantation of the lung(s) or heart and lungs remains a complex therapy; it is important; therefore, to consider the sum of all contraindications and comorbidities. Absolute contraindications include malignancy that is expected to significantly limit future survival, persistent, recurrent or unsuccessfully treated major or systemic infections, systemic illness or comorbidities that would be expected to substantially negatively impact the successful completion and/or outcome of transplant surgery, untreatable advanced dysfunction of another organ system, coronary artery disease not amenable to percutaneous intervention or bypass grafting, or associated with significant impairment of left ventricular function, chest wall/spinal deformity that would pose a contraindication to transplant, a pattern of demonstrated noncompliance which would place a transplanted organ at serious risk of failure, and human immunodeficiency virus (HIV) disease unless in selected individuals.

The presence of several relative contraindications can combine to increase the risks of transplantation above a safe level (Orens, 2006). Relative contraindications to transplantation include, but are not limited to (Maurer, 2005; Gammie, 2001; Steinman, 2001):

- current, ongoing substance abuse, including tobacco, alcohol and narcotic/other addictive pain medications
- cerebrovascular disease or accident, or progressive neuropathy or myopathy that is not amenable to rehabilitation

- body mass index (BMI) less than 17 or greater than 33
- any active medical process that is currently not optimally treated and/or stable and that is likely to result in end-organ damage or medical emergency without appropriate management, such as active peptic ulcer disease, diverticular disease, active hepatitis, cholecystitis, pancreatitis, hypertension, autoimmune disease, or cytopenia
- untreated osteoporosis with a T-score greater than 2.5 standard deviations (SD) from mean or Z-score greater than two SD from mean
- hepatic fibrosis or cirrhosis
- hepatitis C with biopsy-proven, histologic evidence of hepatic disease
- uncorrected abdominal aortic aneurysm greater than four centimeters
- diabetes mellitus with end-organ damage, such as neuropathy, nephropathy or retinopathy
- advanced age
- peripheral vascular disease not amenable to surgical or percutaneous therapy as evidenced by:
 - asymptomatic stenosis greater than 75% or symptomatic carotid stenosis of less severity
 - ankle brachial index less than 0.7 or substantial risk of limb loss with diminished perfusion
- critical or unstable clinical condition (e.g. shock, mechanical ventilation or extracorporeal membrane oxygenation)
- colonization with highly resistant or highly virulent bacteria, fungi or mycobacteria
- severe or symptomatic osteoporosis

Additionally, there are other conditions that may affect the outcome of lung or heart-lung transplantation and require further investigation to ensure the best chance for a successful outcome:

- progressive neuromuscular disease
- prednisone use greater than 20 mg per day or 40 mg every other day
- recent pulmonary embolism/infarction
- mechanical ventilation
- previous major thoracic surgery or pleural procedures
- colonization with pan-resistant organisms, especially Burkholderia cepacia
- primary systemic disease, such as amyloidosis

Retransplantation

Retransplantation remains a controversial procedure, in part due to ethical concerns over the limited supply of organs. The recipient of the retransplantation procedure often suffers from the systemic sequelae of short- or long-term immunosuppression, infection, and technical issues attributable to the initial transplantation surgery (Kawut, 2008). Outcomes after repeat lung transplantation are generally poorer than those seen with the primary transplantation procedure. Survival rates for repeat lung transplantation performed between 1997 and 2004 were 66.3%, 38.8%, and 27.9%, respectively, at one-, three-, and five-years (OPTN, 2011). Although data are limited, lung retransplantation may be an appropriate therapeutic option for highly selected individuals for complications of transplantation that are refractory to other medical or surgical therapies. OPTN survival data for repeat heart/lung transplantation were not computed due to the low number of transplants performed.

Professional Societies/Organizations

American College of Cardiology/American Heart Association (ACC/AHA): On behalf of the ACC/AHA, Warnes et al. (2009) published Updated 2008 Guidelines for the Management of Congenital Heart Disease: Executive Summary, which notes that heart-lung transplantation is usually reserved for patients with uncorrectable or previously repaired or palliated congenital heart disease associated with significant pulmonary vascular obstructive disease, (e.g., single-ventricle physiology with pulmonary vascular disease, left ventricular dysfunction with associated pulmonary vascular disease). When a simple cardiac defect (e.g., atrial septal defect, ventricular septal defect, patent ductus arteriosus) is present, the defect can often be repaired at lung transplantation. In the presence of more complex intracardiac abnormalities, combined heart-lung transplantation is usually most appropriate.

American Society of Transplantation (AST) and the American Society of Transplant Surgeons (ASTS): On behalf of the AST and ASTS, Faro et al. (2007) noted that, in general, lung transplantation should be

considered in selected children with end-stage or progressive lung disease or life-threatening pulmonary vascular disease for which there is no other medical therapy.

Pulmonary Scientific Council of the International Society for Heart and Lung Transplantation (ISHLT):

On behalf of the ISHLT, Orens et al. (2006) noted that lung transplantation is an appropriate treatment option for end-stage pulmonary disease when alternative maximum medical and surgical options have failed. Selection of the type of donor (i.e., cadaveric or living donor) and the type of transplant (i.e. single, double or lobar) is dependent on the patient's diagnosis, clinical status, and availability of the donor organ. In the International Guidelines for Selection of Lung Transplant Candidates: 2006 Update-A Consensus Report from the Pulmonary Scientific Council of the ISHLT (Orens, 2006), the following absolute contraindications are noted:

- Malignancy in the last 2 years, with the exception of cutaneous squamous and basal cell tumors. In general, a 5-year disease-free interval is prudent. The role of lung transplantation for localized bronchioalveolar cell carcinoma remains controversial
- Untreatable advanced dysfunction of another major organ system (e.g., heart, liver, or kidney). Coronary artery disease not amenable to percutaneous intervention or bypass grafting, or associated with significant impairment of left ventricular function, is an absolute contraindication to lung transplantation, but heart-lung transplantation could be considered in highly selected cases
- Non-curable chronic extrapulmonary infection including chronic active viral hepatitis B, hepatitis C, and human immunodeficiency virus
- Significant chest wall deformity.
- Documented nonadherence or inability to follow through with medical therapy or office follow-up, or both
- Untreatable psychiatric or psychological condition associated with the inability to cooperate or comply with medical therapy
- Absence of a consistent or reliable social support system
- Substance addiction (e.g., alcohol, tobacco, narcotics) that is either active or within the last 6 months.

The following relative contraindications are also noted:

- Age older than 65 years. Older patients have less optimal survival, likely due to comorbidities, and therefore recipient age should be a factor in candidate selection. Although there cannot be endorsement of an upper age limit as an absolute contraindication (recognizing that advanced age alone in an otherwise acceptable candidate with few comorbidities does not necessarily compromise successful transplant outcomes), the presence of several relative contraindications can combine to increase the risks of transplantation above a safe level.
- Critical or unstable clinical condition (e.g., shock, mechanical ventilation or extracorporeal membrane oxygenation)
- Severely limited functional status with a poor rehabilitation potential
- Colonization with highly resistant or highly virulent bacteria, fungi, or mycobacteria
- Severe obesity defined as a body mass index exceeding 30kg/m²
- Severe or symptomatic osteoporosis

- Mechanical ventilation. Carefully selected candidates on mechanical ventilation without other acute or chronic organ dysfunction, who are able to actively participate in a meaningful rehabilitation program, may be successfully transplanted.
- Other medical conditions that have not resulted in end-stage organ damage, such as diabetes mellitus, systemic hypertension, peptic ulcer disease, or gastroesophageal reflux should be optimally treated before transplantation. Patients with coronary artery disease may undergo percutaneous intervention before transplantation or coronary artery bypass grafting concurrent with the procedure.

Summary

Although data are not robust, lung and heart-lung transplantation are considered acceptable treatment options for selected individuals with end-stage lung or cardiopulmonary disease that is not amenable to other medical or surgical treatment.

Coding/Billing Information

Note: This list of codes may not be all-inclusive.

Covered when medically necessary:

CPT®* Codes	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
33930	Donor cardiectomy-pneumonectomy (including cold preservation)
33933	Backbench standard preparation of cadaver donor heart/lung allograft prior to transplantation, including dissection of allograft from surrounding soft tissues to prepare aorta, superior vena cava, inferior vena cava, and trachea for implantation
33935	Heart-lung transplant with recipient cardiectomy-pneumonectomy

HCPCS Codes	Description
S2060	Lobar lung transplantation
S2061	Donor lobectomy (lung) for transplantation, living donor
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 pre- and post-transplant care in the global definition

ICD-9-CM Diagnosis Codes	Description
135	Sarcoidosis

273.4	Alpha-1 antitrypsin deficiency
277.00	Cystic fibrosis without mention of meconium ileus
277.02	Cystic fibrosis with pulmonary manifestations
279.00	Hypogammaglobulinemia
279.06	Common variable immunodeficiency
416.0	Primary pulmonary hypertension
416.8	Other chronic pulmonary heart diseases
416.9	Unspecified chronic pulmonary heart disease
428.0 – 428.9	Heart failure
490	Bronchitis, not specified as acute or chronic
491.1	Mucopurulent chronic bronchitis
491.20	Obstructive chronic bronchitis, without exacerbation
491.21	Obstructive chronic bronchitis, with (acute) exacerbation
491.22	With acute bronchitis
491.8	Other chronic bronchitis
491.9	Unspecified chronic bronchitis
492.8	Other emphysema
494.0-494.1	Bronchiectasis
506.4	Chronic respiratory conditions due to fumes and vapors
512.8	Other spontaneous pneumothorax
515	Postinflammatory pulmonary fibrosis
516.3	Idiopathic fibrosing alveolitis
518.83	Chronic respiratory failure
518.89	Other diseases of lung, not elsewhere classified
745.0	Bulbus cordis anomalies and anomalies of cardiac septal closure, common truncus
745.4	Ventricular septal defect
748.4	Congenital cystic lung
748.5	Congenital agenesis, hypoplasia, and dysplasia of lung
770.7	Chronic respiratory disease arising in the perinatal period
782.5	Cyanosis
786.09	Symptoms involving respiratory system and other chest symptoms, Other
799.02	Hypoxemia
996.83	Complications of transplanted heart
996.84	Complications of transplanted lung

***Current Procedural Terminology (CPT®) © 2010 American Medical Association: Chicago, IL.**

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Policy History

Pre-Merger Organizations	Last Review Date	Policy Number	Title
CIGNA HealthCare	8/15/2008	0130	Lung and Heart-Lung Transplantation
Great-West Healthcare	4/7/2006	95.220.06	Transplantation, Lung and Heart-Lung

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