

DR. SUMEET K ASRANI (Orcid ID : 0000-0001-9174-5670)

DR. GERALD SCOTT WINDER (Orcid ID : 0000-0002-2355-7317)

Article type : Letters to the Editor

Payer coverage and liver transplantation for alcohol associated hepatitis

Gerald Scott Winder MD MSc¹

Sumeet K Asrani MD MSc^{2*}

¹Clinical Assistant Professor

Departments of Psychiatry and Surgery

University of Michigan

Ann Arbor, MI, USA

²Baylor University Medical Center

This is the author manuscript accepted for publication and has undergone full peer review but has not been through the copyediting, typesetting, pagination and proofreading process, which may lead to differences between this version and the [Version of Record](#). Please cite this article as [doi: 10.1002/LT.25763](https://doi.org/10.1002/LT.25763)

This article is protected by copyright. All rights reserved

Dallas, TX, USA

*Corresponding author

Baylor University Medical Center, Dallas, Texas

Email: Sumeet.Asrani@bswhealth.org

Phone: 214-820-8500

No relevant financial disclosures

We duly note the insurance challenges discussed by Eswaran and Chan. Many insurance payers continue to require fixed pre-transplant sobriety periods (i.e. “6-month rules”) despite the lack of evidence to support them(1-3). While payers reserve the right to skepticism about any center’s evolving policies regarding liver transplantation (LT) for alcohol-associated hepatitis (AH), we anticipate that payers’ approach to these patients will progress. As 1) transplant centers update their institutional criteria regarding LT/AH, 2) acceptable outcomes are demonstrated in a transparent manner and 3) professional societies offer guidance, we anticipate that insurance payers’ policies will follow suit.(4) Notably, to achieve success this should include coverage for LT and for essential mental health and substance use disorder (MH/SUD) treatment before and after LT.

Drinking is one of innumerable behaviors, habits, and choices that affect human health and medical outcomes. Other key transplant examples include patient adherence to medications and clinic visits as well as weight and nutrition management. In an era of alarming alcohol-related trends(5), the transplant field must simultaneously work diligently to maintain stigma-free, equitable, high standards for organ allocation while striving to provide excellent MH/SUD care for recurrent alcohol use disorder (AUD) in LT patients regardless of indication.

Other meaningful actions by transplant centers may also help. Expansion of pre- and post-transplant psychosocial personnel and services that are cross-trained in MH/SUD and transplant whenever possible, demonstrates a center's commitment to high level relapse monitoring and its expanded ability to intervene. Centers must facilitate MH/SUD care plans consistently over the years post-transplant given variable trajectories of post-transplant drinking(6). Longitudinal use of toxicology (especially biomarkers like serum phosphatidylethanol and urinary ethyl glucuronide) and psychometrics are helpful tools for monitoring LT/AH patients and anticipating crises. Given the dense populations and broad geographic areas transplant centers serve, established collaborations with community MH/SUD providers as well as use of telemedicine may ease insurance payers' concerns about LT patient follow-up and care access. Centers should track and publish a wider array of LT/AH outcomes. In addition to "harder" survival, graft failure, and slip/relapse outcomes, meaningful "softer" LT outcomes like AUD treatment retention, successful AUD treatment re-engagement, regained sobriety, mental health and quality of life metrics, and post-relapse renormalization of liver function tests will be essential to measuring effective LT/AH care. Payers may also be reassured to see that, in an age of clinician burnout, transplant centers prioritize the mental health of their own staff given the challenges inherent to managing MH/SUD matters in LT patients.

While LT in AH patients is a vital issue of the day, human behavior, habit, and addiction remain, on the whole, intrinsic to *all* aspects of LT.

1. Brown Jr RS. Transplantation for alcoholic hepatitis—time to rethink the 6-month “rule”. In: Mass Medical Soc; 2011.
2. Beresford TP, Everson GT. Liver transplantation for alcoholic liver disease: bias, beliefs, 6-month rule, and relapse—but where are the data? *Liver Transpl* 2000;6:777-778.
3. Shawcross DL, O'Grady JG. The 6-month abstinence rule in liver transplantation. *Lancet* 2010;376:216-217.
4. Asrani SK, Trotter J, Lake J, Ahmed A, Bonagura A, Cameron A, DiMartini A, et al. Meeting Report: The Dallas Consensus Conference on Liver Transplantation for Alcohol Associated Hepatitis. *Liver Transpl* 2020;26:127-140.
5. Spillane S, Shiels MS, Best AF, Haozous EA, Withrow DR, Chen Y, Berrington de González A, et al. Trends in Alcohol-Induced Deaths in the United States, 2000-2016. *JAMA Network Open* 2020;3:e1921451-e1921451.
6. DiMartini A, Dew MA, Day N, Fitzgerald MG, Jones BL, DeVera M, Fontes P. Trajectories of alcohol consumption following liver transplantation. *American Journal of Transplantation* 2010;10:2305-2312.