Molina Clinical Policy
Hematopoietic Stem Cell Transplantation for Multiple Myeloma and POEMS Syndrome: Policy No. 122

Last Approval: 6/8/2022
Next Review Due By: June 2023

DISCLAIMER

This Molina Clinical Policy (MCP) is intended to facilitate the Utilization Management process. Policies are not a supplementation or recommendation for treatment; Providers are solely responsible for the diagnosis, treatment and clinical recommendations for the Member. It expresses Molina's determination as to whether certain services or supplies are medically necessary, experimental, investigational, or cosmetic for purposes of determining appropriateness of payment. The conclusion that a particular service or supply is medically necessary does not constitute a representation or warranty that this service or supply is covered (e.g., will be paid for by Molina) for a particular Member. The Member's benefit plan determines coverage – each benefit plan defines which services are covered, which are excluded, and which are subject to dollar caps or other limits. Members and their Providers will need to consult the Member's benefit plan to determine if there are any exclusion(s) or other benefit limitations applicable to this service or supply. If there is a discrepancy between this policy and a Member's plan of benefits, the benefits plan will govern. In addition, coverage may be mandated by applicable legal requirements of a State, the Federal government or CMS for Medicare and Medicaid Members. CMS's Coverage Database can be found on the CMS website. The coverage directive(s) and criteria from an existing National Coverage Determination (NCD) or Local Coverage Determination (LCD) will supersede the contents of this MCP and provide the directive for all Medicare members. References included were accurate at the time of policy approval and publication.

OVERVIEW

Multiple myeloma is a rare form of cancer identified by excessive production (proliferation) and improper function of certain cells (plasma cells) found in the bone marrow. Plasma cells (white blood cells) produced in the bone marrow normally reside there however, excessive cells may eventually mass together to form a tumor or tumors in the body, specifically the bone marrow. Solitary plasmacytoma refers to cases where only a single tumor is present; multiple myeloma refers to cases with multiple tumors present or the bone marrow has greater than 10% plasma cells. Plasma cells play a crucial role in the immune system and secrete a type of antibody called immunoglobulin proteins (M-proteins). An overproduction of plasma cells leads to unusually high levels of M proteins. (NORD, 2019). The main symptoms of multiple myeloma may include bone pain (especially in the back and ribs); anemia leading to weakness, fatigue, and lack of pallor; and renal abnormalities. Pneumonia may also be present in those prone to bacterial infections. (NORD, 2019).

While rare, approximately 100,000 Americans currently have multiple myeloma – it accounts for 10% of all hematological malignancies diagnoses in the United States. Diagnoses are slightly higher in males than females and is typically discovered between the fourth and seventh decade of life (average age at diagnosis is 68). (NORD, 2019). In 2022, an estimated 34,470 new cases of multiple myeloma are expected to be diagnosed which accounts for 1.8% of all new cancer cases. An estimated 12,640 deaths are expected in 2022, accounting for 2.1% of all cancer deaths. (NIH, 2022).

Monoclonal Gammopathy of Undetermined Significance (MGUS) and Smoldering Multiple Myeloma (SMM)

Patients who have been newly diagnosed are evaluated to verify the diagnosis as the premalignant stages of multiple myeloma. Monoclonal gammopathy of undetermined significance (MGUS) and smoldering multiple myeloma (SMM) can be misdiagnosed as multiple myeloma. For example, patients with MGUS can have renal failure as a result of diabetes or hypertension, or who have bone lesions from other types of cancers. These patients may be misdiagnosed with multiple myeloma if findings are incorrectly attributed to the plasma cell dyscrasia. In patients that have end-organ damage, it should be determined if it is truly secondary to the underlying plasma cell disorder or to an unrelated process. ([1] Rajkumar, 2022).

MGUS is characterized by the presence of M-proteins in the blood; levels found in the urine may be low. Patients with do not have the physical symptoms associated with multiple myeloma (e.g., anemia, bony lesions, kidney abnormalities). Some patients ultimately develop a malignant disorder such as multiple myeloma, Waldenstrom macroglobulinemia, or amyloidosis. (NORD, 2019).

Patients with SMM have more myeloma cells than someone with asymptomatic myeloma or MGUS. At this stage, the disease may cause bone damage, anemia, kidney problems, or hypercalcemia. Levels of M protein and plasma cells in the bone marrow are higher in patients with SMM than those with MGUS (10-60% of all cells in marrow are plasma cells). However, there is still no evidence of symptoms or signs of myeloma, such as significant bone disease or anemia. Bisphosphonates may be prescribed for patients with symptoms of osteoporosis or osteopenia. Most people

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with SMM eventually develop myeloma. Patients should be monitored – treatment may be recommended if the disease progresses, specifically in patients at risk of developing symptoms within 18 months to 2 years. (ASCO, 2021).

Those with a confirmed diagnosis of multiple myeloma require treatment whereas those with MGUS and SMM do not; symptomatic patients die within a median of six months without effective therapy. Patients with SMM may remain stable for prolonged length of time. It is uncertain if patients with SMM or multiple myeloma, it is reasonable to re-evaluate the patient in two or three months and to delay therapy until the correct diagnosis is evident. Symptoms should be monitored by the patient and the Provider should be notified immediately if there are changes. ([1] Rajkumar, 2022).

Staging

There are two staging systems used for multiple myeloma – the Durie-Salmon Staging System and the International Staging System (ISS) (Dispenzieri, 2012):

Stage	Durie-Salmon Staging Criteria	International Staging System (ISS) Criteria
I	All of the following: • Hb > 10g/dL • Normal calcium • Skeletal survey – normal or single plasmacytoma or osteoporosis • Low M component production rate: ➢ Serum paraprotein level IgG< 5 g/dL ➢ Serum paraprotein level IgA< 3 g/dL • Urinary light chain excretion < 4 g/24h	Serum beta-2 microglobulin <3.5mg/L Serum Albumin ≥ 3.5g/dL
II	Neither Stage I or III	Neither stage I or III
III	One or more of the following: • Hb < 8.5g/dL • high calcium > 12 mg/dL • Skeletal survey: Three or more lytic bone lesions • Low M component production rate: ➢ Serum paraprotein level IgG > 7g/dL ➢ Serum paraprotein level if IgA, > 5 g/dL • Urinary light chain excretion > 12g/24h	Serum beta-2 microglobulin <5.5mg/L
Notes	Sub-classification criteria: A: Normal renal function: serum creatinine < 2 mg/dL B: Abnormal renal function: serum creatinine > 2 mg/dL	

Hematopoietic Stem Cell (HSC) Transplant

Once risk stratification has been completed, patients are assessed to determine eligibility for autologous hematopoietic cell transplantation (HCT). Compared with chemotherapy alone, autologous HCT appears to prolong both event-free and overall survival. Stem cell collection should occur early during treatment, independent of if the plan is for HCT to be incorporated into the initial treatment or postponed until the time of first relapse. Eligibility for autologous HCT in patients with multiple myeloma varies across countries and institutions. The United States does not have a strict age limit and decisions are made on a case-by-case basis. Most centers consider patients ineligible for autologous HCT if any of the following criteria are present:

- Over age 77
- Frank cirrhosis of the liver
- Eastern Cooperative Oncology Group (ECOG) performance status 3 or 4 unless due to bone pain
- New York Heart Association functional status Class III or IV

Autologous hematopoietic cell transplantation (HCT) involves the use of a patient's own hematopoietic cells to reconstitute the bone marrow following treatment for cancer with intensive chemotherapy and/or radiation therapy. This contrasts with allogeneic HCT, in which hematopoiesis is restored using hematopoietic cells from another individual (e.g., a sibling, volunteer donor, other relative, or umbilical cord blood). Autologous HCT is indicated for multiple myeloma; it is also indicated for Hodgkin lymphoma, Diffuse large B cell lymphoma, Follicular lymphoma, Peripheral T cell lymphoma, Mantle cell lymphoma, acute myeloid leukemia, amyloidosis, Waldenström macroglobulinemia, and testicular germ cell cancer. A registry study found that when compared with younger patients,

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over 2000 patients (age ≥ 70) experienced similar outcomes following autologous HCT for multiple myeloma. (Holmberg et al., 2022).

Autologous

Current recommendations for treatment of multiple myeloma in patients newly diagnosed and under age 70 includes high-dose therapy followed by autologous hematopoietic cell transplantation (HCT). It should be performed at the time of initial diagnosis or at relapse. While not curative, this combined treatment may improve chances of event-free survival and overall survival compared to standard-dose myeloma treatments alone. Candidates for autologous HCT undergo induction chemotherapy – it is administered for approximately four months prior to stem cell collection in an effort to reduce the number of tumor cells in the patient's bone marrow and peripheral blood as well as improve symptom outcomes and alleviate end-organ damage. An induction regimen may include bortezomib, lenalidomide, dexamethasone (VRd). ([2] Rajkumar, 2022).

Many patients are prescribed a preparative regimen of high-dose melphalan (200 mg/m2) rather than lower-dose melphalan plus total body irradiation or more intensive preparative regimens. (Patients with serum creatinine >2.0 mg/dL at the time of transplantation may receive a lower dose of melphalan, typically 140 mg/m2). Patients over age 65 and who are candidates for HCT, a single dose of melphalan (200 mg/m2) is recommended as the conditioning regimen versus tandem intermediate-dose melphalan 100 mg/m2. Patients over age 70 are recommended to receive a lower dose of melphalan (140 mg/m2). ([2] Rajkumar, 2022).

Treatment for patients with relapsed multiple myeloma following an autologous HCT include: a second autologous HCT; allogeneic HCT as part of a clinical trial; or treatment with salvage chemotherapy regimens. A second autologous HCT is a reasonable approach for patients who are transplant-eligible and have attained a response duration longer than 18 months (without maintenance therapy) or more than 36 months (with maintenance therapy). Patients under age 65 and who have a suitable matched donor, non-myeloablative allogeneic HCT or salvage chemotherapy is a potential treatment. ([2] Rajkumar, 2022).

Allogenic

A minority of patients will be eligible for allogeneic HCT, but the role of allogeneic approaches in MM remains investigational and controversial ([1] Rajkumar, 2022). Allogeneic HCT has the potential for producing cure in patients with multiple myeloma. Use is limited however, as even ideal candidates have a high rate of treatment-related mortality. In addition, efficacy of allogenic HCT compared to autologous HCT has not been fully studied. Mortality related to allogenic HCT is decreasing due to the advent of nonmyeloablative preparative regimens. New chemotherapeutic agents (e.g., bortezomib, lenalidomide) are also being combined with initial treatment of multiple myeloma; survival is increasing with chemotherapy alone or with autologous HCT. The use of allogeneic HCT requires additional study for the treatment of multiple myeloma. ([3] Rajkumar, 2022).

POEMS Syndrome

POEMS syndrome (Polyneuropathy, Organomegaly, Endocrinopathy, Monoclonal protein, Skin changes) is distinguished by the presence of a monoclonal plasma cell disorder, peripheral neuropathy, and one or more of the following ([4] Rajkumar, 2022):

- Osteosclerotic myeloma *
- Castleman disease (angiofollicular lymph node hyperplasia) *
- Increased levels of serum vascular endothelial growth factor (VEGF) *
- Organomegaly
- Endocrinopathy
- Edema
- Typical skin changes
- Papilledema

* Major criteria for diagnosis of POEMS Syndrome

Monoclonal gammopathy of undetermined significance (MGUS) results when an abnormal protein (monoclonal protein) is detected in the blood. While MGUS typically is not problematic, symptoms can include numbness, tingling or

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weakness. For some patients, MGUS eventually progresses into other types of blood cancer (e.g., multiple myeloma, macroglobulinemia or B-cell lymphoma). Osteosclerotic myeloma is also a form of multiple myeloma. When symptoms other than CRAB (hypercalcemia, renal dysfunction, anemia, or sclerotic bone lesions), consideration of a POEMS syndrome diagnosis should be explored. Patients typically have symptoms similar to classic multiple myeloma however, instead of the patient having thin and holey bones, osteosclerosis is found (a condition evidenced by abnormal density and hardening of bone). (NORD, 2021).

COVERAGE POLICY

All transplants require prior authorization from the Corporate Transplant Department. Solid organ transplant requests will be reviewed by the Corporate Senior Medical Director or qualified clinical designee. All other transplants will be reviewed by the Corporate Senior Medical Director or covering Medical Director. If the criteria are met using appropriate NCD and/or LCD guidelines, State regulations, and/or MCP policies the Corporate Senior Medical Director's designee can approve the requested transplant.

Office visits with participating Providers do NOT require prior authorization. Providers should see the Member in office visits as soon as possible and without delay. Failure to see the Member in office visits may be considered a serious quality of care concern.

Pre-Transplant Evaluation

(AMR, 2019; CMS, 2016; Jang et al., 2014; Ishii et al., 2013; Kuwabara et al., 2012; ASBMT, 2003; ECOG, n.d.; [1-4] NMDP, n.d.)

Please see *MCP-323 Pre-Transplant Evaluation* for additional criteria and information.

Criteria for transplant evaluation include:

1. History and physical examination; **AND**
2. Psychosocial evaluation and clearance:
   a. No behavioral health disorder by history or psychosocial issues:
      - If history of behavioral health disorder, no severe psychosis or personality disorder;
      - Mood/anxiety disorder must be excluded or treated;
      - Member has understanding of surgical risk and post procedure compliance and follow-up required.

   AND
   b. Adequate family and social support.

AND

3. EKG; **AND**
4. Chest x-ray; **AND**
5. Cardiac clearance in the presence of any of the following:
   a. Chronic smokers; **OR**
   b. Members > 50 years age; **OR**
   c. Those with a clinical or family history of heart disease or diabetes.

AND

6. Pulmonary clearance if evidence of pulmonary artery hypertension (PAH) or chronic pulmonary disease; **AND**
7. Neurological exam and clearance for transplant including **ONE** of the following:
   - Normal exam by H&P; **OR**
   - Abnormal neurological exam with positive findings including **ONE** of the following:
     - Lumbar puncture normal cytology; **OR**
     - Lumbar puncture with cytological exam abnormal: CNS disease treated prior to clearance.

AND

8. A Performance Status that includes **ONE** of the following:
   a. Karnofsky score 70-100%; **OR**
   b. Eastern Cooperative Oncology Group (ECOG) Grade 0-2.

AND

9. Lab studies that include:
   a. Complete blood count; kidney profile (blood urea nitrogen, creatinine); electrolytes; calcium; phosphorous; albumin; liver function tests; and coagulation profile (prothrombin time, and partial thromboplastin time);*
   b. Serologic screening for: HIV; Epstein Barr virus (EBV); Hepatitis virus B (HBV); Hepatitis C (HCV); cytomegalovirus (CMV); RPR and/or FTA:*
      - If HIV positive **ALL** of the following must be met:
        i. CD4 count >200 cells/mm-3 for >6 months; **AND**
        ii. HIV-1 RNA undetectable; **AND**
        iii. On stable anti-retroviral therapy >3 months; **AND**
        iv. No other complications from AIDS (e.g., opportunistic infection, including aspergillus, tuberculosis, coccidioides mycosis, resistant fungal infections, Kaposi's sarcoma, or other neoplasm).
      - If abnormal serology, need physician plan to address and/or treatment as indicated.
        i. Antinuclear antibody, smooth muscle antibody, antimitochondrial antibody
        ii. Ceruloplasmin, α1-antitrypsin phenotype
        iii. Alpha-fetoprotein
   c. Urine drug screen (UDS) if Member is current or gives a history of past drug abuse.

AND

10. Colonoscopy (if indicated or if Member is age ≥ 50) with complete workup and treatment of abnormal results as indicated; an initial screening colonoscopy after initial negative screening requires a follow-up colonoscopy every 10 years).*

AND

11. Gynecological examination with Pap smear for women ages ≥ 21 to ≤ 65 years of age or if indicated (not indicated in women who have had a total abdominal hysterectomy [TAH] or a total vaginal hysterectomy [TVH]) within the last three years with complete workup and treatment of abnormal results as indicated.

Within the last 12 months:

1. Dental examination or oral exam showing good dentition and oral care or no abnormality on panorex or plan for treatment of problems pre- or post-transplant; **AND**
2. Mammogram (if indicated or > age 40) with complete workup and treatment of abnormal results as indicated;* **AND**
3. PSA if history of prostate cancer or previously elevated PSA with complete workup and treatment of abnormal results as indicated.*

* Participating Centers of Excellence may waive these criteria.

Criteria for Hematopoietic Stem Cell Transplantation (HSCT) Transplantation

1. Autologous Hematopoietic Cell Transplant (AuSCT) **may be considered medically necessary** to treat multiple myeloma or POEMS syndrome for Members with **ONE** of the following:

   a. Diagnosis of Durie-Salmon Stage II or III multiple myeloma and **ONE** of the following:
      - A partial response to post induction therapy defined as a 50% decrease either in measurable paraprotein (serum and/or urine) or in bone marrow infiltration sustained for at least 1 month; **OR**

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- Relapsed disease post induction therapy defined as increased M proteins in serum and urine; **OR**
- Refractory disease post induction chemotherapy defined as disease that is unresponsive to post induction chemotherapy.

OR

b. Diagnosis of disseminated POEMS syndrome defined as diffuse sclerotic lesions or disseminated bone marrow involvement

2. A second autologous hematopoietic cell transplantation **may be considered medically necessary** for the treatment of responsive multiple myeloma or POEMS syndrome that has relapsed after a durable complete or partial remission following an autologous transplantation.

3. Allogenic Hematopoietic Stem Cell Transplantation **may be considered medically necessary** to treat multiple myeloma for individuals with early relapse (less than 24 months) after primary therapy that included an autologous HCT.

4. Tandem Hematopoietic Cell Transplant **may be considered medically necessary** for individuals with active multiple myeloma and the first and second transplantation should be within a 6-month period for either of the following:
   - Autologous-autologous tandem hematopoietic cell transplant; or
   - Initial autologous hematopoietic cell transplant followed by reduced-intensity conditioning allogeneic hematopoietic cell transplant

In addition, the following must be met:

1. The requesting transplant recipient should not have any of the following **absolute contraindications**:
   a. Cardiac, pulmonary, and nervous system disease that cannot be corrected and is a prohibitive risk for surgery; **OR**
   b. Malignant neoplasm with a high risk for reoccurrence, non-curable malignancy (excluding localized skin cancer); **OR**
   c. Systemic and/or uncontrolled infection; **OR**
   d. AIDS (CD4 count < 200cells/mm3); **OR**
   e. Unwilling or unable to follow post-transplant regimen as evidenced by **ONE** of the following:
      - Documented history of non-compliance; **OR**
      - Inability to follow through with medication adherence or office follow-up.

   OR

   f. Chronic illness with one year or less life expectancy; **OR**
   g. Limited, irreversible rehabilitation potential; **OR**
   h. Active untreated substance abuse issues (requires documentation supporting that Member is free from addiction for minimally 6 months if previous addiction was present); **OR**
   i. No adequate social or family support.

AND

2. The requesting transplant recipient should be evaluated carefully and potentially treated if any of the relative contraindications below are present. (Irreversible lung disease patients require consultation and clearance by a Pulmonologist prior to consideration of transplantation).
   a. Smoking, documentation supporting free from smoking for 6 months; **OR**
   b. Active peptic ulcer disease; **OR**
   c. Active gastroesophageal reflux disease; **OR**
   d. CVA with long term impairment that is not amendable to rehabilitation or a patient with CVA/transient ischemic attack within past 6 months; **OR**
   e. Obesity with body mass index of >30 kg/m^2 may increase surgical risk; **OR**
   f. Chronic liver disease such as Hepatitis B/C/D, or cirrhosis which increases the risk of death from sepsis and hepatic failure requires consultation by a gastroenterologist or hepatologist; **OR**
   g. Gall bladder disease requires ultrasound of the gall bladder with treatment prior to transplantation.

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Continuation of Therapy

When extension of a previously approved transplant authorization is requested, review using updated clinical information is appropriate.

1. If Molina Healthcare has authorized prior requests for transplantation **ALL** of the following information is required for medical review:
   a. Presence of no absolute contraindication as listed above; **AND**
   b. History and physical within the last 12 months; **AND**
   c. Kidney profile within the last 12 months; **AND**
   d. Cardiac update if history of cardiac disease within two years (≥ 50 years of age); **AND**
   e. Psychosocial evaluation or update within the last 12 months; **AND**
   f. Per initial and updated history and physical, any other clinically indicated tests and/or scans as determined by transplant center physician or Molina Medical Director.

2. If authorized prior requests for transplantation were obtained from another insurer, **ALL** of the following information is required for medical review:
   a. Authorization letter/documentation from previous insurer; **AND**
   b. Presence of no absolute contraindication as listed above; **AND**
   c. History and physical within the last 12 months; **AND**
   d. Cardiac update if history of cardiac disease within two years (≥ 50 years of age); **AND**
   e. Psychosocial evaluation or update within the last 12 months; **AND**
   f. Per initial and updated history and physical, any other clinically indicated tests and/or scans as determined by transplant center physician or Molina Medical Director.

For Members with Significant or Daily Marijuana Use

1. Documentation of compliance with a physician prescribed and managed program of abstinence, and a reasonable expectation that the Member will be abstinent from marijuana use during the transplant and immediate post-transplant time period. Daily marijuana use is an absolute contraindication for both transplant and pre-transplant evaluation unless there is a state mandate applicable for medical marijuana use and transplants, and there is documentation of Member compliance with a physician prescribed plan of care for prescribed marijuana use.
2. If the Member's marijuana use is in compliance with a formal, State-based program for managed medical marijuana, the request should include:
   - Documentation of the Plan of Care for medical marijuana (including the medical decision making that supports the use of medical marijuana); **AND**
   - Transplant Provider agreement with the Plan of Care (including agreement to be accountable for managing the Member's use of medical marijuana).

Limitations and Exclusions

1. Autologous (ablative or non-myeloablative) stem cell transplantation when the above criteria are not met.
2. Hematopoietic stem cell collection, storage and freezing for a future unplanned transplant.
3. Allogeneic hematopoietic cell transplant to treat POEMS syndrome.
4. Tandem hematopoietic cell transplant for POEMS syndrome.

DOCUMENTATION REQUIREMENTS. Molina Healthcare reserves the right to require that additional documentation be made available as part of its coverage determination; quality improvement; and fraud; waste and abuse prevention processes. Documentation required may include, but is not limited to, patient records, test results and credentials of the provider ordering or performing a drug or service. Molina Healthcare may deny reimbursement or take additional appropriate action if the documentation provided does not support the initial determination that the drugs or services were medically necessary, not investigational or experimental, and otherwise within the scope of benefits afforded to the member, and/or the documentation demonstrates a pattern of billing or other practice that is inappropriate or excessive.

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SUMMARY OF MEDICAL EVIDENCE

National and Specialty Organizations

Several professional society organizations have recommended that autologous HCT is the preferred method of treatment following primary therapy for eligible patients and is an option for primary progressive or refractory disease post induction treatment. (NCCN, 2022; NCI, 2022; ASBMT, 2003; Hahn et al., 2003; [1-3] NMDP, n.d.).

The **National Comprehensive Cancer Network Guidelines (NCCN) (2022)** published guidelines for multiple myeloma and made the following recommendations:

- Autologous Transplant for active (symptomatic) myeloma proceeding after induction therapy to high-dose therapy and stem cell transplant.
- Additional treatment post-autologous cell transplant may include a second autologous cell transplant on or off clinical trial depending on the interval between the preceding stem cell transplant and documented progression.
- Tandem transplant is recommended for active (symptomatic) myeloma for response or stable disease.
- Allogeneic Transplant is recommended for active (symptomatic) myeloma and may include nonmyeloablative (mini) following autologous stem cell transplant or fully myeloablative, preferably in a clinical trial. Current data do not support mini-allografting alone. The same recommendation is applied to post-autologous cell transplant scenarios for progressive disease and response or stable disease.
- For patients treated with or without a prior transplant, allogeneic cell transplant is also a recommended option for transplant candidates with relapse or progressive disease.

The **Society for Immunotherapy of Cancer (SITC)** (2020) published a *Consensus Statement on Immunotherapy for the Treatment of Multiple Myeloma.*

The **International Myeloma Working Group (IMWG)** published the following documents:

- *Consensus Statement and Guidelines Regarding the Current Status of Stem Cell Collection and High-Dose Therapy for Multiple Myeloma and the Role of Plerixafor (AMD 3100)*
- *Group Consensus Approach to the Treatment of Multiple Myeloma Patients Who are Candidates for Autologous Stem Cell Transplantation*
- *Recommendations for the Treatment of Multiple Myeloma-Related Bone Disease*
- *Recommendations for the Treatment of Relapsed and Refractory Multiple Myeloma*

SUPPLEMENTAL INFORMATION

None.

CODING & BILLING INFORMATION

CPT Codes

CPT	Description
	Collection Codes
38205	Blood-derived hematopoietic progenitor cell harvesting for transplantation, per collection; allogeneic
38206	Blood-derived hematopoietic progenitor cell harvesting for transplantation, per collection; autologous
38230	Bone marrow harvesting for transplantation; allogeneic
38232	Bone marrow harvesting for transplantation; autologous
	Cell Processing Services
38207	Transplant preparation of hematopoietic progenitor cells; cryopreservation and storage
38208	Transplant preparation of hematopoietic progenitor cells; thawing of previously frozen harvest, without washing
38209	Transplant preparation of hematopoietic progenitor cells; thawing of previously frozen harvest, with

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	washing
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
	Cell infusion codes
38240	Bone marrow or blood-derived peripheral stem cell transplantation; allogeneic
38241	Bone marrow or blood-derived peripheral stem cell transplantation; autologous
38242	Bone marrow or blood-derived peripheral stem cell transplantation; allogeneic donor lymphocyte infusions
38243	Bone marrow or blood-derived peripheral stem cell transplantation; allogeneic hematopoietic cellular transplant boost

HCPCS Codes

HCPCS	Description
S2140	Cord blood harvesting for transplantation, allogeneic
S2142	Cord blood derived stem-cell transplantation, allogeneic
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 pre-and post-transplant care in the global definition

ICD-10 Code

ICD-10	Description
C90.0	Multiple Myeloma

CODING DISCLAIMER. Codes listed in this policy are for reference purposes only and may not be all-inclusive. Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement. Listing of a service or device code in this policy does not guarantee coverage. Coverage is determined by the benefit document. Molina adheres to Current Procedural Terminology (CPT®), a registered trademark of the American Medical Association (AMA). All CPT codes and descriptions are copyrighted by the AMA; this information is included for informational purposes only. Providers and facilities are expected to utilize industry standard coding practices for all submissions. When improper billing and coding is not followed, Molina has the right to reject/deny the claim and recover claim payment(s). Due to changing industry practices, Molina reserves the right to revise this policy as needed.

APPROVAL HISTORY

6/8/2022 Policy reviewed, no changes to criteria; included section on marijuana use; updated Overview, Summary of Medical Evidence and Reference sections.
6/17/2020, 6/9/2021 Policy reviewed, no changes to criteria, updated guidelines and references.
6/19/2019 Added criteria for POEMS Syndrome. For MM removed age limitation, revised the criteria for first, second and tandem stem cell transplant based on updated professional society guidelines, updated references. General recommendation and summary of medical evidence sections were condensed for ease of application.
9/13/2018 Policy reviewed, no criteria changes, reference section updated.
12/14/2016, 6/22/2017 Policy reviewed, no changes.
8/12/2015 Policy reviewed and updated with revisions made to the pre-transplant criteria, minor revision to the criteria to include upper age limit of 78, and criteria for Allogenic Stem Cell Transplantation was added. Guideline and reference sections were updated.
12/12/2012 New policy.

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APPENDIX

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