

Medicare Advantage Medical Policy



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BMT - Hematopoietic Cell Transplantation for Plasma Cell Dyscrasias, Including Multiple Myeloma, Plasma Cell Leukemia, Plasmacytoma, and POEMS Syndrome – Medicare Advantage

Medicare Advantage Plan

- ☒ Medicare Plus BlueSM
- ☒ BCN AdvantageSM

UM Committee Approval Date: 1/28/2026

Effective Date: 2/28/2026

Description

Hematopoietic cell transplantation (HCT) is a procedure in which hematopoietic cells are intravenously infused to restore bone marrow function in cancer patients who receive bone-marrow-toxic doses of cytotoxic drugs with or without whole-body radiotherapy. Hematopoietic stem cells may be obtained from the transplant recipient (autologous HCT) or from a donor (allogeneic HCT). They can be newly harvested from bone marrow, peripheral blood, or umbilical cord blood shortly after delivery of neonates.

Related Medical Coverage Policies

- BMT – Hematopoietic Cell Transplantation for Genetic Diseases and Acquired Anemias, Allogenic
- BMT – Hematopoietic Cell Transplantation for Autoimmune Diseases
- BMT – Hematopoietic Cell Transplantation for CNS Tumors, Embryonal Tumors and Ependymoma
- BMT – Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer
- BMT – Hematopoietic Cell Transplantation in the Treatment of Germ-Cell Tumors
- BMT – Hematopoietic Cell Transplantation in the Treatment of Germ-Cell Tumors

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.

CMS Guidance	Additional Guidance
NCD with CED (Coverage with Evidence Development) Decision Memo: Allogeneic Hematopoietic Stem Cell Transplant for Multiple Myeloma CAG # 00444R HCT for Multiple Myeloma is non-covered when furnished outside of a CMS approved CED Study. List of studies that have been determined to meet the requirements for coverage CED can be found here at: https://www.cms.gov/medicare/coverage/evidence National Coverage Determinations 110.23: Stem Cell Transplant Local Coverage Determinations and Articles WPS L39477, A59259 - Allogeneic Hematopoietic Cell Transplantation for Primary Refractory or Relapsed Hodgkin's and Non-Hodgkin's Lymphoma with B-Cell or T-Cell Origin CGS L39434, A59215 - Allogeneic Hematopoietic Cell Transplantation for Primary Refractory or Relapsed Hodgkin's and Non-Hodgkin's Lymphoma with B-Cell or T-Cell Origin First Coast None NGS	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 Plasma Cell Dyscrasias, Including Multiple Myeloma, Plasma Cell Leukemia, Plasmacytoma, and POEMS Syndrome</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.

L39513, A59311 - Allogeneic Hematopoietic Cell Transplantation for Primary Refractory or Relapsed Hodgkin's and Non-Hodgkin's Lymphoma with B-Cell or T-Cell Origin Noridian JE L39396, A59175 - Allogeneic Hematopoietic Cell Transplantation for Primary Refractory or Relapsed Hodgkin's and Non-Hodgkin's Lymphoma with B-Cell or T-Cell Origin Noridian JF L39398, A59177 - Allogeneic Hematopoietic Cell Transplantation for Primary Refractory or Relapsed Hodgkin's and Non-Hodgkin's Lymphoma with B-Cell or T-Cell Origin Novitas None Palmetto L39270, A59042 - Allogeneic Hematopoietic Cell Transplantation for Primary Refractory or Relapsed Hodgkin's and Non-Hodgkin's Lymphoma with B-Cell or T-Cell Origin	
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Code	Description
38204	Management of recipient hematopoietic cell donor search and cell acquisition
38205	Blood-derived hematopoietic progenitor cell harvesting for transplantation, per collection, allogeneic
38206	Blood-derived hematopoietic progenitor cell harvesting for transplantation, per collection, autologous
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	Bone marrow harvesting for transplantation; allogeneic
38232	Bone marrow harvesting for transplantation; autologous
38240	Hematopoietic progenitor cell (HPC); allogeneic transplantation per donor
38241	Hematopoietic progenitor cell (HPC); autologous transplantation
38242	Allogeneic lymphocyte infusions

Code	Description
0337U	Oncology (plasma cell disorders and myeloma), circulating plasma cell immunologic selection, identification, morphological characterization, and enumeration of plasma cells based on differential CD138, CD38, CD19, and CD45 protein biomarker expression, peripheral blood
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 posttransplant care in the global definition

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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” 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.

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
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 be 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
8/16/2025	07/16/2025	MA policy foundational language updated. Adoption of JUMP policy updates.
2/28/2026	1/28/2026	NCD with CED language added to CMS guidance. Adoption of JUMP policy