Bone Marrow and/or Peripheral Blood Stem Cell Transplant
SRG-004

Iowa Medicaid Program	Prior Authorization	**Effective Date**	09/11/2009
Revision Number	8	**Last Reviewed**	10/16/2026
Reviewed By	Transplant Consultant, MMD	**Next Review**	10/15/2027
Approved By	Medicaid Clinical Advisory Committee	**Approved Date**	09/12/2019

Criteria

Prior authorization is required.

Bone Marrow and/or Peripheral Blood Stem Cell Transplant are considered medically necessary when **ALL** the following are met:

1. Must have clearance from psych/social consult; **AND**
2. Documentation of underlying co-morbidity(ies); **AND**
3. Pertinent lab values; **AND**
4. All radiology results pertinent to the disease process for which treatment is being requested; **AND**
5. Member has a diagnosis which is amenable to treatment with a stem cell transplant.

Solid tumor requests which are not currently covered under 441-78.1(20)"a"(2) or (3) will be handled through the Exception to Policy process.

Coding

The following list of codes is provided for reference purposes only and may not be all inclusive. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment, nor does the exclusion of a code imply that its association to the HCPCS/CPT code is inappropriate.

CPT	Description
38240	HPC allogeneic transplantation per donor.
38241	HPC autologous transplantation.

Compliance

1. Should conflict exist between this policy and applicable statute, the applicable statute shall supersede.
2. Federal and State law, as well as contract language, including definitions and specific contract provisions or exclusions, take precedence over medical policy and must be considered first in determining eligibility for coverage.
3. Medical technology is constantly evolving, and Iowa Medicaid reserves the right to review and update medical policy on an annual and as-needed basis.

Medical necessity guidelines have been developed for determining coverage for member benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. Criteria are revised and updated annually, or more frequently if new evidence becomes available that suggests needed revisions.

References

Ohler, L. & Cupples, S., (2008). Core Curriculum for Transplant Nurses. Mosby Elsevier, Philadelphia, PA.

IAC 441-78.1(20)”a”(2) or (3).

Deeg HJ. Sandmaier BM. Allogeneic hematopoietic cell transplantation: Indications, eligibility, and prognosis. UpToDate. This topic last updated: Jan 30, 2025. Accessed 6/17/2025

Negrin RS. Hematopoietic cell transplantation (HCT): Sources of hematopoietic stem/progenitor cells. UpToDate. This topic last updated: Jan 19, 2024. Accessed 6/17/2025

Stem Cell Transplantation. National Coverage Determination. CMS. Manual Section Number 110.23. Implementation Date 10/07/2024.

Development of utilization management criteria may also involve research into other state Medicaid programs, other payer policies, consultation with experts and review by the Medicaid Clinical Advisory Committee (CAC). These sources may not be referenced individually unless they are specifically published and are otherwise applicable to the criteria at issue.

Criteria Change History

Criteria Change History

Signature

Signature

Change Date	Changed By	Description of Change	Version
10/16/2026	CAC	Annual Specialist Review.	8
Signature William (Bill) Jagiello, DO			
Change Date	**Changed By**	**Description of Change**	**Version**
07/18/2025	CAC	Annual Specialist Review. References updated. Dental Clearance removed from criteria.	7
Signature William (Bill) Jagiello, DO			
Change Date	**Changed By**	**Description of Change**	**Version**
04/19/2024	CAC	Annual Review.	6
Signature William (Bill) Jagiello, DO			
Change Date	**Changed By**	**Description of Change**	**Version**
01/20/2023	CAC	Annual Review.	5
Signature William (Bill) Jagiello, DO			
Change Date	**Changed By**	**Description of Change**	**Version**
01/21/2022	CAC	Annual review. Formatting changes.	4
Signature William (Bill) Jagiello, DO			
Change Date	**Changed By**	**Description of Change**	**Version**
03/13/2018		Added Criterion #6.	3
Signature C. David Smith, MD			
Change Date	**Changed By**	**Description of Change**	**Version**
04/17/2015		Added last paragraph in References.	2
Signature			
Change Date	**Changed By**	**Description of Change**	**Version**
06/19/2014	Policy	Under criteria added IAC reference and also added under References.	1
Signature			

CAC = Medicaid Clinical Advisory Committee