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Medical Policy

Hematopoietic Cell Transplantation for Solid Tumors of Childhood

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Policy Number: 208

BCBSA Reference Number: 8.01.34 (For Plan internal use only)

Related Policies

Hematopoietic Cell Transplantation for CNS Embryonal Tumors and Ependymoma, #[205](#)

Policy

Commercial Members: Managed Care (HMO and POS), PPO, and Indemnity

Autologous hematopoietic cell transplantation may be considered [MEDICALLY NECESSARY](#) for:

- Initial treatment of high-risk neuroblastoma,
- Recurrent or refractory neuroblastoma,
- Initial treatment of high-risk Ewing sarcoma,
- Recurrent or refractory Ewing sarcoma, and
- Metastatic retinoblastoma.

Tandem autologous hematopoietic cell transplantation may be considered [MEDICALLY NECESSARY](#) for high-risk neuroblastoma.

Autologous hematopoietic cell transplantation is considered [INVESTIGATIONAL](#) as initial treatment of low- or intermediate-risk neuroblastoma, initial treatment of low- or intermediate-risk Ewing sarcoma, and for other solid tumors of childhood including, but not limited, to the following:

- Rhabdomyosarcoma,
- Wilms tumor,
- Osteosarcoma, and
- Retinoblastoma without metastasis.

Tandem autologous hematopoietic cell transplantation is [INVESTIGATIONAL](#) for the treatment of all other types of pediatric solid tumors except high-risk neuroblastoma, as noted above.

Allogeneic (myeloablative or nonmyeloablative) hematopoietic cell transplantation is [INVESTIGATIONAL](#) for treatment of pediatric solid tumors.

Salvage allogeneic (myeloablative or nonmyeloablative) hematopoietic cell transplantation for pediatric solid tumors that relapse after autologous transplant or fail to respond is considered **INVESTIGATIONAL**.

Prior Authorization Information

Inpatient

- For services described in this policy, precertification/preauthorization **IS REQUIRED** for all products if the procedure is performed **inpatient**.

Outpatient

- For services described in this policy, see below for products where prior authorization **might be required** if the procedure is performed **outpatient**.

	Outpatient
Commercial Managed Care (HMO and POS)	Prior authorization is required .
Commercial PPO and Indemnity	Prior authorization is required .

Requesting Prior Authorization Using Authorization Manager

Providers will need to use [Authorization Manager](#) to submit initial authorization requests for services. Authorization Manager, available 24/7, is the quickest way to review authorization requirements, request authorizations, submit clinical documentation, check existing case status, and view/print the decision letter. For commercial members, the requests must meet medical policy guidelines.

To ensure the service request is processed accurately and quickly:

- Enter the facility's NPI or provider ID for where services are being performed.
- Enter the appropriate surgeon's NPI or provider ID as the servicing provider, *not* the billing group.

Authorization Manager Resources

Refer to our [Authorization Manager](#) page for tips, guides, and video demonstrations.

CPT Codes / HCPCS Codes / ICD Codes

Inclusion or exclusion of a code does not constitute or imply member coverage or provider reimbursement. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage as it applies to an individual member.

Providers should report all services using the most up-to-date industry-standard procedure, revenue, and diagnosis codes, including modifiers where applicable.

The following codes are included below for informational purposes only; this is not an all-inclusive list.

The above medical necessity criteria MUST be met for the following codes to be covered for Commercial Members: Managed Care (HMO and POS), PPO, Indemnity, Medicare HMO Blue and Medicare PPO Blue

CPT Codes

CPT codes:	Code Description
38241	Bone marrow or blood-derived peripheral stem-cell transplantation; autologous

HCPCS Codes

HCPCS codes:	Code Description
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 in the global definition (including drugs; hospitalization; medical surgical, diagnostic and emergency services)

ICD-10 Procedure Codes

ICD-10-PCS procedure codes:	Code Description
30233G0	Transfusion of Autologous Bone Marrow into Peripheral Vein, Percutaneous Approach
30233X0	Transfusion of Autologous Cord Blood Stem Cells into Peripheral Vein, Percutaneous Approach
30233Y0	Transfusion of Autologous Hematopoietic Stem Cells into Peripheral Vein, Percutaneous Approach
30243G0	Transfusion of Autologous Bone Marrow into Central Vein, Percutaneous Approach
30243X0	Transfusion of Autologous Cord Blood Stem Cells into Central Vein, Percutaneous Approach
30243Y0	Transfusion of Autologous Hematopoietic Stem Cells into Central Vein, Percutaneous Approach
30263G0	Transfusion of Autologous Bone Marrow into Central Artery, Percutaneous Approach
30263X0	Transfusion of Autologous Cord Blood Stem Cells into Central Artery, Percutaneous Approach
30263Y0	Transfusion of Autologous Hematopoietic Stem Cells into Central Artery, Percutaneous Approach
3E03305	Introduction of Other Antineoplastic into Peripheral Vein, Percutaneous Approach
3E04305	Introduction of Other Antineoplastic into Central Vein, Percutaneous Approach
3E05305	Introduction of Other Antineoplastic into Peripheral Artery, Percutaneous Approach
3E06305	Introduction of Other Antineoplastic into Central Artery, Percutaneous Approach

The following CPT, HCPCS and ICD Procedure codes are considered investigational for Commercial Members: Managed Care (HMO and POS), PPO, Indemnity, Medicare HMO Blue and Medicare PPO Blue:

CPT Codes

CPT codes:	Code Description
38240	Bone marrow or blood-derived peripheral stem-cell transplantation; allogeneic

HCPCS Codes

HCPCS codes:	Code Description
S2142	Cord blood derived stem-cell transplantation, allogeneic

ICD-10 Procedure Codes

ICD-10-PCS procedure codes:	Code Description
30233G1	Transfusion of Nonautologous Bone Marrow into Peripheral Vein, Percutaneous Approach
30233X1	Transfusion of Nonautologous Cord Blood Stem Cells into Peripheral Vein, Percutaneous Approach
30233Y1	Transfusion of Nonautologous Hematopoietic Stem Cells into Peripheral Vein, Percutaneous Approach
30243G1	Transfusion of Nonautologous Bone Marrow into Central Vein, Percutaneous Approach
30243X1	Transfusion of Nonautologous Cord Blood Stem Cells into Central Vein, Percutaneous Approach

30243Y1	Transfusion of Nonautologous Hematopoietic Stem Cells into Central Vein, Percutaneous Approach
30263G1	Transfusion of Nonautologous Bone Marrow into Central Artery, Percutaneous Approach
30263X1	Transfusion of Nonautologous Cord Blood Stem Cells into Central Artery, Percutaneous Approach
30263Y1	Transfusion of Nonautologous Hematopoietic Stem Cells into Central Artery, Percutaneous Approach

Description

Solid Tumors of Childhood

Solid tumors of childhood arise from mesodermal, ectodermal, and endodermal cells of origin.¹ Some common solid tumors of childhood are neuroblastoma, Ewing sarcoma/Ewing sarcoma family of tumors (ESFT), Wilms tumor, rhabdomyosarcoma, osteosarcoma, and retinoblastoma.

General Treatment

The prognosis for pediatric solid tumors has improved more recently, mostly due to the application of multiagent chemotherapy and improvements in local control therapy (including aggressive surgery and advancements in radiotherapy).² However, patients with metastatic, refractory, or recurrent disease continue to have poor prognoses, and these “high-risk” patients are candidates for more aggressive therapy, including autologous hematopoietic cell transplantation (HCT), to improve event-free survival (EFS) and overall survival (OS).

Descriptions of pediatric-onset solid tumors addressed herein are as follows.

Peripheral Neuroblastoma

Neuroblastoma is the most common extracranial solid tumor of childhood,¹ with approximately 90% of cases presenting in children younger than 5 years of age. These tumors originate where sympathetic nervous system tissue is present, within the adrenal medulla or paraspinal sympathetic ganglia, but have diverse clinical behavior depending on a variety of risk factors.

Patients with neuroblastoma are stratified into prognostic risk groups (low, intermediate, high) that determine treatment plans. Risk variables include age at diagnosis, clinical stage of disease, tumor histology, and certain molecular characteristics, including the presence of the *MYCN* oncogene. Tumor histology is categorized as favorable or unfavorable, according to the degree of tumor differentiation, the proportion of tumor stromal component, and index of cellular proliferation.³ It is well-established that *MYCN* amplification is associated with rapid tumor progression and a poor prognosis,⁴ even in the setting of other coexisting favorable factors. Loss of heterozygosity (LOH) at chromosome arms 1p and 11q frequently occurs in neuroblastoma.⁵ Although 1p LOH is associated with *MYCN* amplification, 11q is usually found in tumors without this abnormality.⁵ Some recent studies have shown that 1p LOH and unbalanced 11q LOH are strongly associated with outcome in patients with neuroblastoma, and both are independently predictive of worse progression-free survival (PFS) in patients with low- and intermediate-risk disease.³ Although the use of these LOH markers in assigning treatment in patients is evolving, they may prove useful to stratify treatment.

In the early 1990s, a uniform clinical staging system based on surgical resectability and distant spread, the International Neuroblastoma Staging System, was adopted by pediatric cooperative groups (see Table 1).

Table 1. International Neuroblastoma Staging System

Stage	Description
1	Localized tumor with complete gross excision, with or without microscopic residual disease; lymph nodes negative for tumor
2A	Localized tumor with incomplete gross excision; lymph nodes negative for tumor
2B	Localized tumor with or without complete gross excision, with ipsilateral lymph nodes positive for tumor

3	Unresectable unilateral tumor infiltrating across the midline, with or without regional lymph node involvement; or localized unilateral tumor with contralateral regional lymph node involvement; or midline tumor with bilateral extension by infiltration or by lymph node involvement
4	Any primary tumor with dissemination to distant lymph nodes, bone, bone marrow, liver, skin, and/or other organs, except as defined for stage 4S
4S	Localized primary tumor as defined for stage 1, 2A, or 2B, with dissemination limited to skin, liver, and/or bone marrow (marrow involvement less than 10%), limited to children younger than 1 year of age

The low-risk group includes patients younger than 1 year of age with stage 1, 2, or 4S disease with favorable histopathologic findings and no *MYCN* oncogene amplification. High-risk neuroblastoma is characterized by age older than 1 year, disseminated disease, *MYCN* oncogene amplification, and unfavorable histopathologic findings.

The International Neuroblastoma Risk Group (2009) proposed a revised staging system, which incorporated pretreatment imaging parameters instead of surgical findings (see Table 2).⁶

Table 2. International Neuroblastoma Risk Group Staging System⁶

Stage	Description
L1	Localized tumor not involving vital structures as defined by the list of Image-Defined Risk Factors and confined to 1 body compartment
L2	Locoregional tumor with presence of 1 or more Image-Defined Risk Factors
M	Distant metastatic disease (except stage MS)
MS	Metastatic disease in children younger than 18 months with metastases confined to skin, liver, and/or bone marrow

Treatment

In general, most patients with the low-stage disease have excellent outcomes with minimal therapy; and with International Neuroblastoma Staging System stage-1 disease, most patients can be treated by surgery alone.⁷ Most infants, even with disseminated disease, have favorable outcomes with chemotherapy and surgery.⁷

For intermediate-risk disease, moderately intensive multiagent chemotherapy is the mainstay of therapy.⁸ Surgery is needed to obtain a diagnosis, and the extent of resection necessary to obtain an optimal outcome is not established.⁹ Patients at high-risk have historically had very low (<15%) long-term OS. Current therapy for high-risk disease typically includes an aggressive multimodal approach with chemotherapy, surgical resection, and radiotherapy.¹⁰

Treatment of recurrent disease is determined by the risk group at diagnosis and the extent of disease and age of the patient at recurrence.

Ewing Sarcoma Family of Tumors

ESFT encompasses a group of tumors that share some degree of neuroglial differentiation and a characteristic underlying molecular pathogenesis (chromosomal translocation).¹¹ The translocation usually involves chromosome 22 and results in fusion of the *EWS* gene with 1 of the members of the ETS (E26 transformation-specific) family of transcription factors, either *FLI1* (90% to 95%) or *ERG* (5% to 10%).¹² These fusion products function as oncogenic aberrant transcription factors. Detection of these fusions is considered to be specific for the ESFT and helps further validate diagnosis. Included in ESFT are “classic” Ewing sarcoma of bone, extraosseous Ewing, peripheral primitive neuroectodermal tumor, and Askin tumors (chest wall).

Most commonly diagnosed in adolescence, ESFT can be found in bone (most commonly) or soft tissue; however, the spectrum of ESFT has also been described in various organ systems. Ewing is the second most common primary malignant bone tumor.¹³ The most common primary sites are the pelvic bones, the long bones of the lower extremities, and the bones of the chest wall.

Treatment

Current therapy for Ewing sarcoma typically includes induction chemotherapy, followed by local control with surgery and/or radiotherapy (dependent on tumor size and location), followed by adjuvant chemotherapy. Multiagent chemotherapy, surgery, and radiotherapy have improved PFS rates in patients with the localized disease to 60% to 70%.¹⁴ The presence of metastatic disease is the most unfavorable prognostic feature, and the outcome for patients presenting with metastatic disease is poor, with 20% to 30% PFS. Other adverse prognostic factors that may categorize a patient as having “high-risk” Ewing are tumor location (eg, patients with pelvic primaries have worse outcomes), larger tumor size, and older age of the patient. However, “high-risk” Ewing has not always been consistently defined in the literature.

Rhabdomyosarcoma

Rhabdomyosarcoma, the most common soft tissue sarcoma of childhood, shows skeletal muscle differentiation. The most common primary sites are the head and neck (eg, parameningeal, orbital, pharyngeal), genitourinary tract, and extremities.¹⁵

Treatment

Specific treatment is based on tumor location, resection, and node status, and may involve surgery, radiotherapy, and chemotherapy.¹⁶ Five-year survival rates for rhabdomyosarcoma increased between 1975 and 2017 from 53% to 71% in children younger than 15 years and from 30% to 52% in patients 15 to 19 years of age.¹⁵

Approximately 15% of children present with metastatic disease, and despite the introduction of new drugs and intensified treatment, the 5-year survival is 20% to 30% for this “high-risk” group.^{17,18} Similarly, postrelapse mortality is very high. The prognosis of the metastatic disease is affected by tumor histology, age at diagnosis, the site of metastatic disease, and the number of metastatic sites.¹⁵

Wilms Tumor

Wilms tumor is the most common primary malignant renal tumor of childhood.¹⁹ In the United States, Wilms tumor is staged using the National Wilms Tumor Study system, which is based on surgical evaluation before chemotherapy (see Table 3).²⁰

Table 3. National Wilms Tumor Study Staging

Stage	Description
I	(a) Tumor is limited to the kidney and completely excised; (b) The tumor was not ruptured before or during removal; (c) The vessels of the renal sinus are not involved beyond 2 mm (d) There is no residual tumor apparent beyond the margins of excision
II	(a) Tumor extends beyond the kidney but is completely excised (b) No residual tumor is apparent at or beyond the margins of excision (c) Tumor thrombus in vessels outside the kidney is stage II if the thrombus is removed en bloc with the tumor
III	Residual tumor confined to the abdomen: (a) Lymph nodes in the renal hilum, the periaortic chains, or beyond are found to contain tumor (b) Diffuse peritoneal contamination by the tumor (c) Implants are found on the peritoneal surfaces (d) Tumor extends beyond the surgical margins either microscopically or grossly (e) Tumor is not completely respectable because of local infiltration into vital structures
IV	Presence of hematogenous metastases or metastases to distant lymph nodes
V	Bilateral renal involvement at the time of initial diagnosis

Adapted from Metzger and Dome (2005).²⁰

Treatment

In the United States, National Wilms Tumor Study and Children's Oncology Group protocols are based on primary resection for unilateral tumors, followed by escalating levels of chemotherapy and radiotherapy depending on tumor stage and other prognostic factors. Tumor histology, tumor stage, molecular and genetic markers (eg, LOH at chromosome 16q), and age (>2 years) are all associated with increased risks of recurrence and death. Wilms tumors are highly sensitive to chemotherapy and radiotherapy, and current cure rates exceed 85%.²¹ Between 10% and 15% of patients with favorable histology and 50% of patients with anaplastic tumors, experience tumor progression or relapse.²¹

Similar risk-adapted strategies are being tested for the 15% of patients who experience a relapse. Success rates after relapse range from 25% to 45%. For patients with adverse prognostic factors (histologically anaplastic tumors, relapse <6 to 12 months after nephrectomy, second or subsequent relapse, relapse within the radiation field, bone or brain metastases), the EFS rate is less than 15%.²²

Osteosarcoma

Osteosarcoma is a primary malignant bone tumor and the most common bone cancer in children and adolescents; it is characterized by infiltration of bone or osteoid by the tumor cells.²³ Peak incidence occurs around puberty, most commonly in long bones such as the femur or humerus. Osteosarcomas are characterized by variants in the *TP53* tumor suppressor gene.²⁴

The prognosis of osteosarcoma has greatly improved, with 5-year survival rates increasing between 1975 and 2020 from 40% to 72% in children younger than 15 years and from 56% to 71% in 15- to 19-year olds.²⁴ Prognostic factors for patients with localized disease include site and size of the primary tumor, the presence of metastases at the time of diagnosis, resection adequacy, and tumor response to neoadjuvant chemotherapy.

Treatment

For patients with recurrent osteosarcoma, the most important prognostic factor is surgical respectability. There is a 5-year survival rate of 20% to 45% in patients who had a complete resection of metastatic pulmonary tumors and a 20% survival rate for patients with metastatic tumors at other sites.²⁴

Retinoblastoma

Retinoblastoma is the most common primary tumor of the eye in children. It may occur as a heritable (25% to 30%) or nonheritable (70% to 75%) tumor.²⁵ Cases may be unilateral or bilateral, with bilateral tumors almost always being the heritable type.

Treatment

Treatment options depend on the extent of disease. Retinoblastoma is usually confined to the eye, and with current therapy, has a high cure rate. However, once disease spreads beyond the eye, survival rates drop significantly; 5 year disease-free survival is reported to be less than 10% in those with the extraocular disease, and stage 4B disease (ie, disease metastatic to the central nervous system) has been lethal in virtually all cases reported.²⁶

The strategy for nonmetastatic disease depends on the disease extent but may include focal therapies (eg, laser photocoagulation, cryotherapy, plaque radiotherapy), intravitreal chemotherapy, intra-arterial chemotherapy, systemic chemotherapy, enucleation, or a combination.²⁷ For metastatic disease, intensive multimodal therapy with high-dose chemotherapy (HDC), with or without radiotherapy, is standard care.

Notes: Other solid tumors of childhood include germ cell tumors, which are considered in policy #[247](#). For solid tumors classified as embryonal tumors arising in the central nervous system, see policy #[205](#) and for central nervous system tumors derived from glial cells (ie, astrocytoma, oligodendroglioma, or glioblastoma multiforme) policy #[159](#).

Hematopoietic Cell Transplantation

HCT is a procedure in which hematopoietic stem cells are infused to restore bone marrow function in cancer patients who receive bone-marrow-toxic doses of drugs, with or without whole body radiotherapy.

Hematopoietic stem cells may be obtained from the transplant recipient (autologous HCT) or a donor (allogeneic HCT). 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 “naive” and thus are associated with a lower incidence of rejection or graft-versus-host disease.

Immunologic compatibility between infused hematopoietic stem cells and the recipient is not an issue in autologous HCT; however, immunologic compatibility between donor and patient is critical for achieving a good outcome of allogeneic HCT. Compatibility is established by typing of human leukocyte antigens using cellular, serologic, or molecular techniques. Human leukocyte antigens refer to the tissue type expressed at class I and class II loci on chromosome 6. Depending on the disease being treated, an acceptable donor (except umbilical cord blood) will match the patient at all or most human leukocyte antigens loci.

Summary

Description

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

Summary of Evidence

For individuals who have high-risk or relapsed peripheral neuroblastoma who receive single or tandem autologous HCT, the evidence includes randomized controlled trials (RCTs) , systematic reviews with meta-analyses of those trials, and observational studies. Relevant outcomes are overall survival (OS) , disease-specific survival (DSS) , and treatment-related mortality (TRM) and morbidity. In the pooled analysis, patients with high-risk neuroblastoma treated with first-line therapy with single autologous HCT with myeloablative conditioning had significantly improved event-free survival (EFS) compared with standard therapy. Similarly, nonrandomized comparative studies, single-arm studies, and case series evaluating tandem autologous HCT showed improvements in EFS for children with high-risk neuroblastoma. A recent RCT found that tandem autologous HCT resulted in statistically significantly better EFS compared with single HCT. The evidence is sufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who have high-risk Ewing sarcoma who receive single or tandem autologous HCT, the evidence includes an RCT, single-arm studies, and case series. Relevant outcomes are OS, DSS, and TRM and morbidity. Although early nonrandomized studies were promising, more recent prospective nonrandomized study results have been inconsistent regarding whether HCT extends survival compared with typical conventional therapy. An RCT comparing consolidation with high-dose chemotherapy (HDC) plus autologous HCT to standard chemotherapy plus whole lung irradiation in patients with Ewing sarcoma with pulmonary and/or pleural metastases did not find a significant improvement in EFS in the group that received HCT. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who have rhabdomyosarcoma (RMS) who receive single autologous HCT, the evidence includes a systematic review and nonrandomized comparative studies. Relevant outcomes are OS, DSS , and TRM and morbidity. Available studies have not demonstrated improvements in OS or EFS with autologous HCT. Additional research is needed to demonstrate a benefit with autologous HCT for pediatric RMS. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who have Wilms tumor who receive single autologous HCT, the evidence includes retrospective studies and a meta-analysis. Relevant outcomes are OS, DSS, and TRM and morbidity. In the meta-analysis, overall 4-year survival rates were similar between patients receiving HCT and

receiving chemotherapy. There was a trend suggesting that patients with lung-only stage 3 or 4 relapse might benefit from autologous HCT. However, the overall body of evidence is limited. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who have osteosarcoma who receive single autologous HCT, the evidence includes case series, a prospective single-arm study, and a retrospective study. Relevant outcomes are OS, DSS, and TRM and morbidity. An interim analysis of the prospective single-arm study showed that patients receiving autologous HCT were experiencing lower EFS rates than historical controls, resulting in all patients being enrolled in the standard of care chemotherapy. Conversely, a retrospective study found favorable EFS and OS rates with HDC plus autologous HCT in patients with nonmetastatic osteosarcoma with low-degree necrosis after neoadjuvant chemotherapy. The overall body of evidence is limited. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who have localized retinoblastoma who receive single autologous HCT, there are no studies. Relevant outcomes are OS, DSS, and TRM and morbidity. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who have metastatic retinoblastoma who receive single autologous HCT, the evidence includes small case series and case reports, and prospective and retrospective studies. Relevant outcomes are OS, DSS, and TRM and morbidity. Results from the limited data have suggested that autologous HCT may prolong EFS and OS, particularly in patients without central nervous system involvement (stage 4A disease). Given the poor prognosis for this indication with conventional therapies, the incremental improvement with autologous HCT might be considered a significant benefit. However, the overall body of evidence is limited. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

Policy History

Date	Action
3/2024	Annual policy review. Description, summary, and references updated. Policy statements unchanged.
9/2023	Policy clarified to include prior authorization requests using Authorization Manager.
3/2023	Annual policy review. Minor editorial refinements to policy statements; intent unchanged.
2/2022	Annual policy review. Description, summary, and references updated. Policy statements unchanged.
3/2021	Annual policy review. Description, summary, and references updated. Policy statements unchanged. Clarified coding information.
1/2021	Medicare information removed. See MP #132 Medicare Advantage Management for local coverage determination and national coverage determination reference.
4/2020	Bone marrow harvesting codes were removed. Outpatient prior authorization is not required.
3/2020	Annual policy review. Description, summary, and references updated. Policy statements unchanged.
3/2019	Annual policy review. Description, summary, and references updated. Policy statements unchanged.
1/2019	Outpatient prior authorization is required for all commercial products. Effective 1/1/2019.
2/2018	Coding information clarified.
10/2017	Annual policy review. "Metastatic retinoblastoma" added to first medically necessary statement. In first investigational statement, "retinoblastoma" changed to "retinoblastoma without metastases." Title changed. Effective 10/1/2017.
6/2015	Annual policy review. New references added.
1/2015	Clarified coding information.

7/2014	Annual policy review. New references added.
6/2014	Updated Coding section with ICD10 procedure and diagnosis codes, effective 10/2015.
6/2013	Annual policy review. New references added.
2/2013	Annual policy review. New medically necessary and investigational indications described. Effective 2/4/2013.
12/2012	Updated to add new CPT code 38243.
11/2011-4/2012	Medical policy ICD 10 remediation: Formatting, editing and coding updates. No changes to policy statements.
7/2011	Reviewed - Medical Policy Group - Hematology and Oncology. No changes to policy statements.
5/2011	Reviewed - Medical Policy Group - Pediatrics and Endocrinology. No changes to policy statements.
3/22/2011	Annual policy review. Changes to policy statements.
9/2010	Reviewed - Medical Policy Group - Hematology and Oncology. No changes to policy statements.
8/1/2010	New policy, effective 8/1/2010, describing covered and non-covered indications.

Information Pertaining to All Blue Cross Blue Shield Medical Policies

Click on any of the following terms to access the relevant information:

[Medical Policy Terms of Use](#)

[Managed Care Guidelines](#)

[Indemnity/PPO Guidelines](#)

[Clinical Exception Process](#)

[Medical Technology Assessment Guidelines](#)

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