Easy Choice Health Plan

Missouri Care

'Ohana Health Plan, a plan offered by WellCare Health Insurance of Arizona

OneCare (Care1st Health Plan Arizona, Inc.)

Staywell of Florida

WellCare (Arizona, Arkansas, Connecticut, Florida, Georgia, Illinois, Kentucky, Louisiana, Mississippi, Nebraska, New Jersey, New York, South Carolina, Tennessee, Texas)

WellCare Prescription Insurance

WellCare Texan Plus (Medicare – Dallas & Houston markets)

Stem Cell Transplantation

Policy Number: HS-069

Original Effective Date: 12/18/2008

Revised Date(s): 12/18/2010; 8/12/2011; 5/3/2012; 5/2/2013; 6/5/2014; 5/7/2015; 11/3/2016; 9/7/2017; 9/6/2018

APPLICATION STATEMENT

The application of the Clinical Coverage Guideline is subject to the benefit determinations set forth by the Centers for Medicare and Medicaid Services (CMS) National and Local Coverage Determinations and state-specific Medicaid mandates, if any.

DISCLAIMER

The Clinical Coverage Guideline (CCG) is intended to supplement certain standard WellCare benefit plans and aid in administering benefits. Federal and state law, contract language, etc. take precedence over the CCG (e.g., Centers for Medicare and Medicaid Services [CMS] National Coverage Determinations [NCDs], Local Coverage Determinations [LCDs] or other published documents). The terms of a member's particular Benefit Plan, Evidence of Coverage, Certificate of Coverage, etc., may differ significantly from this Coverage Position. For example, a member's benefit plan may contain specific exclusions related to the topic addressed in this CCG. Additionally, CCGs relate exclusively to the administration of health benefit plans and are NOT recommendations for treatment, nor should they be used as treatment guidelines. Providers are responsible for the treatment and recommendations provided to the member. The application of the CCG is subject to the benefit determinations set forth by the Centers for Medicare and Medicaid Services (CMS) National and Local Coverage Determinations, and any state-specific Medicaid mandates. Links are current at time of approval by the Medical Policy Committee (MPC) and are subject to change. Lines of business are also subject to change without notice and are noted on www.wellcare.com. Guidelines are also available on the site by selecting the Provider tab, then "Tools" and "Clinical Guidelines".

BACKGROUND

Stem-cell transplantation refers to the transplantation of hematopoietic stem cells (HSCs) into a patient. HSCs are immature cells that can develop into any of the three types of blood cells (red cells, white cells or platelets). HSCs are created in the bone marrow and are found in the bone marrow (BM) and peripheral blood. There is also a high concentration of HSCs in umbilical-cord blood. HSC transplantation (HSCT) can be either autologous (i.e., using the patient's own stem cells) or allogeneic (i.e., using stem cells from a donor). HSCT is provided to patients with hematological disorders to rescue the patients from treatment-induced aplasia after high-dose chemotherapy and/or radiotherapy has been administered to eliminate the recipient's immune system.

Durie-Salmon Classification for Multiple Myeloma

Stage I - The earliest stage of multiple myeloma and is characterized by the following:

- No sign of anemia (hemoglobin values are normal; greater than 10 g/dL)
- No sign of hypercalcemia (serum calcium values are normal; less than 12 mg/dL)
- X rays of bone are normal or exhibit only a single bone plasmacytoma
- Low M protein production rates:
  - IgG value is less than 5 g/dL
  - IgA value is less than 3 g/dL
  - Bence-Jones protein (free immunoglobulin light chains in urine) as measured by protein electrophoresis is less than 4g/24h

Stage II - Intermediate stage of multiple myeloma; more advanced than Stage I but not as advanced as Stage III.

Stage III - Advanced stage of multiple myeloma; classification assigned if one or more of the following are present:
- Anemia (hemoglobin value is less than 8.5 g/dL)
- Hypercalcemia (serum calcium value greater than 12 mg/dL)
- X-rays reveal multiple bone lesions
- High M protein production rates:
  - IgG value is greater than 7 g/dL
  - IgA value is greater than 5 g/dL
  - Bence-Jones protein is greater than 12g/24h

POSITION STATEMENT

Applicable To:
- ☑ Medicaid
- ☑ Medicare

Exclusions

Allogeneic bone marrow transplantation **is considered experimental and NOT a covered benefit** for the treatment of multiple myeloma or any other indication not listed below.

Autologous Stem Cell Transplantation (AuSCT) **is considered experimental and NOT a covered benefit** for treatment for the following indications:
- Acute leukemia not in remission; **OR,**
- Chronic granulocytic leukemia; **OR,**
- Solid tumors (other than neuroblastoma); **OR,**
- Tandem transplantation (multiple rounds of AuSCT) for members with multiple myeloma; **OR,**
- Non-primary AL amyloidosis; **OR,**
- Indications not listed above.

Coverage

Allogeneic Stem Cell Transplantation

Members undergoing Allogenic Stem Cell Transplantation (ASCT) **must complete a pre-transplant evaluation** as evidenced by all of the following:
- Psychosocial screen to include the following three items:
  - Drug / alcohol screen with no drug / alcohol abuse by history **OR** drug / alcohol free for ≥ 6 months
  - Behavioral health disorder with no behavioral health disorder by history and physical examination **OR** treated behavioral health disorder; **AND**
  - Adequate social / family support.
- Performance status of Karnofsky score ≥ 70% **OR** Eastern Cooperative Oncology Group grade 0-2.

Original Effective Date: 12/18/2008 - Revised: 12/18/2010, 8/12/2011, 5/3/2012, 5/2/2013, 6/5/2014, 5/7/2015, 11/3/2016, 9/7/2017, 9/6/2018

Allogeneic bone marrow transplantation **is considered medically necessary and a covered benefit** for the treatment of the following indications:

- Aplastic anemia; **OR**
- Leukemia; **OR**
- Leukemia in remission; **OR**
- Multiple myeloma; **OR**
- Myelofibrosis; **OR**
- Sickle cell disease; **OR**
- Severe combined immunodeficiency disease (SCID); **OR**
- Wiskott-Aldrich syndrome.

ASCT for Acute Myelogenous Leukemia (AML)

ASCT **is considered medically necessary and a covered benefit** for AML if **ALL** of the following criteria are met:

- HLA matched donor; **AND,**
- Therapeutic response confirmed by bone marrow Bx as evidenced by one of the following:
  - First remission in intermediate / high-risk patient; **OR,**
  - Second remission; **OR,**
  - Relapsed disease; **OR,**
  - Induction failure.
- Pre-transplant evaluation (see criteria above).

ASCT for Lymphocytic Leukemia

ASCT **is considered medically necessary and a covered benefit** for lymphocytic leukemia if **ALL** of the following criteria are met:

- HLA matched donor; **AND,**
- Therapeutic response confirmed by bone marrow Bx as evidenced by one of the following:
  - First remission in intermediate / high-risk patient; **OR,**
  - Second remission; **OR,**
  - Relapsed disease; **OR,**
  - Induction failure.

AND,

- Pre-transplant evaluation to include (in addition to items listed above), a neurological screen with results of one of the following:
  - Normal by history and physical examination; **OR,**
  - Positive symptoms from normal cytology by LP and treated CNS disease.

ASCT for Myelodyplastic Syndrome

ASCT **is considered medically necessary and a covered benefit** for myelodysplastic syndrome if **ALL** of the following criteria are met:

- HLA matched donor; **AND,**
- Intermediate-risk / high-rish patient by IPSS*; **AND,**
- Pre-transplant evaluation (see criteria above).

* NOTE: IPSS = International Prognostic Scoring System

Original Effective Date: 12/18/2008 - Revised: 12/18/2010, 8/12/2011, 5/3/2012, 5/2/2013, 6/5/2014, 5/7/2015, 11/3/2016, 9/7/2017, 9/6/2018

ASCT for Chronic Myelogenous Leukemia (CML)

ASCT **is considered medically necessary and a covered benefit** for CML if **ALL** of the following criteria are met:

- HLA matched donor; **AND,**
- Disease stage confirmed by bone marrow Bx – chronic phase **OR** accelerated phase **OR** blast crisis; **AND,**
- No / incomplete response to imatinib mesylate; **AND,**
- Pre-transplant evaluation (see criteria above).

ASCT for Non-Hodgkin's Lymphoma

ASCT **is considered medically necessary and a covered benefit** for Non-Hodgkin's Lymphoma if **ALL** of the following criteria are met:

- HLA matched donor; **AND,**
- Type of Non-Hodgkin's Lymphoma includes **one** of the following:
  - Diffuse large B cell with first remission in intermediate high-risk patient **OR** relapsed disease; **OR,**
  - Mantle cell and first remission; **OR,**
  - Burkitt's lymphoma as evidenced by the following:
    - Therapeutic response with first remission **OR** relapsed disease in chemosensitive patient; **AND,**
    - A neurological screen with results of one of the following:
      - Normal by history and physical examination; **OR,**
      - Positive symptoms from normal cytology by LP and treated CNS disease.

AND

- Pre-transplant evaluation (see criteria above).

ASCT for Chronic Lymphocytic Leukemia (CLL)

ASCT **is considered medically necessary and a covered benefit** for CLL if **ALL** of the following criteria are met:

- HLA matched donor; **AND,**
- Therapeutic response confirmed by bone marrow Bx as evidenced by one of the following:
  - First remission in intermediate / high-risk patient; **OR,**
  - Second remission; **OR,**
  - Relapsed disease; **OR,**
  - Induction failure.
- Pre-transplant evaluation (see criteria above).

Autologous Stem Cell Transplantation (AuSCT)

Members undergoing AuSCT **must complete a pre-transplant evaluation** as evidenced by all of the following:

- Serum creatinine / creatinine clearance results; **AND,**
- Psychosocial screen to include the following three items:
  - Drug / alcohol screen with no drug / alcohol abuse by history **OR** drug / alcohol free for ≥ 6 months
  - Behavioral health disorder with no behavioral health disorder by history and physical examination **OR** treated behavioral health disorder; **AND**
  - Adequate social / family support.
- Performance status of Karnofsky score ≥ 70% **OR** Eastern Cooperative Oncology Group grade 0-2.

Original Effective Date: 12/18/2008 - Revised: 12/18/2010, 8/12/2011, 5/3/2012, 5/2/2013, 6/5/2014, 5/7/2015, 11/3/2016, 9/7/2017, 9/6/2018

AuSCT for Multiple Myeloma

AuSCT **is considered medically necessary and a covered benefit** for Durie-Salmon Stage II or III members if **ALL** of the following criteria are met:

- Newly diagnosed or responsive multiple myeloma* ; **AND,**
- Adequate cardiac, renal, pulmonary, and hepatic function; **AND,**
- Treatment responsive as evidenced by at one of the following post induction therapy for active myeloma;
  - Improved symptoms; **OR,**
  - Relapsed disease; **OR,**
  - Refractory disease.

AND,

- Pre-transplant evaluation (see criteria above).

*NOTE: This includes those members with previously untreated disease, those with at least a partial response to prior chemotherapy (defined as a 50% decrease either in measurable paraprotein [serum and/or urine] or in bone marrow infiltration, sustained for at least one month), and those in responsive relapse.

AuSCT for Leukemia, Neuroblastoma, Hodgkin's Lymphoma & Non-Hodgkin's Lymphoma

AuSCT **is considered medically necessary** for the treatment of members with the following indications:

- Acute leukemia in remission who have a high probability of relapse and who have no human leucocyte antigens (HLA)-matched; **OR,**
- Resistant non-Hodgkin's lymphomas or those presenting with poor prognostic features following initial response; **OR,**
- Recurrent or refractory neuroblastoma; **OR,**
- Advanced Hodgkin's disease who have failed conventional therapy and have no HLA-matched donor

AuSCT **is considered medically necessary** for Hodgkin's Lymphoma if a therapeutic response is evidenced by one of the following:

- Induction failure; **OR,**
- Partial remission; **OR,**
- Relapsed disease.

AND,

- Pre-transplant evaluation (see criteria above).

AuSCT **is considered medically necessary and a covered benefit** when diagnosed with one of the following types of Non-Hodgkin's Lymphoma:

- Diffuse large B cell with first remission in intermediate high-risk patient **OR** relapsed disease; **OR,**
- Mantle cell and first remission; **OR,**
- Burkitt's lymphoma as evidenced by the following:
  - Therapeutic response with first remission **OR** relapsed disease in chemosensitive patient; **AND,**
  - A neurological screen with results of one of the following:
    - Normal by history and physical examination; **OR,**
    - Positive symptoms from normal cytology by LP and treated CNS disease.

AND

- Pre-transplant evaluation (see criteria above).

AuSCT for Acute Myelogenous Leukemia (AML)

AuSCT **is considered medically necessary** for the treatment of members with AML meeting the following criteria:

- Identified human leucocyte antigens (HLA) donor; **AND,**

- Therapeutic response confirmed by bone marrow with first remission ≥ 6 months **AND** second complete remission attained; **AND,**
- Pre-transplant evaluation to include (in addition to items listed above), a neurological screen with results of one of the following:
  - Normal by history and physical examination; **OR,**
  - Positive symptoms from normal cytology by LP and treated CNS disease.

AuSCT for Breast Cancer

AuSCT **is considered medically necessary** for breast cancer if **ONE** of the following criteria are met:

- Chemosensitive Stage IV disease; **OR,**
- Stage IV disease with relapse after a complete response to first line therapy for metastatic disease; **OR,**
- Therapy is administered as part of a clinical trial.

CODING

Covered CPT®* Codes

38204 Management of recipient hematopoietic progenitor cell donor search and cell acquisition
38205 Blood-derived hematopoietic progenitor cell harvesting for transplantation, per collection; allogeneic
38206 Blood-derived hematopoietic progenitor cell harvesting for transplantation, per collection; autologous
38207 Transplant preparation of hematopoietic progenitor cells; cryopreservation and storage
38208 Transplant preparation of hematopoietic progenitor cells; thawing of previously frozen harvest, without washing , per donor
38209 Transplant preparation of hematopoietic progenitor cells; thawing of previously frozen harvest, with washing , per donor
38210 Transplant preparation of hematopoietic progenitor cells; specific cell depletion within harvest, T-cell depletion
38211 Transplant preparation of hematopoietic progenitor cells; tumor cell depletion
38212 Transplant preparation of hematopoietic progenitor cells; red blood cell removal
38213 Transplant preparation of hematopoietic progenitor cells; platelet depletion
38214 Transplant preparation of hematopoietic progenitor cells; plasma (volume) depletion
38215 Transplant preparation of hematopoietic progenitor cells; cell concentration in plasma, mononuclear, or buffy coat layer
38220 Bone marrow; aspiration only
38221 Bone marrow; biopsy, needle or trocar
38230 Bone marrow harvesting for transplantation; allogeneic
38232 Bone marrow harvesting for transplantation; autologous
38240 Hematopoietic progenitor cell (HPC); allogeneic transplantation per donor
38241 Hematopoietic progenitor cell (HPC); autologous transplantation
38242 Allogeneic lymphocyte infusions
38243 Hematopoietic progenitor cell(HPC); HPC boost

Covered HCPCS Codes

S2150 Bone marrow or blood-derived stem cells (peripheral or umbilical), allogeneic or autologous, harvesting, transplantation, and related complications; including: pheresis and cell preparation/storage; marrow ablative therapy; drugs, supplies, hospitalization with outpatient follow-up; medical/surgical, diagnostic, emergency, and rehabilitative services; and the number of days of ~~per~~ pre- and post-transplant care in the global definition.

ICD-10-PCS (Inpatient Only)

Refer to the following ICD-10-PCS tables for specific code assignment based on physician documentation.

NOTE: Per ICD-10-PCS Coding Guidelines, "ICD-10-PCS codes are composed of seven characters. Each character is an axis of classification that specifies information about the procedure performed. Within a defined code range, a character specifies the same type of information in that axis of classification. One of 34 possible values can be assigned to each axis of classification in the seven-character code".

079 Med/Surg Lymphatic and Hemic Systems Drainage
07D Med/Surg Lymphatic and Hemic Systems Extraction
302 Administration Circulatory Transfusion
6A5 Extracorporeal therapies; physiological systems; pheresis

Covered ICD-10-CM Diagnosis Codes

ASCT - Allogeneic Stem Cell Transplantation Covered Diagnosis

C83.10 Mantle cell lymphoma, unspecified site
C83.70 - C83.79 Burkitt lymphoma **,**unspecified site (C83.70)
C85.80 - C85.89 Other specified types of non-Hodgkin lymphoma unspecified site (C85.80)
C91.00 Acute lymphoblastic leukemia not having achieved remission
C92.00 - C92.92 Acute myeloblastic leukemia , not having achieved remission (C92.00)

D46.0 - D46.9 Myelodysplastic syndromes , unspecified (D46.9) (D46.0) Refractory anemia without ring sideroblasts, so stated
D61.01 - D61.9 D61.01 Constitutional (pure) red blood cell aplasia
D81.0 - D81.2 Severe combined immunodeficiency [SCID] with reticular dysgenesis (D81.0)
D82.0 Wiskott-Aldrich syndrome

AuSCT - Autologous Stem Cell Transplantation Covered Diagnosis
C50.011 - C50.929 Malignant neoplasm of nipple and areola, right female breast (C50.011)
C81.00 Nodular lymphocyte predominant Hodgkin lymphoma, unspecified site
C83.10 - C83.39 Mantle cell lymphoma , unspecified site (C83.10)
C83.70 - C83.79 Burkitt lymphoma , unspecified site (C83.70)
C85.80 - C85.89 Other specified types of non-Hodgkin lymphoma unspecified site (C85.80)
C90.00 - C90.02 Multiple myeloma not having achieved remission (C90.00)
C91.01 Acute lymphoblastic- leukemia, in remission
C92.00 - C92.92 Acute myeloblastic leukemia
Various Codes Neuroblastoma, by specified or unspecified site**;** recurrent or refractory;

Covered ICD-10 Diagnosis Codes
C82.51 Diffuse follicle center lymphoma, lymph nodes of head, face, and neck
C82.52 Diffuse follicle center lymphoma, intrathoracic lymph nodes
C82.53 Diffuse follicle center lymphoma, intra-abdominal lymph nodes
C82.54 Diffuse follicle center lymphoma, lymph nodes of axilla and upper limb
C82.55 Diffuse follicle center lymphoma, lymph nodes of inguinal region and lower limb
C82.56 Diffuse follicle center lymphoma, intrapelvic lymph nodes
C82.57 Diffuse follicle center lymphoma, spleen
C82.58 Diffuse follicle center lymphoma, lymph nodes of multiple sites
C83.10 Mantle cell lymphoma, unspecified site
C83.11 Mantle cell lymphoma, lymph nodes of head, face, and neck
C83.12 Mantle cell lymphoma, intrathoracic lymph nodes
C83.13 Mantle cell lymphoma, intra-abdominal lymph nodes
C83.14 Mantle cell lymphoma, lymph nodes of axilla and upper limb
C83.15 Mantle cell lymphoma, lymph nodes of inguinal region and lower limb
C83.16 Mantle cell lymphoma, intrapelvic lymph nodes
C83.17 Mantle cell lymphoma, spleen
C83.18 Mantle cell lymphoma, lymph nodes of multiple sites
C83.19 Mantle cell lymphoma, extranodal and solid organ sites
C83.70 Burkitt lymphoma, unspecified site
C83.71 Burkitt lymphoma, lymph nodes of head, face, and neck
C83.72 Burkitt lymphoma, intrathoracic lymph nodes
C83.73 Burkitt lymphoma, intra-abdominal lymph nodes
C83.74 Burkitt lymphoma, lymph nodes of axilla and upper limb
C83.75 Burkitt lymphoma, lymph nodes of inguinal region and lower limb
C83.76 Burkitt lymphoma, intrapelvic lymph nodes
C83.77 Burkitt lymphoma, spleen
C83.78 Burkitt lymphoma, lymph nodes of multiple sites
C83.79 Burkitt lymphoma, extranodal and solid organ sites
C84.91 Mature T/NK-cell lymphomas, unspecified, lymph nodes of head, face, and neck
C84.A1 Cutaneous T-cell lymphoma, unspecified lymph nodes of head, face, and neck
C84.A2 Cutaneous T-cell lymphoma, unspecified, intrathoracic lymph nodes
C84.A3 Cutaneous T-cell lymphoma, unspecified, intra-abdominal lymph nodes
C84.A4 Cutaneous T-cell lymphoma, unspecified, lymph nodes of axilla and upper limb
C84.A5 Cutaneous T-cell lymphoma, unspecified, lymph nodes of inguinal region and lower limb
C84.A6 Cutaneous T-cell lymphoma, unspecified, intrapelvic lymph nodes
C84.A7 Cutaneous T-cell lymphoma, unspecified, spleen
C84.A8 Cutaneous T-cell lymphoma, unspecified, lymph nodes of multiple sites
C84.Z1 Other mature T/NK-cell lymphomas, lymph nodes of head, face, and neck
C84.Z2 Other mature T/NK-cell lymphomas, intrathoracic lymph nodes
C84.Z3 Other mature T/NK-cell lymphomas, intra-abdominal lymph nodes
C84.Z4 Other mature T/NK-cell lymphomas, lymph nodes of axilla and upper limb
C84.Z5 Other mature T/NK-cell lymphomas, lymph nodes of inguinal region and lower limb
C84.Z6 Other mature T/NK-cell lymphomas, intrapelvic lymph nodes
C84.Z7 Other mature T/NK-cell lymphomas, spleen
C84.Z8 Other mature T/NK-cell lymphomas, lymph nodes of multiple sites
C84.92 Mature T/NK-cell lymphomas, unspecified, intrathoracic lymph nodes
C84.93 Mature T/NK-cell lymphomas, unspecified, intra-abdominal lymph nodes
C84.94 Mature T/NK-cell lymphomas, unspecified, lymph nodes of axilla and upper limb
C84.95 Mature T/NK-cell lymphomas, unspecified, lymph nodes of inguinal region and lower limb

C84.96	Mature T/NK-cell lymphomas, unspecified, intrapelvic lymph nodes
C84.97	Mature T/NK-cell lymphomas, unspecified, spleen
C84.98	Mature T/NK-cell lymphomas, unspecified, lymph nodes of multiple sites
C85.11	Unspecified B-cell lymphoma, lymph nodes of head, face, and neck
C85.12	Unspecified B-cell lymphoma, intrathoracic lymph nodes
C85.13	Unspecified B-cell lymphoma, intra-abdominal lymph nodes
C85.14	Unspecified B-cell lymphoma, lymph nodes of axilla and upper limb
C85.15	Unspecified B-cell lymphoma, lymph nodes of inguinal region and lower limb
C85.16	Unspecified B-cell lymphoma, intrapelvic lymph nodes
C85.17	Unspecified B-cell lymphoma, spleen
C85.18	Unspecified B-cell lymphoma, lymph nodes of multiple sites
C85.21	Mediastinal (thymic) large B-cell lymphoma, lymph nodes of head, face, and neck
C85.22	Mediastinal (thymic) large B-cell lymphoma, intrathoracic lymph nodes
C85.23	Mediastinal (thymic) large B-cell lymphoma, intra-abdominal lymph nodes
C85.24	Mediastinal (thymic) large B-cell lymphoma, lymph nodes of axilla and upper limb
C85.25	Mediastinal (thymic) large B-cell lymphoma, lymph nodes of inguinal region and lower limb
C85.26	Mediastinal (thymic) large B-cell lymphoma, intrapelvic lymph nodes
C85.27	Mediastinal (thymic) large B-cell lymphoma, spleen
C85.28	Mediastinal (thymic) large B-cell lymphoma, lymph nodes of multiple sites
C85.80	Other specified types of non-Hodgkin lymphoma, unspecified site
C85.81	Other specified types of non-Hodgkin lymphoma, lymph nodes of head, face, and neck
C85.82	Other specified types of non-Hodgkin lymphoma, intrathoracic lymph nodes
C85.83	Other specified types of non-Hodgkin lymphoma, intra-abdominal lymph nodes
C85.84	Other specified types of non-Hodgkin lymphoma, lymph nodes of axilla and upper limb
C85.85	Other specified types of non-Hodgkin lymphoma, lymph nodes of inguinal region and lower limb
C85.86	Other specified types of non-Hodgkin lymphoma, intrapelvic lymph nodes
C85.87	Other specified types of non-Hodgkin lymphoma, spleen
C85.88	Other specified types of non-Hodgkin lymphoma, lymph nodes of multiple sites
C85.89	Other specified types of non-Hodgkin lymphoma, extranodal and solid organ sites
C85.91	Non-Hodgkin lymphoma, unspecified, lymph nodes of head, face, and neck
C85.92	Non-Hodgkin lymphoma, unspecified, intrathoracic lymph nodes
C85.93	Non-Hodgkin lymphoma, unspecified, intra-abdominal lymph nodes
C85.94	Non-Hodgkin lymphoma, unspecified, lymph nodes of axilla and upper limb
C85.95	Non-Hodgkin lymphoma, unspecified, lymph nodes of inguinal region and lower limb
C85.96	Non-Hodgkin lymphoma, unspecified, intrapelvic lymph nodes
C85.97	Non-Hodgkin lymphoma, unspecified, spleen
C85.98	Non-Hodgkin lymphoma, unspecified, lymph nodes of multiple sites
C86.0	Extranodal NK/T-cell lymphoma, nasal type
C86.1	Hepatosplenic T-cell lymphoma
C86.2	Enteropathy-type (intestinal) T-cell lymphoma
C86.3	Subcutaneous panniculitis-like T-cell lymphoma
C91.00	Acute lymphoblastic leukemia not having achieved remission
C91.01	Acute lymphoblastic leukemia, in remission
C91.02	Acute lymphoblastic leukemia, in relapse
C91.10	Chronic lymphocytic leukemia of B-cell type not having achieved remission
C91.11	Chronic lymphocytic leukemia of B-cell type in remission
C91.12	Chronic lymphocytic leukemia of B-cell type in relapse
C91.30	Prolymphocytic leukemia of B-cell type not having achieved remission
C91.31	Prolymphocytic leukemia of B-cell type, in remission
C91.32	Prolymphocytic leukemia of B-cell type, in relapse
C91.50	Adult T-cell lymphoma/leukemia (HTLV-1-associated) not having achieved remission
C91.51	Adult T-cell lymphoma/leukemia (HTLV-1-associated), in remission
C91.60	Prolymphocytic leukemia of T-cell type not having achieved remission
C91.61	Prolymphocytic leukemia of T-cell type, in remission
C91.62	Prolymphocytic leukemia of T-cell type, in relapse
C91.90	Lymphoid leukemia, unspecified not having achieved remission
C91.91	Lymphoid leukemia, unspecified, in remission
C91.92	Lymphoid leukemia, unspecified, in relapse
C91.A0	Mature B-cell leukemia Burkitt-type not having achieved remission
C91.A1	Mature B-cell leukemia Burkitt-type, in remission
C91.A2	Mature B-cell leukemia Burkitt-type, in relapse
C91.Z0	Other lymphoid leukemia not having achieved remission
C91.Z1	Other lymphoid leukemia, in remission
C91.Z2	Other lymphoid leukemia, in relapse
C92.01	Acute myeloblastic leukemia, in remission

C92.02	Acute myeloblastic leukemia, in relapse
C92.41	Acute promyelocytic leukemia, in remission
C92.42	Acute promyelocytic leukemia, in relapse
C92.51	Acute myelomonocytic leukemia, in remission
C92.52	Acute myelomonocytic leukemia, in relapse
C92.61	Acute myeloid leukemia with 11q23-abnormality in remission
C92.62	Acute myeloid leukemia with 11q23-abnormality in relapse
C92.A1	Acute myeloid leukemia with multilineage dysplasia, in remission
C92.A2	Acute myeloid leukemia with multilineage dysplasia, in relapse
D46.0	Refractory anemia without ring sideroblasts, so stated
D46.1	Refractory anemia with ring sideroblasts
D46.20	Refractory anemia with excess of blasts, unspecified
D46.21	Refractory anemia with excess of blasts 1
D46.22	Refractory anemia with excess of blasts 2
D46.9	Myelodysplastic syndrome, unspecified
D46.A	Refractory cytopenia with multilineage dysplasia
D46.B	Refractory cytopenia with multilineage dysplasia and ring sideroblasts
D46.C	Myelodysplastic syndrome with isolated del(5q) chromosomal abnormality
D46.Z	Other myelodysplastic syndromes
D61.01	Constitutional (pure) red blood cell aplasia
D61.09	Other constitutional aplastic anemia
D81.0	Severe combined immunodeficiency [SCID] with reticular dysgenesis
D81.1	Severe combined immunodeficiency [SCID] with low T- and B-cell numbers
D81.2	Severe combined immunodeficiency [SCID] with low or normal B-cell numbers
D81.6	Major histocompatibility complex class I deficiency
D81.7	Major histocompatibility complex class II deficiency
D81.89	Other combined immunodeficiencies
D81.9	Combined immunodeficiency, unspecified
D82.0	Wiskott-Aldrich syndrome

Non-Covered ICD-10-CM Diagnosis Codes

ASCT - Allogeneic Stem Cell Transplantation non-covered diagnosis
C90.00 - C90.02 Multiple myeloma not having achieved remission (C90.00)

AuSCT - Autologous Stem Cell Transplantation non-covered diagnosis

C90.00 - C90.02	Tandem transplantation (multiple rounds of AuSCT) for members with multiple myeloma
C92.10	Chronic myeloid leukemia, BCR/ABL-positive, not having achieved remission
C92.11	Chronic myeloid leukemia , BCR/ABL-positive, in remission
C95.00	Acute leukemia of unspecified cell type not having achieved remission
C95.10	Chronic leukemia of unspecified cell type, not having achieved remission
E85.0 - E85.9	Amyloidosis ,unspecified (E85.9)

Coding information is provided for informational purposes only. The inclusion or omission of a CPT, HCPCS, or ICD-10 code does not imply member coverage or provider reimbursement. Consult the member's benefits that are in place at time of service to determine coverage (or non-coverage) as well as applicable federal / state laws.

REFERENCES

1. Guidelines, policy statements and reviews. American Society for Blood and Marrow Transplantation Web site. http://www.asbmt.org. Published 2008. Accessed August 27, 2018.
2. National coverage determination for stem cell transplantation (110.8.1). Centers for Medicare and Medicaid Services Web site. http://www.cms.hhs.gov/mcd/search.asp. Published January 3, 2006. Accessed August 27, 2018.
3. NCCN clinical practice guidelines in oncology: breast cancer. National Comprehensive Cancer Network Web site. https://www.nccn.org/professionals/physician_gls/f_guidelines.asp. Published 2015. Accessed August 27, 2018.

MEDICAL POLICY COMMITTEE HISTORY AND REVISIONS

Date	Action
9/6/2018, 9/7/2017, 11/3/2016	• Approved by MPC. Updated item from CMS NCD.
5/7/2015, 6/5/2014	• Approved by MPC. No changes.
5/2/2013	• Approved by MPC. Added additional criteria for autologous and allogeneic stem cell transplantation.
5/13/2012	• Approved by MPC. No changes.
12/1/2011	• New template design approved by MPC.
8/12/2011	• Approved by MPC. No changes.