

Medicare Advantage Medical Policy



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Bone Marrow Transplant - Hematopoietic Cell Transplant for Genetic Diseases and Acquired Anemias, Allogeneic – Medicare Advantage

Medicare Advantage Plan

- ☒ Medicare Plus BlueSM
- ☒ BCN AdvantageSM

UM Committee Approval Date: 7/15/2026
Effective Date: 8/15/2026

Description

A number of inherited and acquired conditions have the potential for severe and/or progressive disease. For some conditions, allogeneic hematopoietic cell transplantation (allo-HCT) has been used to alter the natural history of the disease or potentially offer a cure.

Related Medical Coverage Policies

- BMT – Hematopoietic Cell Transplantation for Autoimmune Diseases - Medicare Advantage
- BMT – Hematopoietic Cell Transplantation for CNS Embryonal Tumors and Ependymoma - Medicare Advantage
- BMT – Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer - Medicare Advantage
- BMT – Hematopoietic Cell Transplantation for Germ-Cell Tumors - Medicare Advantage
- BMT – Hematopoietic Cell Transplantation for Myelodysplastic Syndromes and Myeloproliferative Neoplasms - Medicare Advantage
- BMT – Hematopoietic Cell Transplantation for Plasma Cell Dyscrasias, Including Multiple Myeloma and POEMS Syndrome - Medicare Advantage

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 consistent with 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.

CMS Guidance	Additional Guidance
NCD with CED (Coverage with Evidence Development): CAG - 00444R – Stem Cell Transplantation (Multiple Myeloma, Myelofibrosis, and Sickle Cell Disease) Stem Cell Transplantation (Multiple Myeloma, Myelofibrosis, and Sickle Cell Disease) are non-covered when furnished outside of a CMS approved CED Study. To access the list of studies that have been determined to meet the requirements for CED coverage, please visit CMS site for Coverage with Evidence Development at: https://www.cms.gov/Medicare/Coverage/Coverage-with-Evidence-Development/ National Coverage Determinations NCD: 110.23 - Stem Cell Transplant Local Coverage Determinations and Articles WPS L36807, A57772 - Moldx: Molecular Diagnostic Tests (MDT)*	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>Bone Marrow Transplant - Hematopoietic Cell Transplant for Genetic Diseases and Acquired Anemias, Allogeneic</i> To access this policy, please visit the BCBSM Medical Policy Router Search page at https://www.bcbsm.com/providers/mpradmin/ and enter the policy name in the search field.

CMS Guidance	Additional Guidance
A57851 Moldx: HLA Testing for Transplant Histocompatibility* CGS L36021, A56973 - Moldx: Molecular Diagnostic Tests (MDT)* A56885 - Moldx: HLA Testing for Transplant Histocompatibility* First Coast L34519, A57451 - Molecular Pathology Procedures A58918 - Molecular Pathology and Genetic Testing Noridian JE & JF L35160, A57526 - Moldx: Molecular Diagnostic Tests (MDT)* A57970 - Moldx: HLA Testing for Transplant Histocompatibility* Novitas L35062, A56541 - Biomarkers Overview A58917 - Molecular Pathology and Genetic Testing Palmetto L35025, A56853 - Moldx: Molecular Diagnostic Tests (MDT)* A56859 - Moldx: HLA Testing for Transplant Histocompatibility* Wellpoint Federal L35000, A56199 - Molecular Pathology Procedures	

Code	Description
38204	Management of recipient hematopoietic progenitor cell donor search and cell acquisition
38205	Blood-derived hematopoietic progenitor cell harvesting for transplantation per collection, allogeneic
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
38230	Allogeneic bone marrow harvesting for transplantation
38240	Hematopoietic progenitor cell (HPC); allogeneic transplantation per donor.

Code	Description
38242	Allogeneic donor lymphocyte infusions
38243	Hematopoietic progenitor cell (HPC); HPC boost
81267	Chimerism (engraftment) analysis, post stem cell transplantation specimen (e.g., hematopoietic stem cell), includes comparison to previously performed baseline analyses; without cell selection.
81268	Chimerism (engraftment) analysis, post stem cell transplantation specimen (e.g., hematopoietic stem cell), includes comparison to previously performed baseline analyses; with cell selection.
81370	HLA Class I and II typing, low resolution (e.g., antigen equivalents); HLA-A, -B, -C, -DRB1/3/4/5, and -DQB1
81371	HLA Class I and II typing, low resolution (e.g., antigen equivalents); HLA-A, -B, and -DRB1/3/4/5 (e.g., verification typing)
81372	HLA Class I typing, low resolution (e.g., antigen equivalents); complete (i.e., HLA-A, -B, and -C)
81373	HLA Class I typing, low resolution (e.g., antigen equivalents); 1 locus (e.g., HLA-A, -B, or -C), each
81374	HLA Class I typing, low resolution; (e.g., antigen equivalents (e.g., B*27), each
81375	HLA Class II typing, low resolution, (e.g., antigen equivalent) for HLA-DRB1/3/4/5 and -DQB1
81376	HLA Class II typing, low-resolution (e.g., antigen equivalent), one locus (e.g., HLA-DRB1/3/4/5, -DQB1, DQA1, -DPB1, or -DPA1), each.
81377	HLA Class II typing, low-resolution (e.g., antigen equivalent), one antigen equivalent, each
81378	HLA Class I and II typing, high resolution (i.e., alleles or allele groups), HLA-A, -B, -C, and -DRB1
81379	HLA Class I typing, high resolution (i.e., alleles or allele groups); complete HLA-A, -B, and -C)
81380	HLA Class I typing high resolution (i.e., alleles or allele groups); one locus (e.g., HLA-A, -B, or -C), each
81381	HLA Class I typing high resolution (i.e., alleles or allele groups); one allele or allele group (e.g., B*57.01P), each
81382	HLA Class II typing, high resolution (i.e., alleles or allele groups); 1 locus (e.g., HLA-DRB1, -DRB3, -DRB4, -DRB5, -DQB1, -DQA1, -DPB1, or -DPA1), each
81383	HLA Class II typing, high resolution (i.e., alleles or allele groups); 1 allele or allele group (e.g., HLA-DQB1*06:02P), each
86812	HLA typing; A, B, or C (e.g., A10, B7, B27), single antigen
86813	HLA typing; A, B, or C, multiple antigens
86816	HLA typing; DR/DQ, single antigen
86817	HLA typing; DR/DQ, multiple antigens
86821	HLA typing; lymphocyte culture, mixed (MLC)
**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

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* CMS MoIDX Program

The MoIDX Program, administered by Palmetto GBA, is a Medicare Molecular Diagnostic Program that aims to identify and establish coverage and reimbursement for molecular diagnostic

tests. This program is implemented by several Medicare Administrative Contractors (MACs), including **WPS, CGS, Noridian, and Palmetto**.

The MoIDX Program evaluates genetic and proteomic tests to determine their analytical and clinical validity (AV/CV) and clinical utility (CU), ensuring that each test meets Medicare criteria.

The program's coverage determinations are maintained in the DEX™ Diagnostic Exchange registry. Dex Diagnostic Exchange Registry Coverage Determinations:

1. Not Covered: Not covered tests in the Dex Registry have undergone a review of their clinical utility and analytical validity and have been determined to not meet the requirements for medical necessity under Section 1862(a)(1)(A) of the Social Security Act. As a result, they are not considered medically reasonable or necessary for Medicare coverage.
2. No Determinations: Tests that have not completed the required technical assessment (TA) review are, by default, also considered not medically reasonable or necessary for Medicare under Section 1862(a)(1)(A) until the review is completed. The MoIDX Program does not provide coverage for tests provided with dates of services prior to the effective date of approval.
3. Covered: Covered Tests in Dex Registry have completed the required TA review and have been determined to be medically reasonable and necessary for Medicare under Section 1862(a)(1)(A). However, coverage is not automatic and is subject to the following conditions:
 - a. The test must meet the applicable criteria outlined in NCDs, LCDs, and LCAs; and
 - b. The patient must exhibit signs or symptoms of a relevant disease or condition, making the test medically necessary for their care.

For specific coding and billing information on covered and excluded tests, please refer to the MoIDX website at <https://www.palmettogba.com/MoIDX>. This website provides up-to-date information on the program's coverage determinations and guidelines.

NOTE: Per § 2.3.3. of the Molecular Diagnostic Program [MoIDX®] Manual, the MoIDX Program does not provide coverage for tests that have not been reviewed and approved through the MoIDX process or for tests provided with dates of services prior to the effective date of approval. For additional information regarding what tests will fall into a Medicare benefit category or which tests are statutory excluded (e.g., predictive, prenatal, and carrier testing and tests considered screening in the absence of clinical signs and symptoms of disease that are not specifically identified by the law) please refer to

<https://www.palmettogba.com/palmetto/moldxv2.nsf/DID/DPR5GEM991>

**** Status Indicator Code:** The National Physician Fee Schedule Relative Value File (NPF SRVF), which is published by Medicare, indicates HCPCS codes starting with “S” or “H” 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. For any code associated with a product or service

determined to be noncovered by policy (either CMS or health plan policy if CMS is silent) medical record review, including prior authorization, will not be required.

CMS Medicare Administrative Contractors (MAC) Jurisdictions Guidance

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
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
Wellpoint Federal - Previously known as National Government Services, Inc. (NGS)	CT, IL, MA, ME, MN, NH, NY, RI, VT, WI,
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 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 for 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.
10/17/2025	09/17/2025	12/23/2025: NCD with CED language added to CMS guidance
08/15/2026	07/15/2026	Annual Review: Reformatted guidance and code tables. Adopted JUMP policy updates