Clinical Policy: Hematopoietic Stem-Cell Transplantation for Lymphoma

Reference Number: WNC.CP.239 Coding Implications
Last Review Date: 11/24 Revision Log

See Important Reminder **at the end of this policy for important regulatory and legal information.**

Note: When state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Description[1]

This policy describes the medical necessity criteria for Hematopoietic Stem-Cell Transplantation (HSCT) for Lymphoma.

Policy/Criteria[1]

I. WellCare of North Carolina® shall cover allogeneic HSCT for **Small Lymphocytic Lymphoma (SLL)** using either a myeloablative or reduced-intensity pretransplant conditioning regimen to treat CLL or SLL in memberss with markers of poor-risk disease.

II. WellCare of North Carolina® shall cover HSCT for **Non-Hodgkin's Lymphoma (NHL)** in the following situations:

- **A.** For members with NHL B-cell subtypes considered aggressive (except mantle cell lymphoma), either allogeneic HSCT using a myeloablative conditioning regimen or autologous HSCT:
  1. As salvage therapy for members who do not achieve a complete remission (CR) after first-line treatment (induction) with a full course of standard-dose chemotherapy;
  2. To achieve or consolidate a CR for those in a chemo sensitive first or subsequent relapse; **OR**
  3. To consolidate a first CR in members with diffuse large B-cell lymphoma, with an age adjusted International Prognostic Index score that predicts a high- or high-intermediate risk of relapse.
- **B.** For patients with mantle cell lymphoma:
  1. Autologous HSCT to consolidate a first remission; **OR**
  2. Allogeneic HSCT, myeloablative or reduced-intensity conditioning as salvage therapy.
- **C.** For patients with NHL B-cell subtypes considered indolent, either allogeneic HSCT using a myeloablative conditioning regimen or autologous HSCT:
  1. As salvage therapy for members who do not achieve CR after first line treatment (induction) with a full course of standard-dose chemotherapy; **OR**

2. To achieve or consolidate CR for those in a first or subsequent chemo sensitive relapse, whether or not their lymphoma has undergone transformation to a higher grade.

D. Reduced intensity conditioning allogeneic HSCT may be considered medically necessary as a treatment of NHL in members who meet criteria for an allogeneic HSCT but who do not qualify for a myeloablative allogeneic HSCT.

E. For members with mature T-cell or NK-cell (peripheral T-cell) neoplasms:
1. Autologous HSCT to consolidate a first complete remission in high-risk subtypes; **OR**
2. Autologous or allogeneic HSCT (myeloablative or reduced-intensity conditioning) as salvage therapy.

F. Donor lymphocyte infusion is considered medically necessary and, therefore, covered following allogeneic HSCT that is medically necessary for the treatment of NHL that has relapsed or is refractory, to prevent relapse in the setting of a high risk of relapse, or to convert an individual from mixed to full donor chimerism.

III. WellCare of North Carolina® shall cover HSCT for **Hodgkin Lymphoma (HL)** in **ANY** the following situations:

A. Single autologous HSCT in members with primary refractory Hodgkin disease or relapsed HL;

B. Allogeneic HSCT, using either myeloablative or reduced-intensity conditioning regimens in members with primary refractory or relapsed HL;

C. Tandem autologous HSCT for **any** of the following:
1. Members with primary refractory HL; **OR**
2. Members with relapsed disease with poor risk features who do not attain a complete remission to cytoreductive chemotherapy prior to transplantation.

D. Donor lymphocyte infusion is considered medically necessary and, therefore, covered following allogeneic HSCT that is medically necessary for the treatment of HL that has relapsed or is refractory, to prevent relapse in the setting of a high risk of relapse, or to convert an individual from mixed to full donor chimerism.

IV. WellCare of North Carolina® **shall not** cover HSCT for **SLL** in the following situations:

A. Allogeneic HSCT to treat SLL except as noted in Section I of this policy;

B. Autologous HSCT to treat SLL.

V. WellCare of North Carolina® **shall not** cover HSCT for **NHL** in the following situations:

A. For members with mantle cell lymphoma:
1. Autologous HSCT as salvage therapy; **OR**
2. Allogeneic HSCT to consolidate a first remission

B. Either autologous HSCT or allogeneic HSCT:
1. As initial therapy (i.e., without a full course of standard-dose induction chemotherapy) for any NHL;
2. To consolidate a first complete remission (CR) for members with diffuse large B-cell lymphoma and an International Prognostic Index score that predicts a low- or low-intermediate risk of relapse; **OR**

3. To consolidate a first complete remission (CR) for those with indolent NHL B-cell subtypes.

C. Tandem transplants to treat members with any stage, grade, or subtype of NHL

D. For members with mature T-cell or NK-cell (peripheral T-cell) neoplasms, allogeneic HSCT to consolidate a first remission.

VI. WellCare of North Carolina® **shall not** cover HSCT for **HL** in the following situations:

A. A second autologous stem cell transplantation for relapsed lymphoma after a prior autologous HSCT;

B. Other uses of HSCT in members with HL, including initial therapy for newly diagnosed disease to consolidate a first complete remission.

C. When the member's psychosocial history limits the member's ability to comply with pre- and post-transplant medical care.

D. When current member or caretaker non-compliance would make compliance with a disciplined medical regime improbable.

Background[1]

Hematopoietic stem-cell transplantation (HSCT) refers to a procedure in which hematopoietic stem cells are infused to restore bone marrow function in cancer patients who receive bone marrow-toxic doses of cytotoxic drugs with or without whole-body radiation therapy. Hematopoietic stem cells may be obtained from the transplant recipient (autologous HSCT) or from a donor (allogeneic HSCT). They can be harvested from bone marrow, peripheral blood, or umbilical cord blood shortly after delivery of neonates. Although cord blood is an allogeneic source, the stem cells in it are antigenically "naïve" and thus are associated with a lower incidence of rejection or graft-versus-host disease (GVHD).

Immunologic compatibility between infused hematopoietic stem cells and the recipient is not an issue in autologous HSCT. However, immunologic compatibility between donor and patient is a critical factor for achieving a good outcome of allogeneic HSCT. Compatibility is established by typing human leukocyte antigens (HLA) using cellular, serologic, or molecular techniques. HLA refers to the tissue type expressed at the HLA A, B, and DR loci on each arm of chromosome 6. Depending on the disease being treated, an acceptable donor will match the patient at all or most of the HLA loci.

SLL is a neoplasm of hematopoietic origin characterized by the accumulation of lymphocytes with a mature, generally well-differentiated morphology; these cells are generally confined to lymph nodes.

A heterogeneous group of lymphoproliferative malignancies, **NHL** usually originates in lymphoid tissue. Historically, uniform treatment of patients with NHL was hampered by the lack of a uniform classification system. In 1982, the Working Formulation (WF) was developed to unify different classification systems into one. The WF divided NHL into low-, intermediate-, and high-grade, with subgroups based on histologic cell type. Since our understanding of NHL

has improved, the diagnosis has become more sophisticated and includes the incorporation of new immunophenotyping and genetic techniques. As a result, the WF has become outdated.

HL is a relatively uncommon B-cell lymphoma. In 2011, an estimated 8,830 new diagnoses and 1,300 deaths will occur in the U.S. The disease has a bimodal distribution, with most patients diagnosed between the ages of 15 and 30 years, with a second peak in adults aged 55 and older.

Donor Lymphocyte Infusion is a type of therapy in which lymphocytes from the blood of a donor are given to a member who has already received a stem cell transplant from the same donor. The donor lymphocytes may kill remaining cancer cells.

Coding Implications
This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2024, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

Reviews, Revisions, and Approvals	Reviewed Date	Approval Date
Original approval date	04/21	05/21
Reviewed CPT codes.	12/21	02/22
Annual Review	11/22	11/22
NCHC verbiage removed from NC Guidance Verbiage.	04/23	04/23
Annual Review. CPT codes removed.	11/23	11/23
Annual Review. Removed “Medicaid and health choice” verbiage from References. Changes Beneficiary to Member throughout policy.	11/24	11/24

References
1. State of North Carolina Medicaid Clinical Coverage Policy No: 11A-7 Hematopoietic Stem-Cell Transplantation for Hodgkin Lymphoma. Program Specific Clinical Coverage Policies | NC Medicaid (ncdhhs.gov). Published August 15, 2023 Accessed July 18, 2024..
2. State of North Carolina Medicaid Clinical Coverage Policy No: 11A-11 Hematopoietic Stem-Cell Transplant for Non-Hodgkin’s Lymphoma. Program Specific Clinical Coverage Policies | NC Medicaid (ncdhhs.gov). Published August 15, 2023. Accessed July 18, 2024..
3. State of North Carolina Medicaid Clinical Coverage Policy No: 11A-16 Hematopoietic Stem-Cell Transplantation for Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL). Program Specific Clinical Coverage Policies | NC Medicaid (ncdhhs.gov). Published August 15, 2023. Accessed July 18, 2024..

North Carolina Guidance
Eligibility Requirements

a. An eligible beneficiary shall be enrolled in the NC Medicaid Program (Medicaid is NC Medicaid program, unless context clearly indicates otherwise);
b. Provider(s) shall verify each Medicaid beneficiary's eligibility each time a service is rendered.
c. The Medicaid beneficiary may have service restrictions due to their eligibility category that would make them ineligible for this service.

EPSDT Special Provision: Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age

a. 42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid beneficiary under 21 years of age if the service is medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed practitioner).

This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his or her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the beneficiary's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the beneficiary's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product or procedure:

1. that is unsafe, ineffective, or experimental or investigational.
2. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure meets all EPSDT criteria, including to correct or improve or maintain the beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT and Prior Approval Requirements

1. If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does NOT eliminate the requirement for prior approval.

2. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *NCTracks Provider Claims and Billing Assistance Guide*, and on the EPSDT provider page. The Web addresses are specified below:
   NCTracks Provider Claims and Billing Assistance Guide:
   https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html
   EPSDT provider page: https://medicaid.ncdhhs.gov/

Provider(s) Eligible to Bill for the Procedure, Product, or Service
To be eligible to bill for the procedure, product, or service related to this policy, the provider(s) shall:

a. meet Medicaid qualifications for participation;
b. have a current and signed Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement; and
c. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

Compliance
Provider(s) shall comply with the following in effect at the time the service is rendered:

a. All applicable agreements, federal, state and local laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements; and
b. All NC Medicaid's clinical (medical) coverage policies, guidelines, policies, provider manuals, implementation updates, and bulletins published by the Centers for Medicare and Medicaid Services (CMS), DHHS, DHHS division(s) or fiscal contractor(s).

Claims-Related Information
Provider(s) shall comply with the NC Tracks Provider Claims and Billing Assistance Guide, Medicaid bulletins, fee schedules, NC Medicaid's clinical coverage policies and any other relevant documents for specific coverage and reimbursement for Medicaid:

a. Claim Type - as applicable to the service provided:
   Professional (CMS-1500/837P transaction)
   Institutional (UB-04/837I transaction)
   Unless directed otherwise, Institutional Claims must be billed according to the National Uniform Billing Guidelines. All claims must comply with National Coding Guidelines.
b. International Classification of Diseases and Related Health Problems, Tenth Revisions, Clinical Modification (ICD-10-CM) and Procedural Coding System (PCS) - Provider(s) shall report the ICD-10-CM and Procedural Coding System (PCS) to the highest level of specificity that supports medical necessity. Provider(s) shall use the current ICD-10 edition and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for code description, as it is no longer documented in the policy.
c. Code(s) - Provider(s) shall report the most specific billing code that accurately and completely describes the procedure, product or service provided. Provider(s) shall use the Current Procedural Terminology (CPT), Health Care Procedure Coding System (HCPCS), and UB-04 Data Specifications Manual (for a complete listing of valid revenue codes) and any subsequent editions in effect at the time of service. Provider(s) shall refer

to the applicable edition for the code description, as it is no longer documented in the policy. If no such specific CPT or HCPCS code exists, then the provider(s) shall report the procedure, product or service using the appropriate unlisted procedure or service code.
Unlisted Procedure or Service
CPT: The provider(s) shall refer to and comply with the Instructions for Use of the CPT Codebook, Unlisted Procedure or Service, and Special Report as documented in the current CPT in effect at the time of service.
HCPCS: The provider(s) shall refer to and comply with the Instructions For Use of HCPCS National Level II codes, Unlisted Procedure or Service and Special Report as documented in the current HCPCS edition in effect at the time of service

d. Modifiers - Providers shall follow applicable modifier guidelines.
e. Billing Units - Provider(s) shall report the appropriate code(s) used which determines the billing unit(s).
f. Co-payments -
For Medicaid refer to Medicaid State Plan:
https://medicaid.ncdhhs.gov/get-involved/nc-health-choice-state-plan

g. Reimbursement - Provider(s) shall bill their usual and customary charges. For a schedule of rates, refer to: https://medicaid.ncdhhs.gov/.

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to

applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members/enrollees and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members/enrollees and their representatives agree to be bound by such terms and conditions by providing services to members/enrollees and/or submitting claims for payment for such services.