SHP Autologous Hematopoietic Stem Cell Transplantation (HSCT)

AUTH: SHP Surgical 08 v1 (AC)

MCG Health
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Coverage

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Under EPSDT, any other medically necessary transplant procedures that are not experimental or investigational are limited to persons under the age of 21.

Members must use contracted facilities unless approved by the Plan.

Individuals with plans without transplant benefits are excluded from coverage.

See the appropriate benefit document for specific coverage determination. Member specific benefits take precedence over medical policy.

Application to Products

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Policy is applicable to all products.

Authorization Requirements

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Pre-certification by the Plan is required.

Description of Item or Service

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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.

Exceptions and Limitations

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- There is insufficient scientific evidence to support the medical necessity of autologous hematopoietic stem cell transplantation (HSCT) for the following as they are not shown to improve health outcomes upon technology review:
    - Breast cancer (except Optima Virginia Medicaid Plans)
    - 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 (except Optima Virginia Medicaid Plans)
- There is insufficient scientific evidence to support the medical necessity of autologous hematopoietic stem cell transplantation (HSCT) for uses other than those listed in the clinical indications for procedure section.

Clinical Indications for Procedure

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- Autologous Hematopoietic Stem Cell Transplantation (HSCT) is considered medically necessary for individuals with **1 or more** of the following
    - Individual has Optima Medicare plan and **1 or more** of the following
        - Individual with acute leukemia in remission who has high probability of relapse and who has no human leucocyte antigens (HLA)-matched
        - Individual with resistant non-Hodgkin's lymphoma or presenting with poor prognostic features following initial response
        - Individual with recurrent or refractory neuroblastoma
        - Individual with advanced Hodgkin's disease who has failed conventional therapy and has no HLA-matched donor
        - Individual with multiple myeloma as indicated by **ALL** of the following
            - Single autologous stem cell transplant
            - Durie-Salmon stage II or III
            - Newly diagnosed or responsive multiple myeloma (includes those beneficiaries with previously untreated disease, those with at least partial response to prior chemotherapy (defined as 50% decrease either in measurable paraprotein (serum and/or urine) or in bone marrow infiltration, sustained for at least 1 month), and those in responsive relapse)
            - Adequate cardiac, renal, pulmonary, and hepatic function
        - Primary amyloid light chain amyloidosis, as indicated by **ALL** of the following
            - Provided in conjunction with high-dose melphalan therapy
            - Amyloid deposition in 2 or fewer organs
            - Cardiac left ventricular ejection fraction greater than 45%
    - Individual has Optima Virginia Medicaid Plan with **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
    - Individual has Optima Commercial Plan 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 or 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
            - Chronic myelogenous leukemia
            - Germ cell tumors of the ovary with **1 or more** of the following
                - After relapse
                - Chemosensitive tumor
                - Primary refractory disease
            - Hodgkin’s lymphoma 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 for **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
                        - Intermediate international prognostic index (IPI) at diagnosis
                        - high 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

Document History

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- 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

Coding Information

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- CPT/HCPCS codes covered if policy criteria is met:
    - CPT 38241 – Hematopoietic progenitor cell (HPC); autologous transplantation
- CPT/HCPCS codes considered not medically necessary per this Policy:
    - None

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