Allogeneic Hematopoietic Stem Cell Transplantation

Table of Content

Effective Date	1/1993
Next Review Date	3/1/2024
Coverage Policy	Surgical 213
Version	3

All requests for authorization for the services described by this medical policy will be reviewed per Early and Periodic Screening, Diagnostic and Treatment (EPSDT) guidelines. These services may be authorized under individual consideration for Medicaid members under the age of 21-years if the services are judged to be medically necessary to correct or ameliorate the member's condition. Department of Medical Assistance Services (DMAS), Supplement B - EPSDT (Early and Periodic Screening, Diagnosis and Treatment) Manual.*.

Purpose:

This policy addresses Allogeneic hematopoietic stem cell transplantation.

Description & Definitions:

Allogeneic hematopoietic stem cell transplantation involves transferring of stem cells from a healthy person with a similar genetic makeup (the donor) to the individual's body after high-intensity chemotherapy or radiation.

Criteria:

Allogeneic Hematopoietic Stem Cell Transplantation is considered medically necessary for all **of the following**:

- Individual has diagnosis of **1 or more** of the following:
  - Aplastic Anemia
  - Beta Thalassemia major
  - Breast cancer
  - Heritable Bone Marrow Syndrome
  - Leukemia
  - Lymphoma
  - Myeloma
  - Paroxysmal Nocturnal Hemoglobinuria
  - Sickle Cell Disease
- Current medical therapy has failed, and the individual has failed to respond to appropriate therapeutic management
- The individual is not in an irreversible terminal state
- The transplant is likely to prolong life and restore a range of physical and social function suited to activities of daily living

Allogeneic hematopoietic stem cell transplantation is not Medically necessary for any use other than those indicated in clinical criteria, to include but not limited to:

- Autoimmune diseases
- Bile duct cancer (cholangiocarcinoma)
- Cancer of the fallopian tubes
- Cervical cancer
- Colon cancer
- Epithelial ovarian cancers
- Esophageal cancer
- Ewing Sarcoma
- For the treatment of diabetes mellitus
- Gallbladder cancer
- Germ cell tumors
- Lung cancer
- Malignant Astrocytomas and Gliomas
- Melanoma
- Nasopharyngeal cancer
- Neuroendocrine tumors
- Osteosarcoma
- Pancreas cancer
- Paranasal sinus cancer
- POEMS Syndrome (polyneuropathy, organomegaly, endocrinopathy, M protein, and skin changes)
- Primitive neuro-ectodermal tumor (PNET)
- Prostate cancer
- Rectal cancer
- Renal cell cancer
- Retinoblastoma
- Rhabdomyosarcoma
- Soft tissue sarcoma
- Stomach cancer
- Thymus cancer
- Thyroid cancer
- Tumors of unknown primary origin
- Uterine cancer
- Wilms' tumor (nephroblastoma)

Coding:

Medically necessary with criteria:

Coding	Description
38240	Hematopoietic progenitor cell (HPC); allogeneic transplantation per donor

Considered Not Medically Necessary:

Coding	Description
	None

U.S. Food and Drug Administration (FDA) - approved only products only.

Document History:

Revised Dates:

- 2022: March
- 2019: November
- 2015: February, August, September
- 2014: February, May, November
- 2013: February
- 2012: March, November
- 2011: March
- 2010: February, August
- 2009: January, October
- 2008: January, September
- 2005: May
- 2003: April
- 2002: February
- 2001: December
- 1999: December

Reviewed Dates:

- 2023: March
- 2018: October
- 2017: November
- 2016: February
- 2012: February
- 2011: February
- 2010: June
- 2006: March, April, May, June
- 2004: April, September
- 2003: February
- 2000: December
- 1998: October
- 1996: June
- 1994: September

Effective Date:

- January 1993

References:

Specialty Association Guidelines; Government Regulations; Winifred S. Hayes, Inc; UpToDate; Literature Review; Specialty Advisors; National Coverage Determination (NCD); Local Coverage Determination (LCD).

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Special Notes: *

This medical policy express Sentara Health Plan's determination of medically necessity of services, and they are based upon a review of currently available clinical information. These policies are used when no specific guidelines for coverage are provided by the Department of Medical Assistance Services of Virginia (DMAS). Medical Policies may be superseded by state Medicaid Plan guidelines. Medical policies are not a substitute for clinical judgment or for any prior authorization requirements of the health plan. These policies are not an explanation of benefits.

Medical policies can be highly technical and complex and are provided here for informational purposes. These medical policies are intended for use by health care professionals. The medical policies do not constitute medical advice or medical care. Treating health care professionals are solely responsible for diagnosis, treatment and medical advice. Sentara Health Plan members should discuss the information in the medical policies with their treating health care professionals. Medical technology is constantly evolving and these medical policies are subject to change without notice, although Sentara Health Plan will notify providers as required in advance of changes that could have a negative impact on benefits.

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) covers services, products, or procedures for children, if those items are determined to be medically necessary to "correct or ameliorate" (make better) a defect, physical or mental illness, or condition (health problem) identified through routine medical screening or examination, regardless of whether coverage for the same service or support is an optional or limited service under the state plan. Children enrolled in the FAMIS Program are not eligible for all EPSDT treatment services. All requests for authorization for the services described by this medical policy will be reviewed per EPSDT guidelines. These services may be authorized under individual consideration for Medicaid members under the age of 21-years if the services are judged to by medically necessary to correct or ameliorate the member's condition. *Department of Medical Assistance Services (DMAS), Supplement B - EPSDT (Early and Periodic Screening, Diagnosis and Treatment) Manual.*

Keywords:

Acute lymphoblastic leukemia, Acute lymphocytic leukemia, Acute Myeloid Leukemia, adrenoleukodystrophy, Albers-Schonberg disease, Alpha-mannosidosis, aplastic anemia, Beta Thalassemia major, Breast cancer, Chediak-Higashi syndrome, Childhood-onset adrenoleukodystrophy, Chronic granulomatous disease, Chronic Myeloid Leukemia, Chronic myelo-monocytic leukemia, Diamond-Blackfan anemia, Fanconi's anemia, Fucosidosis, Gaucher's disease, Globoid cell , kodystrophy, Hemophagocytic Lymphohistiocytosis, Heritable Bone Marrow Syndrome, High-risk neuroblastoma, Hodgkin disease, homozygous beta-thalassemia, Homozygous sickle cell disease, Hunter's syndrome, Hurler's syndrome, infantile genetic agranulocytosis, Infantile malignant osteopetrosis, juvenile myelo-monocytic leukemia, Kostmann's syndrome, Krabbe Disease, leukemia, Leukocyte adhesion deficiencies, Lymphoma, marble bone disease, Maroteaux-Lamy Syndrome, Metachromatic leukodystrophy, Morquio syndrome, Mucolipidoses, Mucopolysaccharoidosis, Multiple myeloma, Myelodysplastic syndrome, Myelofibrosis, Myeloid sarcoma, Myeloma, Myeloproliferative disorders, Non-Hodgkin's lymphoma, Paroxysmal Nocturnal Hemoglobinuria, Primary granulocyte dysfunction, Refractory Hodgkin disease, SanFilippo's syndrome, Severe aplastic anemia, Severe combined immunodeficiency, severe congenital neutropenia, SHP Allogeneic Hematopoietic Stem Cell Transplantation, SHP Surgical 213, sickle beta thalassemia, Sickle Cell Disease, Sly syndrome, Thalassemia, Wiskott-Aldrich syndrome, Wolman syndrome, X-linked Lymphoproliferative Syndrome