Medical Necessity Guidelines: Hematopoietic Stem-Cell Transplantation (HSCT) for the Treatment of Non-Hodgkin’s Lymphoma: Adult

Effective: October 10, 2018

Prior Authorization Required
If REQUIRED, submit supporting clinical documentation pertinent to service request.

<table>
<thead>
<tr>
<th>Applies to:</th>
<th>Yes ☒ No ☐</th>
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</thead>
<tbody>
<tr>
<td>COMMERCIAL Products</td>
<td></td>
</tr>
<tr>
<td>☒ Tufts Health Plan Commercial products; Fax: 617.972.9409</td>
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</tr>
<tr>
<td>☒ Tufts Health Freedom Plan products; Fax: 617.972.9409</td>
<td></td>
</tr>
<tr>
<td>• CareLinkSM – Refer to CareLink Procedures, Services and Items Requiring Prior Authorization</td>
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<tr>
<td>TUFTS HEALTH PUBLIC PLANS Products</td>
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<tr>
<td>☒ Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product); Fax: 888.415.9055</td>
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<tr>
<td>☒ Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans; Fax: 888.415.9055</td>
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<tr>
<td>☒ Tufts Health RITogether – A Rhode Island Medicaid Plan; Fax: 857.304.6404</td>
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<tr>
<td>☒ Tufts Health Unify* – OneCare Plan (a dual-eligible product); Fax: 781.393.2607</td>
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<td>*The MNG applies to Tufts Health Unify members unless a less restrictive LCD or NCD exists.</td>
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SENIOR Products

• Tufts Health Plan Senior Care Options (SCO), (a dual-eligible product) – Refer to the Tufts Health Plan SCO Prior Authorization List
• Tufts Medicare Preferred HMO, (a Medicare Advantage product) – Refer to the Tufts Medicare Preferred HMO Prior Authorization and Inpatient Notification List

Note: While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you will need to make sure that prior authorization has been obtained.

OVERVIEW

Stem cells are cells in the bone marrow that give the body a constant source of blood cells. Stem cell transplants are used to re-supply the bone marrow when it has been destroyed by disease, chemotherapy, or radiation. Depending on the source of the stem cells, this procedure may be called a bone marrow transplant, a peripheral blood stem cell transplant, or a cord blood transplant (American Cancer Society, 2007).

Hematopoietic stem cell transplantation (HSCT) is a rapidly evolving technique that offers a potential cure for hematologic cancers (leukemias, lymphomas, myeloma) and other hematologic disorders (e.g., primary immunodeficiency, aplastic anemia, myelodysplasia). HSCT may be autologous or allogeneic; bone marrow, peripheral blood, or umbilical cord stem cells may be used. Peripheral blood has largely replaced bone marrow as a source of stem cells, especially in autologous HSCT because stem cell harvest is easier, and neutrophil and platelet counts recover faster. Umbilical cord HSCT has been mainly restricted to children because the number of stem cells is low (Merck Manual, 2006).

Non-Hodgkin lymphoma (non-Hodgkin’s lymphoma or NHL) is a cancer of lymphoid tissue, a part of the lymphatic system. It is sometimes just called lymphoma. Lymphomas first start from errors that occur in the DNA of lymphocytes in either the lymph nodes or other lymphoid tissue (such as the spleen or bone marrow) and spread from there (American Cancer Society, 2007).

To initiate the prior authorization process, it is necessary to complete and submit the Stem Cell Transplant Request for Coverage Form.

CLINICAL COVERAGE CRITERIA

Autologous HSCT

Tufts Health Plan may authorize coverage of an autologous HSCT when the Member meets one of the following criteria:
1. Recurrent, or refractory aggressive, or highly aggressive advanced stage disease (Stage III or IV) when Member responds to high dose chemotherapy. Purging is not covered.
2. Refractory indolent disease.
3. Recurrent indolent disease if relapse is within 12 months of initial remission.
4. Indolent disease transformation to aggressive disease.

**Allogeneic HSCT**

Tufts Health Plan may authorize coverage of allogeneic HSCT when the Member has a matched sibling or unrelated donor and one of the following criteria is met:

1. Refractory indolent disease.
2. Recurrent indolent disease if relapse is within 12 months of the initial remission.

**Non-myeloablative Allogeneic HSCT**

Tufts Health Plan will cover non-myeloablative allogeneic HSCT for Members with low grade lymphoma and who are unable to undergo fully ablative transplantation.

**Note:** For the treatment of Chronic Lymphocytic Lymphoma/Small Lymphocytic Lymphoma (CLL/SLL) refer to Medical Necessity Guideline #2107709: HSCT for the Treatment of Chronic Lymphocytic Lymphoma/Small Lymphocytic Lymphoma (CLL/SLL).

**LIMITATIONS**

Tufts Health Plan does not cover tandem autologous or allogeneic HSCT for this diagnosis.

**CODES**

The following CPT/HCPCS codes require prior authorization:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>38204</td>
<td>Management of recipient hematopoietic progenitor cell donor search and cell acquisition</td>
</tr>
<tr>
<td>38205</td>
<td>Blood-derived hematopoietic progenitor cell harvesting for transplantation, per collection; allogeneic</td>
</tr>
<tr>
<td>38206</td>
<td>Blood-derived hematopoietic progenitor cell harvesting for transplantation, per collection; autologous</td>
</tr>
<tr>
<td>38207</td>
<td>Transplant preparation of hematopoietic progenitor cells; cryopreservation and storage</td>
</tr>
<tr>
<td>38230</td>
<td>Bone marrow harvesting for transplantation</td>
</tr>
<tr>
<td>38240</td>
<td>Bone marrow or blood-derived peripheral stem transplantation; allogeneic</td>
</tr>
<tr>
<td>38241</td>
<td>Bone marrow or blood-derived peripheral stem cell transplantation; autologous</td>
</tr>
<tr>
<td>38242</td>
<td>Bone marrow or blood-derived peripheral stem cell transplantation; allogeneic donor lymphocyte infusions</td>
</tr>
<tr>
<td>38243</td>
<td>Hematopoietic progenitor cell (HPC); HPC boost</td>
</tr>
<tr>
<td>S2140</td>
<td>Cord blood harvesting for transplantation, allogenean</td>
</tr>
<tr>
<td>S2142</td>
<td>Cord blood-derived stem-cell transplantation, allogenean</td>
</tr>
<tr>
<td>S2150</td>
<td>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 pre-and post-transplant care in the global definition</td>
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**REFERENCES**


**APPROVAL HISTORY**

November 2006: Reviewed by the Clinical Coverage Criteria Committee

Subsequent endorsement date(s) and changes made:
- March 16, 2007: New Format
- April 25, 2008: Reviewed and renewed without changes
- April 6, 2009: Reviewed and renewed without changes
- November 1, 2009: Reviewed by Medical Affairs Medical Policy Committee, no changes
- December 2010: Reviewed at MSPAC. Addition of coverage for non myeloablative transplantation for Members with low grade lymphoma
- December 14, 2011: Reviewed by Integrated Medical Policy Advisory Committee (IMPAC), no changes
- December 12, 2012: Reviewed by IMPAC, donor source information added per current NCCN guidelines, coding updated
- December 11, 2013: Reviewed by IMPAC, renewed without changes
- December 10, 2014: Reviewed by IMPAC, reviewed without changes
- September 2015: Branding and template change to distinguish Tufts Health Plan products in "Applies to" section. Added Tufts Health Freedom Plan products, effective January 1, 2016.
- October 14, 2015: Reviewed by IMPAC, renewed without changes
- July 20, 2016: Reviewed by IMPAC, reviewed without changes
- November 9, 2016: Reviewed by IMPAC, reviewed without changes
- November 23, 2016: Contact information updated
- April 2017: Added RITogether Plan product to template. For MNGs applicable to RITogether, effective date is August 1, 2017
- September 18, 2017: Administrative update
- December 13, 2017: Reviewed by IMPAC, renewed without changes
- October 10, 2018: Reviewed by IMPAC, renewed without changes
- October, 2018: Template and disclaimer updated

**Background, Product and Disclaimer Information**

Medical Necessity Guidelines are developed to determine coverage for benefits, and are published to provide a better understanding of the basis upon which coverage decisions are made. We make coverage decisions using these guidelines, along with the Member’s benefit document, and in coordination with the Member’s physician(s) on a case-by-case basis considering the individual Member’s health care needs.

Medical Necessity Guidelines are developed for selected therapeutic or diagnostic services found to be safe and proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in our service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. We revise and update Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.
For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Medical Necessity Guideline and a self-insured Member’s benefit document, the provisions of the benefit document will govern.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this guideline is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to eligibility and benefits on the date of service, coordination of benefits, referral/authorization, utilization management guidelines when applicable, and adherence to plan policies, plan procedures, and claims editing logic.