Clinical Policy: Stem Cell Therapy for Musculoskeletal Conditions

Reference Number: WA.CP.MP.526 Coding Implications
Date of Last Revision: 02/23 Revision Log
Effective Date: 03/01/23

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

This policy describes the medical necessity guidelines for stem cell therapy for musculoskeletal conditions.

Policy/Criteria

I. It is the policy of Coordinated Care of Washington, Inc., in accordance with the Health Care Authority's Health Technology Assessment, that stem cell therapy is **not medically necessary** for the treatment of musculoskeletal conditions.

Background

This policy is based on the Washington State Health Care Authority (HCA) Health Technology Assessment (HTA).

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2019, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT® Codes	Description
38205	Blood derived hematopoietic progenitor cell harvesting for transplantation, per collection, allogeneic
38206	Blood derived hematopoietic progenitor cell harvesting for transplantation, autologous
38212	Transplant preparation of hematopoietic progenitor cells; red blood cell removal
38215	Transplant preparation of hematopoietic progenitor cells; cell concentration in plasma, mononuclear or buffy coat layer
38230	Bone marrow harvesting for transplantation; allogeneic
38232	Bone marrow harvesting for transplantation; autologous
38240	Hematopoietic progenitor cell (HPC); allogeneic transplantation per donor
38241	Hematopoietic progenitor cell (HPC); autologous transplantation
0565T	Autologous cellular implant derived from adipose tissue for the treatment of osteoarthritis of the knees; tissue harvesting and cellular implant creation

CPT® Codes	Description
0566T	Autologous cellular implant derived from adipose tissue for the treatment of osteoarthritis of the knees; injxn of implant into knee joint incl. ultrasound guidance

HCPCS Codes	Description
S2150	Bone marrow or blood-derived stem cells (peripheral or umbilical), allogeneic or autologous, harvesting, transplantation, and related complications; including: pheresis and cell preparation/storage; marrow ablative therapy; drugs, supplies, hospitalization with outpatient follow-up; medical/surgical, diagnostic, emergency, and rehabilitative services; and the number of days of pre and post-transplant care in the global definition

Reviews, Revisions, and Approvals	Date	Approval Date
Policy developed.	02/21	03/21
Annual review. Changed headings to "Date of Last Revision" and added "Effective Date". Replaced "not covered" with "not medically necessary". Updated references.	02/22	02/22
Annual review. Updated references. Added CPT codes 38230 and 38232 and HCPCS code S2150.	02/23	02/23

References

1. Skelly, A., Brodt, E., Junge, M., Kantner, S. (Aggregate Analytics). *Stem Cell Therapy for Musculoskeletal Conditions*. Washington Health Technology Assessment. February 17, 2020.
2. Washington State Health Care Authority. *Physician-related Services/Health Care Billing Guide*. https://www.hca.wa.gov/assets/billers-and-providers/Physician-related-services-bg-20230101.pdf Revision effective January 1, 2023.

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

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Note: For Medicaid members/enrollees, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

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