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State/Territory Name: WI

State Plan Amendment (SPA) #: 12-007

This file contains the following documents in the order listed:

Department of Health & Human Services
Centers for Medicare & Medicaid Services
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601-5519

CENTERS FOR MEDICARE & MEDICAID SERVICES

March 7, 2014

Brett Davis, Administrator and Medicaid Director
Division of Health Care Access and Accountability
Wisconsin Department of Health Services
1 West Wilson Street
P. O. Box 309
Madison, Wisconsin 53701-0309

Dear Mr. Davis:

Enclosed for your records is an approved copy of the following State Plan Amendment:

Transmittal #12-007	--Prior Authorization for Organ Transplants --Effective April, 1, 2012

If you have any additional questions, please have a member of your staff contact Charles Friedrich at (608) 442-9125 or Charles.Friedrich@cms.hhs.gov.

Sincerely,

/s/
Verlon Johnson
Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Enclosure

cc: Al Matano, Wisconsin Department of Health Services

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 12-007

2. STATE: Wisconsin

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: 04/01/2012

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:

7. FEDERAL BUDGET IMPACT:
a. FFY 2012 ..... $0K
b. FFY 2013 ..... $0K

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
~~Attachment 4.19-A page 20 and 21.~~ 23
~~Attachment 3.1-A Supplement 1 page 3.~~
~~Attachment 3.1-B Supplement 1 page 2.~~
Attachment 3.1-E pages 2 and 3.

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
~~Same~~
~~Same~~
~~Same~~
Same

10. SUBJECT OF AMENDMENT:

Prior authorization for organ transplants

11. GOVERNOR'S REVIEW *(Check One)*:
☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNA[redacted]

13. TYPED NAME:
Brett Davis

14. TITLE:
State Medicaid Director

15. DATE SUBMITTED:
6/28/12

16. RETURN TO:
Brett Davis
State Medicaid Director
Division of Health Care Access and Accountability
1 W. Wilson St.
P.O. Box 309
Madison, WI 53701-0309

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
6/28/12

18. DATE APPROVED:
3/7/14

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
4/1/12

20. SIGNATURE OF REGIONAL OFFICIAL:
/s/

21. TYPED NAME:
Verlon Johnson

22. TITLE:
Associate Regional Administrator

23. REMARKS:

FORM HCFA-179 (07-92)

STANDARDS FOR THE COVERAGE OF ORGAN TRANSPLANT SERVICES, continued

Medical Assistance Medical Audit Committee (MAMAC) Criteria Pertinent to Organ Transplant Programs, continued.

- The program must have arrangements for required follow-up care available and convenient for the circumstances.

- The organ transplant providers must accept Wisconsin Medical Assistance recipients and rates of reimbursement.

- The program must have adequate medical criteria for the selection of patients undergoing the procedure. Factors considered relevant may include age, overall health status, patient histories (including possible active drug/alcohol dependence), that will affect the likely success of the transplant procedure.

- In making the selection of patients undergoing the procedure, the program treats similarly situated individuals alike.

- Any restriction on the facilities or practitioners which may provide organ transplant procedures is consistent with the accessibility of high quality care to individuals eligible for the procedures under this State plan.

- All of the above criteria must be satisfied.

Coverage Criteria

In order for a transplant to be a covered Medicaid service, the following criteria must apply:

- Bone Marrow Transplants

  Diagnoses/clinical conditions include but are not limited to Alder's-Schonberg syndrome, aplastic anemia, bare lymphocyte syndrome, Burkitts B-cell Acute Lymphoblasitic Anemia, germ cell cancer, Hodgkin's, infantile malignant osteoporosis, leukemia (acute and chronic), malignant melanoma, neuroblastoma (Stage IV), primitive neuroectodermal tumor (PNET) (multifocal), severe combined imunodeficiency, Wiscott-Aldrich syndrome.

  Limited to tertiary care centers that have the capacities and physician staffing appropriate to the performance of this highly demanding procedure.

- Heart Transplant

  Diagnoses/clinical conditions include but are not limited to end-stage heart disease resulting from primary cardiomyopathy, congenital heart disease, valvular disease and end-stage coronary artery disease.

STANDARDS FOR THE COVERAGE OF ORGAN TRANSPLANT SERVICES, continued

Coverage Criteria, continued

- Heart-Lung and Lung Transplants

  Diagnosis/clinical conditions include but are not limited to cystic fibrosis, cor pulmonale, pulmonary fibrosis, alpha 1 antitrypsin deficiency, pulmonary thromboembolism, chronic obstructive pulmonary disease.

- Liver Transplants

  Diagnosis/clinical conditions include but are not limited to end-stage renal disease resulting in biliary atresia, alcohol-related liver cirrhosis/hepatitis (requires abstinence of six months or more preceding the transplant and has successfully completed a certified AODA program), cancer of liver (primary hepatoma or cholangiolytic carcinoma), chronic active hepatitis, fulminant hepatic failure of pregnancy, hepatic failure due to hepatic toxins, hepatic vein thrombosis (Budd-Chiari syndrome), hepatitis B (when gamma globulin is administered before and 11 months after transplant), certain inborn errors in metabolism resulting in end-stage liver damage, and miscellaneous metabolic diseases.

  Diagnosis/clinical conditions not included are AIDS, primary hepatic malignancy with extension outside liver or metastases, secondary hepatic malignancy, or the recipient's chronological age or concurrent physical deterioration significantly militates against a successful outcome.

- Pancreas Transplants

  Diagnosis/clinical conditions include but are not limited to diabetes mellitus with severe complications such as end-stage kidney disease, progressive severe visual disturbance, and severe neurological disorder.

Prior Authorization Criteria for Bone Marrow and Stem Cell Transplants

For bone marrow and stem cell transplants, the hospital in which the transplant will be performed must obtain prior authorization from the Department's Chief Medical Officer, who determines whether the proposed procedure meets the diagnostic and clinical criteria adopted by the Department. The diagnoses and clinical conditions which support a decision to proceed with bone marrow and stem cell transplants are listed in the section "Coverage Criteria," above.