Sentara Health Plans

Commercial

Autologous Hematopoietic Stem Cell Transplantation (HSCT)

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Effective Date	1/1993
Next Review Date	3/1/2024
Coverage Policy	Surgical 08
Version	1

Member-specific benefits take precedence over medical policy and benefits may vary across plans. Refer to the individual's benefit plan for details *.

Purpose:

This policy addresses the medical necessity of Autologous hematopoietic stem cell transplantation.

Description & Definitions:

Autologous hematopoietic stem cell transplantation is when the individual's own stem cells are removed before high dose chemotherapy or radiation, frozen for storage then thawed and returned. This process is used to replace damaged or destroyed bone marrow with blood-forming stem cells from the individual's own blood after treatment.

Criteria:

Autologous Hematopoietic Stem Cell Transplantation (HSCT) is considered medically necessary for individuals with **All** of the following:

- Individual has no comorbidities that would reduce life expectancy
- Individual is medically compliant
- Individual is free of an active substance abuse problem
- Individual has diagnosis of **1 or more** of the following:
  - Acute myelogenous leukemia for all of the following:
    - Individual with 1 or more of the following:
      - Acute promyelocytic leukemia
      - Acute myelocytic leukemia
    - Individual with 1 more of the following:
      - First or second remission if responsive to previous chemotherapy
      - Relapsed acute myelogenous leukemia if responsive to previous chemotherapy
  - Amyloidosis
  - Chronic lymphocytic leukemia with **All** of the following:
    - Individual has exhausted all other traditional treatments
  - Germ cell tumors of the ovary for individual with **1 or more** of the following:

        - After relapse
        - Chemosensitive tumor
        - Primary refractory disease
    - Hodgkin's lymphoma for individual with **1 or more** of the following:
        - First relapse in chemosensitive disease
        - Partial remission after radiotherapy for isolated lesions
        - Primary refractory disease
    - Multiple myeloma
    - Multiple sclerosis refractory to treatment or with relapsing-remitting course
    - Neuroblastoma is considered medically necessary with **All** of the following:
        - Stage IV or high-risk stage III neuroblastoma
        - No disease progression after initial course of chemotherapy
    - Non-Hodgkin's Lymphoma with **All** of the following:
        - Individual with **1 or more** of the following:
            - Burkitt lymphoma
            - Diffuse large B-cell lymphoma with **1 or more** of the following:
                - High international prognostic index (IPI) at diagnosis
                - Intermediate international prognostic index (IPI) at diagnosis
            - Follicular B-cell lymphoma
            - Lymphoblastic lymphoma
            - Mantel cell lymphoma
            - Mixed cell lymphoma
            - Small cell lymphoma
            - Small cleaved cell lymphoma
            - T-cell lymphoma
        - Individual with a chemosensitive tumor
        - Individual with **1 or more** of the following:
            - Relapse and second or greater complete remission
            - First complete remission
    - Polyneuropathy, organomegaly, endocrinopathy, M protein, and skin changes (POEMS syndrome)
    - Primitive neuroectodermal tumors (PNET) and ependymoma (with or without associated radiotherapy, for the treatment of primitive neuroectodermal tumors, such as medulloblastoma and ependymoma, arising in the central nervous system or pineal blastoma)
    - Testicular cancer for individuals who relapse after an initial course of standard dose chemotherapy

Autologous hematopoietic stem cell transplantation (HSCT) is **not medically necessary** for any use other than those indicated in clinical criteria, to include but not limited to:

- Breast cancer
- Childhood-onset adrenoleukodystrophy
- Chronic myelogenous leukemia
- Diamond-Blackfan anemia
- Fanconi's anemia
- Immunodeficiency disorders
- Mucopolysaccharidosis
- Myelodysplastic syndrome
- Myelofibrosis
- Paroxysmal nocturnal hemoglobinuria
- Pure red cell aplasia
- Severe aplastic anemia
- Soft tissue sarcoma or Ewing sarcoma

- Thalassemia major or sickle cell anemia in children or young adults

Coding:

Medically necessary with criteria:

Coding	Description
38241	Hematopoietic progenitor cell (HPC); autologous transplantation

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
- 2014: February, May, November
- 2013: February
- 2012: February
- 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, June
- 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

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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: *

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.

Services mean both medical and behavioral health (mental health) services and supplies unless We specifically tell You otherwise. We do not cover any services that are not listed in the Covered Services section unless required to be covered under state or federal laws and regulations. We do not cover any services that are not Medically Necessary. We sometimes give examples of specific services that are not covered but that does not mean that other similar services are covered. Some services are covered only if We authorize them. When We say You or Your We mean You and any of Your family members covered under the Plan. Call Member Services if You have questions.

Keywords:

Acute myelogenous leukemia, Amyloidosis, Aplastic Anemia, Autologous Stem Cell Transplants, Beta Thalassemia major, bone marrow, Breast cancer, Chronic lymphocytic leukemia, Chronic myelogenous leukemia, Ewing sarcoma, Germ cell tumors of the ovary, Hematopoietic Stem Cell Transplants, Heritable Bone Marrow Syndrome, Hodgkin’s lymphoma, Leukemia, Lymphoma, Multiple myeloma, Multiple sclerosis, Myelodsplastic syndrome, Myeloma, Neuroblastoma, Paroxysmal Nocturnal Hemoglobinuria, PNET, POEMS syndrome, Polyneuropathy, organomegaly, endocrinopathy, M protein, and skin changes, Primitive neuroectodermal tumors, SHP Autologous Hematopoietic Stem Cell Transplantation (HSCT), SHP Surgical 08, Sickle Cell Disease, Soft tissue sarcoma, Testicular cancer, transplants