

---

<b>Subject:</b>	Hematopoietic Stem Cell Transplantation for Genetic Diseases and Aplastic Anemias	<b>Publish Date:</b>	06/28/2024
<b>Document #:</b>	TRANS.00029	<b>Last Review Date:</b>	11/09/2023
<b>Status:</b>	Reviewed		

---

## Description/Scope

This document addresses hematopoietic stem cell transplantation for genetic diseases and aplastic anemias. The document also addresses autologous hematopoietic stem cell mobilization and pheresis when conducted as part of the development of an ex vivo gene therapy for the treatment of a genetic disease.

**Note:** For additional information and criteria for umbilical cord transplants see:

- MED.00140 Gene Therapy for Beta Thalassemia
- MED.00142 Gene Therapy for Cerebral Adrenoleukodystrophy
- TRANS.00016 Umbilical Cord Blood Progenitor Cell Collection, Storage and Transplantation

---

Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage. The member's contract benefits in effect on the date that services are rendered must be used. Medical Policy, which addresses medical efficacy, should be considered before utilizing medical opinion in adjudication. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from the health plan.

© CPT Only – American Medical Association

The requirements below are specific to the Florida Medicaid Managed Care Plan and are not a part of the Medical Policy or Clinical UM guideline approved by Elevance Health's Medical Policy and Technology Assessment Committee.

**If the Florida Medicaid Managed Care Plan intends to deny coverage on the basis that a diagnostic test, therapeutic procedure, or medical device or technology is experimental or investigational, the Managed Care Plan shall submit a request for coverage determination to the Agency in accordance with rule 59G-1.035, F.A.C and Core SMMC Contract, Attachment II, Section VI.G.4.d.**

**Below is a list of the materials the plans are required to submit when they deny coverage as experimental/investigational:**

- A. Include the CPT or HCPCS code(s)**
- B. Include a list of other state Medicaid agencies and private insurers who cover the service**
- C. Include information about the health service from the U.S. Food and Drug Administration**
- D. Include known risks of the service and health outcomes of others who have received it**
- E. Include a list of covered alternative services, if any, that could be used to treat the condition**
- F. Identify a specific recipient needing the service**
- G. Include the recipient's health history**
- H. Include the disease information necessitating the requested service**
- I. Include a rationale for the immediacy of the review**

### Additional required information

- A. Submit the rationale used to preliminarily indicate the service is experimental/investigational**
  - 1. Include peer-reviewed journal articles in PDF format with links to the online articles**
  - 2. Include evidence-based clinical guidelines reviewed by the plan**
- B. Submit direct contact information (name, phone number, & email address) for the Medical Director**

### Position Statement

#### Medically Necessary:

*Allogeneic (ablative and non-myeloablative) hematopoietic stem cell transplantation* is considered **medically necessary** for individuals with the following disorders. In addition, individuals with Aplastic Anemia, Sickle Cell Disease or Thalassemia should meet the Disease Specific Criteria below.

- A. Bone Marrow Failure Syndromes
  1. Acquired aplastic anemia (drug, idiopathic, immune disorder, toxin or viral infection)
  2. Heritable bone marrow syndromes:
    - a. Congenital amegakaryocytic thrombocytopenia (CAMT)
    - b. Diamond-Blackfan anemia (DBA)
    - c. Dyskeratosis congenita
    - d. Fanconi's anemia (FA)
    - e. Schwachman-Diamond syndrome (SDS)
  3. Paroxysmal nocturnal hemoglobinuria (PNH)

Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage. The member's contract benefits in effect on the date that services are rendered must be used. Medical Policy, which addresses medical efficacy, should be considered before utilizing medical opinion in adjudication. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from the health plan.

© CPT Only – American Medical Association

The requirements below are specific to the Florida Medicaid Managed Care Plan and are not a part of the Medical Policy or Clinical UM guideline approved by Elevance Health's Medical Policy and Technology Assessment Committee.

**If the Florida Medicaid Managed Care Plan intends to deny coverage on the basis that a diagnostic test, therapeutic procedure, or medical device or technology is experimental or investigational, the Managed Care Plan shall submit a request for coverage determination to the Agency in accordance with rule 59G-1.035, F.A.C and Core SMMC Contract, Attachment II, Section VI.G.4.d.**

**Below is a list of the materials the plans are required to submit when they deny coverage as experimental/investigational:**

- A. Include the CPT or HCPCS code(s)
- B. Include a list of other state Medicaid agencies and private insurers who cover the service
- C. Include information about the health service from the U.S. Food and Drug Administration
- D. Include known risks of the service and health outcomes of others who have received it
- E. Include a list of covered alternative services, if any, that could be used to treat the condition
- F. Identify a specific recipient needing the service
- G. Include the recipient's health history
- H. Include the disease information necessitating the requested service
- I. Include a rationale for the immediacy of the review

#### Additional required information

- A. Submit the rationale used to preliminarily indicate the service is experimental/investigational
  1. Include peer-reviewed journal articles in PDF format with links to the online articles
  2. Include evidence-based clinical guidelines reviewed by the plan
- B. Submit direct contact information (name, phone number, & email address) for the Medical Director

## Hematopoietic Stem Cell Transplantation for Genetic Diseases and Aplastic Anemias

---

- B. Immunodeficiencies
    - 1. Hemophagocytic Lymphohistiocytosis (HLH)
    - 2. Immune dysregulation, polyendocrinopathy, enteropathy, X-linked (IPEX) syndrome
    - 3. Severe Combined Immunodeficiency (SCID)
    - 4. Wiskott-Aldrich Syndrome (WAS)
    - 5. X-linked lymphoproliferative syndrome
    - 6. Chediak-Higashi syndrome
    - 7. Primary granuloocyte dysfunction
    - 8. Chronic granulomatous disease
  - C. Storage disorders
    - 1. Hurler Syndrome (MPS I)
    - 2. Hunter Syndrome (MPS II)
    - 3. Maroteaux-Lamy Syndrome (MPS VI)
    - 4. SanFilippo's (MPS III)
    - 5. Gaucher disease
  - D. Leukodystrophies
    - 1. Adrenoleukodystrophy (ALD)
- 

Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage. The member's contract benefits in effect on the date that services are rendered must be used. Medical Policy, which addresses medical efficacy, should be considered before utilizing medical opinion in adjudication. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from the health plan.

© CPT Only – American Medical Association

The requirements below are specific to the Florida Medicaid Managed Care Plan and are not a part of the Medical Policy or Clinical UM guideline approved by Elevance Health's Medical Policy and Technology Assessment Committee.

**If the Florida Medicaid Managed Care Plan intends to deny coverage on the basis that a diagnostic test, therapeutic procedure, or medical device or technology is experimental or investigational, the Managed Care Plan shall submit a request for coverage determination to the Agency in accordance with rule 59G-1.035, F.A.C and Core SMMC Contract, Attachment II, Section VI.G.4.d.**

**Below is a list of the materials the plans are required to submit when they deny coverage as experimental/investigational:**

- A. **Include the CPT or HCPCS code(s)**
- B. **Include a list of other state Medicaid agencies and private insurers who cover the service**
- C. **Include information about the health service from the U.S. Food and Drug Administration**
- D. **Include known risks of the service and health outcomes of others who have received it**
- E. **Include a list of covered alternative services, if any, that could be used to treat the condition**
- F. **Identify a specific recipient needing the service**
- G. **Include the recipient's health history**
- H. **Include the disease information necessitating the requested service**
- I. **Include a rationale for the immediacy of the review**

### **Additional required information**

- A. **Submit the rationale used to preliminarily indicate the service is experimental/investigational**
  - 1. **Include peer-reviewed journal articles in PDF format with links to the online articles**
  - 2. **Include evidence-based clinical guidelines reviewed by the plan**
- B. **Submit direct contact information (name, phone number, & email address) for the Medical Director**

## Hematopoietic Stem Cell Transplantation for Genetic Diseases and Aplastic Anemias

---

2. Globoid Cell Leukodystrophy (GBL; Krabbe's disease)
3. Metachromatic Leukodystrophy (MLD)
- E. Hemoglobinopathies
  1. Sickle Cell Disease
  2. Thalassemia (homozygous beta-thalassemia)
- F. Infantile malignant osteopetrosis (Albers-Schonberg disease or marble bone disease)
- G. Other autosomal recessive disorders
  1. Leukocyte adhesion deficiencies
  2. Kostmann's syndrome (severe congenital neutropenia, infantile genetic agranulocytosis)

A repeat allogeneic (ablative or non-myeloablative) hematopoietic stem cell transplantation due to primary graft failure or failure to engraft is considered **medically necessary**.

Autologous hematopoietic stem cell mobilization and pheresis is considered **medically necessary** for the treatment of a genetic disease as part of the development of an FDA-approved ex vivo gene therapy (for example, betibeglogene autotemcel or elivaldogene autotemcel).

---

Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage. The member's contract benefits in effect on the date that services are rendered must be used. Medical Policy, which addresses medical efficacy, should be considered before utilizing medical opinion in adjudication. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from the health plan.

© CPT Only – American Medical Association

The requirements below are specific to the Florida Medicaid Managed Care Plan and are not a part of the Medical Policy or Clinical UM guideline approved by Elevance Health's Medical Policy and Technology Assessment Committee.

**If the Florida Medicaid Managed Care Plan intends to deny coverage on the basis that a diagnostic test, therapeutic procedure, or medical device or technology is experimental or investigational, the Managed Care Plan shall submit a request for coverage determination to the Agency in accordance with rule 59G-1.035, F.A.C and Core SMMC Contract, Attachment II, Section VI.G.4.d.**

**Below is a list of the materials the plans are required to submit when they deny coverage as experimental/investigational:**

- A. Include the CPT or HCPCS code(s)
- B. Include a list of other state Medicaid agencies and private insurers who cover the service
- C. Include information about the health service from the U.S. Food and Drug Administration
- D. Include known risks of the service and health outcomes of others who have received it
- E. Include a list of covered alternative services, if any, that could be used to treat the condition
- F. Identify a specific recipient needing the service
- G. Include the recipient's health history
- H. Include the disease information necessitating the requested service
- I. Include a rationale for the immediacy of the review

### Additional required information

- A. Submit the rationale used to preliminarily indicate the service is experimental/investigational
  1. Include peer-reviewed journal articles in PDF format with links to the online articles
  2. Include evidence-based clinical guidelines reviewed by the plan
- B. Submit direct contact information (name, phone number, & email address) for the Medical Director

## Hematopoietic Stem Cell Transplantation for Genetic Diseases and Aplastic Anemias

---

### **Investigational and Not Medically Necessary:**

*Allogeneic (ablative and non-myeloablative) hematopoietic stem cell transplantation* is considered **investigational and not medically necessary** for the treatment of all genetic diseases not listed above including, but not limited to cystic fibrosis, and all acquired anemias not specifically identified above as medically necessary.

*Autologous hematopoietic stem cell transplantation* is considered **investigational and not medically necessary** for the treatment of all genetic diseases including, but not limited to cystic fibrosis, and all acquired anemias.

*A planned tandem allogeneic hematopoietic stem cell transplantation or autologous hematopoietic stem cell transplantation* is considered **investigational and not medically necessary** for all genetic diseases and for all acquired anemias.

*A second or repeat allogeneic (ablative or non-myeloablative) hematopoietic stem cell transplant* due to persistent, progressive or relapsed disease is considered **investigational and not medically necessary**.

*Hematopoietic stem cell harvesting for a future but unscheduled transplant* is considered **investigational and not medically necessary**.

---

Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage. The member's contract benefits in effect on the date that services are rendered must be used. Medical Policy, which addresses medical efficacy, should be considered before utilizing medical opinion in adjudication. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from the health plan.

© CPT Only – American Medical Association

The requirements below are specific to the Florida Medicaid Managed Care Plan and are not a part of the Medical Policy or Clinical UM guideline approved by Elevance Health's Medical Policy and Technology Assessment Committee.

**If the Florida Medicaid Managed Care Plan intends to deny coverage on the basis that a diagnostic test, therapeutic procedure, or medical device or technology is experimental or investigational, the Managed Care Plan shall submit a request for coverage determination to the Agency in accordance with rule 59G-1.035, F.A.C and Core SMMC Contract, Attachment II, Section VI.G.4.d.**

**Below is a list of the materials the plans are required to submit when they deny coverage as experimental/investigational:**

- A. **Include the CPT or HCPCS code(s)**
- B. **Include a list of other state Medicaid agencies and private insurers who cover the service**
- C. **Include information about the health service from the U.S. Food and Drug Administration**
- D. **Include known risks of the service and health outcomes of others who have received it**
- E. **Include a list of covered alternative services, if any, that could be used to treat the condition**
- F. **Identify a specific recipient needing the service**
- G. **Include the recipient's health history**
- H. **Include the disease information necessitating the requested service**
- I. **Include a rationale for the immediacy of the review**

### **Additional required information**

- A. **Submit the rationale used to preliminarily indicate the service is experimental/investigational**
  1. **Include peer-reviewed journal articles in PDF format with links to the online articles**
  2. **Include evidence-based clinical guidelines reviewed by the plan**
- B. **Submit direct contact information (name, phone number, & email address) for the Medical Director**

## Hematopoietic Stem Cell Transplantation for Genetic Diseases and Aplastic Anemias

---

*Autologous hematopoietic stem cell mobilization and pheresis* is considered **investigational and not medically necessary** for the treatment of a genetic disease when the medically necessary criteria above are not met.

### Disease Specific Criteria

#### ***Aplastic Anemia Criteria:***

- One of the following:
  - 55 years of age or younger do not need to have failed immunosuppressive therapy
  - Older than 55 years of age, or non-HLA identical donor, have to have failed immunosuppressive therapy

#### ***Sickle Cell Criteria:***

- Children less than 16 years of age with homozygous SS disease or S-B thalassemia and who have had at least one of the following complications:
    - Stroke or CNS hemorrhage
    - Clinical evidence of progressive neurologic deterioration, for example, abnormal cerebral MRI and arteriogram and impaired neuropsychiatric testing
    - Sickle cell lung disease, recurrent acute chest syndrome or a combination of both requiring hospitalization and exchange transfusions
- 

Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage. The member's contract benefits in effect on the date that services are rendered must be used. Medical Policy, which addresses medical efficacy, should be considered before utilizing medical opinion in adjudication. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from the health plan.

© CPT Only – American Medical Association

The requirements below are specific to the Florida Medicaid Managed Care Plan and are not a part of the Medical Policy or Clinical UM guideline approved by Elevance Health's Medical Policy and Technology Assessment Committee.

**If the Florida Medicaid Managed Care Plan intends to deny coverage on the basis that a diagnostic test, therapeutic procedure, or medical device or technology is experimental or investigational, the Managed Care Plan shall submit a request for coverage determination to the Agency in accordance with rule 59G-1.035, F.A.C and Core SMMC Contract, Attachment II, Section VI.G.4.d.**

**Below is a list of the materials the plans are required to submit when they deny coverage as experimental/investigational:**

- A. **Include the CPT or HCPCS code(s)**
- B. **Include a list of other state Medicaid agencies and private insurers who cover the service**
- C. **Include information about the health service from the U.S. Food and Drug Administration**
- D. **Include known risks of the service and health outcomes of others who have received it**
- E. **Include a list of covered alternative services, if any, that could be used to treat the condition**
- F. **Identify a specific recipient needing the service**
- G. **Include the recipient's health history**
- H. **Include the disease information necessitating the requested service**
- I. **Include a rationale for the immediacy of the review**

#### **Additional required information**

- A. **Submit the rationale used to preliminarily indicate the service is experimental/investigational**
  1. **Include peer-reviewed journal articles in PDF format with links to the online articles**
  2. **Include evidence-based clinical guidelines reviewed by the plan**
- B. **Submit direct contact information (name, phone number, & email address) for the Medical Director**

## Hematopoietic Stem Cell Transplantation for Genetic Diseases and Aplastic Anemias

- Sickle cell nephropathy

### **Thalassemia Criteria:**

- Thalassemia major only **and**
- Individuals less than or equal to 30 years of age **and**
- The presence of minimal or no portal fibrous or active hepatitis

## Rationale

### *Bone Marrow Failure Syndromes*

Ades and colleagues (2004) reported on 133 subjects treated with matched related allogeneic bone marrow transplants for the treatment of aplastic anemia. The conditioning regimen included thoracoabdominal irradiation (TAI) and cyclophosphamide for 100 subjects, and cyclophosphamide and antithymocyte globulin (ATG) for 33 subjects. The long-term study had a median follow-up of 13.6 years. Survival estimates for 5, 10, and 15 years were  $69\% \pm 4.0\%$ ,  $64.5\% \pm 4.5\%$  and  $58.7\% \pm 5.2\%$ , respectively. Four individuals did not achieve engraftment and were not included in the long-term outcome data analysis. A total of 52 (79%) subjects developed extensive graft

Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage. The member's contract benefits in effect on the date that services are rendered must be used. Medical Policy, which addresses medical efficacy, should be considered before utilizing medical opinion in adjudication. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from the health plan.

© CPT Only – American Medical Association

The requirements below are specific to the Florida Medicaid Managed Care Plan and are not a part of the Medical Policy or Clinical UM guideline approved by Elevance Health's Medical Policy and Technology Assessment Committee.

**If the Florida Medicaid Managed Care Plan intends to deny coverage on the basis that a diagnostic test, therapeutic procedure, or medical device or technology is experimental or investigational, the Managed Care Plan shall submit a request for coverage determination to the Agency in accordance with rule 59G-1.035, F.A.C and Core SMMC Contract, Attachment II, Section VI.G.4.d.**

**Below is a list of the materials the plans are required to submit when they deny coverage as experimental/investigational:**

- Include the CPT or HCPCS code(s)**
- Include a list of other state Medicaid agencies and private insurers who cover the service**
- Include information about the health service from the U.S. Food and Drug Administration**
- Include known risks of the service and health outcomes of others who have received it**
- Include a list of covered alternative services, if any, that could be used to treat the condition**
- Identify a specific recipient needing the service**
- Include the recipient's health history**
- Include the disease information necessitating the requested service**
- Include a rationale for the immediacy of the review**

### **Additional required information**

- Submit the rationale used to preliminarily indicate the service is experimental/investigational**
  - Include peer-reviewed journal articles in PDF format with links to the online articles**
  - Include evidence-based clinical guidelines reviewed by the plan**
- Submit direct contact information (name, phone number, & email address) for the Medical Director**

## Hematopoietic Stem Cell Transplantation for Genetic Diseases and Aplastic Anemias

---

versus host disease (GVHD). A total of 46 deaths after transplantation occurred primarily resulting from GVHD, infection and 1 individual died of cancer.

Results from a retrospective study of 154 individuals with aplastic anemia treated with matched unrelated bone marrow transplants were reported by Kojima (2002). The probability of overall survival at 5 years was 56%. Grade III chronic GVHD was 20% and grade IV GVHD was 30%. Factors of poor prognostic outcomes were transplantation 3 years after diagnosis, individuals older than 20 years, preconditioning regimen without ATG and human leukocyte antigen (HLA)-A or B mismatch by DNA testing.

Allogeneic hematopoietic stem cell transplantation (HSCT) may be an option under specific circumstances for Diamond-Blackfan anemia (DBA), Fanconi's anemia (FA), paroxysmal nocturnal hemoglobinuria, and Schwachman-Diamond syndrome (SDS). In a report from the DBA registry, 20 of 354 registered individuals underwent HSCT, and the 5-year survival rates were 87.5% when recipients received HLA-identical sibling grafts (Gluckman, 2008). Dufour and colleagues (2008) reported in a summary of allogeneic HSCT from matched related donors over 6 years in FA, totaling 103 individuals, that overall survival ranged from 83-88%, with transplant-related mortality ranging from 8%-18.5% and average chronic GVHD of 12%. Santarone and colleagues (2010) performed a retrospective study of 26 individuals with paroxysmal nocturnal hemoglobinuria and concluded that

---

Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage. The member's contract benefits in effect on the date that services are rendered must be used. Medical Policy, which addresses medical efficacy, should be considered before utilizing medical opinion in adjudication. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from the health plan.

© CPT Only – American Medical Association

The requirements below are specific to the Florida Medicaid Managed Care Plan and are not a part of the Medical Policy or Clinical UM guideline approved by Elevance Health's Medical Policy and Technology Assessment Committee.

**If the Florida Medicaid Managed Care Plan intends to deny coverage on the basis that a diagnostic test, therapeutic procedure, or medical device or technology is experimental or investigational, the Managed Care Plan shall submit a request for coverage determination to the Agency in accordance with rule 59G-1.035, F.A.C and Core SMMC Contract, Attachment II, Section VI.G.4.d.**

**Below is a list of the materials the plans are required to submit when they deny coverage as experimental/investigational:**

- A. Include the CPT or HCPCS code(s)**
- B. Include a list of other state Medicaid agencies and private insurers who cover the service**
- C. Include information about the health service from the U.S. Food and Drug Administration**
- D. Include known risks of the service and health outcomes of others who have received it**
- E. Include a list of covered alternative services, if any, that could be used to treat the condition**
- F. Identify a specific recipient needing the service**
- G. Include the recipient's health history**
- H. Include the disease information necessitating the requested service**
- I. Include a rationale for the immediacy of the review**

### **Additional required information**

- A. Submit the rationale used to preliminarily indicate the service is experimental/investigational**
  - 1. Include peer-reviewed journal articles in PDF format with links to the online articles**
  - 2. Include evidence-based clinical guidelines reviewed by the plan**
- B. Submit direct contact information (name, phone number, & email address) for the Medical Director**



## Hematopoietic Stem Cell Transplantation for Genetic Diseases and Aplastic Anemias

---

HSCT may lead to a long-term cure rate as high as 60% in a heterogeneous cohort of seriously ill individuals with paroxysmal nocturnal hemoglobinuria.

Genetic mutations affecting ribosome function are associated with SDS and DBA. Sakamoto and colleagues (2010) reported that treatment of SDS and DBA may include stem cell transplantation. SDS is a rare (13 cases per 1 million) autosomal recessive genetic disorder. This disorder has clinical features which include pancreatic dysfunction, skeletal abnormalities, and aplastic anemia. Individuals with SDS are also at increased risk for myelodysplastic syndrome and transformation to acute myelogenous leukemia. SDS has been treated with HSCT.

Burroughs and colleagues (2009) stated the following in regard to SDS:

In older individuals with this disease, the main causes of death are hemorrhage and infections due to associated hematological abnormalities such as marrow aplasia, neutropenia, MDS, or acute leukemia. Supportive measures include transfusions, pancreatic enzymes, antibiotics and GCSF. The only definitive therapy for marrow failure, MDS or leukemia is hematopoietic stem cell transplants.

---

Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage. The member's contract benefits in effect on the date that services are rendered must be used. Medical Policy, which addresses medical efficacy, should be considered before utilizing medical opinion in adjudication. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from the health plan.

© CPT Only – American Medical Association

The requirements below are specific to the Florida Medicaid Managed Care Plan and are not a part of the Medical Policy or Clinical UM guideline approved by Elevance Health's Medical Policy and Technology Assessment Committee.

**If the Florida Medicaid Managed Care Plan intends to deny coverage on the basis that a diagnostic test, therapeutic procedure, or medical device or technology is experimental or investigational, the Managed Care Plan shall submit a request for coverage determination to the Agency in accordance with rule 59G-1.035, F.A.C and Core SMMC Contract, Attachment II, Section VI.G.4.d.**

**Below is a list of the materials the plans are required to submit when they deny coverage as experimental/investigational:**

- A. Include the CPT or HCPCS code(s)**
- B. Include a list of other state Medicaid agencies and private insurers who cover the service**
- C. Include information about the health service from the U.S. Food and Drug Administration**
- D. Include known risks of the service and health outcomes of others who have received it**
- E. Include a list of covered alternative services, if any, that could be used to treat the condition**
- F. Identify a specific recipient needing the service**
- G. Include the recipient's health history**
- H. Include the disease information necessitating the requested service**
- I. Include a rationale for the immediacy of the review**

### **Additional required information**

- A. Submit the rationale used to preliminarily indicate the service is experimental/investigational**
  - 1. Include peer-reviewed journal articles in PDF format with links to the online articles**
  - 2. Include evidence-based clinical guidelines reviewed by the plan**
- B. Submit direct contact information (name, phone number, & email address) for the Medical Director**

## Hematopoietic Stem Cell Transplantation for Genetic Diseases and Aplastic Anemias

---

Cesaro and colleagues (2005) reported on 26 individuals with SDS from the European Group for Blood and Bone Marrow Transplantation registry given HSCT for treatment of severe aplastic anemia (n=16); myelodysplastic syndrome-acute myelogenous leukemia (MDS-AML) (n=9); or another diagnosis (n=1). Various preparative regimens were used; most included either busulfan (54%) or total-body irradiation (23%) followed by an HLA-matched sibling (n=6), mismatched related (n=1), or unrelated graft (n=19). Graft failure occurred in 5 (19%), and the incidence of grade III to IV acute and chronic GVHD were 24% and 29%, respectively. With a median follow-up of 1.1 years, overall survival (OS) was 65%. Deaths were primarily caused by infections with or without GVHD (n=5) or major organ toxicities (n=3). The analysis suggested that presence of MDS-AML or use of total-body irradiation-based conditioning regimens were factors associated with a poorer outcome.

In 2022, Cesaro and colleagues published recommendations from the European Society for Blood and Marrow Transplantation Severe Aplastic Anaemia Working Party regarding HSCT in individuals affected by SDS. In general, about 10% to 20% of individuals with SDS require treatment with HSCT, an option that is effective in improving survival for this otherwise incurable condition. A 5-year OS of 70.7% has been reported in individuals with bone marrow failure due to SDS who received HSCT, with graft failure and transplant-related mortality being the main factors affecting success of the procedure. Among the key recommendations for improving survival were

---

Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage. The member's contract benefits in effect on the date that services are rendered must be used. Medical Policy, which addresses medical efficacy, should be considered before utilizing medical opinion in adjudication. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from the health plan.

© CPT Only – American Medical Association

The requirements below are specific to the Florida Medicaid Managed Care Plan and are not a part of the Medical Policy or Clinical UM guideline approved by Elevance Health's Medical Policy and Technology Assessment Committee.

**If the Florida Medicaid Managed Care Plan intends to deny coverage on the basis that a diagnostic test, therapeutic procedure, or medical device or technology is experimental or investigational, the Managed Care Plan shall submit a request for coverage determination to the Agency in accordance with rule 59G-1.035, F.A.C and Core SMMC Contract, Attachment II, Section VI.G.4.d.**

**Below is a list of the materials the plans are required to submit when they deny coverage as experimental/investigational:**

- A. Include the CPT or HCPCS code(s)**
- B. Include a list of other state Medicaid agencies and private insurers who cover the service**
- C. Include information about the health service from the U.S. Food and Drug Administration**
- D. Include known risks of the service and health outcomes of others who have received it**
- E. Include a list of covered alternative services, if any, that could be used to treat the condition**
- F. Identify a specific recipient needing the service**
- G. Include the recipient's health history**
- H. Include the disease information necessitating the requested service**
- I. Include a rationale for the immediacy of the review**

### **Additional required information**

- A. Submit the rationale used to preliminarily indicate the service is experimental/investigational**
  - 1. Include peer-reviewed journal articles in PDF format with links to the online articles**
  - 2. Include evidence-based clinical guidelines reviewed by the plan**
- B. Submit direct contact information (name, phone number, & email address) for the Medical Director**

## Hematopoietic Stem Cell Transplantation for Genetic Diseases and Aplastic Anemias

---

early recognition of an indication for HSCT, the importance of regular and structured hematologic follow-up and the potential reduction of transplant-related mortality by using reduced-intensity conditioning regimens.

DBA is a rare (7 cases per 1 million) autosomal dominant red cell aplasia presenting during the first year of life. It is characterized by absent or decreased erythroid precursors in the bone marrow and may be associated with other congenital anomalies. Sakamoto and colleagues (2010) reviewed treatment for SDS and DBA and reported that treatment for these bone marrow failure syndromes include stem cell transplantation.

Bizzetto and colleagues (2011) reported on a European multicenter, retrospective study based on the Eurocord Registry. From 1994 to 2008, 64 individuals with hereditary bone marrow failure syndromes were transplanted from related (n=20) or unrelated donors (n=44). Diagnoses were DBA (21 subjects), congenital amegakaryocytic thrombocytopenia (16 subjects), dyskeratosis congenita (8 subjects), SDS (2 subjects), severe congenital neutropenia (16 subjects) and unclassified (1 subject). In those who received grafts from related donors, all subjects but 1 received an HLA-matched sibling transplant. The cumulative incidence of neutrophil recovery at 60 days was 95%. Two subjects had grade II-IV acute graft-versus-host disease (GVHD), while the 2-year cumulative incidence of chronic GVHD was 11%. The 3-year overall survival rate was 95%. In those who received grafts from unrelated donors, 86% had HLA-mismatched grafts and 3 received 2 umbilical cord blood units. The cumulative incidence of

---

Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage. The member's contract benefits in effect on the date that services are rendered must be used. Medical Policy, which addresses medical efficacy, should be considered before utilizing medical opinion in adjudication. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from the health plan.

© CPT Only – American Medical Association

The requirements below are specific to the Florida Medicaid Managed Care Plan and are not a part of the Medical Policy or Clinical UM guideline approved by Elevance Health's Medical Policy and Technology Assessment Committee.

**If the Florida Medicaid Managed Care Plan intends to deny coverage on the basis that a diagnostic test, therapeutic procedure, or medical device or technology is experimental or investigational, the Managed Care Plan shall submit a request for coverage determination to the Agency in accordance with rule 59G-1.035, F.A.C and Core SMMC Contract, Attachment II, Section VI.G.4.d.**

**Below is a list of the materials the plans are required to submit when they deny coverage as experimental/investigational:**

- A. Include the CPT or HCPCS code(s)
- B. Include a list of other state Medicaid agencies and private insurers who cover the service
- C. Include information about the health service from the U.S. Food and Drug Administration
- D. Include known risks of the service and health outcomes of others who have received it
- E. Include a list of covered alternative services, if any, that could be used to treat the condition
- F. Identify a specific recipient needing the service
- G. Include the recipient's health history
- H. Include the disease information necessitating the requested service
- I. Include a rationale for the immediacy of the review

### **Additional required information**

- A. Submit the rationale used to preliminarily indicate the service is experimental/investigational
  1. Include peer-reviewed journal articles in PDF format with links to the online articles
  2. Include evidence-based clinical guidelines reviewed by the plan
- B. Submit direct contact information (name, phone number, & email address) for the Medical Director

## Hematopoietic Stem Cell Transplantation for Genetic Diseases and Aplastic Anemias

---

neutrophil recovery at day 60 in this group was 55%. The 100-day cumulative incidence of grade II-IV acute graft-versus-host disease was 24%, while the 2-year cumulative incidence of chronic GVHD was 53%. The 3-year overall survival rate was 61%. Better overall survival was associated with age younger than 5 years and  $6.1 \times 10^7$ /kg or more total nucleated cells infused. Study results indicated that for individuals with hereditary bone marrow failure syndromes, related umbilical cord blood transplantation was associated with improved outcomes.

In 2012, Samarasinghe and colleagues retrospectively analyzed outcomes of children with idiopathic severe aplastic anemia in the United Kingdom who were treated with either immunosuppressive therapy (IST) or matched unrelated donor (MUD) HSCT. The 6-month cumulative response rate following IST was 32.5% (n=43). The 5-year estimated failure-free survival (FFS) following IST was 13.3%. The 44 successive children who received a 10-antigen MUD HSCT had an estimated 5-year FFS of 95.01%. Forty of these children had failed IST previously. There were no cases of graft failure and median donor chimerism was 100%.

Congenital amegakaryocytic thrombocytopenia (CAMT) is an exceedingly rare inherited autosomal recessive disorder characterized by thrombocytopenia and an absence of megakaryocytes at birth. Allogeneic HSCT is the only curative therapy. The published literature demonstrating successful outcomes of allogeneic HSCT for this disorder consists mainly of single or small case reports (Frangoul, 2010; King, 2005; Muraoka, 2005; Rao, 2015;

---

Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage. The member's contract benefits in effect on the date that services are rendered must be used. Medical Policy, which addresses medical efficacy, should be considered before utilizing medical opinion in adjudication. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from the health plan.

© CPT Only – American Medical Association

The requirements below are specific to the Florida Medicaid Managed Care Plan and are not a part of the Medical Policy or Clinical UM guideline approved by Elevance Health's Medical Policy and Technology Assessment Committee.

**If the Florida Medicaid Managed Care Plan intends to deny coverage on the basis that a diagnostic test, therapeutic procedure, or medical device or technology is experimental or investigational, the Managed Care Plan shall submit a request for coverage determination to the Agency in accordance with rule 59G-1.035, F.A.C and Core SMMC Contract, Attachment II, Section VI.G.4.d.**

**Below is a list of the materials the plans are required to submit when they deny coverage as experimental/investigational:**

- A. **Include the CPT or HCPCS code(s)**
- B. **Include a list of other state Medicaid agencies and private insurers who cover the service**
- C. **Include information about the health service from the U.S. Food and Drug Administration**
- D. **Include known risks of the service and health outcomes of others who have received it**
- E. **Include a list of covered alternative services, if any, that could be used to treat the condition**
- F. **Identify a specific recipient needing the service**
- G. **Include the recipient's health history**
- H. **Include the disease information necessitating the requested service**
- I. **Include a rationale for the immediacy of the review**

### **Additional required information**

- A. **Submit the rationale used to preliminarily indicate the service is experimental/investigational**
  1. **Include peer-reviewed journal articles in PDF format with links to the online articles**
  2. **Include evidence-based clinical guidelines reviewed by the plan**
- B. **Submit direct contact information (name, phone number, & email address) for the Medical Director**

## Hematopoietic Stem Cell Transplantation for Genetic Diseases and Aplastic Anemias

---

Woods, 2014; Steele, 2005; Yesilipek, 2000). Additionally, Mahadeo and colleagues (2015) reported on 5 consecutive children with CAMT who demonstrated durable engraftment and correction of hematological abnormalities after treatment with myeloablative umbilical cord transplant. At a median follow-up of 14 years, all subjects were alive with sustained donor cell engraftment.

Dyskeratosis congenita is a rare inherited disorder of bone marrow failure with few allogeneic HSCT outcomes published. Hematopoietic cell transplantation represents the only known cure for bone marrow failure in this condition; however, it can result in significant toxicities. Dietz and colleagues (2011) reported on 6 individuals with dyskeratosis congenita that underwent allogeneic HCT with a nonmyeloablative conditioning regimen. Graft sources included related stem cells (1), unrelated bone marrow (2) and unrelated double umbilical cord blood (3). Complete donor engraftment was achieved in 5 of the 6 subjects. At a median follow-up of 26.5 months, 4 persons remained alive, 3 of whom were recipients of unrelated grafts. The authors concluded that encouraging short-term survival can be achieved with HSCT in persons with dyskeratosis congenita using a preparative regimen designed to promote donor engraftment and minimize life-threatening disease-specific complications such as pulmonary fibrosis.

---

Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage. The member's contract benefits in effect on the date that services are rendered must be used. Medical Policy, which addresses medical efficacy, should be considered before utilizing medical opinion in adjudication. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from the health plan.

© CPT Only – American Medical Association

The requirements below are specific to the Florida Medicaid Managed Care Plan and are not a part of the Medical Policy or Clinical UM guideline approved by Elevance Health's Medical Policy and Technology Assessment Committee.

**If the Florida Medicaid Managed Care Plan intends to deny coverage on the basis that a diagnostic test, therapeutic procedure, or medical device or technology is experimental or investigational, the Managed Care Plan shall submit a request for coverage determination to the Agency in accordance with rule 59G-1.035, F.A.C and Core SMMC Contract, Attachment II, Section VI.G.4.d.**

**Below is a list of the materials the plans are required to submit when they deny coverage as experimental/investigational:**

- A. Include the CPT or HCPCS code(s)**
- B. Include a list of other state Medicaid agencies and private insurers who cover the service**
- C. Include information about the health service from the U.S. Food and Drug Administration**
- D. Include known risks of the service and health outcomes of others who have received it**
- E. Include a list of covered alternative services, if any, that could be used to treat the condition**
- F. Identify a specific recipient needing the service**
- G. Include the recipient's health history**
- H. Include the disease information necessitating the requested service**
- I. Include a rationale for the immediacy of the review**

### **Additional required information**

- A. Submit the rationale used to preliminarily indicate the service is experimental/investigational**
  - 1. Include peer-reviewed journal articles in PDF format with links to the online articles**
  - 2. Include evidence-based clinical guidelines reviewed by the plan**
- B. Submit direct contact information (name, phone number, & email address) for the Medical Director**

## Hematopoietic Stem Cell Transplantation for Genetic Diseases and Aplastic Anemias

---

A retrospective study by Gadalla and colleagues (2013) described results of 34 individuals with dyskeratosis congenita who underwent allogeneic HSCT between 1981 and 2009. The median age at transplantation was 13 years (range, 2-35). Approximately 50% of the transplants were from related donors. A total of 30 individuals achieved neutrophil recovery with a cumulative incidence of 73% by day 28. The day-100 probability of platelet recovery was 72%. The day-100 probability of grade II to IV acute GVHD and the 3-year probability of chronic GVHD were 24% and 37%, respectively. The 10-year probability of survival was 30% with 14 individuals alive at last follow-up. Twenty of the 34 (59%) died, and 10 deaths occurred within 4 months from transplantation because of graft failure (n=6) or other transplantation-related complications. Another 10 deaths occurred after 4 months; 6 of them occurred more than 5 years after transplantation, and 4 of these were due to pulmonary failure. Transplantation regimen intensity and transplantations from mismatched related or unrelated donors were associated with early mortality. Late mortality was attributed mainly to pulmonary complications and probably related to the underlying disease.

### *Immunodeficiency Disorders*

Allogeneic HSCT may provide correction of primary immunodeficiencies, a genetically heterogeneous group of diseases that affect distinct components of the immune system. Gennery and colleagues (2008) reported that results

---

Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage. The member's contract benefits in effect on the date that services are rendered must be used. Medical Policy, which addresses medical efficacy, should be considered before utilizing medical opinion in adjudication. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from the health plan.

© CPT Only – American Medical Association

The requirements below are specific to the Florida Medicaid Managed Care Plan and are not a part of the Medical Policy or Clinical UM guideline approved by Elevance Health's Medical Policy and Technology Assessment Committee.

**If the Florida Medicaid Managed Care Plan intends to deny coverage on the basis that a diagnostic test, therapeutic procedure, or medical device or technology is experimental or investigational, the Managed Care Plan shall submit a request for coverage determination to the Agency in accordance with rule 59G-1.035, F.A.C and Core SMMC Contract, Attachment II, Section VI.G.4.d.**

**Below is a list of the materials the plans are required to submit when they deny coverage as experimental/investigational:**

- A. **Include the CPT or HCPCS code(s)**
- B. **Include a list of other state Medicaid agencies and private insurers who cover the service**
- C. **Include information about the health service from the U.S. Food and Drug Administration**
- D. **Include known risks of the service and health outcomes of others who have received it**
- E. **Include a list of covered alternative services, if any, that could be used to treat the condition**
- F. **Identify a specific recipient needing the service**
- G. **Include the recipient's health history**
- H. **Include the disease information necessitating the requested service**
- I. **Include a rationale for the immediacy of the review**

### **Additional required information**

- A. **Submit the rationale used to preliminarily indicate the service is experimental/investigational**
  1. **Include peer-reviewed journal articles in PDF format with links to the online articles**
  2. **Include evidence-based clinical guidelines reviewed by the plan**
- B. **Submit direct contact information (name, phone number, & email address) for the Medical Director**

## Hematopoietic Stem Cell Transplantation for Genetic Diseases and Aplastic Anemias

---

of HSCT for primary immunodeficiencies have improved incrementally over time, with survival and cure of 90% for some defined diseases.

A rare and lethal autoimmunity disorder, immune dysregulation, polyendocrinopathy, enteropathy, X-linked (IPEX) syndrome is caused by mutations in the forkhead box P3 (FOXP3) gene. Successful allogeneic HSCT for IPEX syndrome has been described in the published literature consisting of mainly single case reports (Baud, 2001; Bis, 2015; Dorsey, 2009). Additionally, in 2007, Rao and colleagues described successful allogeneic HSCT in 4 individuals with IPEX syndrome using a reduced-intensity conditioning regimen that resulted in stable donor engraftment, reconstitution of FOXP3+ T regulatory CD4+ cells, and improvement of gastrointestinal symptoms.

### *Storage Disorders*

The mucopolysaccharidoses (MPS) form a group of inherited metabolic diseases caused by the absence or dysfunction of specific enzymes required to break down mucopolysaccharides, also called glycosaminoglycans. The glycosaminoglycans accumulate in most tissues and affect all body systems, including the central nervous system. Historically, allogeneic HSCT has been utilized, mostly as a treatment for Hurler syndrome (MPS I). However, a specialty consensus review supported the use of allogeneic HSCT for other MPS diseases.

---

Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage. The member's contract benefits in effect on the date that services are rendered must be used. Medical Policy, which addresses medical efficacy, should be considered before utilizing medical opinion in adjudication. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from the health plan.

© CPT Only – American Medical Association

The requirements below are specific to the Florida Medicaid Managed Care Plan and are not a part of the Medical Policy or Clinical UM guideline approved by Elevance Health's Medical Policy and Technology Assessment Committee.

**If the Florida Medicaid Managed Care Plan intends to deny coverage on the basis that a diagnostic test, therapeutic procedure, or medical device or technology is experimental or investigational, the Managed Care Plan shall submit a request for coverage determination to the Agency in accordance with rule 59G-1.035, F.A.C and Core SMMC Contract, Attachment II, Section VI.G.4.d.**

**Below is a list of the materials the plans are required to submit when they deny coverage as experimental/investigational:**

- A. Include the CPT or HCPCS code(s)**
- B. Include a list of other state Medicaid agencies and private insurers who cover the service**
- C. Include information about the health service from the U.S. Food and Drug Administration**
- D. Include known risks of the service and health outcomes of others who have received it**
- E. Include a list of covered alternative services, if any, that could be used to treat the condition**
- F. Identify a specific recipient needing the service**
- G. Include the recipient's health history**
- H. Include the disease information necessitating the requested service**
- I. Include a rationale for the immediacy of the review**

### **Additional required information**

- A. Submit the rationale used to preliminarily indicate the service is experimental/investigational**
  - 1. Include peer-reviewed journal articles in PDF format with links to the online articles**
  - 2. Include evidence-based clinical guidelines reviewed by the plan**
- B. Submit direct contact information (name, phone number, & email address) for the Medical Director**

## Hematopoietic Stem Cell Transplantation for Genetic Diseases and Aplastic Anemias

---

Hurler syndrome (MPS-I) is a lysosomal storage disease caused by an enzyme deficiency characterized by progressive multisystem morbidity and early childhood death if not treated. Aldenhoven and colleagues (2015) performed a retrospective analysis on the long-term outcomes of 217 individuals with Hurler syndrome treated with allogeneic HSCT. Study participants were successfully engrafted with a median follow-up age of 9.2 years. After transplantation, the clinical course of each subject improved; however, residual disease burden remained present in most cases. The authors noted that age at transplantation was an important predictor for better outcomes and early diagnosis and timely transplantation were of utmost importance.

Hunter syndrome (MPS II) is a rare X-linked recessive disorder that has an incidence estimated at 1.3 boys per 100,000 births (Guffon, 2008). Hunter Syndrome is characterized by mutations in the gene coding for the enzyme iduronate-2-sulphatase (IDS). Guffon (2008) reported long-term results 7 to 17 years after allogeneic hematopoietic stem cell transplant in a series of 8 individuals with varying severities of Hunter Syndrome. Seven of the 8 individuals were alive at the time of the last assessment. The only death was due to a non-transplant related cause. Two individuals with normal intelligence quotient (IQ) at the time of transplantation attained adulthood while maintaining normal IQ as well as social and scholastic development.

### *Leukodystrophies*

---

Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage. The member's contract benefits in effect on the date that services are rendered must be used. Medical Policy, which addresses medical efficacy, should be considered before utilizing medical opinion in adjudication. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from the health plan.

© CPT Only – American Medical Association

The requirements below are specific to the Florida Medicaid Managed Care Plan and are not a part of the Medical Policy or Clinical UM guideline approved by Elevance Health's Medical Policy and Technology Assessment Committee.

**If the Florida Medicaid Managed Care Plan intends to deny coverage on the basis that a diagnostic test, therapeutic procedure, or medical device or technology is experimental or investigational, the Managed Care Plan shall submit a request for coverage determination to the Agency in accordance with rule 59G-1.035, F.A.C and Core SMMC Contract, Attachment II, Section VI.G.4.d.**

**Below is a list of the materials the plans are required to submit when they deny coverage as experimental/investigational:**

- A. Include the CPT or HCPCS code(s)**
- B. Include a list of other state Medicaid agencies and private insurers who cover the service**
- C. Include information about the health service from the U.S. Food and Drug Administration**
- D. Include known risks of the service and health outcomes of others who have received it**
- E. Include a list of covered alternative services, if any, that could be used to treat the condition**
- F. Identify a specific recipient needing the service**
- G. Include the recipient's health history**
- H. Include the disease information necessitating the requested service**
- I. Include a rationale for the immediacy of the review**

### **Additional required information**

- A. Submit the rationale used to preliminarily indicate the service is experimental/investigational**
  - 1. Include peer-reviewed journal articles in PDF format with links to the online articles**
  - 2. Include evidence-based clinical guidelines reviewed by the plan**
- B. Submit direct contact information (name, phone number, & email address) for the Medical Director**



## Hematopoietic Stem Cell Transplantation for Genetic Diseases and Aplastic Anemias

---

Leukodystrophies have been defined as inherited metabolic disorders of myelin, resulting in progressive destruction of, or the failure to develop normal white matter (Berger, 2001). Orchard and colleagues (2010) reported that adrenoleukodystrophy is an X-linked disorder, and in approximately 40% of cases, a progressive, inflammatory condition develops in the central nervous system. Early in the course of the disease, allogeneic transplantation can arrest the disease process in cerebral adrenoleukodystrophy. Disease phenotype and the extent of disease at the time of transplantation are of fundamental importance in determining outcomes for globoid cell leukodystrophy (Krabbe's disease) and metachromatic leukodystrophy. Both diseases are similar in that they have a varied phenotype. Allogeneic HSCT is considered potentially beneficial for late onset juveniles and adults with metachromatic leukodystrophy in early stages of the disease (Batzios, 2012; Gieselmann, 2010). A small case series (de Hosson, 2011) indicates that allogeneic HSCT may stop progression of the disease in select individuals. Those with later onset globoid cell leukodystrophy in the early stages of the disease may also benefit from allogeneic HSCT (Orchard, 2010).

Cerebral adrenoleukodystrophy (CALD) is a rare and life-threatening hereditary neurological disorder. Early childhood cerebral forms of CALD (called cerebral adrenoleukodystrophy) represent approximately 35 percent of all phenotypes in the group of conditions referred to as ALD. Disease phenotype does not correlate with the type of

---

Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage. The member's contract benefits in effect on the date that services are rendered must be used. Medical Policy, which addresses medical efficacy, should be considered before utilizing medical opinion in adjudication. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from the health plan.

© CPT Only – American Medical Association

The requirements below are specific to the Florida Medicaid Managed Care Plan and are not a part of the Medical Policy or Clinical UM guideline approved by Elevance Health's Medical Policy and Technology Assessment Committee.

**If the Florida Medicaid Managed Care Plan intends to deny coverage on the basis that a diagnostic test, therapeutic procedure, or medical device or technology is experimental or investigational, the Managed Care Plan shall submit a request for coverage determination to the Agency in accordance with rule 59G-1.035, F.A.C and Core SMMC Contract, Attachment II, Section VI.G.4.d.**

**Below is a list of the materials the plans are required to submit when they deny coverage as experimental/investigational:**

- A. **Include the CPT or HCPCS code(s)**
- B. **Include a list of other state Medicaid agencies and private insurers who cover the service**
- C. **Include information about the health service from the U.S. Food and Drug Administration**
- D. **Include known risks of the service and health outcomes of others who have received it**
- E. **Include a list of covered alternative services, if any, that could be used to treat the condition**
- F. **Identify a specific recipient needing the service**
- G. **Include the recipient's health history**
- H. **Include the disease information necessitating the requested service**
- I. **Include a rationale for the immediacy of the review**

### **Additional required information**

- A. **Submit the rationale used to preliminarily indicate the service is experimental/investigational**
  1. **Include peer-reviewed journal articles in PDF format with links to the online articles**
  2. **Include evidence-based clinical guidelines reviewed by the plan**
- B. **Submit direct contact information (name, phone number, & email address) for the Medical Director**

## Hematopoietic Stem Cell Transplantation for Genetic Diseases and Aplastic Anemias

---

mutation, and different phenotypes can be seen within the same family. The result of the faulty gene is toxic buildup of VLCFAs, predominantly in the adrenal glands, brain, and spinal cord leading to loss of myelin sheath in the nerves and degeneration of function in the adrenal glands and central and peripheral nervous systems. Due to the X-linked nature of the disease, males (X-chromosome hemizygotes) are predominantly affected. Early symptoms of CALD may not be easily detected and may include adrenal insufficiency or behavioral problems. As the disease progresses, more severe symptoms arise, including vision and hearing problems/loss, seizures, swallowing problems, loss of voluntary and involuntary motor function, followed by death. Decline in intellectual abilities is also common. The 5-year survival rate is approximately 50% if untreated.

Prior to the FDA approval of elivaldogene autotemcel, the only available disease-modifying treatment for CALD was HSCT, which involves the transfer of blood stem cells from a genetically matched donor. Such treatment has been reported to provide stabilization of neurologic symptoms but has serious potential complications such as GVHD and graft failure, and matched donors are frequently unavailable. For individuals with CALD who undergo successful HSCT at an early stage of disease, five-year survival is greater than 90 percent. HSCT does not appear to affect the course of adrenal dysfunction in patients with ALD, so patients require ongoing monitoring for adrenal dysfunction, and treatment, if necessary. HSCT is not recommended in individuals without MRI evidence of cerebral involvement, given that approximately one-half of these individuals will remain free of cerebral disease.

---

Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage. The member's contract benefits in effect on the date that services are rendered must be used. Medical Policy, which addresses medical efficacy, should be considered before utilizing medical opinion in adjudication. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from the health plan.

© CPT Only – American Medical Association

The requirements below are specific to the Florida Medicaid Managed Care Plan and are not a part of the Medical Policy or Clinical UM guideline approved by Elevance Health's Medical Policy and Technology Assessment Committee.

**If the Florida Medicaid Managed Care Plan intends to deny coverage on the basis that a diagnostic test, therapeutic procedure, or medical device or technology is experimental or investigational, the Managed Care Plan shall submit a request for coverage determination to the Agency in accordance with rule 59G-1.035, F.A.C and Core SMMC Contract, Attachment II, Section VI.G.4.d.**

**Below is a list of the materials the plans are required to submit when they deny coverage as experimental/investigational:**

- A. Include the CPT or HCPCS code(s)**
- B. Include a list of other state Medicaid agencies and private insurers who cover the service**
- C. Include information about the health service from the U.S. Food and Drug Administration**
- D. Include known risks of the service and health outcomes of others who have received it**
- E. Include a list of covered alternative services, if any, that could be used to treat the condition**
- F. Identify a specific recipient needing the service**
- G. Include the recipient's health history**
- H. Include the disease information necessitating the requested service**
- I. Include a rationale for the immediacy of the review**

### **Additional required information**

- A. Submit the rationale used to preliminarily indicate the service is experimental/investigational**
  - 1. Include peer-reviewed journal articles in PDF format with links to the online articles**
  - 2. Include evidence-based clinical guidelines reviewed by the plan**
- B. Submit direct contact information (name, phone number, & email address) for the Medical Director**

## Hematopoietic Stem Cell Transplantation for Genetic Diseases and Aplastic Anemias

---

HCST is also not recommended in individuals with advanced disease given that available evidence suggests that HCST does not improve clinical outcomes in these individuals. Management of patients with advanced cerebral involvement is primarily supportive.

To address CALD, bluebird bio, Inc. (Somerville, MA) has developed a new gene replacement therapy product, elivaldogene autotemcel (Skysona®). This product is composed of genetically modified autologous CD34+ cells that have been altered to include the wild-type ABCD1 DNA. This product is custom manufactured for each recipient using their own hematopoietic stem cells, which are harvested after mobilization, (a period of treatment intended to increase the desired type of cells used in the process). Once the cells have been collected, the individual undergoes full myeloablative conditioning to eliminate their existing hematopoietic system with the intention of replacing it with the new modified cells. The modified cells are infused into the individual and are intended to engraft into the bone marrow and create new stem cells, some of those cells migrate to the nervous system and adrenal glands, where they are intended to produce functional ALDP to locally breakdown VLCFAs and stabilize the treated individual's condition. The result of this type of treatment is intended to be life-long, but robust long-term data are not available at this time. Individuals undergoing treatment with elivaldogene autotemcel require long-term, regular monitoring for treatment success and for the evaluation of potential adverse events. Like HCST,

---

Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage. The member's contract benefits in effect on the date that services are rendered must be used. Medical Policy, which addresses medical efficacy, should be considered before utilizing medical opinion in adjudication. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from the health plan.

© CPT Only – American Medical Association

The requirements below are specific to the Florida Medicaid Managed Care Plan and are not a part of the Medical Policy or Clinical UM guideline approved by Elevance Health's Medical Policy and Technology Assessment Committee.

**If the Florida Medicaid Managed Care Plan intends to deny coverage on the basis that a diagnostic test, therapeutic procedure, or medical device or technology is experimental or investigational, the Managed Care Plan shall submit a request for coverage determination to the Agency in accordance with rule 59G-1.035, F.A.C and Core SMMC Contract, Attachment II, Section VI.G.4.d.**

**Below is a list of the materials the plans are required to submit when they deny coverage as experimental/investigational:**

- A. Include the CPT or HCPCS code(s)**
- B. Include a list of other state Medicaid agencies and private insurers who cover the service**
- C. Include information about the health service from the U.S. Food and Drug Administration**
- D. Include known risks of the service and health outcomes of others who have received it**
- E. Include a list of covered alternative services, if any, that could be used to treat the condition**
- F. Identify a specific recipient needing the service**
- G. Include the recipient's health history**
- H. Include the disease information necessitating the requested service**
- I. Include a rationale for the immediacy of the review**

### **Additional required information**

- A. Submit the rationale used to preliminarily indicate the service is experimental/investigational**
  - 1. Include peer-reviewed journal articles in PDF format with links to the online articles**
  - 2. Include evidence-based clinical guidelines reviewed by the plan**
- B. Submit direct contact information (name, phone number, & email address) for the Medical Director**

## Hematopoietic Stem Cell Transplantation for Genetic Diseases and Aplastic Anemias

elivaldogene autotemcel does not treat or prevent adrenal insufficiency. For more information on gene replacement therapy for CALD, see MED.00142 Gene Therapy for Cerebral Adrenoleukodystrophy.

### *Hemoglobinopathies*

Early reports of allogeneic HSCT for sickle cell disease (Walters, 1996; Walters, 2000) describe treatment results of 48 children, less than 16 years of age. Results from the two reports were similar with overall survival rates ranging from 91%-94% and event-free survival from 73%-84% with a median follow-up ranging from 23.9 months to 57.9 months post transplantation. Vermynen and colleagues (1997) described a European study of 50 individuals with sickle cell anemia who underwent transplantation of hematopoietic stem cells (bone marrow, 48; cord blood, 2). Two individuals (17 and 23 years old) did not fulfill the age criteria (less than 16 years), but still underwent transplant. Overall survival and event free survival at 11 years were 93% and 82%, respectively.

Bernaudin and colleagues (2007) reported on the largest experience as of that time related to allogeneic HSCT for sickle cell disease. Between November 1988 and December 2004, 87 individuals (age range, 2 to 22 years), received donor allografts from siblings after a myeloablative conditioning regimen (CR). The only change in the CR during the study period was the introduction of ATG in March 1992. The rejection rate was 22.6% before the use of ATG but 3% thereafter. With a median follow-up of 6 years (range, 2.0 to 17.9 years), the overall and event-

---

Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage. The member's contract benefits in effect on the date that services are rendered must be used. Medical Policy, which addresses medical efficacy, should be considered before utilizing medical opinion in adjudication. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from the health plan.

© CPT Only – American Medical Association

The requirements below are specific to the Florida Medicaid Managed Care Plan and are not a part of the Medical Policy or Clinical UM guideline approved by Elevance Health's Medical Policy and Technology Assessment Committee.

**If the Florida Medicaid Managed Care Plan intends to deny coverage on the basis that a diagnostic test, therapeutic procedure, or medical device or technology is experimental or investigational, the Managed Care Plan shall submit a request for coverage determination to the Agency in accordance with rule 59G-1.035, F.A.C and Core SMMC Contract, Attachment II, Section VI.G.4.d.**

**Below is a list of the materials the plans are required to submit when they deny coverage as experimental/investigational:**

- A. **Include the CPT or HCPCS code(s)**
- B. **Include a list of other state Medicaid agencies and private insurers who cover the service**
- C. **Include information about the health service from the U.S. Food and Drug Administration**
- D. **Include known risks of the service and health outcomes of others who have received it**
- E. **Include a list of covered alternative services, if any, that could be used to treat the condition**
- F. **Identify a specific recipient needing the service**
- G. **Include the recipient's health history**
- H. **Include the disease information necessitating the requested service**
- I. **Include a rationale for the immediacy of the review**

### **Additional required information**

- A. **Submit the rationale used to preliminarily indicate the service is experimental/investigational**
  1. **Include peer-reviewed journal articles in PDF format with links to the online articles**
  2. **Include evidence-based clinical guidelines reviewed by the plan**
- B. **Submit direct contact information (name, phone number, & email address) for the Medical Director**

## Hematopoietic Stem Cell Transplantation for Genetic Diseases and Aplastic Anemias

---

free survival rates were 93.1% and 86.1%, respectively. There were 6 transplant related deaths reported with the cause being graft versus host (GVHD) in 4 of these individuals. None of the cord blood transplant recipients developed GVHD. Since 2000, there have been no deaths and only 2 graft rejections among 44 individuals. The authors also reported that since January 2000, 5 individuals over 15 years of age have successfully received transplants.

Hsieh and colleagues (2009) conducted a phase 1-2 study aimed to determine the feasibility of non-myeloablative allogeneic HSCT for adults with severe sickle cell disease. Ten adults (age range, 16 to 45 years) with severe sickle cell disease underwent non-myeloablative transplantation with peripheral-blood stem cells which were obtained from HLA-matched siblings. From the 10 individuals transplanted, only 2 persons were age 40 or over, with the remaining 8 ranging from 16-27 years of age. All 10 individuals were alive and there were no cases of GVHD at a median follow-up of 30 months post transplantation. The authors reported that successful engraftment occurred in 9 of the 10 adults. Study limitations included a small sample size.

Oringanje and colleagues (2020) performed a Cochrane review examining whether stem cell transplantation improves survival and prevents symptoms and complications associated with sickle cell disease. No randomized controlled trials assessing the benefit or risk of HSCTs were found and as such, the authors could not make

---

Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage. The member's contract benefits in effect on the date that services are rendered must be used. Medical Policy, which addresses medical efficacy, should be considered before utilizing medical opinion in adjudication. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from the health plan.

© CPT Only – American Medical Association

The requirements below are specific to the Florida Medicaid Managed Care Plan and are not a part of the Medical Policy or Clinical UM guideline approved by Elevance Health's Medical Policy and Technology Assessment Committee.

**If the Florida Medicaid Managed Care Plan intends to deny coverage on the basis that a diagnostic test, therapeutic procedure, or medical device or technology is experimental or investigational, the Managed Care Plan shall submit a request for coverage determination to the Agency in accordance with rule 59G-1.035, F.A.C and Core SMMC Contract, Attachment II, Section VI.G.4.d.**

**Below is a list of the materials the plans are required to submit when they deny coverage as experimental/investigational:**

- A. Include the CPT or HCPCS code(s)**
- B. Include a list of other state Medicaid agencies and private insurers who cover the service**
- C. Include information about the health service from the U.S. Food and Drug Administration**
- D. Include known risks of the service and health outcomes of others who have received it**
- E. Include a list of covered alternative services, if any, that could be used to treat the condition**
- F. Identify a specific recipient needing the service**
- G. Include the recipient's health history**
- H. Include the disease information necessitating the requested service**
- I. Include a rationale for the immediacy of the review**

### **Additional required information**

- A. Submit the rationale used to preliminarily indicate the service is experimental/investigational**
  - 1. Include peer-reviewed journal articles in PDF format with links to the online articles**
  - 2. Include evidence-based clinical guidelines reviewed by the plan**
- B. Submit direct contact information (name, phone number, & email address) for the Medical Director**

## Hematopoietic Stem Cell Transplantation for Genetic Diseases and Aplastic Anemias

---

recommendations for or against the procedure. Despite the lack of randomized trials, case series and observational reports have demonstrated improved overall survival and event free survival rates for allogeneic HSCT in certain individuals with sickle cell disease.

Allogeneic HSCT has been available as a potentially curative treatment of beta thalassemia for several decades. This involves the transplantation of stem cells from the donor's bone marrow or peripheral blood cells, and essentially involves replacing defective genes with healthy genes from another individual. Allogeneic HSCT is most effective when it is performed early in the course of disease before individuals experience complications related to transfusions or iron overload, ideally before 14 years of age. Survival rates of 90% or higher for early allogeneic HSCT have been reported. The decision to pursue HSCT is influenced by the availability of a well-matched donor; while the presence of human leukocyte antigen [HLA]-identical sibling donor is considered optimal, registry data has found similar survival outcomes in individuals who received HLA-matched related and HLA-matched unrelated donor transplantation (Li, 2019). Recent experiences evaluating transplantation with haploidentical donors in individuals with transfusion-dependent beta thalassemia have reported promising outcomes (Sun, 2018). HCT outcomes from the European Group for Blood and Marrow Transplantation registry database on 1493 individuals with beta thalassemia major transplanted after year 2000 found an overall survival for the whole

---

Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage. The member's contract benefits in effect on the date that services are rendered must be used. Medical Policy, which addresses medical efficacy, should be considered before utilizing medical opinion in adjudication. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from the health plan.

© CPT Only – American Medical Association

The requirements below are specific to the Florida Medicaid Managed Care Plan and are not a part of the Medical Policy or Clinical UM guideline approved by Elevance Health's Medical Policy and Technology Assessment Committee.

**If the Florida Medicaid Managed Care Plan intends to deny coverage on the basis that a diagnostic test, therapeutic procedure, or medical device or technology is experimental or investigational, the Managed Care Plan shall submit a request for coverage determination to the Agency in accordance with rule 59G-1.035, F.A.C and Core SMMC Contract, Attachment II, Section VI.G.4.d.**

**Below is a list of the materials the plans are required to submit when they deny coverage as experimental/investigational:**

- A. Include the CPT or HCPCS code(s)**
- B. Include a list of other state Medicaid agencies and private insurers who cover the service**
- C. Include information about the health service from the U.S. Food and Drug Administration**
- D. Include known risks of the service and health outcomes of others who have received it**
- E. Include a list of covered alternative services, if any, that could be used to treat the condition**
- F. Identify a specific recipient needing the service**
- G. Include the recipient's health history**
- H. Include the disease information necessitating the requested service**
- I. Include a rationale for the immediacy of the review**

### **Additional required information**

- A. Submit the rationale used to preliminarily indicate the service is experimental/investigational**
  - 1. Include peer-reviewed journal articles in PDF format with links to the online articles**
  - 2. Include evidence-based clinical guidelines reviewed by the plan**
- B. Submit direct contact information (name, phone number, & email address) for the Medical Director**

## Hematopoietic Stem Cell Transplantation for Genetic Diseases and Aplastic Anemias

---

cohort at two years of 88% (range 68 to 91%) (Baronciani, 2016). Potential complications of HSCT include graft rejection and GVHD (Srivastava, 2017).

Gene replacement therapy is another potential curative treatment for beta thalassemia. Betibeglogene autotemcel (Zynteglo, Bluebird Bio) gene therapy involves inserting a functional copy of the HBB gene into a patient's hematopoietic stem cells outside the body using a lentiviral vector and then transplanting the modified stem cells back into the patient's blood stream, with the aim that the functional HBB gene will result in normal beta-globin protein expression. Zynteglo is a one-time gene therapy product that is administered as a single dose. While Zynteglo gene replacement therapy is not an autologous HSCT, it does require patients to undergo hematopoietic stem cell (HSC) mobilization followed by pheresis to obtain CD34+ cells for Zynteglo manufacturing (as well as administration of full myeloablative conditioning before infusion of Zynteglo) (U.S. FDA, 2022).

The safety and effectiveness of Zynteglo were demonstrated in two multicenter clinical studies that included adult and pediatric subjects with beta thalassemia requiring regular transfusions. Effectiveness was established based on achieving transfusion independence, which is attained when the patient maintains a pre-determined level of hemoglobin without needing any red blood cell transfusions for at least 12 months. Of 41 participants receiving Zynteglo, 89% achieved transfusion independence (U.S. FDA, 2022).

---

Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage. The member's contract benefits in effect on the date that services are rendered must be used. Medical Policy, which addresses medical efficacy, should be considered before utilizing medical opinion in adjudication. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from the health plan.

© CPT Only – American Medical Association

The requirements below are specific to the Florida Medicaid Managed Care Plan and are not a part of the Medical Policy or Clinical UM guideline approved by Elevance Health's Medical Policy and Technology Assessment Committee.

**If the Florida Medicaid Managed Care Plan intends to deny coverage on the basis that a diagnostic test, therapeutic procedure, or medical device or technology is experimental or investigational, the Managed Care Plan shall submit a request for coverage determination to the Agency in accordance with rule 59G-1.035, F.A.C and Core SMMC Contract, Attachment II, Section VI.G.4.d.**

**Below is a list of the materials the plans are required to submit when they deny coverage as experimental/investigational:**

- A. Include the CPT or HCPCS code(s)**
- B. Include a list of other state Medicaid agencies and private insurers who cover the service**
- C. Include information about the health service from the U.S. Food and Drug Administration**
- D. Include known risks of the service and health outcomes of others who have received it**
- E. Include a list of covered alternative services, if any, that could be used to treat the condition**
- F. Identify a specific recipient needing the service**
- G. Include the recipient's health history**
- H. Include the disease information necessitating the requested service**
- I. Include a rationale for the immediacy of the review**

### **Additional required information**

- A. Submit the rationale used to preliminarily indicate the service is experimental/investigational**
  - 1. Include peer-reviewed journal articles in PDF format with links to the online articles**
  - 2. Include evidence-based clinical guidelines reviewed by the plan**
- B. Submit direct contact information (name, phone number, & email address) for the Medical Director**

## Hematopoietic Stem Cell Transplantation for Genetic Diseases and Aplastic Anemias

---

The use of autologous stem cells in gene replacement therapy removes the need for a compatible stem cell donor which has limited the ability of individuals to receive allogeneic SCT. For more information on gene replacement therapy for Beta Thalassemia, see MED.00140 Gene Therapy for Beta Thalassemia.

### *Infantile Malignant Osteopetrosis*

Driessen and colleagues (2003) retrospectively analyzed 122 children who had received an allogeneic HSCT for autosomal recessive osteopetrosis between 1980 and 2001. The actuarial probabilities of 5 years of disease free survival were 73% for recipients of a genotype HLA-identical HSCT (n=40), 43% for recipients of a phenotype HLA-identical or 1 HLA-antigen mismatch graft from a related donor (n=21), 40% for recipients of a graft from a matched unrelated donor (n=20) and 24% for those who received a graft from an HLA-haplotype-mismatch related donor (n=41). In the latter group, a trend towards improvement was achieved at the end of the study period (17% before 1994, 45% after 1994, P=0.11). Causes of death after transplant were graft failure and early transplant-related complications. Conservation of vision was better in children transplanted before the age of 3 months. Final height was related to height at the time of transplant and better preserved in children transplanted early. Most children attended regular school or education for the visually handicapped. The authors noted that, at present, allogeneic HSCT is the only curative treatment for this rare, usually fatal, congenital disease.

---

Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage. The member's contract benefits in effect on the date that services are rendered must be used. Medical Policy, which addresses medical efficacy, should be considered before utilizing medical opinion in adjudication. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from the health plan.

© CPT Only – American Medical Association

The requirements below are specific to the Florida Medicaid Managed Care Plan and are not a part of the Medical Policy or Clinical UM guideline approved by Elevance Health's Medical Policy and Technology Assessment Committee.

**If the Florida Medicaid Managed Care Plan intends to deny coverage on the basis that a diagnostic test, therapeutic procedure, or medical device or technology is experimental or investigational, the Managed Care Plan shall submit a request for coverage determination to the Agency in accordance with rule 59G-1.035, F.A.C and Core SMMC Contract, Attachment II, Section VI.G.4.d.**

**Below is a list of the materials the plans are required to submit when they deny coverage as experimental/investigational:**

- A. Include the CPT or HCPCS code(s)
- B. Include a list of other state Medicaid agencies and private insurers who cover the service
- C. Include information about the health service from the U.S. Food and Drug Administration
- D. Include known risks of the service and health outcomes of others who have received it
- E. Include a list of covered alternative services, if any, that could be used to treat the condition
- F. Identify a specific recipient needing the service
- G. Include the recipient's health history
- H. Include the disease information necessitating the requested service
- I. Include a rationale for the immediacy of the review

### **Additional required information**

- A. Submit the rationale used to preliminarily indicate the service is experimental/investigational
  1. Include peer-reviewed journal articles in PDF format with links to the online articles
  2. Include evidence-based clinical guidelines reviewed by the plan
- B. Submit direct contact information (name, phone number, & email address) for the Medical Director



## Hematopoietic Stem Cell Transplantation for Genetic Diseases and Aplastic Anemias

---

### *Other Autosomal Recessive Disorders*

Other autosomal recessive disorders that have been treated with allogeneic HSCT are leukocyte adhesion deficiencies and Kostmann's syndrome (severe congenital neutropenia, infantile genetic agranulocytosis).

Etzioni (2007) reported that individuals with leukocyte adhesion deficiencies suffer from life threatening bacterial infections, and in its severe form, death usually occurs in early childhood unless allogeneic stem cell transplantation is performed. Carlsson and colleagues (2011) reported that allogeneic HSCT is the only curative treatment for severe congenital neutropenia.

### *Cystic Fibrosis*

In 2004, Spencer and Jaffe hypothesized about the use of autologous umbilical cord hematopoietic stem cell transplant and gene therapy to treat cystic fibrosis. However, there have been no prospective randomized trials to assess the efficacy and safety to support the use of stem cell transplantation for this indication.

### *Poor Graft Function*

---

Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage. The member's contract benefits in effect on the date that services are rendered must be used. Medical Policy, which addresses medical efficacy, should be considered before utilizing medical opinion in adjudication. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from the health plan.

© CPT Only – American Medical Association

The requirements below are specific to the Florida Medicaid Managed Care Plan and are not a part of the Medical Policy or Clinical UM guideline approved by Elevance Health's Medical Policy and Technology Assessment Committee.

**If the Florida Medicaid Managed Care Plan intends to deny coverage on the basis that a diagnostic test, therapeutic procedure, or medical device or technology is experimental or investigational, the Managed Care Plan shall submit a request for coverage determination to the Agency in accordance with rule 59G-1.035, F.A.C and Core SMMC Contract, Attachment II, Section VI.G.4.d.**

**Below is a list of the materials the plans are required to submit when they deny coverage as experimental/investigational:**

- A. Include the CPT or HCPCS code(s)**
- B. Include a list of other state Medicaid agencies and private insurers who cover the service**
- C. Include information about the health service from the U.S. Food and Drug Administration**
- D. Include known risks of the service and health outcomes of others who have received it**
- E. Include a list of covered alternative services, if any, that could be used to treat the condition**
- F. Identify a specific recipient needing the service**
- G. Include the recipient's health history**
- H. Include the disease information necessitating the requested service**
- I. Include a rationale for the immediacy of the review**

### **Additional required information**

- A. Submit the rationale used to preliminarily indicate the service is experimental/investigational**
  - 1. Include peer-reviewed journal articles in PDF format with links to the online articles**
  - 2. Include evidence-based clinical guidelines reviewed by the plan**
- B. Submit direct contact information (name, phone number, & email address) for the Medical Director**

## Hematopoietic Stem Cell Transplantation for Genetic Diseases and Aplastic Anemias

---

Poor graft function or graft failure is one of the major causes of morbidity and mortality after HSCT. Poor graft function is defined as slow or incomplete recovery of blood cell counts following a stem cell transplant or decreasing blood counts after initially successful hematopoietic engraftment following a stem cell transplant. There are various options for the management of poor graft function. Stem cell "boost" is a non-standardized term that is used to describe an infusion of additional hematopoietic stem cells to an individual who has undergone recent HSCT and has poor graft function (Larocca, 2006). The infusion of additional hematopoietic stem cells is to mitigate either graft failure or rejection with or without immunosuppression. This process may include the collection of additional hematopoietic stem cells from a donor and infusion into the transplant recipient. Note that a "boost" is distinct from a repeat transplant and that there may be separate medical necessity criteria for a repeat transplant.

### *Other Considerations*

In 2015, the American Society for Blood and Marrow Transplantation (Majhail and colleagues) issued guidelines on indications for autologous and allogeneic hematopoietic cell transplantation. Definitions used for classifying indications were: standard of care (S); standard of care, clinical evidence available (C); standard of care, rare indication (R); Developmental (D); and not generally recommended (N). Nonmalignant indications for

---

Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage. The member's contract benefits in effect on the date that services are rendered must be used. Medical Policy, which addresses medical efficacy, should be considered before utilizing medical opinion in adjudication. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from the health plan.

© CPT Only – American Medical Association

The requirements below are specific to the Florida Medicaid Managed Care Plan and are not a part of the Medical Policy or Clinical UM guideline approved by Elevance Health's Medical Policy and Technology Assessment Committee.

**If the Florida Medicaid Managed Care Plan intends to deny coverage on the basis that a diagnostic test, therapeutic procedure, or medical device or technology is experimental or investigational, the Managed Care Plan shall submit a request for coverage determination to the Agency in accordance with rule 59G-1.035, F.A.C and Core SMMC Contract, Attachment II, Section VI.G.4.d.**

**Below is a list of the materials the plans are required to submit when they deny coverage as experimental/investigational:**

- A. **Include the CPT or HCPCS code(s)**
- B. **Include a list of other state Medicaid agencies and private insurers who cover the service**
- C. **Include information about the health service from the U.S. Food and Drug Administration**
- D. **Include known risks of the service and health outcomes of others who have received it**
- E. **Include a list of covered alternative services, if any, that could be used to treat the condition**
- F. **Identify a specific recipient needing the service**
- G. **Include the recipient's health history**
- H. **Include the disease information necessitating the requested service**
- I. **Include a rationale for the immediacy of the review**

### **Additional required information**

- A. **Submit the rationale used to preliminarily indicate the service is experimental/investigational**
  1. **Include peer-reviewed journal articles in PDF format with links to the online articles**
  2. **Include evidence-based clinical guidelines reviewed by the plan**
- B. **Submit direct contact information (name, phone number, & email address) for the Medical Director**

## Hematopoietic Stem Cell Transplantation for Genetic Diseases and Aplastic Anemias

---

hematopoietic cell transplantation in “pediatric patients” (generally age below 18 years of age) include the following classifications:

- Severe aplastic anemia, new diagnosis (S for allogeneic and N for autologous)
  - Severe aplastic anemia, relapse/refractory (S for allogeneic and N for autologous)
  - Fanconi’s anemia (R for allogeneic and N for autologous)
  - Dyskeratosis congenita (R for allogeneic and N for autologous)
  - Blackfan-Diamond anemia (R for allogeneic and N for autologous)
  - Sickle cell disease (C for allogeneic and N for autologous)
  - Thalassemia (S for allogeneic and N for autologous)
  - Congenital amegakaryocytic thrombocytopenia (R for allogeneic and N for autologous)
  - Severe combined immune deficiency (R for allogeneic and N for autologous)
  - T cell immunodeficiency, SCID variants (R for allogeneic and N for autologous)
  - Wiskott-Aldrich syndrome (R for allogeneic and N for autologous)
  - Hemophagocytic disorders (R for allogeneic and N for autologous)
  - Lymphoproliferative disorders (R for allogeneic and N for autologous)
  - Severe congenital neutropenia (R for allogeneic and N for autologous)
- 

Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage. The member’s contract benefits in effect on the date that services are rendered must be used. Medical Policy, which addresses medical efficacy, should be considered before utilizing medical opinion in adjudication. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from the health plan.

© CPT Only – American Medical Association

The requirements below are specific to the Florida Medicaid Managed Care Plan and are not a part of the Medical Policy or Clinical UM guideline approved by Elevance Health’s Medical Policy and Technology Assessment Committee.

**If the Florida Medicaid Managed Care Plan intends to deny coverage on the basis that a diagnostic test, therapeutic procedure, or medical device or technology is experimental or investigational, the Managed Care Plan shall submit a request for coverage determination to the Agency in accordance with rule 59G-1.035, F.A.C and Core SMMC Contract, Attachment II, Section VI.G.4.d.**

**Below is a list of the materials the plans are required to submit when they deny coverage as experimental/investigational:**

- A. **Include the CPT or HCPCS code(s)**
- B. **Include a list of other state Medicaid agencies and private insurers who cover the service**
- C. **Include information about the health service from the U.S. Food and Drug Administration**
- D. **Include known risks of the service and health outcomes of others who have received it**
- E. **Include a list of covered alternative services, if any, that could be used to treat the condition**
- F. **Identify a specific recipient needing the service**
- G. **Include the recipient’s health history**
- H. **Include the disease information necessitating the requested service**
- I. **Include a rationale for the immediacy of the review**

### **Additional required information**

- A. **Submit the rationale used to preliminarily indicate the service is experimental/investigational**
  1. **Include peer-reviewed journal articles in PDF format with links to the online articles**
  2. **Include evidence-based clinical guidelines reviewed by the plan**
- B. **Submit direct contact information (name, phone number, & email address) for the Medical Director**

## Hematopoietic Stem Cell Transplantation for Genetic Diseases and Aplastic Anemias

---

- Chronic granulomatous disease (R for allogeneic and N for autologous)
- Other phagocytic cell disorders (R for allogeneic and N for autologous)
- IPEX syndrome (R for allogeneic and N for autologous)
- Juvenile rheumatoid arthritis (D for allogeneic and R for autologous)
- Systemic sclerosis (D for allogeneic and R for autologous)
- Other autoimmune and immune dysregulation disorders (R for allogeneic and N for autologous)
- Mucopolysaccharoidoses (MPS-1 and MPS-V1) (R for allogeneic and N for autologous)
- Other metabolic diseases (R for allogeneic and N for autologous)
- Osteopetrosis (R for allogeneic and N for autologous)
- Globoid cell leukodystrophy (Krabbe) (R for allogeneic and N for autologous)
- Metachromatic leukodystrophy (R for allogeneic and N for autologous)
- Cerebral X-linked adrenoleukodystrophy (R for allogeneic and N for autologous)

Nonmalignant indications for hematopoietic cell transplantation in adults (generally age 18 years or greater) include the following classifications:

- Severe aplastic anemia, new diagnosis (S for allogeneic and N for autologous)
- 

Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage. The member's contract benefits in effect on the date that services are rendered must be used. Medical Policy, which addresses medical efficacy, should be considered before utilizing medical opinion in adjudication. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from the health plan.

© CPT Only – American Medical Association

The requirements below are specific to the Florida Medicaid Managed Care Plan and are not a part of the Medical Policy or Clinical UM guideline approved by Elevance Health's Medical Policy and Technology Assessment Committee.

**If the Florida Medicaid Managed Care Plan intends to deny coverage on the basis that a diagnostic test, therapeutic procedure, or medical device or technology is experimental or investigational, the Managed Care Plan shall submit a request for coverage determination to the Agency in accordance with rule 59G-1.035, F.A.C and Core SMMC Contract, Attachment II, Section VI.G.4.d.**

**Below is a list of the materials the plans are required to submit when they deny coverage as experimental/investigational:**

- A. Include the CPT or HCPCS code(s)**
- B. Include a list of other state Medicaid agencies and private insurers who cover the service**
- C. Include information about the health service from the U.S. Food and Drug Administration**
- D. Include known risks of the service and health outcomes of others who have received it**
- E. Include a list of covered alternative services, if any, that could be used to treat the condition**
- F. Identify a specific recipient needing the service**
- G. Include the recipient's health history**
- H. Include the disease information necessitating the requested service**
- I. Include a rationale for the immediacy of the review**

### **Additional required information**

- A. Submit the rationale used to preliminarily indicate the service is experimental/investigational**
  - 1. Include peer-reviewed journal articles in PDF format with links to the online articles**
  - 2. Include evidence-based clinical guidelines reviewed by the plan**
- B. Submit direct contact information (name, phone number, & email address) for the Medical Director**

## Hematopoietic Stem Cell Transplantation for Genetic Diseases and Aplastic Anemias

---

- Severe aplastic anemia, relapse/refractory (S for allogeneic and N for autologous)
  - Fanconi's anemia (R for allogeneic and N for autologous)
  - Dyskeratosis congenita (R for allogeneic and N for autologous)
  - Sickle cell disease (C for allogeneic and N for autologous)
  - Thalassemia (D for allogeneic and N for autologous)
  - Hemophagocytic syndromes, refractory (R for allogeneic and N for autologous)
  - Mast cell diseases (R for allogeneic and N for autologous)
  - Common variable immunodeficiency (R for allogeneic and N for autologous)
  - Wiskott-Aldrich syndrome (R for allogeneic and N for autologous)
  - Chronic granulomatous disease (R for allogeneic and N for autologous)
  - Multiple sclerosis (N for allogeneic and D for autologous)
  - Systemic sclerosis (N for allogeneic and D for autologous)
  - Rheumatoid arthritis (N for allogeneic and D for autologous)
  - Systemic lupus erythematosus (N for allogeneic and D for autologous)
  - Crohn's disease (N for allogeneic and D for autologous)
  - Polymyositis-dermatomyositis (N for allogeneic and D for autologous)
- 

Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage. The member's contract benefits in effect on the date that services are rendered must be used. Medical Policy, which addresses medical efficacy, should be considered before utilizing medical opinion in adjudication. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from the health plan.

© CPT Only – American Medical Association

The requirements below are specific to the Florida Medicaid Managed Care Plan and are not a part of the Medical Policy or Clinical UM guideline approved by Elevance Health's Medical Policy and Technology Assessment Committee.

**If the Florida Medicaid Managed Care Plan intends to deny coverage on the basis that a diagnostic test, therapeutic procedure, or medical device or technology is experimental or investigational, the Managed Care Plan shall submit a request for coverage determination to the Agency in accordance with rule 59G-1.035, F.A.C and Core SMMC Contract, Attachment II, Section VI.G.4.d.**

**Below is a list of the materials the plans are required to submit when they deny coverage as experimental/investigational:**

- Include the CPT or HCPCS code(s)**
- Include a list of other state Medicaid agencies and private insurers who cover the service**
- Include information about the health service from the U.S. Food and Drug Administration**
- Include known risks of the service and health outcomes of others who have received it**
- Include a list of covered alternative services, if any, that could be used to treat the condition**
- Identify a specific recipient needing the service**
- Include the recipient's health history**
- Include the disease information necessitating the requested service**
- Include a rationale for the immediacy of the review**

### **Additional required information**

- Submit the rationale used to preliminarily indicate the service is experimental/investigational**
  - Include peer-reviewed journal articles in PDF format with links to the online articles**
  - Include evidence-based clinical guidelines reviewed by the plan**
- Submit direct contact information (name, phone number, & email address) for the Medical Director**

## Hematopoietic Stem Cell Transplantation for Genetic Diseases and Aplastic Anemias

---

### Conclusion

At this time there is a lack of evidence in the peer-reviewed medical literature, in terms of long-term safety and efficacy, to support the use of HSCT, for the indications listed above as investigational and not medically necessary. Additional study demonstrating improved outcomes is needed.

### Background/Overview

Over the years, there has been a growing body of literature describing the application of allogeneic hematopoietic blood cell transplantation to correct genetic disorders and aplastic anemias. For certain genetic diseases and aplastic anemia, allogeneic hematopoietic blood cell transplantation may provide a potential treatment option.

Aplastic anemia is a rare, non-contagious disease that occurs when the bone marrow is damaged and stops making a sufficient quantity of blood cells for the body's needs. Aplastic anemia may be acquired or inherited, with the most commonly occurring being the acquired type. Most often, inherited aplastic anemias are diagnosed in children and acquired aplastic anemias are more common in adults. Some research suggests that stem cell damage may occur

---

Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage. The member's contract benefits in effect on the date that services are rendered must be used. Medical Policy, which addresses medical efficacy, should be considered before utilizing medical opinion in adjudication. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from the health plan.

© CPT Only – American Medical Association

The requirements below are specific to the Florida Medicaid Managed Care Plan and are not a part of the Medical Policy or Clinical UM guideline approved by Elevance Health's Medical Policy and Technology Assessment Committee.

**If the Florida Medicaid Managed Care Plan intends to deny coverage on the basis that a diagnostic test, therapeutic procedure, or medical device or technology is experimental or investigational, the Managed Care Plan shall submit a request for coverage determination to the Agency in accordance with rule 59G-1.035, F.A.C and Core SMMC Contract, Attachment II, Section VI.G.4.d.**

**Below is a list of the materials the plans are required to submit when they deny coverage as experimental/investigational:**

- A. Include the CPT or HCPCS code(s)**
- B. Include a list of other state Medicaid agencies and private insurers who cover the service**
- C. Include information about the health service from the U.S. Food and Drug Administration**
- D. Include known risks of the service and health outcomes of others who have received it**
- E. Include a list of covered alternative services, if any, that could be used to treat the condition**
- F. Identify a specific recipient needing the service**
- G. Include the recipient's health history**
- H. Include the disease information necessitating the requested service**
- I. Include a rationale for the immediacy of the review**

### Additional required information

- A. Submit the rationale used to preliminarily indicate the service is experimental/investigational**
  - 1. Include peer-reviewed journal articles in PDF format with links to the online articles**
  - 2. Include evidence-based clinical guidelines reviewed by the plan**
- B. Submit direct contact information (name, phone number, & email address) for the Medical Director**

## Hematopoietic Stem Cell Transplantation for Genetic Diseases and Aplastic Anemias

because the individual's immune system is reacting against bone marrow, interfering with the ability to make blood cells. Hematopoietic stem cell lines are no longer being replaced and the remaining stem cells are working less effectively, so the levels of red cells, white cells and platelets begin to drop. If blood levels drop too low, a person can experience fatigue (low red cells), bleeding under the skin, in the mouth and from the nose, or heavy periods (low platelets), or an increase in the number and severity of infections (low white cells). Aplastic anemias may result in the production of abnormal cells that may be associated with certain types of cancers such as leukemia. Examples of types of inherited aplastic anemias include Fanconi anemia, Diamond-Blackfan syndrome, and Shwachman-Diamond syndrome. In general, treatment for aplastic anemia may include immunosuppressants, blood product transfusions, anti-infectives and bone marrow or stem cell transplant (also known as hematopoietic blood cell transplant).

Genetic disorders may involve inborn errors of metabolism. In these disorders, a single gene defect leads to the absence of a key protein, which leads to the clinical phenotype of the disease. Allogeneic HSCT provides a means of replacing the missing protein, potentially improving the clinical phenotype. The most significant experience has been in the treatment of mucopolysaccharidoses I (Hurler Syndrome) and leukodystrophies, although case reports have described transplantation therapy for many other genetic disorders.

---

Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage. The member's contract benefits in effect on the date that services are rendered must be used. Medical Policy, which addresses medical efficacy, should be considered before utilizing medical opinion in adjudication. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from the health plan.

© CPT Only – American Medical Association

The requirements below are specific to the Florida Medicaid Managed Care Plan and are not a part of the Medical Policy or Clinical UM guideline approved by Elevance Health's Medical Policy and Technology Assessment Committee.

**If the Florida Medicaid Managed Care Plan intends to deny coverage on the basis that a diagnostic test, therapeutic procedure, or medical device or technology is experimental or investigational, the Managed Care Plan shall submit a request for coverage determination to the Agency in accordance with rule 59G-1.035, F.A.C and Core SMMC Contract, Attachment II, Section VI.G.4.d.**

**Below is a list of the materials the plans are required to submit when they deny coverage as experimental/investigational:**

- A. Include the CPT or HCPCS code(s)**
- B. Include a list of other state Medicaid agencies and private insurers who cover the service**
- C. Include information about the health service from the U.S. Food and Drug Administration**
- D. Include known risks of the service and health outcomes of others who have received it**
- E. Include a list of covered alternative services, if any, that could be used to treat the condition**
- F. Identify a specific recipient needing the service**
- G. Include the recipient's health history**
- H. Include the disease information necessitating the requested service**
- I. Include a rationale for the immediacy of the review**

### **Additional required information**

- A. Submit the rationale used to preliminarily indicate the service is experimental/investigational**
  - 1. Include peer-reviewed journal articles in PDF format with links to the online articles**
  - 2. Include evidence-based clinical guidelines reviewed by the plan**
- B. Submit direct contact information (name, phone number, & email address) for the Medical Director**

## Hematopoietic Stem Cell Transplantation for Genetic Diseases and Aplastic Anemias

---

### *Beta Thalassemia*

Beta-thalassemia is an inherited blood disorder that causes a reduction of normal hemoglobin and red blood cells in the blood, through mutations in the beta-globin subunit, leading to inadequate delivery of oxygen in the body. The diminished levels of red blood cells can lead to a number of health issues including dizziness, fatigue, weakness, bone abnormalities and other serious complications. Transfusion-dependent beta thalassemia, the most severe form of the condition, typically requires life-long red blood cell transfusions as the standard course of treatment. However, frequent transfusions can be associated with multiple health complications of their own, including, but not limited to iron overload cardiomyopathy and cirrhosis of the liver due to an excessive build-up of iron in the body. For more information on gene replacement therapy for Beta Thalassemia, see MED.00140 Gene Therapy for Beta Thalassemia.

### *Cerebral Adrenoleukodystrophy (CALD)*

Adrenoleukodystrophy is a rare, metabolic, X-linked disorder caused by a mutation in the ABCD1 gene which results in the toxic buildup of very long-chain fatty acids (VLCFA) in the brain and spinal cord. Cerebral ALD (CALD) is the most severe and neurodegenerative form of this condition. The accumulation of VLCFA in the

---

Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage. The member's contract benefits in effect on the date that services are rendered must be used. Medical Policy, which addresses medical efficacy, should be considered before utilizing medical opinion in adjudication. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from the health plan.

© CPT Only – American Medical Association

The requirements below are specific to the Florida Medicaid Managed Care Plan and are not a part of the Medical Policy or Clinical UM guideline approved by Elevance Health's Medical Policy and Technology Assessment Committee.

**If the Florida Medicaid Managed Care Plan intends to deny coverage on the basis that a diagnostic test, therapeutic procedure, or medical device or technology is experimental or investigational, the Managed Care Plan shall submit a request for coverage determination to the Agency in accordance with rule 59G-1.035, F.A.C and Core SMMC Contract, Attachment II, Section VI.G.4.d.**

**Below is a list of the materials the plans are required to submit when they deny coverage as experimental/investigational:**

- A. Include the CPT or HCPCS code(s)**
- B. Include a list of other state Medicaid agencies and private insurers who cover the service**
- C. Include information about the health service from the U.S. Food and Drug Administration**
- D. Include known risks of the service and health outcomes of others who have received it**
- E. Include a list of covered alternative services, if any, that could be used to treat the condition**
- F. Identify a specific recipient needing the service**
- G. Include the recipient's health history**
- H. Include the disease information necessitating the requested service**
- I. Include a rationale for the immediacy of the review**

### **Additional required information**

- A. Submit the rationale used to preliminarily indicate the service is experimental/investigational**
  - 1. Include peer-reviewed journal articles in PDF format with links to the online articles**
  - 2. Include evidence-based clinical guidelines reviewed by the plan**
- B. Submit direct contact information (name, phone number, & email address) for the Medical Director**



## Hematopoietic Stem Cell Transplantation for Genetic Diseases and Aplastic Anemias

---

adrenal cortex and white matter of the brain and spinal cord results in the progressive destruction of myelin. Without myelin, these nerves can no longer relay information to and from the brain.

The use of gene replacement therapy has been proposed for the treatment of CALD. Elivaldogene autotemcel is an autologous hematopoietic stem cell-based gene therapy for individuals with CALD. This type of treatment requires a pre-treatment procedure which includes mobilization and pheresis to collect CD34+ cells for genetic manipulation as well as myeloablative conditioning. For more information on gene replacement therapy for CALD, see MED.00142 Gene Therapy for Cerebral Adrenoleukodystrophy.

### *Sickle Cell Disease*

Sickle cell disease is a rare group of inherited disorders involving atypical hemoglobin molecules that distort red blood cells into a sickled shape. Complications of the disease can include severe pain crises, multiple organ dysfunction, acute chest syndrome and stroke. Typical therapeutic interventions are preventive and supportive measures. However, allogeneic HSCT has also been used under specific circumstances to replace the defective cells to correct the disorder.

---

Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage. The member's contract benefits in effect on the date that services are rendered must be used. Medical Policy, which addresses medical efficacy, should be considered before utilizing medical opinion in adjudication. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from the health plan.

© CPT Only – American Medical Association

The requirements below are specific to the Florida Medicaid Managed Care Plan and are not a part of the Medical Policy or Clinical UM guideline approved by Elevance Health's Medical Policy and Technology Assessment Committee.

**If the Florida Medicaid Managed Care Plan intends to deny coverage on the basis that a diagnostic test, therapeutic procedure, or medical device or technology is experimental or investigational, the Managed Care Plan shall submit a request for coverage determination to the Agency in accordance with rule 59G-1.035, F.A.C and Core SMMC Contract, Attachment II, Section VI.G.4.d.**

**Below is a list of the materials the plans are required to submit when they deny coverage as experimental/investigational:**

- A. Include the CPT or HCPCS code(s)**
- B. Include a list of other state Medicaid agencies and private insurers who cover the service**
- C. Include information about the health service from the U.S. Food and Drug Administration**
- D. Include known risks of the service and health outcomes of others who have received it**
- E. Include a list of covered alternative services, if any, that could be used to treat the condition**
- F. Identify a specific recipient needing the service**
- G. Include the recipient's health history**
- H. Include the disease information necessitating the requested service**
- I. Include a rationale for the immediacy of the review**

### **Additional required information**

- A. Submit the rationale used to preliminarily indicate the service is experimental/investigational**
  - 1. Include peer-reviewed journal articles in PDF format with links to the online articles**
  - 2. Include evidence-based clinical guidelines reviewed by the plan**
- B. Submit direct contact information (name, phone number, & email address) for the Medical Director**

## Hematopoietic Stem Cell Transplantation for Genetic Diseases and Aplastic Anemias

---

### *Hematopoietic Stem Cell transplant (HSCT)*

HSCT is a process which includes mobilization, harvesting, and transplant of stem cells after the administration of high dose chemotherapy (HDC), radiotherapy or a combination of both. High-dose chemotherapy involves the administration of cytotoxic agents using doses several times greater than the standard therapeutic dose. In some cases, whole body or localized radiotherapy is also given and is included in the term HDC when applicable. The rationale for HDC is that many cytotoxic agents act according to a steep dose-response curve. Thus, small increments in dosage will result in relatively large increases in tumor cell kill. Increasing the dosage also increases the incidence and severity of adverse effects related primarily to bone marrow ablation (e.g., opportunistic infections, hemorrhage, or organ failure). Bone marrow ablation is the most significant side effect of HDC. As a result, HDC is accompanied by a re-infusion of hematopoietic stem cells, which are primitive cells capable of replication and formation into mature blood cells, in order to repopulate the marrow. The potential donors of stem cells include:

1. Autologous - Stem cells harvested from the individual's own bone marrow prior to the cytotoxic therapy
2. Allogeneic - Stem cells harvested from a histocompatible donor (Note: this document does not require a specific level of histocompatibility be present as part of the medical necessity evaluation)

---

Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage. The member's contract benefits in effect on the date that services are rendered must be used. Medical Policy, which addresses medical efficacy, should be considered before utilizing medical opinion in adjudication. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from the health plan.

© CPT Only – American Medical Association

The requirements below are specific to the Florida Medicaid Managed Care Plan and are not a part of the Medical Policy or Clinical UM guideline approved by Elevance Health's Medical Policy and Technology Assessment Committee.

**If the Florida Medicaid Managed Care Plan intends to deny coverage on the basis that a diagnostic test, therapeutic procedure, or medical device or technology is experimental or investigational, the Managed Care Plan shall submit a request for coverage determination to the Agency in accordance with rule 59G-1.035, F.A.C and Core SMMC Contract, Attachment II, Section VI.G.4.d.**

**Below is a list of the materials the plans are required to submit when they deny coverage as experimental/investigational:**

- A. **Include the CPT or HCPCS code(s)**
- B. **Include a list of other state Medicaid agencies and private insurers who cover the service**
- C. **Include information about the health service from the U.S. Food and Drug Administration**
- D. **Include known risks of the service and health outcomes of others who have received it**
- E. **Include a list of covered alternative services, if any, that could be used to treat the condition**
- F. **Identify a specific recipient needing the service**
- G. **Include the recipient's health history**
- H. **Include the disease information necessitating the requested service**
- I. **Include a rationale for the immediacy of the review**

#### **Additional required information**

- A. **Submit the rationale used to preliminarily indicate the service is experimental/investigational**
  1. **Include peer-reviewed journal articles in PDF format with links to the online articles**
  2. **Include evidence-based clinical guidelines reviewed by the plan**
- B. **Submit direct contact information (name, phone number, & email address) for the Medical Director**

## Hematopoietic Stem Cell Transplantation for Genetic Diseases and Aplastic Anemias

---

Donor stem cells, either autologous or allogeneic, can be collected from either the bone marrow or the peripheral blood. Stem cells may be harvested from the peripheral blood using a pheresis procedure. To increase the number of stem cells in the peripheral circulation, donors may be pretreated with a course of chemotherapy or hematopoietic growth factors, or both.

In addition, blood harvested from the umbilical cord and placenta shortly after delivery of neonates contains stem and progenitor cells. Although cord blood is an allogeneic source, these stem cells are antigenically “naïve” and thus, are associated with a lower incidence of rejection or graft versus host disease.

The most appropriate stem cell source for a particular individual depends upon his or her disease, treatment history, and the availability of a compatible donor. The most appropriate source of stem cells for each person must balance the risks of graft failure and reinfusion of malignant cells in autologous procedures, the risks of graft rejection, and graft versus host disease in allogeneic procedures.

While the intensity of the regimens used for conditioning in conventional HDC varies, collectively they have been termed “myeloablative.” Several less intense conditioning regimens have been developed recently and rely more on immunosuppression than cytotoxic effects to permit engraftment of donor cells. These regimens, collectively termed “non-myeloablative”, also vary in intensity with substantial overlap between the ranges for “myeloablative”

---

Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage. The member’s contract benefits in effect on the date that services are rendered must be used. Medical Policy, which addresses medical efficacy, should be considered before utilizing medical opinion in adjudication. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from the health plan.

© CPT Only – American Medical Association

The requirements below are specific to the Florida Medicaid Managed Care Plan and are not a part of the Medical Policy or Clinical UM guideline approved by Elevance Health’s Medical Policy and Technology Assessment Committee.

**If the Florida Medicaid Managed Care Plan intends to deny coverage on the basis that a diagnostic test, therapeutic procedure, or medical device or technology is experimental or investigational, the Managed Care Plan shall submit a request for coverage determination to the Agency in accordance with rule 59G-1.035, F.A.C and Core SMMC Contract, Attachment II, Section VI.G.4.d.**

**Below is a list of the materials the plans are required to submit when they deny coverage as experimental/investigational:**

- A. Include the CPT or HCPCS code(s)**
- B. Include a list of other state Medicaid agencies and private insurers who cover the service**
- C. Include information about the health service from the U.S. Food and Drug Administration**
- D. Include known risks of the service and health outcomes of others who have received it**
- E. Include a list of covered alternative services, if any, that could be used to treat the condition**
- F. Identify a specific recipient needing the service**
- G. Include the recipient’s health history**
- H. Include the disease information necessitating the requested service**
- I. Include a rationale for the immediacy of the review**

### **Additional required information**

- A. Submit the rationale used to preliminarily indicate the service is experimental/investigational**
  - 1. Include peer-reviewed journal articles in PDF format with links to the online articles**
  - 2. Include evidence-based clinical guidelines reviewed by the plan**
- B. Submit direct contact information (name, phone number, & email address) for the Medical Director**

## Hematopoietic Stem Cell Transplantation for Genetic Diseases and Aplastic Anemias

---

and “non-myeloablative” regimens. Studies have shown that donor allogeneic stem cells can engraft in recipients using less-intensive conditioning regimens that are sufficiently immunosuppressive to permit graft-host tolerance. This manifests as a stable mixed donor-host hematopoietic chimerism. Once chimerism has developed, a further infusion of donor leukocytes may be given to eradicate malignant cells by inducing a graft vs. tumor effect. Non-myeloablative allogeneic transplants also referred to as “mini-transplant” or “reduced intensity conditioning (RIC) transplant”, are thought to be potentially as effective as conventional HDC followed by allogeneic stem cell transplantation, but with decreased morbidity and mortality related to the less intense non-myeloablative chemotherapy conditioning regimen. Consequently, for individuals with malignancies who are eligible for conventional HDC/ allogeneic stem cell transplantation, conditioning with milder, non-myeloablative regimens represents a technical modification of an established procedure.

Tandem high-dose or non-myeloablative chemotherapy with autologous stem cell support or allogeneic stem cell support is the planned administration of two cycles of high-dose chemotherapy, alone or with total body irradiation, each of which is followed by re-infusion of stem cells. Despite treatment with high-dose chemotherapy, many individuals with advanced malignancies eventually relapse, indicating the presence of residual neoplastic cells. The hypothesis is that eradication of residual tumor cells can be achieved using multiple cycles of myeloablative or non-myeloablative chemotherapy with stem cell support.

---

Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage. The member’s contract benefits in effect on the date that services are rendered must be used. Medical Policy, which addresses medical efficacy, should be considered before utilizing medical opinion in adjudication. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from the health plan.

© CPT Only – American Medical Association

The requirements below are specific to the Florida Medicaid Managed Care Plan and are not a part of the Medical Policy or Clinical UM guideline approved by Elevance Health’s Medical Policy and Technology Assessment Committee.

**If the Florida Medicaid Managed Care Plan intends to deny coverage on the basis that a diagnostic test, therapeutic procedure, or medical device or technology is experimental or investigational, the Managed Care Plan shall submit a request for coverage determination to the Agency in accordance with rule 59G-1.035, F.A.C and Core SMMC Contract, Attachment II, Section VI.G.4.d.**

**Below is a list of the materials the plans are required to submit when they deny coverage as experimental/investigational:**

- A. Include the CPT or HCPCS code(s)**
- B. Include a list of other state Medicaid agencies and private insurers who cover the service**
- C. Include information about the health service from the U.S. Food and Drug Administration**
- D. Include known risks of the service and health outcomes of others who have received it**
- E. Include a list of covered alternative services, if any, that could be used to treat the condition**
- F. Identify a specific recipient needing the service**
- G. Include the recipient’s health history**
- H. Include the disease information necessitating the requested service**
- I. Include a rationale for the immediacy of the review**

### **Additional required information**

- A. Submit the rationale used to preliminarily indicate the service is experimental/investigational**
  - 1. Include peer-reviewed journal articles in PDF format with links to the online articles**
  - 2. Include evidence-based clinical guidelines reviewed by the plan**
- B. Submit direct contact information (name, phone number, & email address) for the Medical Director**

## Hematopoietic Stem Cell Transplantation for Genetic Diseases and Aplastic Anemias

---

### *Other Considerations*

Hematopoietic stem cell transplant (HSCT) is an important therapeutic modality for many malignant and nonmalignant hematologic diseases and its applicability continues to expand as its use in established therapies is refined and new indications are identified. In addition, the number individuals who could benefit from HSCT has increased due to advancements, such as reduced intensity conditioning regimens, which have made HSCT safer (Majhail, 2015). However, the risks associated with transplant-associated morbidity and mortality remain significant. Most transplant centers utilize forums, boards or conferences where the treatment options of individual HSCT candidates are discussed (Majhail, 2015). Okamoto (2017) notes:

The medical decision-making process for a transplant procedure is complex which requires assessing several factors besides the underlying indication for transplantation. Those include patient/disease factors, and transplant factors such as planned conditioning/graft-versus-host disease (GVHD) prophylaxis and stem cell source. Patient factors include their overall health and comorbidities, prior therapies, and how patients responded to those therapies, age, and disease/disease risk.

---

Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage. The member's contract benefits in effect on the date that services are rendered must be used. Medical Policy, which addresses medical efficacy, should be considered before utilizing medical opinion in adjudication. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from the health plan.

© CPT Only – American Medical Association

The requirements below are specific to the Florida Medicaid Managed Care Plan and are not a part of the Medical Policy or Clinical UM guideline approved by Elevance Health's Medical Policy and Technology Assessment Committee.

**If the Florida Medicaid Managed Care Plan intends to deny coverage on the basis that a diagnostic test, therapeutic procedure, or medical device or technology is experimental or investigational, the Managed Care Plan shall submit a request for coverage determination to the Agency in accordance with rule 59G-1.035, F.A.C and Core SMMC Contract, Attachment II, Section VI.G.4.d.**

**Below is a list of the materials the plans are required to submit when they deny coverage as experimental/investigational:**

- A. Include the CPT or HCPCS code(s)**
- B. Include a list of other state Medicaid agencies and private insurers who cover the service**
- C. Include information about the health service from the U.S. Food and Drug Administration**
- D. Include known risks of the service and health outcomes of others who have received it**
- E. Include a list of covered alternative services, if any, that could be used to treat the condition**
- F. Identify a specific recipient needing the service**
- G. Include the recipient's health history**
- H. Include the disease information necessitating the requested service**
- I. Include a rationale for the immediacy of the review**

### **Additional required information**

- A. Submit the rationale used to preliminarily indicate the service is experimental/investigational**
  - 1. Include peer-reviewed journal articles in PDF format with links to the online articles**
  - 2. Include evidence-based clinical guidelines reviewed by the plan**
- B. Submit direct contact information (name, phone number, & email address) for the Medical Director**

## Hematopoietic Stem Cell Transplantation for Genetic Diseases and Aplastic Anemias

There are a number of clinical assessment and prognostic tools which evaluate individuals based upon multiple factors. The earlier, simpler tools, such as the Charlson Comorbidity Index (CCI) were useful in predicting outcomes but lacked the sensitivity of subsequent tools such as the HCT-specific comorbidity index (HCT-CI). The HCT-CI score has been validated in multiple HSCT settings to independently predict non-relapse mortality (NRM) rates by weighting 17 relevant comorbidities. The HCT-CI was further enhanced by the incorporation of some laboratory biomarkers into an augmented version. While these tools provide valuable prognostic information, the decision to transplant is unique to each individual and needs to include a specific risk-benefit analysis in partnership with the individual's physicians and other caregivers.

### Definitions

**Aplastic anemia:** Bone marrow is unable to make blood cells.

**Chest syndrome:** A sudden breathing problem in some individuals with sickle cell.

**Conditioning:** A preparative regimen of chemotherapy given as part of a bone marrow/peripheral blood stem cell transplant protocol; may be myeloablative, non-myeloablative or tandem.

Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage. The member's contract benefits in effect on the date that services are rendered must be used. Medical Policy, which addresses medical efficacy, should be considered before utilizing medical opinion in adjudication. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from the health plan.

© CPT Only – American Medical Association

The requirements below are specific to the Florida Medicaid Managed Care Plan and are not a part of the Medical Policy or Clinical UM guideline approved by Elevance Health's Medical Policy and Technology Assessment Committee.

**If the Florida Medicaid Managed Care Plan intends to deny coverage on the basis that a diagnostic test, therapeutic procedure, or medical device or technology is experimental or investigational, the Managed Care Plan shall submit a request for coverage determination to the Agency in accordance with rule 59G-1.035, F.A.C and Core SMMC Contract, Attachment II, Section VI.G.4.d.**

**Below is a list of the materials the plans are required to submit when they deny coverage as experimental/investigational:**

- A. **Include the CPT or HCPCS code(s)**
- B. **Include a list of other state Medicaid agencies and private insurers who cover the service**
- C. **Include information about the health service from the U.S. Food and Drug Administration**
- D. **Include known risks of the service and health outcomes of others who have received it**
- E. **Include a list of covered alternative services, if any, that could be used to treat the condition**
- F. **Identify a specific recipient needing the service**
- G. **Include the recipient's health history**
- H. **Include the disease information necessitating the requested service**
- I. **Include a rationale for the immediacy of the review**

### Additional required information

- A. **Submit the rationale used to preliminarily indicate the service is experimental/investigational**
  1. **Include peer-reviewed journal articles in PDF format with links to the online articles**
  2. **Include evidence-based clinical guidelines reviewed by the plan**
- B. **Submit direct contact information (name, phone number, & email address) for the Medical Director**

## Hematopoietic Stem Cell Transplantation for Genetic Diseases and Aplastic Anemias

---

Consolidation: Repetitive cycles of treatment during the immediate post-remission period; used especially for leukemia; also known as intensification therapy.

Cytotoxic: Destructive to cells.

Eastern Cooperative Oncology Group (ECOG) Performance Status: A scale used to determine the individual's level of functioning. This scale may also be referred to as the WHO (World Health Organization) or Zubrod score; based on the following scale:

- 0 Fully active, able to carry on all pre-disease performance without restriction
- 1 Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature, e.g., light house work, office work
- 2 Ambulatory and capable of all selfcare but unable to carry out any work activities. Up and about more than 50% of waking hours
- 3 Capable of only limited selfcare, confined to bed or chair more than 50% of waking hours
- 4 Completely disabled. Cannot carry on any self-care. Totally confined to bed or chair
- 5 Dead

---

Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage. The member's contract benefits in effect on the date that services are rendered must be used. Medical Policy, which addresses medical efficacy, should be considered before utilizing medical opinion in adjudication. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from the health plan.

© CPT Only – American Medical Association

The requirements below are specific to the Florida Medicaid Managed Care Plan and are not a part of the Medical Policy or Clinical UM guideline approved by Elevance Health's Medical Policy and Technology Assessment Committee.

**If the Florida Medicaid Managed Care Plan intends to deny coverage on the basis that a diagnostic test, therapeutic procedure, or medical device or technology is experimental or investigational, the Managed Care Plan shall submit a request for coverage determination to the Agency in accordance with rule 59G-1.035, F.A.C and Core SMMC Contract, Attachment II, Section VI.G.4.d.**

**Below is a list of the materials the plans are required to submit when they deny coverage as experimental/investigational:**

- A. **Include the CPT or HCPCS code(s)**
- B. **Include a list of other state Medicaid agencies and private insurers who cover the service**
- C. **Include information about the health service from the U.S. Food and Drug Administration**
- D. **Include known risks of the service and health outcomes of others who have received it**
- E. **Include a list of covered alternative services, if any, that could be used to treat the condition**
- F. **Identify a specific recipient needing the service**
- G. **Include the recipient's health history**
- H. **Include the disease information necessitating the requested service**
- I. **Include a rationale for the immediacy of the review**

### **Additional required information**

- A. **Submit the rationale used to preliminarily indicate the service is experimental/investigational**
  1. **Include peer-reviewed journal articles in PDF format with links to the online articles**
  2. **Include evidence-based clinical guidelines reviewed by the plan**
- B. **Submit direct contact information (name, phone number, & email address) for the Medical Director**

## Hematopoietic Stem Cell Transplantation for Genetic Diseases and Aplastic Anemias

---

**Ex vivo:** Outside of the living body. Ex vivo gene therapy refers to the process of taking an organ, cells, or tissue from a living body for a treatment or procedure, and then returning to the living body.

**Failure to engraft:** When the hematopoietic stem cells infused during a stem cell transplant do not grow and function adequately in the bone marrow.

**Gaucher disease:** A rare disease where there is a deficiency of the enzyme glucocerebrosidase.

**Gene replacement therapy:** A medical treatment that introduces or alters genetic material to replace the function of a missing or dysfunctional gene with the goal of lessening or eliminating a disease process that results from genetic dysfunction.

**Graft-versus-host disease (GVHD):** The condition that results when the immune cells of a transplant (usually of bone marrow) react against the tissues of the person receiving the transplant.

**HDC:** High-dose chemotherapy.

---

Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage. The member's contract benefits in effect on the date that services are rendered must be used. Medical Policy, which addresses medical efficacy, should be considered before utilizing medical opinion in adjudication. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from the health plan.

© CPT Only – American Medical Association

The requirements below are specific to the Florida Medicaid Managed Care Plan and are not a part of the Medical Policy or Clinical UM guideline approved by Elevance Health's Medical Policy and Technology Assessment Committee.

**If the Florida Medicaid Managed Care Plan intends to deny coverage on the basis that a diagnostic test, therapeutic procedure, or medical device or technology is experimental or investigational, the Managed Care Plan shall submit a request for coverage determination to the Agency in accordance with rule 59G-1.035, F.A.C and Core SMMC Contract, Attachment II, Section VI.G.4.d.**

**Below is a list of the materials the plans are required to submit when they deny coverage as experimental/investigational:**

- A. Include the CPT or HCPCS code(s)**
- B. Include a list of other state Medicaid agencies and private insurers who cover the service**
- C. Include information about the health service from the U.S. Food and Drug Administration**
- D. Include known risks of the service and health outcomes of others who have received it**
- E. Include a list of covered alternative services, if any, that could be used to treat the condition**
- F. Identify a specific recipient needing the service**
- G. Include the recipient's health history**
- H. Include the disease information necessitating the requested service**
- I. Include a rationale for the immediacy of the review**

**Additional required information**

- A. Submit the rationale used to preliminarily indicate the service is experimental/investigational**
  - 1. Include peer-reviewed journal articles in PDF format with links to the online articles**
  - 2. Include evidence-based clinical guidelines reviewed by the plan**
- B. Submit direct contact information (name, phone number, & email address) for the Medical Director**



## Hematopoietic Stem Cell Transplantation for Genetic Diseases and Aplastic Anemias

---

HDC/AlloSCS: High-dose chemotherapy with allogeneic stem cell support.

HDC/AuSCS: High-dose chemotherapy with autologous stem cell support.

Hematopoietic stem cells: Cells that give rise to distinct daughter cells, one cell that replicates the stem cell and one cell that will further proliferate and differentiate into a mature blood cell; also called progenitor cells.

Immunodeficiency: An inability to produce a normal complement of antibodies or sensitized T-cells in response to specific antigens.

Induction chemotherapy: A use of chemotherapy as initial treatment before surgery or radiotherapy of a malignancy.

Infantile malignant osteopetrosis: A hereditary disorder characterized by extreme density, hardness and fragility of the bones with partial or complete obliteration of the marrow cavities.

---

Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage. The member's contract benefits in effect on the date that services are rendered must be used. Medical Policy, which addresses medical efficacy, should be considered before utilizing medical opinion in adjudication. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from the health plan.

© CPT Only – American Medical Association

The requirements below are specific to the Florida Medicaid Managed Care Plan and are not a part of the Medical Policy or Clinical UM guideline approved by Elevance Health's Medical Policy and Technology Assessment Committee.

**If the Florida Medicaid Managed Care Plan intends to deny coverage on the basis that a diagnostic test, therapeutic procedure, or medical device or technology is experimental or investigational, the Managed Care Plan shall submit a request for coverage determination to the Agency in accordance with rule 59G-1.035, F.A.C and Core SMMC Contract, Attachment II, Section VI.G.4.d.**

**Below is a list of the materials the plans are required to submit when they deny coverage as experimental/investigational:**

- A. Include the CPT or HCPCS code(s)**
- B. Include a list of other state Medicaid agencies and private insurers who cover the service**
- C. Include information about the health service from the U.S. Food and Drug Administration**
- D. Include known risks of the service and health outcomes of others who have received it**
- E. Include a list of covered alternative services, if any, that could be used to treat the condition**
- F. Identify a specific recipient needing the service**
- G. Include the recipient's health history**
- H. Include the disease information necessitating the requested service**
- I. Include a rationale for the immediacy of the review**

### **Additional required information**

- A. Submit the rationale used to preliminarily indicate the service is experimental/investigational**
  - 1. Include peer-reviewed journal articles in PDF format with links to the online articles**
  - 2. Include evidence-based clinical guidelines reviewed by the plan**
- B. Submit direct contact information (name, phone number, & email address) for the Medical Director**

## Hematopoietic Stem Cell Transplantation for Genetic Diseases and Aplastic Anemias

**Karnofsky Score:** A measure of the individual's overall physical health, judged by their level of activity; the score uses the following scale:

100%	Normal, no complaints, no signs of disease
90%	Capable of normal activity, few symptoms or signs of disease
80%	Normal activity with some difficulty, some symptoms or signs
70%	Caring for self, not capable of normal activity or work
60%	Requiring some help, can take care of most personal requirements
50%	Requires help often, requires frequent medical care
40%	Disabled, requires special care and help
30%	Severely disabled, hospital admission indicated but no risk of death
20%	Very ill, urgently requiring admission, requires supportive measures or treatment
10%	Moribund, rapidly progressive fatal disease processes
0%	Death

**Kostmann's syndrome:** An inherited disorder, causing low white blood cell counts and infection, noted during infancy.

---

Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage. The member's contract benefits in effect on the date that services are rendered must be used. Medical Policy, which addresses medical efficacy, should be considered before utilizing medical opinion in adjudication. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from the health plan.

© CPT Only – American Medical Association

The requirements below are specific to the Florida Medicaid Managed Care Plan and are not a part of the Medical Policy or Clinical UM guideline approved by Elevance Health's Medical Policy and Technology Assessment Committee.

**If the Florida Medicaid Managed Care Plan intends to deny coverage on the basis that a diagnostic test, therapeutic procedure, or medical device or technology is experimental or investigational, the Managed Care Plan shall submit a request for coverage determination to the Agency in accordance with rule 59G-1.035, F.A.C and Core SMMC Contract, Attachment II, Section VI.G.4.d.**

**Below is a list of the materials the plans are required to submit when they deny coverage as experimental/investigational:**

- A. **Include the CPT or HCPCS code(s)**
- B. **Include a list of other state Medicaid agencies and private insurers who cover the service**
- C. **Include information about the health service from the U.S. Food and Drug Administration**
- D. **Include known risks of the service and health outcomes of others who have received it**
- E. **Include a list of covered alternative services, if any, that could be used to treat the condition**
- F. **Identify a specific recipient needing the service**
- G. **Include the recipient's health history**
- H. **Include the disease information necessitating the requested service**
- I. **Include a rationale for the immediacy of the review**

### **Additional required information**

- A. **Submit the rationale used to preliminarily indicate the service is experimental/investigational**
  1. **Include peer-reviewed journal articles in PDF format with links to the online articles**
  2. **Include evidence-based clinical guidelines reviewed by the plan**
- B. **Submit direct contact information (name, phone number, & email address) for the Medical Director**

## Hematopoietic Stem Cell Transplantation for Genetic Diseases and Aplastic Anemias

---

Lansky Score Performance Status: A measure of the individual's overall physical health, judged by their level of activity; the score uses the following scale:

100	Fully active, normal
90	Minor restrictions in physically strenuous activity
80	Active, but tires more quickly
70	Both greater restriction of and less time spent in play activity
60	Up and around, but minimal active play; keeps busy with quieter activities
50	Gets dressed but lies around much of the day, no active play but able to participate in all quiet play and activities
40	Mostly in bed; participates in quiet activities
30	In bed; needs assistance even for quiet play
20	Often sleeping; play entirely limited to very passive activities
10	No play; does not get out of bed
0	Unresponsive

Leukodystrophy: Any of several inherited diseases characterized by degeneration of the white matter of the brain.

---

Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage. The member's contract benefits in effect on the date that services are rendered must be used. Medical Policy, which addresses medical efficacy, should be considered before utilizing medical opinion in adjudication. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from the health plan.

© CPT Only – American Medical Association

The requirements below are specific to the Florida Medicaid Managed Care Plan and are not a part of the Medical Policy or Clinical UM guideline approved by Elevance Health's Medical Policy and Technology Assessment Committee.

**If the Florida Medicaid Managed Care Plan intends to deny coverage on the basis that a diagnostic test, therapeutic procedure, or medical device or technology is experimental or investigational, the Managed Care Plan shall submit a request for coverage determination to the Agency in accordance with rule 59G-1.035, F.A.C and Core SMMC Contract, Attachment II, Section VI.G.4.d.**

**Below is a list of the materials the plans are required to submit when they deny coverage as experimental/investigational:**

- A. Include the CPT or HCPCS code(s)**
- B. Include a list of other state Medicaid agencies and private insurers who cover the service**
- C. Include information about the health service from the U.S. Food and Drug Administration**
- D. Include known risks of the service and health outcomes of others who have received it**
- E. Include a list of covered alternative services, if any, that could be used to treat the condition**
- F. Identify a specific recipient needing the service**
- G. Include the recipient's health history**
- H. Include the disease information necessitating the requested service**
- I. Include a rationale for the immediacy of the review**

### **Additional required information**

- A. Submit the rationale used to preliminarily indicate the service is experimental/investigational**
  - 1. Include peer-reviewed journal articles in PDF format with links to the online articles**
  - 2. Include evidence-based clinical guidelines reviewed by the plan**
- B. Submit direct contact information (name, phone number, & email address) for the Medical Director**

## Hematopoietic Stem Cell Transplantation for Genetic Diseases and Aplastic Anemias

---

**Myelin:** The protective sheath of the nerve cells in the brain that are in charge of thinking and muscle control.

**Non-myeloablative chemotherapy:** Less intense chemotherapy conditioning regimens, which rely more on immunosuppression than cytotoxic effects to permit engraftment of donor cells.

**Paroxysmal nocturnal hemoglobinuria (PNH):** A rare disease characterized by aplastic anemia, thrombosis, and red urine in the morning due to a breakdown of red blood cells.

**Pheresis:** Any procedure in which blood is collected from a donor and a fluid or solid portion (for instance, plasma, leukocytes, platelets, or cells) is removed and the rest of the blood is returned to the donor; A procedure commonly used for collecting stem cells; also known as apheresis.

**Primary graft failure:** When the hematopoietic stem cells infused during a stem cell transplant do not grow and function in the bone marrow.

**Refractory:** Not readily yielding to treatment.

**Relapse:** The return of symptoms and signs of a disease after a period of improvement.

---

Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage. The member's contract benefits in effect on the date that services are rendered must be used. Medical Policy, which addresses medical efficacy, should be considered before utilizing medical opinion in adjudication. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from the health plan.

© CPT Only – American Medical Association

The requirements below are specific to the Florida Medicaid Managed Care Plan and are not a part of the Medical Policy or Clinical UM guideline approved by Elevance Health's Medical Policy and Technology Assessment Committee.

**If the Florida Medicaid Managed Care Plan intends to deny coverage on the basis that a diagnostic test, therapeutic procedure, or medical device or technology is experimental or investigational, the Managed Care Plan shall submit a request for coverage determination to the Agency in accordance with rule 59G-1.035, F.A.C and Core SMMC Contract, Attachment II, Section VI.G.4.d.**

**Below is a list of the materials the plans are required to submit when they deny coverage as experimental/investigational:**

- A. Include the CPT or HCPCS code(s)**
- B. Include a list of other state Medicaid agencies and private insurers who cover the service**
- C. Include information about the health service from the U.S. Food and Drug Administration**
- D. Include known risks of the service and health outcomes of others who have received it**
- E. Include a list of covered alternative services, if any, that could be used to treat the condition**
- F. Identify a specific recipient needing the service**
- G. Include the recipient's health history**
- H. Include the disease information necessitating the requested service**
- I. Include a rationale for the immediacy of the review**

**Additional required information**

- A. Submit the rationale used to preliminarily indicate the service is experimental/investigational**
  - 1. Include peer-reviewed journal articles in PDF format with links to the online articles**
  - 2. Include evidence-based clinical guidelines reviewed by the plan**
- B. Submit direct contact information (name, phone number, & email address) for the Medical Director**

## Hematopoietic Stem Cell Transplantation for Genetic Diseases and Aplastic Anemias

---

**Remission:** A complete (CR) or partial (PR) disappearance of the signs and symptoms of disease in response to treatment; the period during which a disease is under control; a remission, however, is not necessarily a cure.

**Salvage chemotherapy:** The use of chemotherapy in an individual with recurrence of a malignancy following initial treatment, in hope of a cure or prolongation of life.

**Severe combined immunodeficiency (SCID):** Disorders where both immune cells and special immune proteins needed to fight disease are missing.

**Sickle cell disease:** Inherited blood disease characterized by deformed red blood cells shaped like sickles.

**Stem cell mobilization:** A procedure in which an individual's stem cells are stimulated out of the bone marrow into the bloodstream for collection for future reinfusion.

**Tandem:** A planned administration of two cycles of high-dose or non-myeloablative chemotherapy, alone or with total body irradiation, each of which is followed by re-infusion of stem cells; also known as double transplant.

**Thalassemia:** A group of inherited anemias affecting the hemoglobin chain genes.

---

Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage. The member's contract benefits in effect on the date that services are rendered must be used. Medical Policy, which addresses medical efficacy, should be considered before utilizing medical opinion in adjudication. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from the health plan.

© CPT Only – American Medical Association

The requirements below are specific to the Florida Medicaid Managed Care Plan and are not a part of the Medical Policy or Clinical UM guideline approved by Elevance Health's Medical Policy and Technology Assessment Committee.

**If the Florida Medicaid Managed Care Plan intends to deny coverage on the basis that a diagnostic test, therapeutic procedure, or medical device or technology is experimental or investigational, the Managed Care Plan shall submit a request for coverage determination to the Agency in accordance with rule 59G-1.035, F.A.C and Core SMMC Contract, Attachment II, Section VI.G.4.d.**

**Below is a list of the materials the plans are required to submit when they deny coverage as experimental/investigational:**

- A. Include the CPT or HCPCS code(s)**
- B. Include a list of other state Medicaid agencies and private insurers who cover the service**
- C. Include information about the health service from the U.S. Food and Drug Administration**
- D. Include known risks of the service and health outcomes of others who have received it**
- E. Include a list of covered alternative services, if any, that could be used to treat the condition**
- F. Identify a specific recipient needing the service**
- G. Include the recipient's health history**
- H. Include the disease information necessitating the requested service**
- I. Include a rationale for the immediacy of the review**

### **Additional required information**

- A. Submit the rationale used to preliminarily indicate the service is experimental/investigational**
  - 1. Include peer-reviewed journal articles in PDF format with links to the online articles**
  - 2. Include evidence-based clinical guidelines reviewed by the plan**
- B. Submit direct contact information (name, phone number, & email address) for the Medical Director**

## Hematopoietic Stem Cell Transplantation for Genetic Diseases and Aplastic Anemias

Wiskott-Aldrich syndrome: An inherited, usually fatal, childhood immunodeficiency disease.

X-linked lymphoproliferative syndrome: A rare genetic disease of males transmitted from the mother in which the person's white blood cells are unable to fight infections.

### Coding

*The following codes for treatments and procedures applicable to this document are included below for informational purposes. Inclusion or exclusion of a procedure, diagnosis or device code(s) does not constitute or imply member coverage or provider reimbursement policy. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.*

### When services may be Medically Necessary when criteria are met for allogeneic transplantation:

#### CPT

38204	Management of recipient hematopoietic progenitor cell donor search and cell acquisition
38205	Blood-derived hematopoietic progenitor cell harvesting for transplantation, per collection; allogeneic

Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage. The member's contract benefits in effect on the date that services are rendered must be used. Medical Policy, which addresses medical efficacy, should be considered before utilizing medical opinion in adjudication. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from the health plan.

© CPT Only – American Medical Association

The requirements below are specific to the Florida Medicaid Managed Care Plan and are not a part of the Medical Policy or Clinical UM guideline approved by Elevance Health's Medical Policy and Technology Assessment Committee.

**If the Florida Medicaid Managed Care Plan intends to deny coverage on the basis that a diagnostic test, therapeutic procedure, or medical device or technology is experimental or investigational, the Managed Care Plan shall submit a request for coverage determination to the Agency in accordance with rule 59G-1.035, F.A.C and Core SMMC Contract, Attachment II, Section VI.G.4.d.**

**Below is a list of the materials the plans are required to submit when they deny coverage as experimental/investigational:**

- A. Include the CPT or HCPCS code(s)
- B. Include a list of other state Medicaid agencies and private insurers who cover the service
- C. Include information about the health service from the U.S. Food and Drug Administration
- D. Include known risks of the service and health outcomes of others who have received it
- E. Include a list of covered alternative services, if any, that could be used to treat the condition
- F. Identify a specific recipient needing the service
- G. Include the recipient's health history
- H. Include the disease information necessitating the requested service
- I. Include a rationale for the immediacy of the review

### Additional required information

- A. Submit the rationale used to preliminarily indicate the service is experimental/investigational
  1. Include peer-reviewed journal articles in PDF format with links to the online articles
  2. Include evidence-based clinical guidelines reviewed by the plan
- B. Submit direct contact information (name, phone number, & email address) for the Medical Director

## Hematopoietic Stem Cell Transplantation for Genetic Diseases and Aplastic Anemias

---

38207-38215	Transplant preparation of hematopoietic progenitor cells [includes codes 38207, 38208, 38209, 38210, 38211, 38212, 38213, 38214, 38215; for allogeneic transplant]
38230	Bone marrow harvesting for transplantation; allogeneic
38240	Hematopoietic progenitor cell (HPC); allogeneic transplantation per donor
38243	Hematopoietic progenitor cell (HPC); HPC boost
<b>HCPCS</b>	
S2142	Cord blood-derived stem cell transplantation, allogeneic
S2150	Bone marrow or blood-derived peripheral 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 [when specified as allogeneic]

### ICD-10 Procedure

*Allogeneic transplantation*

---

Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage. The member's contract benefits in effect on the date that services are rendered must be used. Medical Policy, which addresses medical efficacy, should be considered before utilizing medical opinion in adjudication. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from the health plan.

© CPT Only – American Medical Association

The requirements below are specific to the Florida Medicaid Managed Care Plan and are not a part of the Medical Policy or Clinical UM guideline approved by Elevance Health's Medical Policy and Technology Assessment Committee.

**If the Florida Medicaid Managed Care Plan intends to deny coverage on the basis that a diagnostic test, therapeutic procedure, or medical device or technology is experimental or investigational, the Managed Care Plan shall submit a request for coverage determination to the Agency in accordance with rule 59G-1.035, F.A.C and Core SMMC Contract, Attachment II, Section VI.G.4.d.**

**Below is a list of the materials the plans are required to submit when they deny coverage as experimental/investigational:**

- A. Include the CPT or HCPCS code(s)
- B. Include a list of other state Medicaid agencies and private insurers who cover the service
- C. Include information about the health service from the U.S. Food and Drug Administration
- D. Include known risks of the service and health outcomes of others who have received it
- E. Include a list of covered alternative services, if any, that could be used to treat the condition
- F. Identify a specific recipient needing the service
- G. Include the recipient's health history
- H. Include the disease information necessitating the requested service
- I. Include a rationale for the immediacy of the review

### Additional required information

- A. Submit the rationale used to preliminarily indicate the service is experimental/investigational
  1. Include peer-reviewed journal articles in PDF format with links to the online articles
  2. Include evidence-based clinical guidelines reviewed by the plan
- B. Submit direct contact information (name, phone number, & email address) for the Medical Director

## Hematopoietic Stem Cell Transplantation for Genetic Diseases and Aplastic Anemias

---

30233G2-30243G4	Transfusion of allogeneic bone marrow, related, unrelated or unspecified into peripheral or central vein, percutaneous approach [includes codes 30233G2, 30233G3, 30233G4, 30243G2, 30243G3, 30243G4]
30233U2-30243U4	Transfusion of allogeneic T-cell depleted hematopoietic stem cells, related, unrelated or unspecified into peripheral or central vein, percutaneous approach [includes codes 30233U2, 30233U3, 30233U4, 30243U2, 30243U3, 30243U4]
30233X2-30243X4	Transfusion of allogeneic cord blood stem cells, related, unrelated or unspecified into peripheral or central vein, percutaneous approach [includes codes 30233X2, 30233X3, 30233X4, 30243X2, 30243X3, 30243X4]
30233Y2-30243Y4	Transfusion of allogeneic hematopoietic stem cells, related, unrelated or unspecified into peripheral or central vein, percutaneous approach [includes codes 30233Y2, 30233Y3, 30233Y4, 30243Y2, 30243Y3, 30243Y4] <i>Pheresis [when specified as allogeneic]</i>
6A550ZV	Pheresis of hematopoietic stem cells, single [when specified as allogeneic]
6A551ZV	Pheresis of hematopoietic stem cells, multiple [when specified as allogeneic]

### ICD-10 Diagnosis

---

Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage. The member's contract benefits in effect on the date that services are rendered must be used. Medical Policy, which addresses medical efficacy, should be considered before utilizing medical opinion in adjudication. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from the health plan.

© CPT Only – American Medical Association

The requirements below are specific to the Florida Medicaid Managed Care Plan and are not a part of the Medical Policy or Clinical UM guideline approved by Elevance Health's Medical Policy and Technology Assessment Committee.

**If the Florida Medicaid Managed Care Plan intends to deny coverage on the basis that a diagnostic test, therapeutic procedure, or medical device or technology is experimental or investigational, the Managed Care Plan shall submit a request for coverage determination to the Agency in accordance with rule 59G-1.035, F.A.C and Core SMMC Contract, Attachment II, Section VI.G.4.d.**

**Below is a list of the materials the plans are required to submit when they deny coverage as experimental/investigational:**

- A. Include the CPT or HCPCS code(s)**
- B. Include a list of other state Medicaid agencies and private insurers who cover the service**
- C. Include information about the health service from the U.S. Food and Drug Administration**
- D. Include known risks of the service and health outcomes of others who have received it**
- E. Include a list of covered alternative services, if any, that could be used to treat the condition**
- F. Identify a specific recipient needing the service**
- G. Include the recipient's health history**
- H. Include the disease information necessitating the requested service**
- I. Include a rationale for the immediacy of the review**

#### **Additional required information**

- A. Submit the rationale used to preliminarily indicate the service is experimental/investigational**
  - 1. Include peer-reviewed journal articles in PDF format with links to the online articles**
  - 2. Include evidence-based clinical guidelines reviewed by the plan**
- B. Submit direct contact information (name, phone number, & email address) for the Medical Director**



## Hematopoietic Stem Cell Transplantation for Genetic Diseases and Aplastic Anemias

---

D56.1	Beta thalassemia
D56.8-D56.9	Thalassemia, other and unspecified
D57.00-D57.819	Sickle cell disorders
D59.5	Paroxysmal nocturnal hemoglobinuria (Marchiafava-Micheli)
D60.0-D60.9	Acquired pure red cell aplasia (erythroblastopenia)
D61.01-D61.9	Other aplastic anemias and other bone marrow failure syndromes
D69.42	Congenital and hereditary thrombocytopenia purpura [when specified as congenital amegakaryocytic thrombocytopenia]
D70.0-D70.9	Neutropenia
D71	Functional disorders of polymorphonuclear neutrophils (chronic granulomatous disease)
D76.1	Hemophagocytic lymphohistiocytosis
D81.0-D81.2	Severe combined immunodeficiency (SCID)
D81.31	Severe combined immunodeficiency due to adenosine deaminase deficiency
D81.9	Combined immunodeficiency, unspecified (SCID NOS)
D82.0	Wiskott-Aldrich syndrome
D82.3	Immunodeficiency following hereditary defective response to Epstein-Barr virus (X-linked lymphoproliferative disease)

---

Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage. The member's contract benefits in effect on the date that services are rendered must be used. Medical Policy, which addresses medical efficacy, should be considered before utilizing medical opinion in adjudication. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from the health plan.

© CPT Only – American Medical Association

The requirements below are specific to the Florida Medicaid Managed Care Plan and are not a part of the Medical Policy or Clinical UM guideline approved by Elevance Health's Medical Policy and Technology Assessment Committee.

**If the Florida Medicaid Managed Care Plan intends to deny coverage on the basis that a diagnostic test, therapeutic procedure, or medical device or technology is experimental or investigational, the Managed Care Plan shall submit a request for coverage determination to the Agency in accordance with rule 59G-1.035, F.A.C and Core SMMC Contract, Attachment II, Section VI.G.4.d.**

**Below is a list of the materials the plans are required to submit when they deny coverage as experimental/investigational:**

- A. Include the CPT or HCPCS code(s)**
- B. Include a list of other state Medicaid agencies and private insurers who cover the service**
- C. Include information about the health service from the U.S. Food and Drug Administration**
- D. Include known risks of the service and health outcomes of others who have received it**
- E. Include a list of covered alternative services, if any, that could be used to treat the condition**
- F. Identify a specific recipient needing the service**
- G. Include the recipient's health history**
- H. Include the disease information necessitating the requested service**
- I. Include a rationale for the immediacy of the review**

### **Additional required information**

- A. Submit the rationale used to preliminarily indicate the service is experimental/investigational**
  - 1. Include peer-reviewed journal articles in PDF format with links to the online articles**
  - 2. Include evidence-based clinical guidelines reviewed by the plan**
- B. Submit direct contact information (name, phone number, & email address) for the Medical Director**

**Hematopoietic Stem Cell Transplantation for Genetic Diseases and Aplastic Anemias**

---

D82.9	Immunodeficiency associated with major defect, unspecified [when specified as IPEX syndrome]
D83.1	Common variable immunodeficiency with predominant immunoregulatory T-cell disorders [when specified as IPEX syndrome]
E70.330	Chediak-Higashi syndrome
E71.520-E71.529	X-linked adrenoleukodystrophy
E75.22	Gaucher disease
E75.23	Krabbe disease
E75.25	Metachromatic leukodystrophy
E76.01-E76.03	Mucopolysaccharidosis, type I (Hurler's syndrome)
E76.1	Mucopolysaccharidosis, type II (Hunter's syndrome)
E76.22	Sanfilippo mucopolysaccharidoses (type III)
E76.29	Other mucopolysaccharidoses (type VI Maroteaux-Lamy syndrome)
Q78.2	Osteopetrosis (Albers-Schonberg syndrome)
Q82.8	Other specified congenital malformations of skin [when specified as dyskeratosis congenita]

**When services are Investigational and Not Medically Necessary for allogeneic transplantation:**

---

Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage. The member's contract benefits in effect on the date that services are rendered must be used. Medical Policy, which addresses medical efficacy, should be considered before utilizing medical opinion in adjudication. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from the health plan.

© CPT Only – American Medical Association

The requirements below are specific to the Florida Medicaid Managed Care Plan and are not a part of the Medical Policy or Clinical UM guideline approved by Elevance Health's Medical Policy and Technology Assessment Committee.

**If the Florida Medicaid Managed Care Plan intends to deny coverage on the basis that a diagnostic test, therapeutic procedure, or medical device or technology is experimental or investigational, the Managed Care Plan shall submit a request for coverage determination to the Agency in accordance with rule 59G-1.035, F.A.C and Core SMMC Contract, Attachment II, Section VI.G.4.d.**

**Below is a list of the materials the plans are required to submit when they deny coverage as experimental/investigational:**

- A. Include the CPT or HCPCS code(s)**
- B. Include a list of other state Medicaid agencies and private insurers who cover the service**
- C. Include information about the health service from the U.S. Food and Drug Administration**
- D. Include known risks of the service and health outcomes of others who have received it**
- E. Include a list of covered alternative services, if any, that could be used to treat the condition**
- F. Identify a specific recipient needing the service**
- G. Include the recipient's health history**
- H. Include the disease information necessitating the requested service**
- I. Include a rationale for the immediacy of the review**

**Additional required information**

- A. Submit the rationale used to preliminarily indicate the service is experimental/investigational**
  - 1. Include peer-reviewed journal articles in PDF format with links to the online articles**
  - 2. Include evidence-based clinical guidelines reviewed by the plan**
- B. Submit direct contact information (name, phone number, & email address) for the Medical Director**

## Hematopoietic Stem Cell Transplantation for Genetic Diseases and Aplastic Anemias

---

For the procedure and diagnosis codes listed above when criteria are not met, for all other genetic and aplastic anemia diagnoses not listed including the following diagnoses, or when the code describes a procedure indicated in the Position Statement section as investigational and not medically necessary

### ICD-10 Diagnosis

	Including, but not limited to, the following:
D56.0	Alpha thalassemia
D56.2-D56.5	Thalassemia other than beta
E84.0-E84.9	Cystic fibrosis

### When services may be Medically Necessary when criteria are met for harvesting and transplant of autologous stem cells:

For the following codes for services related to gene therapy

### CPT

38206	Blood-derived hematopoietic progenitor cell harvesting for transplantation, per collection; autologous
38232	Bone marrow harvesting for transplantation; autologous

---

Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage. The member's contract benefits in effect on the date that services are rendered must be used. Medical Policy, which addresses medical efficacy, should be considered before utilizing medical opinion in adjudication. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from the health plan.

© CPT Only – American Medical Association

The requirements below are specific to the Florida Medicaid Managed Care Plan and are not a part of the Medical Policy or Clinical UM guideline approved by Elevance Health's Medical Policy and Technology Assessment Committee.

**If the Florida Medicaid Managed Care Plan intends to deny coverage on the basis that a diagnostic test, therapeutic procedure, or medical device or technology is experimental or investigational, the Managed Care Plan shall submit a request for coverage determination to the Agency in accordance with rule 59G-1.035, F.A.C and Core SMMC Contract, Attachment II, Section VI.G.4.d.**

**Below is a list of the materials the plans are required to submit when they deny coverage as experimental/investigational:**

- A. Include the CPT or HCPCS code(s)
- B. Include a list of other state Medicaid agencies and private insurers who cover the service
- C. Include information about the health service from the U.S. Food and Drug Administration
- D. Include known risks of the service and health outcomes of others who have received it
- E. Include a list of covered alternative services, if any, that could be used to treat the condition
- F. Identify a specific recipient needing the service
- G. Include the recipient's health history
- H. Include the disease information necessitating the requested service
- I. Include a rationale for the immediacy of the review

### Additional required information

- A. Submit the rationale used to preliminarily indicate the service is experimental/investigational
  1. Include peer-reviewed journal articles in PDF format with links to the online articles
  2. Include evidence-based clinical guidelines reviewed by the plan
- B. Submit direct contact information (name, phone number, & email address) for the Medical Director

## Hematopoietic Stem Cell Transplantation for Genetic Diseases and Aplastic Anemias

---

38241 Hematopoietic progenitor cell (HPC); autologous transplantation [when specified as infusion of a gene replacement product]

### ICD-10 Procedure

*Pheresis [when specified as autologous]*  
6A550ZV Pheresis of hematopoietic stem cells, single [when specified as autologous]  
6A551ZV Pheresis of hematopoietic stem cells, multiple [when specified as autologous]

### ICD-10 Diagnosis

D56.1 Beta thalassemia  
D57.00-D57.819 Sickle cell disorders  
E71.520 Childhood cerebral X-linked adrenoleukodystrophy  
E75.25 Metachromatic leukodystrophy

### When services are Investigational and Not Medically Necessary for harvesting autologous stem cells:

For the procedure and diagnosis codes listed above when criteria not met or not related to gene therapy or for the following diagnoses

---

Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage. The member's contract benefits in effect on the date that services are rendered must be used. Medical Policy, which addresses medical efficacy, should be considered before utilizing medical opinion in adjudication. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from the health plan.

© CPT Only – American Medical Association

The requirements below are specific to the Florida Medicaid Managed Care Plan and are not a part of the Medical Policy or Clinical UM guideline approved by Elevance Health's Medical Policy and Technology Assessment Committee.

**If the Florida Medicaid Managed Care Plan intends to deny coverage on the basis that a diagnostic test, therapeutic procedure, or medical device or technology is experimental or investigational, the Managed Care Plan shall submit a request for coverage determination to the Agency in accordance with rule 59G-1.035, F.A.C and Core SMMC Contract, Attachment II, Section VI.G.4.d.**

**Below is a list of the materials the plans are required to submit when they deny coverage as experimental/investigational:**

- A. Include the CPT or HCPCS code(s)
- B. Include a list of other state Medicaid agencies and private insurers who cover the service
- C. Include information about the health service from the U.S. Food and Drug Administration
- D. Include known risks of the service and health outcomes of others who have received it
- E. Include a list of covered alternative services, if any, that could be used to treat the condition
- F. Identify a specific recipient needing the service
- G. Include the recipient's health history
- H. Include the disease information necessitating the requested service
- I. Include a rationale for the immediacy of the review

### Additional required information

- A. Submit the rationale used to preliminarily indicate the service is experimental/investigational
  1. Include peer-reviewed journal articles in PDF format with links to the online articles
  2. Include evidence-based clinical guidelines reviewed by the plan
- B. Submit direct contact information (name, phone number, & email address) for the Medical Director

## Hematopoietic Stem Cell Transplantation for Genetic Diseases and Aplastic Anemias

---

### ICD-10 Diagnosis

	Including, but not limited to, the following:
D56.0	Alpha thalassemia
D56.2-D56.9	Other thalassemia
D59.5	Paroxysmal nocturnal hemoglobinuria (Marchiafava-Micheli)
D60.0-D60.9	Acquired pure red cell aplasia (erythroblastopenia)
D61.01-D61.9	Other aplastic anemias and other bone marrow failure syndromes
D69.42	Congenital and hereditary thrombocytopenia purpura [when specified as congenital amegakaryocytic thrombocytopenia]
D70.0-D70.9	Neutropenia
D71	Functional disorders of polymorphonuclear neutrophils (chronic granulomatous disease)
D76.1	Hemophagocytic lymphohistiocytosis
D81.0-D81.2	Severe combined immunodeficiency (SCID)
D81.31	Severe combined immunodeficiency due to adenosine deaminase deficiency
D81.9	Combined immunodeficiency, unspecified (SCID NOS)
D82.0	Wiskott-Aldrich syndrome

---

Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage. The member's contract benefits in effect on the date that services are rendered must be used. Medical Policy, which addresses medical efficacy, should be considered before utilizing medical opinion in adjudication. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from the health plan.

© CPT Only – American Medical Association

The requirements below are specific to the Florida Medicaid Managed Care Plan and are not a part of the Medical Policy or Clinical UM guideline approved by Elevance Health's Medical Policy and Technology Assessment Committee.

**If the Florida Medicaid Managed Care Plan intends to deny coverage on the basis that a diagnostic test, therapeutic procedure, or medical device or technology is experimental or investigational, the Managed Care Plan shall submit a request for coverage determination to the Agency in accordance with rule 59G-1.035, F.A.C and Core SMMC Contract, Attachment II, Section VI.G.4.d.**

**Below is a list of the materials the plans are required to submit when they deny coverage as experimental/investigational:**

- A. **Include the CPT or HCPCS code(s)**
- B. **Include a list of other state Medicaid agencies and private insurers who cover the service**
- C. **Include information about the health service from the U.S. Food and Drug Administration**
- D. **Include known risks of the service and health outcomes of others who have received it**
- E. **Include a list of covered alternative services, if any, that could be used to treat the condition**
- F. **Identify a specific recipient needing the service**
- G. **Include the recipient's health history**
- H. **Include the disease information necessitating the requested service**
- I. **Include a rationale for the immediacy of the review**

### Additional required information

- A. **Submit the rationale used to preliminarily indicate the service is experimental/investigational**
  1. **Include peer-reviewed journal articles in PDF format with links to the online articles**
  2. **Include evidence-based clinical guidelines reviewed by the plan**
- B. **Submit direct contact information (name, phone number, & email address) for the Medical Director**

## Hematopoietic Stem Cell Transplantation for Genetic Diseases and Aplastic Anemias

D82.3	Immunodeficiency following hereditary defective response to Epstein-Barr virus (X-linked lymphoproliferative disease)
D82.9	Immunodeficiency associated with major defect, unspecified [when specified as IPEX syndrome]
D83.1	Common variable immunodeficiency with predominant immunoregulatory T-cell disorders [when specified as IPEX syndrome]
E70.330	Chediak-Higashi syndrome
E71.521-E71.529	Adolescent, other X-linked adrenoleukodystrophy
E75.22	Gaucher disease
E75.23	Krabbe disease
E76.01-E76.03	Mucopolysaccharidosis, type I (Hurler's syndrome)
E76.1	Mucopolysaccharidosis, type II (Hunter's syndrome)
E76.22	Sanfilippo mucopolysaccharidoses (type III)
E76.29	Other mucopolysaccharidoses (type VI Maroteaux-Lamy syndrome)
E84.0-E84.9	Cystic fibrosis
Q78.2	Osteopetrosis (Albers-Schonberg syndrome)

Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage. The member's contract benefits in effect on the date that services are rendered must be used. Medical Policy, which addresses medical efficacy, should be considered before utilizing medical opinion in adjudication. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from the health plan.

© CPT Only – American Medical Association

The requirements below are specific to the Florida Medicaid Managed Care Plan and are not a part of the Medical Policy or Clinical UM guideline approved by Elevance Health's Medical Policy and Technology Assessment Committee.

**If the Florida Medicaid Managed Care Plan intends to deny coverage on the basis that a diagnostic test, therapeutic procedure, or medical device or technology is experimental or investigational, the Managed Care Plan shall submit a request for coverage determination to the Agency in accordance with rule 59G-1.035, F.A.C and Core SMMC Contract, Attachment II, Section VI.G.4.d.**

**Below is a list of the materials the plans are required to submit when they deny coverage as experimental/investigational:**

- A. Include the CPT or HCPCS code(s)
- B. Include a list of other state Medicaid agencies and private insurers who cover the service
- C. Include information about the health service from the U.S. Food and Drug Administration
- D. Include known risks of the service and health outcomes of others who have received it
- E. Include a list of covered alternative services, if any, that could be used to treat the condition
- F. Identify a specific recipient needing the service
- G. Include the recipient's health history
- H. Include the disease information necessitating the requested service
- I. Include a rationale for the immediacy of the review

### Additional required information

- A. Submit the rationale used to preliminarily indicate the service is experimental/investigational
  1. Include peer-reviewed journal articles in PDF format with links to the online articles
  2. Include evidence-based clinical guidelines reviewed by the plan
- B. Submit direct contact information (name, phone number, & email address) for the Medical Director

## Hematopoietic Stem Cell Transplantation for Genetic Diseases and Aplastic Anemias

---

Q82.8 Other specified congenital malformations of skin [when specified as dyskeratosis congenita]

### When services are Investigational and Not Medically Necessary for autologous transplantation:

#### CPT

38207-38215 Transplant preparation of hematopoietic progenitor cells [includes codes 38207, 38208, 38209, 38210, 38211, 38212, 38213, 38214, 38215; for autologous transplant]  
38241 Hematopoietic progenitor cell (HPC); autologous transplantation [not related to gene replacement]

#### HCPCS

S2150 Bone marrow or blood-derived peripheral 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 [when specified as autologous]

---

Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage. The member's contract benefits in effect on the date that services are rendered must be used. Medical Policy, which addresses medical efficacy, should be considered before utilizing medical opinion in adjudication. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from the health plan.

© CPT Only – American Medical Association

The requirements below are specific to the Florida Medicaid Managed Care Plan and are not a part of the Medical Policy or Clinical UM guideline approved by Elevance Health's Medical Policy and Technology Assessment Committee.

**If the Florida Medicaid Managed Care Plan intends to deny coverage on the basis that a diagnostic test, therapeutic procedure, or medical device or technology is experimental or investigational, the Managed Care Plan shall submit a request for coverage determination to the Agency in accordance with rule 59G-1.035, F.A.C and Core SMMC Contract, Attachment II, Section VI.G.4.d.**

**Below is a list of the materials the plans are required to submit when they deny coverage as experimental/investigational:**

- A. Include the CPT or HCPCS code(s)
- B. Include a list of other state Medicaid agencies and private insurers who cover the service
- C. Include information about the health service from the U.S. Food and Drug Administration
- D. Include known risks of the service and health outcomes of others who have received it
- E. Include a list of covered alternative services, if any, that could be used to treat the condition
- F. Identify a specific recipient needing the service
- G. Include the recipient's health history
- H. Include the disease information necessitating the requested service
- I. Include a rationale for the immediacy of the review

#### Additional required information

- A. Submit the rationale used to preliminarily indicate the service is experimental/investigational
  1. Include peer-reviewed journal articles in PDF format with links to the online articles
  2. Include evidence-based clinical guidelines reviewed by the plan
- B. Submit direct contact information (name, phone number, & email address) for the Medical Director

## Hematopoietic Stem Cell Transplantation for Genetic Diseases and Aplastic Anemias

---

### ICD-10 Procedure

	<i>Autologous transplantation</i>
30233G0-30243G0	Transfusion of autologous bone marrow into peripheral or central vein, percutaneous approach [includes codes 30233G0, 30243G0]
30233Y0-30243Y0	Transfusion of autologous hematopoietic stem cells into peripheral or central vein, percutaneous approach [includes codes 30233Y0, 30243Y0]

### ICD-10 Diagnosis

	Including, but not limited to, the following:
D56.0-D56.9	Thalassemia
D57.00-D57.819	Sickle cell disorders
D59.5	Paroxysmal nocturnal hemoglobinuria (Marchiafava-Micheli)
D60.0-D60.9	Acquired pure red cell aplasia (erythroblastopenia)
D61.01-D61.9	Other aplastic anemias and other bone marrow failure syndromes
D69.42	Congenital and hereditary thrombocytopenia purpura [when specified as congenital amegakaryocytic thrombocytopenia]

---

Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage. The member's contract benefits in effect on the date that services are rendered must be used. Medical Policy, which addresses medical efficacy, should be considered before utilizing medical opinion in adjudication. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from the health plan.

© CPT Only – American Medical Association

The requirements below are specific to the Florida Medicaid Managed Care Plan and are not a part of the Medical Policy or Clinical UM guideline approved by Elevance Health's Medical Policy and Technology Assessment Committee.

**If the Florida Medicaid Managed Care Plan intends to deny coverage on the basis that a diagnostic test, therapeutic procedure, or medical device or technology is experimental or investigational, the Managed Care Plan shall submit a request for coverage determination to the Agency in accordance with rule 59G-1.035, F.A.C and Core SMMC Contract, Attachment II, Section VI.G.4.d.**

**Below is a list of the materials the plans are required to submit when they deny coverage as experimental/investigational:**

- A. Include the CPT or HCPCS code(s)
- B. Include a list of other state Medicaid agencies and private insurers who cover the service
- C. Include information about the health service from the U.S. Food and Drug Administration
- D. Include known risks of the service and health outcomes of others who have received it
- E. Include a list of covered alternative services, if any, that could be used to treat the condition
- F. Identify a specific recipient needing the service
- G. Include the recipient's health history
- H. Include the disease information necessitating the requested service
- I. Include a rationale for the immediacy of the review

### Additional required information

- A. Submit the rationale used to preliminarily indicate the service is experimental/investigational
  1. Include peer-reviewed journal articles in PDF format with links to the online articles
  2. Include evidence-based clinical guidelines reviewed by the plan
- B. Submit direct contact information (name, phone number, & email address) for the Medical Director



## Hematopoietic Stem Cell Transplantation for Genetic Diseases and Aplastic Anemias

---

D70.0-D70.9	Neutropenia
D71	Functional disorders of polymorphonuclear neutrophils (chronic granulomatous disease)
D76.1	Hemophagocytic lymphohistiocytosis
D81.0-D81.2	Severe combined immunodeficiency (SCID)
D81.31	Severe combined immunodeficiency due to adenosine deaminase deficiency
D81.9	Combined immunodeficiency, unspecified (SCID NOS)
D82.0	Wiskott-Aldrich syndrome
D82.3	Immunodeficiency following hereditary defective response to Epstein-Barr virus (X-linked lymphoproliferative disease)
D82.9	Immunodeficiency associated with major defect, unspecified [when specified as IPEX syndrome]
D83.1	Common variable immunodeficiency with predominant immunoregulatory T-cell disorders [when specified as IPEX syndrome]
E70.330	Chediak-Higashi syndrome
E71.520-E71.529	X-linked adrenoleukodystrophy
E75.22	Gaucher disease
E75.23	Krabbe disease

---

Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage. The member's contract benefits in effect on the date that services are rendered must be used. Medical Policy, which addresses medical efficacy, should be considered before utilizing medical opinion in adjudication. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from the health plan.

© CPT Only – American Medical Association

The requirements below are specific to the Florida Medicaid Managed Care Plan and are not a part of the Medical Policy or Clinical UM guideline approved by Elevance Health's Medical Policy and Technology Assessment Committee.

**If the Florida Medicaid Managed Care Plan intends to deny coverage on the basis that a diagnostic test, therapeutic procedure, or medical device or technology is experimental or investigational, the Managed Care Plan shall submit a request for coverage determination to the Agency in accordance with rule 59G-1.035, F.A.C and Core SMMC Contract, Attachment II, Section VI.G.4.d.**

**Below is a list of the materials the plans are required to submit when they deny coverage as experimental/investigational:**

- A. Include the CPT or HCPCS code(s)**
- B. Include a list of other state Medicaid agencies and private insurers who cover the service**
- C. Include information about the health service from the U.S. Food and Drug Administration**
- D. Include known risks of the service and health outcomes of others who have received it**
- E. Include a list of covered alternative services, if any, that could be used to treat the condition**
- F. Identify a specific recipient needing the service**
- G. Include the recipient's health history**
- H. Include the disease information necessitating the requested service**
- I. Include a rationale for the immediacy of the review**

### **Additional required information**

- A. Submit the rationale used to preliminarily indicate the service is experimental/investigational**
  - 1. Include peer-reviewed journal articles in PDF format with links to the online articles**
  - 2. Include evidence-based clinical guidelines reviewed by the plan**
- B. Submit direct contact information (name, phone number, & email address) for the Medical Director**

## Hematopoietic Stem Cell Transplantation for Genetic Diseases and Aplastic Anemias

E75.25	Metachromatic leukodystrophy
E76.01-E76.03	Mucopolysaccharidosis, type I (Hurler's syndrome)
E76.1	Mucopolysaccharidosis, type II (Hunter's syndrome)
E76.22	Sanfilippo mucopolysaccharidoses (type III)
E76.29	Other mucopolysaccharidoses (type VI Maroteaux-Lamy syndrome)
E84.0-E84.9	Cystic fibrosis
Q78.2	Osteopetrosis (Albers-Schonberg syndrome)
Q82.8	Other specified congenital malformations of skin [when specified as dyskeratosis congenita]

### References

#### Peer Reviewed Publications:

1. Ades L, Mary JY, Robin M, et al. Long-term outcome after bone marrow transplantation for severe aplastic anemia. *Blood*. 2004; 103(7):2490-2497.
2. Aldenhoven M, Wynn RF, Orchard PJ, et al. Long-term outcome of Hurler syndrome patients after hematopoietic cell transplantation: an international multicenter study. *Blood*. 2015; 125(13):2164-2172.

Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage. The member's contract benefits in effect on the date that services are rendered must be used. Medical Policy, which addresses medical efficacy, should be considered before utilizing medical opinion in adjudication. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from the health plan.

© CPT Only – American Medical Association

The requirements below are specific to the Florida Medicaid Managed Care Plan and are not a part of the Medical Policy or Clinical UM guideline approved by Elevance Health's Medical Policy and Technology Assessment Committee.

**If the Florida Medicaid Managed Care Plan intends to deny coverage on the basis that a diagnostic test, therapeutic procedure, or medical device or technology is experimental or investigational, the Managed Care Plan shall submit a request for coverage determination to the Agency in accordance with rule 59G-1.035, F.A.C and Core SMMC Contract, Attachment II, Section VI.G.4.d.**

**Below is a list of the materials the plans are required to submit when they deny coverage as experimental/investigational:**

- A. Include the CPT or HCPCS code(s)
- B. Include a list of other state Medicaid agencies and private insurers who cover the service
- C. Include information about the health service from the U.S. Food and Drug Administration
- D. Include known risks of the service and health outcomes of others who have received it
- E. Include a list of covered alternative services, if any, that could be used to treat the condition
- F. Identify a specific recipient needing the service
- G. Include the recipient's health history
- H. Include the disease information necessitating the requested service
- I. Include a rationale for the immediacy of the review

#### Additional required information

- A. Submit the rationale used to preliminarily indicate the service is experimental/investigational
  1. Include peer-reviewed journal articles in PDF format with links to the online articles
  2. Include evidence-based clinical guidelines reviewed by the plan
- B. Submit direct contact information (name, phone number, & email address) for the Medical Director

## Hematopoietic Stem Cell Transplantation for Genetic Diseases and Aplastic Anemias

---

3. Bacigalupo A, Locatelli F, Lanino E, et al. Fludarabine, cyclophosphamide and anti-thymocyte globulin for alternative donor transplants in acquired severe aplastic anemia: a report from the EBMT-SAA Working Party. *Bone Marrow Transplant.* 2005; 36(11):947-950.
  4. Batzios SP, Zafeiriou DI. Developing treatment options for metachromatic leukodystrophy. *Mol Genet Metab.* 2012; 105(1):56-63.
  5. Baud O, Goulet O, Canioni D, et al. Treatment of the immune dysregulation, polyendocrinopathy, enteropathy, X-linked syndrome (IPEX) by allogeneic bone marrow transplantation. *N Engl J Med.* 2001; 344(23):1758-1762.
  6. Berger J, Moser HW, Forss-Petter S. Leukodystrophies: recent developments in genetics, molecular biology, pathogenesis and treatment. *Curr Opin Neurol.* 2001; 14(3):305-312.
  7. Bernaudin F, Socie G, Kuentz M, et al. Long-term results of related myeloablative stem-cell transplantation to cure sickle cell disease. *Blood.* 2007; 110(7):2749-2756.
  8. Bhatia M, Walters MC. Hematopoietic cell transplantation for thalassemia and sickle cell disease: past, present and future. *Bone Marrow Transplant.* 2008; 41(2):109-117.
  9. Bis S, Maguiness SM, Gellis SE, et al. Immune dysregulation, polyendocrinopathy, enteropathy, X-linked syndrome associated with neonatal epidermolysis bullosa acquisita. *Pediatr Dermatol.* 2015; 32(3): e74-77.
- 

Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage. The member's contract benefits in effect on the date that services are rendered must be used. Medical Policy, which addresses medical efficacy, should be considered before utilizing medical opinion in adjudication. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from the health plan.

© CPT Only – American Medical Association

The requirements below are specific to the Florida Medicaid Managed Care Plan and are not a part of the Medical Policy or Clinical UM guideline approved by Elevance Health's Medical Policy and Technology Assessment Committee.

**If the Florida Medicaid Managed Care Plan intends to deny coverage on the basis that a diagnostic test, therapeutic procedure, or medical device or technology is experimental or investigational, the Managed Care Plan shall submit a request for coverage determination to the Agency in accordance with rule 59G-1.035, F.A.C and Core SMMC Contract, Attachment II, Section VI.G.4.d.**

**Below is a list of the materials the plans are required to submit when they deny coverage as experimental/investigational:**

- A. **Include the CPT or HCPCS code(s)**
- B. **Include a list of other state Medicaid agencies and private insurers who cover the service**
- C. **Include information about the health service from the U.S. Food and Drug Administration**
- D. **Include known risks of the service and health outcomes of others who have received it**
- E. **Include a list of covered alternative services, if any, that could be used to treat the condition**
- F. **Identify a specific recipient needing the service**
- G. **Include the recipient's health history**
- H. **Include the disease information necessitating the requested service**
- I. **Include a rationale for the immediacy of the review**

### **Additional required information**

- A. **Submit the rationale used to preliminarily indicate the service is experimental/investigational**
  1. **Include peer-reviewed journal articles in PDF format with links to the online articles**
  2. **Include evidence-based clinical guidelines reviewed by the plan**
- B. **Submit direct contact information (name, phone number, & email address) for the Medical Director**

## Hematopoietic Stem Cell Transplantation for Genetic Diseases and Aplastic Anemias

---

10. Bizzetto R, Bonfim C, Rocha V, et al.; Eurocord and SAA-WP from EBMT. Outcomes after related and unrelated umbilical cord blood transplantation for hereditary bone marrow failure syndromes other than Fanconi anemia. *Haematologica*. 2011; 96(1):134-141.
11. Boelens JJ. Trends in haematopoietic cell transplantation for inborn errors of metabolism. *J Inher Metab Dis*. 2006; 29:413-420.
12. Braunlin EA, Stauffer NR, Peters CH, et al. Usefulness of bone marrow transplantation in the Hurler syndrome. *Am J Cardiol*. 2003; 92(7):882-886.
13. Burroughs L, Woolfrey A, Shimamura A. Shwachman-Diamond syndrome: a review of the clinical presentation, molecular pathogenesis, diagnosis, and treatment. *Hematol Oncol Clin North Am*. 2009; 23(2):233-248.
14. Carlsson G, Winiarski J, Ljungman P, et al. Hematopoietic stem cell transplantation in severe congenital neutropenia. *Pediatr Blood Cancer*. 2011; 56(3):444-451.
15. Cesaro S, Donadieu J, Cipolli M, et al. Stem cell transplantation in patients affected by Shwachman-Diamond syndrome: expert consensus and recommendations from the EBMT Severe Aplastic Anaemia Working Party. *Transplant Cell Ther*. 2022; 28(10):637-649.

---

Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage. The member's contract benefits in effect on the date that services are rendered must be used. Medical Policy, which addresses medical efficacy, should be considered before utilizing medical opinion in adjudication. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from the health plan.

© CPT Only – American Medical Association

The requirements below are specific to the Florida Medicaid Managed Care Plan and are not a part of the Medical Policy or Clinical UM guideline approved by Elevance Health's Medical Policy and Technology Assessment Committee.

**If the Florida Medicaid Managed Care Plan intends to deny coverage on the basis that a diagnostic test, therapeutic procedure, or medical device or technology is experimental or investigational, the Managed Care Plan shall submit a request for coverage determination to the Agency in accordance with rule 59G-1.035, F.A.C and Core SMMC Contract, Attachment II, Section VI.G.4.d.**

**Below is a list of the materials the plans are required to submit when they deny coverage as experimental/investigational:**

- A. **Include the CPT or HCPCS code(s)**
- B. **Include a list of other state Medicaid agencies and private insurers who cover the service**
- C. **Include information about the health service from the U.S. Food and Drug Administration**
- D. **Include known risks of the service and health outcomes of others who have received it**
- E. **Include a list of covered alternative services, if any, that could be used to treat the condition**
- F. **Identify a specific recipient needing the service**
- G. **Include the recipient's health history**
- H. **Include the disease information necessitating the requested service**
- I. **Include a rationale for the immediacy of the review**

### **Additional required information**

- A. **Submit the rationale used to preliminarily indicate the service is experimental/investigational**
  1. **Include peer-reviewed journal articles in PDF format with links to the online articles**
  2. **Include evidence-based clinical guidelines reviewed by the plan**
- B. **Submit direct contact information (name, phone number, & email address) for the Medical Director**

## Hematopoietic Stem Cell Transplantation for Genetic Diseases and Aplastic Anemias

---

16. Cesaro S, Oneto R, Messina C, et al.; EBMT Severe Aplastic Anaemia and Paediatric Diseases Working Party. Haematopoietic stem cell transplantation for Shwachman-Diamond disease: a study from the European Group for blood and marrow transplantation. *Br J Haematol.* 2005; 131(2):231-236.
17. D'Andrea AD, Dahl N, Guinan EC, Shimamura A. Marrow failure. *Hematology Am Soc Hematol Educ Program.* 2002;58-72.
18. Deeg HJ, Amylon MD, Harris RE, et al. Marrow transplants from unrelated donors for patients with aplastic anemia: minimum effective dose of total body irradiation. *Biol Blood Marrow Transplant.* 2001; 7(4):208-215.
19. Dietz AC, Orchard PJ, Baker KS, et al. Disease-specific hematopoietic cell transplantation: nonmyeloablative conditioning regimen for dyskeratosis congenita. *Bone Marrow Transplant.* 2011; 46(1):98-104.
20. Dolberg OJ, Levy Y. Idiopathic aplastic anemia: diagnosis and classification. *Autoimmun Rev.* 2014; 13(4-5):569-573.
21. Dorsey MJ, Petrovic A, Morrow MR, et al. FOXP3 expression following bone marrow transplantation for IPEX syndrome after reduced-intensity conditioning. *Immunol Res.* 2009; 44(1-3):179-184.
22. Driessen GJ, Gerritsen EJ, Fischer A, et al. Long-term outcome of haematopoietic stem cell transplantation in autosomal recessive osteopetrosis: an EBMT report. *Bone Marrow Transplant.* 2003; 32(7):657-663.
23. Dufour C, Svahn J. Fanconi anaemia: new strategies. *Bone Marrow Transplant* 2008; 41(suppl 2): S90-95.

---

Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage. The member's contract benefits in effect on the date that services are rendered must be used. Medical Policy, which addresses medical efficacy, should be considered before utilizing medical opinion in adjudication. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from the health plan.

© CPT Only – American Medical Association

The requirements below are specific to the Florida Medicaid Managed Care Plan and are not a part of the Medical Policy or Clinical UM guideline approved by Elevance Health's Medical Policy and Technology Assessment Committee.

**If the Florida Medicaid Managed Care Plan intends to deny coverage on the basis that a diagnostic test, therapeutic procedure, or medical device or technology is experimental or investigational, the Managed Care Plan shall submit a request for coverage determination to the Agency in accordance with rule 59G-1.035, F.A.C and Core SMMC Contract, Attachment II, Section VI.G.4.d.**

**Below is a list of the materials the plans are required to submit when they deny coverage as experimental/investigational:**

- A. **Include the CPT or HCPCS code(s)**
- B. **Include a list of other state Medicaid agencies and private insurers who cover the service**
- C. **Include information about the health service from the U.S. Food and Drug Administration**
- D. **Include known risks of the service and health outcomes of others who have received it**
- E. **Include a list of covered alternative services, if any, that could be used to treat the condition**
- F. **Identify a specific recipient needing the service**
- G. **Include the recipient's health history**
- H. **Include the disease information necessitating the requested service**
- I. **Include a rationale for the immediacy of the review**

### **Additional required information**

- A. **Submit the rationale used to preliminarily indicate the service is experimental/investigational**
  1. **Include peer-reviewed journal articles in PDF format with links to the online articles**
  2. **Include evidence-based clinical guidelines reviewed by the plan**
- B. **Submit direct contact information (name, phone number, & email address) for the Medical Director**

## Hematopoietic Stem Cell Transplantation for Genetic Diseases and Aplastic Anemias

---

24. Etzioni A. Leukocyte adhesion deficiencies: molecular basis, clinical findings, and therapeutic options. *Adv Exp Med Biol.* 2007; 601:51-60.
  25. Frangoul H, Keates-Baleeiro J, Calder C, et al. Unrelated bone marrow transplant for congenital amegakaryocytic thrombocytopenia: report of two cases and review of the literature. *Pediatr Transplant.* 2010; 14(4): E42-45.
  26. Gadalla SM, Sales-Bonfim C, Carreras J, et al. Outcomes of allogeneic hematopoietic cell transplantation in patients with dyskeratosis congenita. *Biol Blood Marrow Transplant.* 2013; 19(8):1238-1243.
  27. Gennery AR, Cant AJ. Advances in hematopoietic stem cell transplantation for primary immunodeficiency. *Immunol Allergy Clin North Am.* 2008; 28(2):439-456.
  28. Gieselmann V, Krägeloh-Mann I. Metachromatic leukodystrophy--an update. *Neuropediatrics.* 2010; 41(1):1-6.
  29. Gluckman E, Wagner JE. Hematopoietic stem cell transplantation in childhood inherited bone marrow failure syndrome. *Bone Marrow Transplant* 2008; 41(2):127-132.
  30. Good RA, Verjee T. Historical and current perspectives on bone marrow transplantation for prevention and treatment of immunodeficiencies and autoimmunities. *Biol Blood Marrow Transplant.* 2001; 7(3):123-135.
  31. Guffon N, Bertrand Y, Forest I, et al. Bone marrow transplantation in children with Hunter Syndrome: outcome after 7 to 17 years. *J Pediatr.* 2009; 154(5):733-737.
- 

Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage. The member's contract benefits in effect on the date that services are rendered must be used. Medical Policy, which addresses medical efficacy, should be considered before utilizing medical opinion in adjudication. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from the health plan.

© CPT Only – American Medical Association

The requirements below are specific to the Florida Medicaid Managed Care Plan and are not a part of the Medical Policy or Clinical UM guideline approved by Elevance Health's Medical Policy and Technology Assessment Committee.

**If the Florida Medicaid Managed Care Plan intends to deny coverage on the basis that a diagnostic test, therapeutic procedure, or medical device or technology is experimental or investigational, the Managed Care Plan shall submit a request for coverage determination to the Agency in accordance with rule 59G-1.035, F.A.C and Core SMMC Contract, Attachment II, Section VI.G.4.d.**

**Below is a list of the materials the plans are required to submit when they deny coverage as experimental/investigational:**

- A. **Include the CPT or HCPCS code(s)**
- B. **Include a list of other state Medicaid agencies and private insurers who cover the service**
- C. **Include information about the health service from the U.S. Food and Drug Administration**
- D. **Include known risks of the service and health outcomes of others who have received it**
- E. **Include a list of covered alternative services, if any, that could be used to treat the condition**
- F. **Identify a specific recipient needing the service**
- G. **Include the recipient's health history**
- H. **Include the disease information necessitating the requested service**
- I. **Include a rationale for the immediacy of the review**

### **Additional required information**

- A. **Submit the rationale used to preliminarily indicate the service is experimental/investigational**
  1. **Include peer-reviewed journal articles in PDF format with links to the online articles**
  2. **Include evidence-based clinical guidelines reviewed by the plan**
- B. **Submit direct contact information (name, phone number, & email address) for the Medical Director**

## Hematopoietic Stem Cell Transplantation for Genetic Diseases and Aplastic Anemias

32. Henter JI, Samuelson-Horne A, Arico M, et al. Treatment of hemophagocytic lymphohistiocytosis with HLH-94 immunochemotherapy and bone marrow transplantation. *Blood*. 2002; 100(7):2367-2373.
33. Hongeng S, Pakakasama S, Chaisiripoomkere W, et al. Outcome of transplantation with unrelated donor bone marrow in children with severe thalassemia. *Bone Marrow Transplant*. 2004; 33(4):377-379.
34. Horwitz ME, Barrett AJ, Brown MR, et al. Treatment of chronic granulomatous disease with nonmyeloablative conditioning and T-cell-depleted hematopoietic allograft. *N Engl J Med*. 2001; 344(12):881-888.
35. Hsieh MM, Kang EM, Fitzhugh CD, et al. Allogeneic hematopoietic stem-cell transplantation for sickle cell disease. *N Engl J Med*. 2009; 361(24):2309-2317.
36. Iannone R, Casella JF, Ruchs EJ, et al. Results of minimally toxic non-myeloablative transplantation in patients with sickle cell anemia and beta thalassemia. *Biol Blood Marrow Transplant*. 2003; 9(8):519-528.
37. Imashuku S. Advances in the management of hemophagocytic lymphohistiocytosis. *Int J Hematol*. 2000; 72(1):1-11.
38. King S, Germeshausen M, Strauss G, et al. Congenital amegakaryocytic thrombocytopenia: a retrospective clinical analysis of 20 patients. *Br J Haematol*. 2005; 131(5):636-644.
39. Larocca A, Piaggio G, Podestà M, et al. Boost of CD34+-selected peripheral blood cells without further conditioning in patients with poor graft function following allogeneic stem cell transplantation. *Haematologica*. 2006; 91(7):935-940.

Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage. The member's contract benefits in effect on the date that services are rendered must be used. Medical Policy, which addresses medical efficacy, should be considered before utilizing medical opinion in adjudication. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from the health plan.

© CPT Only – American Medical Association

The requirements below are specific to the Florida Medicaid Managed Care Plan and are not a part of the Medical Policy or Clinical UM guideline approved by Elevance Health's Medical Policy and Technology Assessment Committee.

**If the Florida Medicaid Managed Care Plan intends to deny coverage on the basis that a diagnostic test, therapeutic procedure, or medical device or technology is experimental or investigational, the Managed Care Plan shall submit a request for coverage determination to the Agency in accordance with rule 59G-1.035, F.A.C and Core SMMC Contract, Attachment II, Section VI.G.4.d.**

**Below is a list of the materials the plans are required to submit when they deny coverage as experimental/investigational:**

- A. **Include the CPT or HCPCS code(s)**
- B. **Include a list of other state Medicaid agencies and private insurers who cover the service**
- C. **Include information about the health service from the U.S. Food and Drug Administration**
- D. **Include known risks of the service and health outcomes of others who have received it**
- E. **Include a list of covered alternative services, if any, that could be used to treat the condition**
- F. **Identify a specific recipient needing the service**
- G. **Include the recipient's health history**
- H. **Include the disease information necessitating the requested service**
- I. **Include a rationale for the immediacy of the review**

### **Additional required information**

- A. **Submit the rationale used to preliminarily indicate the service is experimental/investigational**
  1. **Include peer-reviewed journal articles in PDF format with links to the online articles**
  2. **Include evidence-based clinical guidelines reviewed by the plan**
- B. **Submit direct contact information (name, phone number, & email address) for the Medical Director**

## Hematopoietic Stem Cell Transplantation for Genetic Diseases and Aplastic Anemias

---

40. Locatelli F, Rocha V, Reed W, et al. Related umbilical cord blood transplantation in patients with thalassemia and sickle cell disease. *Blood*. 2003; 101(6):2137-2143.
  41. Locatelli F, Zecca M, Pession A, et al.; Italian pediatric group. The outcome of children with Fanconi anemia given hematopoietic stem cell transplantation and the influence of fludarabine in the conditioning regimen: a report from the Italian pediatric group. *Haematologica*. 2007; 92(10):1381-1388.
  42. Mahadeo KM, Tewari P, Parikh SH, et al. Durable engraftment and correction of hematological abnormalities in children with congenital amegakaryocytic thrombocytopenia following myeloablative umbilical cord blood transplantation. *Pediatr Transplant*. 2015; 19(7):753-757.
  43. Mahmood A, Raymond GV, Dubey P, et al. Survival analysis of haematopoietic cell transplantation for childhood cerebral X-linked adrenoleukodystrophy: a comparison study. *Lancet Neurol*. 2007; 6(8):687-692.
  44. McSweeney PA, Nash RA, Sullivan KM, et al. High-dose immunosuppressive therapy for severe systemic sclerosis: initial outcomes. *Blood*. 2002; 100(5):1602-1610.
  45. Muenzer J, Fisher A. Advances in the treatment of mucopolysaccharidosis type I. *N Engl J Med*. 2004; 350(919):1932-1934.
  46. Muraoka K, Ishii E, Ihara K, et al. Successful bone marrow transplantation in a patient with c-mpl-mutated congenital amegakaryocytic thrombocytopenia from a carrier donor. *Pediatr Transplant*. 2005; 9(1):101-103.
- 

Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage. The member's contract benefits in effect on the date that services are rendered must be used. Medical Policy, which addresses medical efficacy, should be considered before utilizing medical opinion in adjudication. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from the health plan.

© CPT Only – American Medical Association

The requirements below are specific to the Florida Medicaid Managed Care Plan and are not a part of the Medical Policy or Clinical UM guideline approved by Elevance Health's Medical Policy and Technology Assessment Committee.

**If the Florida Medicaid Managed Care Plan intends to deny coverage on the basis that a diagnostic test, therapeutic procedure, or medical device or technology is experimental or investigational, the Managed Care Plan shall submit a request for coverage determination to the Agency in accordance with rule 59G-1.035, F.A.C and Core SMMC Contract, Attachment II, Section VI.G.4.d.**

**Below is a list of the materials the plans are required to submit when they deny coverage as experimental/investigational:**

- A. **Include the CPT or HCPCS code(s)**
- B. **Include a list of other state Medicaid agencies and private insurers who cover the service**
- C. **Include information about the health service from the U.S. Food and Drug Administration**
- D. **Include known risks of the service and health outcomes of others who have received it**
- E. **Include a list of covered alternative services, if any, that could be used to treat the condition**
- F. **Identify a specific recipient needing the service**
- G. **Include the recipient's health history**
- H. **Include the disease information necessitating the requested service**
- I. **Include a rationale for the immediacy of the review**

### **Additional required information**

- A. **Submit the rationale used to preliminarily indicate the service is experimental/investigational**
  1. **Include peer-reviewed journal articles in PDF format with links to the online articles**
  2. **Include evidence-based clinical guidelines reviewed by the plan**
- B. **Submit direct contact information (name, phone number, & email address) for the Medical Director**



## Hematopoietic Stem Cell Transplantation for Genetic Diseases and Aplastic Anemias

---

47. Myers LA, Patel DD, Puck JM, Buckley RH. Hematopoietic stem cell transplantation for severe combined immunodeficiency in the neonatal period leads to superior thymic output and improved survival. *Blood*. 2002; 99(3):872-878.
  48. Ohga S, Mugishima H, Ohara A, et al.; Aplastic Anemia Committee Japanese Society of Pediatric Hematology. Diamond-Blackfan anemia in Japan: clinical outcomes of prednisolone therapy and hematopoietic stem cell transplantation. *Int J Hematol*. 2004; 79(1):22-30.
  49. Okamoto S. Current indications of hematopoietic cell transplantation in adults. *Hematol Oncol Stem Cell Ther*. 2017; 10(4):178-183.
  50. Orchard PJ, Tolar J. Transplant outcomes in leukodystrophies. *Semin Hematol*. 2010; 47(1):70-78.
  51. Ozsahin H, Cavazzana-Calvo M, Notarangelo LD, et al. Long-term outcome following hematopoietic stem-cell transplantation in Wiskott-Aldrich syndrome: collaborative study of the European Society for Immunodeficiencies and European Group for Blood and Marrow Transplantation. *Blood*. 2008; 111(1):439-445.
  52. Peters C, Shapiro EG, Anderson J, et al. Hurler Syndrome: II. Outcome of HLA-genotypically identical sibling and HLA-haploidentical related donor bone marrow transplantation in fifty-four children. *Blood*. 1998; 91(7):2601-2608.
- 

Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage. The member's contract benefits in effect on the date that services are rendered must be used. Medical Policy, which addresses medical efficacy, should be considered before utilizing medical opinion in adjudication. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from the health plan.

© CPT Only – American Medical Association

The requirements below are specific to the Florida Medicaid Managed Care Plan and are not a part of the Medical Policy or Clinical UM guideline approved by Elevance Health's Medical Policy and Technology Assessment Committee.

**If the Florida Medicaid Managed Care Plan intends to deny coverage on the basis that a diagnostic test, therapeutic procedure, or medical device or technology is experimental or investigational, the Managed Care Plan shall submit a request for coverage determination to the Agency in accordance with rule 59G-1.035, F.A.C and Core SMMC Contract, Attachment II, Section VI.G.4.d.**

**Below is a list of the materials the plans are required to submit when they deny coverage as experimental/investigational:**

- A. **Include the CPT or HCPCS code(s)**
- B. **Include a list of other state Medicaid agencies and private insurers who cover the service**
- C. **Include information about the health service from the U.S. Food and Drug Administration**
- D. **Include known risks of the service and health outcomes of others who have received it**
- E. **Include a list of covered alternative services, if any, that could be used to treat the condition**
- F. **Identify a specific recipient needing the service**
- G. **Include the recipient's health history**
- H. **Include the disease information necessitating the requested service**
- I. **Include a rationale for the immediacy of the review**

### **Additional required information**

- A. **Submit the rationale used to preliminarily indicate the service is experimental/investigational**
  1. **Include peer-reviewed journal articles in PDF format with links to the online articles**
  2. **Include evidence-based clinical guidelines reviewed by the plan**
- B. **Submit direct contact information (name, phone number, & email address) for the Medical Director**

## Hematopoietic Stem Cell Transplantation for Genetic Diseases and Aplastic Anemias

---

53. Rao AA, Gourde JA, Marri P, et al. Congenital amegakaryocytic thrombocytopenia: a case report of pediatric twins undergoing matched unrelated bone marrow transplantation. *J Pediatr Hematol Oncol.* 2015; 37(4):304-306.
  54. Rao A, Kamani N, Filipovich A, et al. Successful bone marrow transplantation for IPEX syndrome after reduced-intensity conditioning. *Blood.* 2007; 109(1):383-385.
  55. Sakamoto KM, Shimamura A, Davies SM. Congenital disorders of ribosome biogenesis and bone marrow failure. *Biol Blood Marrow Transplant.* 2010; 16(1Suppl): S12-17.
  56. Samarasinghe S, Steward C, Hiwarkar P, et al. Excellent outcome of matched unrelated donor transplantation in paediatric aplastic anaemia following failure with immunosuppressive therapy: a United Kingdom multicentre retrospective experience. *Br J Haematol.* 2012; 157(3):339-346.
  57. Santarone S, Bacigalupo A, Risitano AM, et al. Hematopoietic stem cell transplantation for paroxysmal nocturnal hemoglobinuria: long-term results of a retrospective study on behalf of the Gruppo Italiano Trapianto Midollo Osseo (GITMO). *Haematologica.* 2010; 95(6):983-988.
  58. Schulz AS, Classen CF, Mihatsch WA, et al. HLA-haploidentical blood progenitor cell transplantation in osteopetrosis. *Blood.* 2002; 99(9):3458-3460.
  59. Sorrow ML, Maris MB, Storb R, et al. Hematopoietic cell transplantation (HCT)-specific comorbidity index: a new tool for risk assessment before allogeneic HCT. *Blood.* 2005; 106(8):2912-2919.
- 

Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage. The member's contract benefits in effect on the date that services are rendered must be used. Medical Policy, which addresses medical efficacy, should be considered before utilizing medical opinion in adjudication. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from the health plan.

© CPT Only – American Medical Association

The requirements below are specific to the Florida Medicaid Managed Care Plan and are not a part of the Medical Policy or Clinical UM guideline approved by Elevance Health's Medical Policy and Technology Assessment Committee.

**If the Florida Medicaid Managed Care Plan intends to deny coverage on the basis that a diagnostic test, therapeutic procedure, or medical device or technology is experimental or investigational, the Managed Care Plan shall submit a request for coverage determination to the Agency in accordance with rule 59G-1.035, F.A.C and Core SMMC Contract, Attachment II, Section VI.G.4.d.**

**Below is a list of the materials the plans are required to submit when they deny coverage as experimental/investigational:**

- A. **Include the CPT or HCPCS code(s)**
- B. **Include a list of other state Medicaid agencies and private insurers who cover the service**
- C. **Include information about the health service from the U.S. Food and Drug Administration**
- D. **Include known risks of the service and health outcomes of others who have received it**
- E. **Include a list of covered alternative services, if any, that could be used to treat the condition**
- F. **Identify a specific recipient needing the service**
- G. **Include the recipient's health history**
- H. **Include the disease information necessitating the requested service**
- I. **Include a rationale for the immediacy of the review**

### **Additional required information**

- A. **Submit the rationale used to preliminarily indicate the service is experimental/investigational**
  1. **Include peer-reviewed journal articles in PDF format with links to the online articles**
  2. **Include evidence-based clinical guidelines reviewed by the plan**
- B. **Submit direct contact information (name, phone number, & email address) for the Medical Director**

## Hematopoietic Stem Cell Transplantation for Genetic Diseases and Aplastic Anemias

---

60. Spencer H, Jaffe A. The potential for stem cell therapy in cystic fibrosis. *J R Soc Med.* 2004; 97 Suppl 44:52-56.
  61. Staba SL, Escolar ML, Poe M, et al. Cord-blood transplants from unrelated donors in patients with Hurler's syndrome. *N Engl J Med.* 2004; 350(19):1960-1969.
  62. Steele M, Hitzler J, Doyle JJ, et al. Reduced intensity hematopoietic stem-cell transplantation across human leukocyte antigen barriers in a patient with congenital amegakaryocytic thrombocytopenia and monosomy 7. *Pediatr Blood Cancer.* 2005; 45(2):212-216.
  63. Storb RF, Lucarelli G, McSweeney PA, Childs RW. Hematopoietic cell transplantation for benign hematologic disorders and solid tumors. *Hematology Am Soc Hematol Educ Program.* 2003:372-397.
  64. Tolar, J, Bonfim C, Grewal S, Orchard P. Engraftment and survival following hematopoietic stem cell transplantation for osteopetrosis using a reduced intensity conditioning regimen. *Bone Marrow Transplant.* 2006; 38(12):783-787.
  65. Trigg ME. Milestones in the development of pediatric hematopoietic stem cell transplantation--50 years of progress. *Pediatr Transplant.* 2002; 6(6):465-474.
  66. Vermynen C, Cornu G, Ferster A, et al. Haematopoietic stem cell transplantation for sickle cell anaemia: the first 50 patients transplanted in Belgium. *Bone Marrow Transplant.* 1998; 22(1):1-6.
  67. Vermynen C. Hematopoietic stem cell transplantation in sickle cell disease. *Blood Rev.* 2003; 17(3):163-166.
- 

Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage. The member's contract benefits in effect on the date that services are rendered must be used. Medical Policy, which addresses medical efficacy, should be considered before utilizing medical opinion in adjudication. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from the health plan.

© CPT Only – American Medical Association

The requirements below are specific to the Florida Medicaid Managed Care Plan and are not a part of the Medical Policy or Clinical UM guideline approved by Elevance Health's Medical Policy and Technology Assessment Committee.

**If the Florida Medicaid Managed Care Plan intends to deny coverage on the basis that a diagnostic test, therapeutic procedure, or medical device or technology is experimental or investigational, the Managed Care Plan shall submit a request for coverage determination to the Agency in accordance with rule 59G-1.035, F.A.C and Core SMMC Contract, Attachment II, Section VI.G.4.d.**

**Below is a list of the materials the plans are required to submit when they deny coverage as experimental/investigational:**

- A. **Include the CPT or HCPCS code(s)**
- B. **Include a list of other state Medicaid agencies and private insurers who cover the service**
- C. **Include information about the health service from the U.S. Food and Drug Administration**
- D. **Include known risks of the service and health outcomes of others who have received it**
- E. **Include a list of covered alternative services, if any, that could be used to treat the condition**
- F. **Identify a specific recipient needing the service**
- G. **Include the recipient's health history**
- H. **Include the disease information necessitating the requested service**
- I. **Include a rationale for the immediacy of the review**

### **Additional required information**

- A. **Submit the rationale used to preliminarily indicate the service is experimental/investigational**
  1. **Include peer-reviewed journal articles in PDF format with links to the online articles**
  2. **Include evidence-based clinical guidelines reviewed by the plan**
- B. **Submit direct contact information (name, phone number, & email address) for the Medical Director**

## Hematopoietic Stem Cell Transplantation for Genetic Diseases and Aplastic Anemias

---

68. Walters MC, Nienhuis AW, Vichinsky E. Novel therapeutic approaches in sickle cell disease. Hematology Am Soc Hematol Educ Program. Hematology. 2002:10-34.
69. Walters MC, Patience M, Leisenring W, et al. Bone marrow transplantation for sickle cell disease. N Engl J Med 1996; 335(6):369-376.
70. Walters MC, Storb R, Patience M, et al. Impact of bone marrow transplantation for symptomatic sickle cell disease: an interim report. Multicenter investigation of bone marrow transplantation for sickle cell disease. Blood 2000; 95(6):1918-1924.
71. Wedderburn LR, Abinun M, Palmer P, Foster HE. Autologous hematopoietic stem cell transplantation in juvenile idiopathic arthritis. Arch Dis Child. 2003; 88(3):201-205.
72. Woods G, Bajwa RP, Rose MJ. Reduced intensity transplantation for congenital amegakaryocytic thrombocytopenia: report of a case and review of the literature. Pediatr Transplant. 2014; 18(1): E31-34.
73. Yeşilipek, Hazar V, Küpesiz A, Yegin O. Peripheral stem cell transplantation in a child with amegakaryocytic thrombocytopenia. Bone Marrow Transplant. 2000; 26(5):571-572.

### Government Agency, Medical Society, and Other Authoritative Publications:

1. Centers for Medicare and Medicaid Services. National Coverage Determination for Stem Cell Transplantation. NCD #110.23. Effective January 27, 2016. Available at: <https://www.cms.gov/medicare-coverage->

---

Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage. The member's contract benefits in effect on the date that services are rendered must be used. Medical Policy, which addresses medical efficacy, should be considered before utilizing medical opinion in adjudication. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from the health plan.

© CPT Only – American Medical Association

The requirements below are specific to the Florida Medicaid Managed Care Plan and are not a part of the Medical Policy or Clinical UM guideline approved by Elevance Health's Medical Policy and Technology Assessment Committee.

**If the Florida Medicaid Managed Care Plan intends to deny coverage on the basis that a diagnostic test, therapeutic procedure, or medical device or technology is experimental or investigational, the Managed Care Plan shall submit a request for coverage determination to the Agency in accordance with rule 59G-1.035, F.A.C and Core SMMC Contract, Attachment II, Section VI.G.4.d.**

**Below is a list of the materials the plans are required to submit when they deny coverage as experimental/investigational:**

- A. **Include the CPT or HCPCS code(s)**
- B. **Include a list of other state Medicaid agencies and private insurers who cover the service**
- C. **Include information about the health service from the U.S. Food and Drug Administration**
- D. **Include known risks of the service and health outcomes of others who have received it**
- E. **Include a list of covered alternative services, if any, that could be used to treat the condition**
- F. **Identify a specific recipient needing the service**
- G. **Include the recipient's health history**
- H. **Include the disease information necessitating the requested service**
- I. **Include a rationale for the immediacy of the review**

### Additional required information

- A. **Submit the rationale used to preliminarily indicate the service is experimental/investigational**
  1. **Include peer-reviewed journal articles in PDF format with links to the online articles**
  2. **Include evidence-based clinical guidelines reviewed by the plan**
- B. **Submit direct contact information (name, phone number, & email address) for the Medical Director**

## Hematopoietic Stem Cell Transplantation for Genetic Diseases and Aplastic Anemias

---

[database/details/ncd-details.aspx?NCID=366&ncdver=1&DocID=110.23&bc=gAAAAAg](https://www.ncbi.nlm.nih.gov/pubmed/366&ncdver=1&DocID=110.23&bc=gAAAAAg). Accessed on October 13, 2023.

2. Majhail NS, Farnia SH, Carpenter PA, et al. Indications for Autologous and Allogeneic Hematopoietic Cell Transplantation: Guidelines from the American Society for Blood and Marrow Transplantation. *Biol Blood Marrow Transplant*. 2015; 21(11):1863-1869.
3. National Institute of Health. Evidence-Based Management of Sickle Cell Disease Expert Panel Report, 2014.
4. Origa R. Beta-Thalassemia. September 2000 (Updated 2023). In: Adam MP, Ardinger HH, Pagon RA, et al., editors. *GeneReviews*® (Internet). Seattle (WA): University of Washington, Seattle; 1993-2022. Available at: <https://www.ncbi.nlm.nih.gov/books/NBK1426/>. Accessed October 13, 2023.
5. Oringanje C, Nemecek E, Oniyangi O. Hematopoietic stem cell transplantation for people with sickle cell disease. *Database Syst Rev*. 2020; (7):CD007001.
6. Raymond GV, Moser AB, Fatemi A. X-Linked Adrenoleukodystrophy. 1999 Mar 26 [Updated 2018 Feb 15]. In: Adam MP, Everman DB, Mirzaa GM, et al., editors. *GeneReviews*® [Internet]. Seattle (WA): University of Washington, Seattle; 1993-2022. Available at: <https://www.ncbi.nlm.nih.gov/books/>. Accessed on October 13, 2023.

---

Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage. The member's contract benefits in effect on the date that services are rendered must be used. Medical Policy, which addresses medical efficacy, should be considered before utilizing medical opinion in adjudication. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from the health plan.

© CPT Only – American Medical Association

The requirements below are specific to the Florida Medicaid Managed Care Plan and are not a part of the Medical Policy or Clinical UM guideline approved by Elevance Health's Medical Policy and Technology Assessment Committee.

**If the Florida Medicaid Managed Care Plan intends to deny coverage on the basis that a diagnostic test, therapeutic procedure, or medical device or technology is experimental or investigational, the Managed Care Plan shall submit a request for coverage determination to the Agency in accordance with rule 59G-1.035, F.A.C and Core SMMC Contract, Attachment II, Section VI.G.4.d.**

**Below is a list of the materials the plans are required to submit when they deny coverage as experimental/investigational:**

- A. **Include the CPT or HCPCS code(s)**
- B. **Include a list of other state Medicaid agencies and private insurers who cover the service**
- C. **Include information about the health service from the U.S. Food and Drug Administration**
- D. **Include known risks of the service and health outcomes of others who have received it**
- E. **Include a list of covered alternative services, if any, that could be used to treat the condition**
- F. **Identify a specific recipient needing the service**
- G. **Include the recipient's health history**
- H. **Include the disease information necessitating the requested service**
- I. **Include a rationale for the immediacy of the review**

### **Additional required information**

- A. **Submit the rationale used to preliminarily indicate the service is experimental/investigational**
  1. **Include peer-reviewed journal articles in PDF format with links to the online articles**
  2. **Include evidence-based clinical guidelines reviewed by the plan**
- B. **Submit direct contact information (name, phone number, & email address) for the Medical Director**

## Hematopoietic Stem Cell Transplantation for Genetic Diseases and Aplastic Anemias

7. U.S. Food and Drug Administration. Label and approval information: SKYSONA (elivaldogene autotemcel). Revised September 2022. Available at: <https://www.fda.gov/media/161640/download>. Accessed on October 13, 2023.
8. U.S. Food and Drug Administration. Label and approval information: ZYNTEGLO (betibeglogene autotemcel). Revised August 2022. Available at: <https://www.fda.gov/media/160991/download>. Accessed on October 13, 2023.

### Websites for Additional Information

1. National Cancer Institute. Blood-Forming Stem Cell Transplants. Reviewed August 12, 2013. Available at: <http://www.cancer.gov/cancertopics/factsheet/Therapy/bone-marrow-transplant>. Accessed on October 13, 2023.
2. National Organization of Rare Disorders (NORD). X-Linked Adrenoleukodystrophy. Last published 2019. Available at: <https://rarediseases.org/rare-diseases/adrenoleukodystrophy/#references>. Accessed on October 13, 2023.

### Index

Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage. The member's contract benefits in effect on the date that services are rendered must be used. Medical Policy, which addresses medical efficacy, should be considered before utilizing medical opinion in adjudication. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from the health plan.

© CPT Only – American Medical Association

The requirements below are specific to the Florida Medicaid Managed Care Plan and are not a part of the Medical Policy or Clinical UM guideline approved by Elevance Health's Medical Policy and Technology Assessment Committee.

**If the Florida Medicaid Managed Care Plan intends to deny coverage on the basis that a diagnostic test, therapeutic procedure, or medical device or technology is experimental or investigational, the Managed Care Plan shall submit a request for coverage determination to the Agency in accordance with rule 59G-1.035, F.A.C and Core SMMC Contract, Attachment II, Section VI.G.4.d.**

**Below is a list of the materials the plans are required to submit when they deny coverage as experimental/investigational:**

- A. **Include the CPT or HCPCS code(s)**
- B. **Include a list of other state Medicaid agencies and private insurers who cover the service**
- C. **Include information about the health service from the U.S. Food and Drug Administration**
- D. **Include known risks of the service and health outcomes of others who have received it**
- E. **Include a list of covered alternative services, if any, that could be used to treat the condition**
- F. **Identify a specific recipient needing the service**
- G. **Include the recipient's health history**
- H. **Include the disease information necessitating the requested service**
- I. **Include a rationale for the immediacy of the review**

#### **Additional required information**

- A. **Submit the rationale used to preliminarily indicate the service is experimental/investigational**
  1. **Include peer-reviewed journal articles in PDF format with links to the online articles**
  2. **Include evidence-based clinical guidelines reviewed by the plan**
- B. **Submit direct contact information (name, phone number, & email address) for the Medical Director**

## Hematopoietic Stem Cell Transplantation for Genetic Diseases and Aplastic Anemias

Betibeglogene autotemce (Zynteglo)  
Elivaldogene autotemcel (Skysona)  
Non-Myeloablative Stem Cell Transplant  
Peripheral Blood Stem Cell  
Reduced Intensity Conditioning (RIC) Transplant  
Stem Cell Support (SCS)  
Stem Cell Transplant (SCT)

### Document History

Status	Date	Action
Reviewed	06/28/2024	Updated Coding section related to diagnoses for gene replacement therapy.
Revised	11/09/2023	Medical Policy & Technology Assessment Committee (MPTAC) review. Updated Rationale, References and Websites for Additional Information sections.
Revised	11/10/2022	MPTAC review. Expanded scope of document to address autologous hematopoietic stem cell mobilization and pheresis for the treatment of genetic diseases as part of the development of an FDA-approved ex vivo gene therapy

Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage. The member's contract benefits in effect on the date that services are rendered must be used. Medical Policy, which addresses medical efficacy, should be considered before utilizing medical opinion in adjudication. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from the health plan.

© CPT Only – American Medical Association

The requirements below are specific to the Florida Medicaid Managed Care Plan and are not a part of the Medical Policy or Clinical UM guideline approved by Elevance Health's Medical Policy and Technology Assessment Committee.

**If the Florida Medicaid Managed Care Plan intends to deny coverage on the basis that a diagnostic test, therapeutic procedure, or medical device or technology is experimental or investigational, the Managed Care Plan shall submit a request for coverage determination to the Agency in accordance with rule 59G-1.035, F.A.C and Core SMMC Contract, Attachment II, Section VI.G.4.d.**

**Below is a list of the materials the plans are required to submit when they deny coverage as experimental/investigational:**

- A. Include the CPT or HCPCS code(s)
- B. Include a list of other state Medicaid agencies and private insurers who cover the service
- C. Include information about the health service from the U.S. Food and Drug Administration
- D. Include known risks of the service and health outcomes of others who have received it
- E. Include a list of covered alternative services, if any, that could be used to treat the condition
- F. Identify a specific recipient needing the service
- G. Include the recipient's health history
- H. Include the disease information necessitating the requested service
- I. Include a rationale for the immediacy of the review

#### Additional required information

- A. Submit the rationale used to preliminarily indicate the service is experimental/investigational
  1. Include peer-reviewed journal articles in PDF format with links to the online articles
  2. Include evidence-based clinical guidelines reviewed by the plan
- B. Submit direct contact information (name, phone number, & email address) for the Medical Director

## Hematopoietic Stem Cell Transplantation for Genetic Diseases and Aplastic Anemias

		(for example, betibeglogene autotemce or elivaldogene autotemcel). Updated Description/Scope, Rationale, Background/Overview, Definitions, Coding, References, Websites for Additional Information and Index sections.
Reviewed	11/11/2021	MPTAC review. Updated References and Websites for Additional Information sections.
	10/01/2021	Updated Coding section with 10/01/2021 ICD-10-PCS changes; removed open approach codes deleted 09/30/2021.
Reviewed	11/05/2020	MPTAC review. Updated Rationale, References and Websites for Additional Information sections. Updated Coding section, clarified diagnosis codes for allogeneic transplantation.
Reviewed	11/07/2019	MPTAC review. Updated References and Websites for Additional Information sections.
	10/01/2019	Updated Coding section with 10/01/2019 ICD-10-CM changes to add D81.31 replacing D81.3; and 10/01/2019 ICD-10-PCS changes, added 30230U2-30243U4; removed 30250G0-30263G1, 30250X1-30263Y1 deleted 09/30/2019.
Reviewed	11/08/2018	MPTAC review.

Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage. The member's contract benefits in effect on the date that services are rendered must be used. Medical Policy, which addresses medical efficacy, should be considered before utilizing medical opinion in adjudication. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from the health plan.

© CPT Only – American Medical Association

The requirements below are specific to the Florida Medicaid Managed Care Plan and are not a part of the Medical Policy or Clinical UM guideline approved by Elevance Health's Medical Policy and Technology Assessment Committee.

**If the Florida Medicaid Managed Care Plan intends to deny coverage on the basis that a diagnostic test, therapeutic procedure, or medical device or technology is experimental or investigational, the Managed Care Plan shall submit a request for coverage determination to the Agency in accordance with rule 59G-1.035, F.A.C and Core SMMC Contract, Attachment II, Section VI.G.4.d.**

**Below is a list of the materials the plans are required to submit when they deny coverage as experimental/investigational:**

- A. Include the CPT or HCPCS code(s)
- B. Include a list of other state Medicaid agencies and private insurers who cover the service
- C. Include information about the health service from the U.S. Food and Drug Administration
- D. Include known risks of the service and health outcomes of others who have received it
- E. Include a list of covered alternative services, if any, that could be used to treat the condition
- F. Identify a specific recipient needing the service
- G. Include the recipient's health history
- H. Include the disease information necessitating the requested service
- I. Include a rationale for the immediacy of the review

### Additional required information

- A. Submit the rationale used to preliminarily indicate the service is experimental/investigational
  1. Include peer-reviewed journal articles in PDF format with links to the online articles
  2. Include evidence-based clinical guidelines reviewed by the plan
- B. Submit direct contact information (name, phone number, & email address) for the Medical Director



## Hematopoietic Stem Cell Transplantation for Genetic Diseases and Aplastic Anemias

Reviewed	10/31/2018	Hematology/Oncology Subcommittee review. Updated References and Websites for Additional Information sections.
Revised	11/02/2017	MPTAC review.
Revised	11/01/2017	Hematology/Oncology Subcommittee review. The document header wording updated from "Current Effective Date" to "Publish Date." In the Position Statement, removed the requirement that individuals must meet the "Individual Selection Criteria for all diagnoses". Updated Background/Overview, References and Websites for Additional Information sections.
Reviewed	11/03/2016	MPTAC review.
Reviewed	11/02/2016	Hematology/Oncology Subcommittee review. Formatting updated in Position Statement section. Rationale, Background, References and Websites sections updated.
	10/01/2016	Updated Coding section with 10/01/2016 ICD-10-PCS procedure code changes.
Revised	11/05/2015	MPTAC review.
Revised	11/04/2015	Hematology/Oncology Subcommittee review. Added congenital amegakaryocytic thrombocytopenia (CAMT), dyskeratosis congenita and IPEX syndrome to the

Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage. The member's contract benefits in effect on the date that services are rendered must be used. Medical Policy, which addresses medical efficacy, should be considered before utilizing medical opinion in adjudication. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from the health plan.

© CPT Only – American Medical Association

The requirements below are specific to the Florida Medicaid Managed Care Plan and are not a part of the Medical Policy or Clinical UM guideline approved by Elevance Health's Medical Policy and Technology Assessment Committee.

**If the Florida Medicaid Managed Care Plan intends to deny coverage on the basis that a diagnostic test, therapeutic procedure, or medical device or technology is experimental or investigational, the Managed Care Plan shall submit a request for coverage determination to the Agency in accordance with rule 59G-1.035, F.A.C and Core SMMC Contract, Attachment II, Section VI.G.4.d.**

**Below is a list of the materials the plans are required to submit when they deny coverage as experimental/investigational:**

- A. Include the CPT or HCPCS code(s)
- B. Include a list of other state Medicaid agencies and private insurers who cover the service
- C. Include information about the health service from the U.S. Food and Drug Administration
- D. Include known risks of the service and health outcomes of others who have received it
- E. Include a list of covered alternative services, if any, that could be used to treat the condition
- F. Identify a specific recipient needing the service
- G. Include the recipient's health history
- H. Include the disease information necessitating the requested service
- I. Include a rationale for the immediacy of the review

### **Additional required information**

- A. Submit the rationale used to preliminarily indicate the service is experimental/investigational
  1. Include peer-reviewed journal articles in PDF format with links to the online articles
  2. Include evidence-based clinical guidelines reviewed by the plan
- B. Submit direct contact information (name, phone number, & email address) for the Medical Director

**Hematopoietic Stem Cell Transplantation for Genetic Diseases and Aplastic Anemias**

		medically necessary statement. Rationale, Background Coding and Reference sections updated. Removed ICD-9 codes from Coding section.
Revised	11/13/2014	MPTAC review.
Revised	11/12/2014	Hematology/Oncology Subcommittee review. Acquired aplastic anemia clarified in medically necessary statement. Rationale and Reference sections updated.
Revised	11/14/2013	MPTAC review.
Revised	11/13/2013	Hematology/Oncology Subcommittee review. Reformatted disease specific criteria in position statement. Added Schwachman-Diamond syndrome to medically necessary statement. Rationale and Reference sections updated.
Reviewed	11/08/2012	MPTAC review.
Reviewed	11/07/2012	Hematology/Oncology Subcommittee review. Reference and Rationale sections updated. Updated Coding section with 01/01/2013 CPT changes.
Reviewed	11/17/2011	MPTAC review.
Reviewed	11/16/2011	Hematology/Oncology Subcommittee review. Rationale, Background and Reference sections updated. Minor clarification made to stem cell harvest language in related investigational and not medically necessary statement. Updated Coding section with 01/01/2012 CPT changes.

Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage. The member's contract benefits in effect on the date that services are rendered must be used. Medical Policy, which addresses medical efficacy, should be considered before utilizing medical opinion in adjudication. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from the health plan.

© CPT Only – American Medical Association

The requirements below are specific to the Florida Medicaid Managed Care Plan and are not a part of the Medical Policy or Clinical UM guideline approved by Elevance Health's Medical Policy and Technology Assessment Committee.

**If the Florida Medicaid Managed Care Plan intends to deny coverage on the basis that a diagnostic test, therapeutic procedure, or medical device or technology is experimental or investigational, the Managed Care Plan shall submit a request for coverage determination to the Agency in accordance with rule 59G-1.035, F.A.C and Core SMMC Contract, Attachment II, Section VI.G.4.d.**

**Below is a list of the materials the plans are required to submit when they deny coverage as experimental/investigational:**

- A. Include the CPT or HCPCS code(s)**
- B. Include a list of other state Medicaid agencies and private insurers who cover the service**
- C. Include information about the health service from the U.S. Food and Drug Administration**
- D. Include known risks of the service and health outcomes of others who have received it**
- E. Include a list of covered alternative services, if any, that could be used to treat the condition**
- F. Identify a specific recipient needing the service**
- G. Include the recipient's health history**
- H. Include the disease information necessitating the requested service**
- I. Include a rationale for the immediacy of the review**

**Additional required information**

- A. Submit the rationale used to preliminarily indicate the service is experimental/investigational**
  - 1. Include peer-reviewed journal articles in PDF format with links to the online articles**
  - 2. Include evidence-based clinical guidelines reviewed by the plan**
- B. Submit direct contact information (name, phone number, & email address) for the Medical Director**

## Hematopoietic Stem Cell Transplantation for Genetic Diseases and Aplastic Anemias

	10/01/2011	Updated Coding section with 10/01/2011 ICD-9 changes.
Revised	11/18/2010	MPTAC review.
Revised	11/17/2010	Hematology/Oncology Subcommittee review. Medically necessary statement clarified with the addition of a sentence indicating that individuals with Aplastic Anemia, Sickle cell Disease or Thalassemia should also meet the Disease Specific criteria. Replaced “bone marrow” with “hematopoietic stem cell” in the investigational and not medically necessary statement addressing planned tandems. Removed “suitably matched HLA donor” from the disease specific criteria. Description, Rationale, Background, References, Definitions, and Index updated.
Revised	11/19/2009	MPTAC review.
Revised	11/18/2009	Hematology/Oncology Subcommittee review. Title modified. Clarified Patient Selection Criteria and stem cell harvest criteria. Updated rationale, background, references and websites.
	05/21/2009	Updated rationale to include information about stem cell “boosts”. Background, references and websites updated.
Revised	11/20/2008	MPTAC review.

Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage. The member’s contract benefits in effect on the date that services are rendered must be used. Medical Policy, which addresses medical efficacy, should be considered before utilizing medical opinion in adjudication. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from the health plan.

© CPT Only – American Medical Association

The requirements below are specific to the Florida Medicaid Managed Care Plan and are not a part of the Medical Policy or Clinical UM guideline approved by Elevance Health’s Medical Policy and Technology Assessment Committee.

**If the Florida Medicaid Managed Care Plan intends to deny coverage on the basis that a diagnostic test, therapeutic procedure, or medical device or technology is experimental or investigational, the Managed Care Plan shall submit a request for coverage determination to the Agency in accordance with rule 59G-1.035, F.A.C and Core SMMC Contract, Attachment II, Section VI.G.4.d.**

**Below is a list of the materials the plans are required to submit when they deny coverage as experimental/investigational:**

- A. Include the CPT or HCPCS code(s)
- B. Include a list of other state Medicaid agencies and private insurers who cover the service
- C. Include information about the health service from the U.S. Food and Drug Administration
- D. Include known risks of the service and health outcomes of others who have received it
- E. Include a list of covered alternative services, if any, that could be used to treat the condition
- F. Identify a specific recipient needing the service
- G. Include the recipient’s health history
- H. Include the disease information necessitating the requested service
- I. Include a rationale for the immediacy of the review

**Additional required information**

- A. Submit the rationale used to preliminarily indicate the service is experimental/investigational
  - 1. Include peer-reviewed journal articles in PDF format with links to the online articles
  - 2. Include evidence-based clinical guidelines reviewed by the plan
- B. Submit direct contact information (name, phone number, & email address) for the Medical Director

## Hematopoietic Stem Cell Transplantation for Genetic Diseases and Aplastic Anemias

Revised	11/19/2008	Hematology/Oncology Subcommittee review. Clarified Patient Selection Criteria. Updated websites.
Reviewed	05/15/2008	MPTAC review.
Reviewed	05/14/2008	Hematology/Oncology Subcommittee review. Revised title to Aplastic Anemias. Updated background and references.
	01/01/2008	Updated Coding section with 01/01/2008 HCPCS changes; removed HCPCS G0267 deleted 12/31/2007. Added definitions, corrected ECOG score information. The phrase “investigational/not medically necessary” was clarified to read “investigational and not medically necessary.” This change was approved at the November 29, 2007 MPTAC meeting.
Revised	05/17/2007	MPTAC review.
Revised	05/16/2007	Hematology/Oncology Subcommittee review. Added informational note to reference TRANS.00016 Umbilical Cord Blood Progenitor Cell Collection, Storage and Transplantation. Addition of cystic fibrosis in the investigational/not medically necessary statement for autologous stem cell transplant. Updated background, references and coding.
Revised	12/07/2006	MPTAC review.

Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage. The member’s contract benefits in effect on the date that services are rendered must be used. Medical Policy, which addresses medical efficacy, should be considered before utilizing medical opinion in adjudication. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from the health plan.

© CPT Only – American Medical Association

The requirements below are specific to the Florida Medicaid Managed Care Plan and are not a part of the Medical Policy or Clinical UM guideline approved by Elevance Health’s Medical Policy and Technology Assessment Committee.

**If the Florida Medicaid Managed Care Plan intends to deny coverage on the basis that a diagnostic test, therapeutic procedure, or medical device or technology is experimental or investigational, the Managed Care Plan shall submit a request for coverage determination to the Agency in accordance with rule 59G-1.035, F.A.C and Core SMMC Contract, Attachment II, Section VI.G.4.d.**

**Below is a list of the materials the plans are required to submit when they deny coverage as experimental/investigational:**

- A. Include the CPT or HCPCS code(s)**
- B. Include a list of other state Medicaid agencies and private insurers who cover the service**
- C. Include information about the health service from the U.S. Food and Drug Administration**
- D. Include known risks of the service and health outcomes of others who have received it**
- E. Include a list of covered alternative services, if any, that could be used to treat the condition**
- F. Identify a specific recipient needing the service**
- G. Include the recipient’s health history**
- H. Include the disease information necessitating the requested service**
- I. Include a rationale for the immediacy of the review**

**Additional required information**

- A. Submit the rationale used to preliminarily indicate the service is experimental/investigational**
  - 1. Include peer-reviewed journal articles in PDF format with links to the online articles**
  - 2. Include evidence-based clinical guidelines reviewed by the plan**
- B. Submit direct contact information (name, phone number, & email address) for the Medical Director**

**Hematopoietic Stem Cell Transplantation for Genetic Diseases and Aplastic Anemias**

Revised	12/06/2006	Hematology/Oncology Subcommittee review. Addition of med nec statement for primary graft failure and inv/nmn statement for second or repeat transplant.
Revised	06/08/2006	MPTAC review.
Revised	06/07/2006	Hematology/Oncology Subcommittee review. Revision to general patient selection criteria.
Revised	12/01/2005	MPTAC review.
Revised	11/30/2005	Hematology/Oncology Subcommittee review. Eliminated age requirements and revised general patient selection criteria.
	11/22/2005	Added reference for Centers for Medicare and Medicaid Services (CMS) – National Coverage Determination (NCD).
Reviewed	07/14/2005	MPTAC review.
Revised	04/28/2005	MPTAC review. Revision based on Pre-merger Anthem and Pre-merger WellPoint Harmonization.

<b>Pre-Merger Organizations</b>	<b>Last Review Date</b>	<b>Document Number</b>	<b>Title</b>
---------------------------------	-------------------------	------------------------	--------------

Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage. The member’s contract benefits in effect on the date that services are rendered must be used. Medical Policy, which addresses medical efficacy, should be considered before utilizing medical opinion in adjudication. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from the health plan.

© CPT Only – American Medical Association

The requirements below are specific to the Florida Medicaid Managed Care Plan and are not a part of the Medical Policy or Clinical UM guideline approved by Elevance Health’s Medical Policy and Technology Assessment Committee.

**If the Florida Medicaid Managed Care Plan intends to deny coverage on the basis that a diagnostic test, therapeutic procedure, or medical device or technology is experimental or investigational, the Managed Care Plan shall submit a request for coverage determination to the Agency in accordance with rule 59G-1.035, F.A.C and Core SMMC Contract, Attachment II, Section VI.G.4.d.**

**Below is a list of the materials the plans are required to submit when they deny coverage as experimental/investigational:**

- A. Include the CPT or HCPCS code(s)**
- B. Include a list of other state Medicaid agencies and private insurers who cover the service**
- C. Include information about the health service from the U.S. Food and Drug Administration**
- D. Include known risks of the service and health outcomes of others who have received it**
- E. Include a list of covered alternative services, if any, that could be used to treat the condition**
- F. Identify a specific recipient needing the service**
- G. Include the recipient’s health history**
- H. Include the disease information necessitating the requested service**
- I. Include a rationale for the immediacy of the review**

**Additional required information**

- A. Submit the rationale used to preliminarily indicate the service is experimental/investigational**
  - 1. Include peer-reviewed journal articles in PDF format with links to the online articles**
  - 2. Include evidence-based clinical guidelines reviewed by the plan**
- B. Submit direct contact information (name, phone number, & email address) for the Medical Director**

**Hematopoietic Stem Cell Transplantation for Genetic Diseases and Aplastic Anemias**

Anthem, Inc.	10/28/2004	TRANS.00002	Stem Cell Transplant following Chemotherapy for Malignant Diseases
WellPoint Health Networks, Inc.	12/02/2004	7.11.03	Allogeneic Bone Marrow or Stem Cell Transplantation
	12/02/2004	7.11.05	Mini-Transplants
	12/02/2004	Clinical Guideline	Bone Marrow Transplant for Inherited Genetic Disorders
	12/02/2004	Clinical Guideline	Bone Marrow Transplant for Non-Malignant Hematologic Disorders

Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage. The member’s contract benefits in effect on the date that services are rendered must be used. Medical Policy, which addresses medical efficacy, should be considered before utilizing medical opinion in adjudication. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from the health plan.

© CPT Only – American Medical Association

The requirements below are specific to the Florida Medicaid Managed Care Plan and are not a part of the Medical Policy or Clinical UM guideline approved by Elevance Health’s Medical Policy and Technology Assessment Committee.

**If the Florida Medicaid Managed Care Plan intends to deny coverage on the basis that a diagnostic test, therapeutic procedure, or medical device or technology is experimental or investigational, the Managed Care Plan shall submit a request for coverage determination to the Agency in accordance with rule 59G-1.035, F.A.C and Core SMMC Contract, Attachment II, Section VI.G.4.d.**

**Below is a list of the materials the plans are required to submit when they deny coverage as experimental/investigational:**

- A. Include the CPT or HCPCS code(s)**
- B. Include a list of other state Medicaid agencies and private insurers who cover the service**
- C. Include information about the health service from the U.S. Food and Drug Administration**
- D. Include known risks of the service and health outcomes of others who have received it**
- E. Include a list of covered alternative services, if any, that could be used to treat the condition**
- F. Identify a specific recipient needing the service**
- G. Include the recipient’s health history**
- H. Include the disease information necessitating the requested service**
- I. Include a rationale for the immediacy of the review**

**Additional required information**

- A. Submit the rationale used to preliminarily indicate the service is experimental/investigational**
  - 1. Include peer-reviewed journal articles in PDF format with links to the online articles**
  - 2. Include evidence-based clinical guidelines reviewed by the plan**
- B. Submit direct contact information (name, phone number, & email address) for the Medical Director**