

Medicare Advantage Medical Policy



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Bone Marrow Transplant – Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer – Medicare Advantage

Medicare Advantage Plan

- ☒ Medicare Plus BlueSM
- ☒ BCN AdvantageSM

UM Committee Approval Date: 9/17/2025

Effective Date: 10/17/2025

Description

The use of hematopoietic cell transplantation (HCT) has been investigated to treat patients with epithelial ovarian cancer. Hematopoietic stem cells are infused to restore bone marrow function after cytotoxic doses of chemotherapeutic agents with or without whole body radiotherapy.

Related Medical Coverage Policies

- BMT – Hematopoietic Cell Transplantation for Autoimmune Diseases
 - BMT – Hematopoietic Cell Transplantation for CNS Embryonal Tumors and Ependymoma
 - BMT – Hematopoietic Cell Transplantation for Genetic Diseases and Acquired Anemias (Allogeneic)
 - BMT – Hematopoietic Cell Transplantation for Germ-Cell Tumors
 - BMT – Hematopoietic Cell Transplantation for Myelodysplastic Syndromes and Myeloproliferative Neoplasms
 - BMT – Hematopoietic Cell Transplantation for Plasma Cell Dyscrasias, Including Multiple Myeloma and POEMS Syndrome
 - Orthopedic Applications of Stem-Cell Therapy (Including Allografts and Bone Substitutes used with Autologous Bone Marrow)
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Policy Guidelines

Blue Cross Blue Shield of Michigan (BCBSM) and Blue Care Network of Michigan (BCN) adhere to guidance from the Centers for Medicare and Medicaid Services (CMS), including

when performing organization determinations for Medicare Advantage plan members. CMS Medicare statutes, regulations, manuals, National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Local Coverage Articles (LCAs) and other sub-regulatory guidance provide the clinical guidelines for coverage determinations, payment integrity functions, and all other uses by CMS regulations. When CMS Medicare guidance is silent, incomplete, or insufficient, CMS permits BCBSM/BCN to utilize “internal coverage criteria”, such as independent criteria, health plan policy research, LCD/LCAs outside the services area or research from independent medical research repositories (i.e., Hayes) for coverage policies 42 CFR § 422.101. BCBSM/BCN internal medical coverage policies are developed and based on current evidence in widely accepted treatment guidelines or clinical literature; in addition, they address how clinical benefits may or may not outweigh member harm.

Clinical review follows guidance provided in the BCBSM Medicare Advantage Coverage Determination Hierarchy policy, which may be found at <https://www.bcbsm.com/providers/mpradmin/> by entering the policy name.

Coverage Guidance

To ensure consistency with coverage guidance, the Medicare statutes, regulations, coverage manuals, NCD, LCD, and LCA should be reviewed and applied first. BCBSM/BCN internal coverage criteria should only be applied when CMS guidance is silent, incomplete, or insufficient for a code

Apart from durable medical equipment (DME), Medicare Administrative Contractor (MAC) jurisdiction for the purpose of clinical determination is based upon place of service. The place of service for laboratory testing is defined as the geographic location of the reference laboratory. Non-jurisdictional LCD/LCAs may not be utilized for a determination unless they have been specifically identified as internal coverage criteria by the policy. Alternatively, jurisdiction for DME MAC is determined by the member place of residence. Please see CMS Medicare Administrative Contractors (MAC) table for state MAC assignments below.

Code	Description	CMS Guidance	Additional Guidance
38204	Management of recipient hematopoietic cell donor search and cell acquisition	National Coverage Determinations 110.23 Stem Cell Transplantation	BCBSM/BCN will follow CMS guidance as the primary source for coverage determinations. However, in instances where CMS guidance is silent, incomplete, or insufficient for a particular code, BCBSM/BCN internal coverage criteria will be applied to ensure consistent and informed decision-making. In such cases, please refer to the relevant BCBSM/BCN policy for guidance: <i>BMT - Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer</i> To access this policy, please visit the BCBS Michigan Medical Policy Router Search page at https://www.bcbsm.com/providers/mpradmin/ and enter the policy name in the search field.
38205	Blood-derived hematopoietic progenitor cell harvesting for transplantation, per collection; allogeneic	Local Coverage Determinations and Articles None	
38206	Blood-derived hematopoietic progenitor cell harvesting for transplantation, per collection; autologous		

Code	Description	CMS Guidance	Additional Guidance
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	;thawing of previously frozen harvest, with washing, per donor		
38210	;specific cell depletion with harvest, T-cell depletion		
38211	;tumor cell depletion		
38212	;red blood cell removal		
38213	;platelet depletion		
38214	;plasma (volume) depletion		
38215	;cell concentration in plasma, mononuclear, or buffy coat layer		
38230	Bone marrow harvesting for transplantation; allogeneic		
38232	Bone marrow harvesting for transplantation; autologous		
38240	Bone marrow or blood-derived peripheral stem-cell transplantation; allogeneic		

Code	Description	CMS Guidance	Additional Guidance
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		
**S2140	Cord blood harvesting for transplantation, allogeneic		
**S2142	Cord blood derived stem-cell transplantation, allogeneic		
**S2150	Bone marrow or blood-derived peripheral stem-cell harvesting and transplantation, allogeneic or autologous, including pheresis, high-dose chemotherapy, and the number of days of post-transplant care on the global definition (including drugs; hospitalization; medical surgical, diagnostic and emergency services)		

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HCPCS® codes, descriptions and materials are copyrighted by Centers for Medicare and Medicaid Services (CMS).

**** Status Indicator Code:** The National Physician Fee Schedule Relative Value File (NPF SRVF), which is published by Medicare, indicates HCPCS codes starting with “S” have been assigned a Status Indicator code of “I” - Not valid for Medicare purposes.

The above information is current as of the review date for this policy. However, the coverage issues and policies maintained by CMS are updated and/or revised periodically. Therefore, the most current CMS information may not be contained in this document.

Please refer to the Medicare Coverage Database website at <https://www.cms.gov/medicare-coverage-database/search.aspx> for the most current applicable NCD, LCD, LCA, and CMS Online Manual System Transmittals.

CMS Medicare Administrative Contractors (MAC) Jurisdictions

Part A and Part B MAC Jurisdictions	
Wisconsin Physicians Service Insurance Corporation (WPS)	IA, IN, KS, MI, MO, NE
CGS Administrators, LLC	KY, OH
First Coast Service Options, Inc	FL, PR, US VI
National Government Services, Inc (NGS)	CT, IL, MA, ME, MN, NH, NY, RI, VT, WI,
Noridian Healthcare Solutions, LLC, Jurisdiction JE	CA, HI, NV, American Samoa, Guam, Northern Mariana Islands
Noridian Healthcare Solutions, LLC, Jurisdiction JF	AK, AZ, ID, MT, ND, OR, SD, UT, WA, WY
Novitas Solutions, Inc	AR, CO, DC, DE, LA, MD, MS, NJ, NM, OK, PA, TX,
Palmetto GBA	AL, GA, TN NC, SC, VA, WV
DME MAC Jurisdictions	
CGS Administrators, LLC, Jurisdictions JB and JC	AL, AR, CO, FL, GA, IL, IN, KY, LA, MI, MN, MS, NM, NC, OH, OK, Puerto Rico, SC, TN, TX, VA, Virgin Island, WI, WV
Noridian Healthcare Solutions, LLC, Jurisdictions JA and JD	AK, American Soamoa, AZ, CA, CT, DE, DC, Guam, HI, ID, IA, KS, MA, MD, ME, MO, MT, ND, NE, NH, NJ, NV, NY, Northern Mariana Islands, OR, PA, RI, SD, UT, VT, WA, WY

Important Reminder

BCBSM and BCN follow CMS Medicare coverage guidance to limit coverage to items and services that are reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member. Medicare Advantage Medical Policies list the criteria BCBSM and BCN use to decide which medical services are considered “reasonable and necessary” when Medicare coverage rules are not fully developed, or as otherwise may permitted by CMS Medicare regulations. Individual member benefit plan documents, such as the Evidence of Coverage and Annual Notice of Change, as well as applicable laws govern benefit coverage, including any inclusion, exclusion, and/or other restrictions.

Medicare Advantage Medical policies are created when permitted by CMS Medicare regulations, reviewed regularly, and may be revised periodically. BCBSM/BCN Medical Policies are proprietary and should not be copied or disseminated without the express, prior written approval of BCBSM. All providers are required to review applicable BCBSM reimbursement policies prior to claim submission and bill for covered services in accordance with those policies. Additionally, providers contracted with BCBSM or BCN’s Medicare Advantage network(s) should review the provider manual for any additional claim submission requirements. Providers not contracted with BCBSM or BCN’s Medicare Advantage network may be required to submit documentation to BCBSM, BCN, or its delegated entity supporting billed claims, including but not limited to applicable medical records.

Note: U.S. Food and Drug Administration (FDA) approval for a specific indication or the issuance of a CPT code is not sufficient for a procedure to be considered medically reasonable

and necessary. Similarly, the presence of a procedure/device code or payment amount for the service in the Medicare fee schedule does not necessarily indicate coverage. If a service is deemed not reasonable and necessary, to treat illness or injury for any reason (including lack of safety and efficacy because it is an experimental procedure, etc.), the procedure is considered not covered.

Disclaimer: This medical policy is not an authorization, certification, explanation of benefits, or a contract for the services, devices, or drugs that is referenced in the medical policy. Medical policies do not constitute medical advice and do not guarantee any results or outcomes or guarantee payment. The medical policy is not intended to replace independent medical judgment for the treatment of individuals. Treating physicians and health care providers are solely responsible for determining what care to provide to their patients. Identification of selected brand names of devices, tests and procedures in a medical coverage policy is for reference only and is not an endorsement of any one device, test, or procedure over another.

Pursuant to Section 1557 and Section 504, Blue Cross does not discriminate on the basis of race, color, national origin, age, disability, or sex (including sex characteristics, intersex traits; pregnancy or related conditions; sexual orientation; gender identity, and sex stereotypes). This includes our rules, benefit designs and medical policies.

BCBSM/BCN Medicare Advantage Policy History

Policy Effective Date	UM Committee Approval Date	Comments
08/17/2024	07/17/2024	Medicare Advantage policy established
10/17/2025	09/17/2025	MA policy foundational language updated. Adoption of JUMP policy updates.