PriorityHealth

MEDICAL POLICY
No. 91459-R1

UMBILICAL CORD BLOOD TESTING AND STORAGE

Effective Date: June 4, 2015	**Review Dates: 10/02, 9/03, 9/04, 9/05, 8/06, 6/07, 6/08, 6/09, 6/10, 6/11, 6/12, 6/13, 5/14, 5/15, 5/16, 5/17, 5/18**
Date Of Origin: October 23, 2002	**Status: Current**

I. POLICY/CRITERIA

Charges to randomly test, freeze and/or store umbilical cord blood for possible future use are not covered.

Compatibility testing and storage of umbilical cord blood may be covered if the criteria defined below are met.

Compatibility **testing** of umbilical cord blood is a covered benefit if **all** of the following apply:

1. an accepted indication for an allogeneic transplant exists*
2. the intended recipient of the transplant is a first-degree relative (parent, sibling) of the infant
3. the intended recipient of the transplant is a current member

Storage of umbilical cord blood is a covered benefit if **all** of the following apply:

1. a clinically acceptable match is present
2. an accepted indication for a allogeneic transplant exists*
3. the intended recipient of the transplant is a current member

*See the Stem Cell/Bone Marrow Transplantation medical policy for allogeneic transplant coverage criteria

II. MEDICAL NECESSITY REVIEW

☐ Required ☒ Not Required ☐ Not Applicable

III. APPLICATION TO PRODUCTS

Coverage is subject to member's specific benefits. Group specific policy will supersede this policy when applicable.

- **HMO/EPO:** ***This policy applies to insured HMO/EPO plans.***
- **POS:** ***This policy applies to insured POS plans.***
- **PPO:** ***This policy applies to insured PPO plans. Consult individual plan documents as state mandated benefits may apply. If there is a conflict between this policy and a plan document, the provisions of the plan document will govern.***

- **ASO:** ***For self-funded plans, consult individual plan documents. If there is a conflict between this policy and a self-funded plan document, the provisions of the plan document will govern.***
- **INDIVIDUAL:** ***For individual policies, consult the individual insurance policy. If there is a conflict between this medical policy and the individual insurance policy document, the provisions of the individual insurance policy will govern.***
- **MEDICARE:** ***Coverage is determined by the Centers for Medicare and Medicaid Services (CMS); if a coverage determination has not been adopted by CMS, this policy applies.***
- **MEDICAID/HEALTHY MICHIGAN PLAN:** ***For Medicaid/Healthy Michigan Plan members, this policy will apply. Coverage is based on medical necessity criteria being met and the appropriate code(s) from the coding section of this policy being included on the Michigan Medicaid Fee Schedule located at: http://www.michigan.gov/mdch/0,1607,7-132-2945_42542_42543_42546_42551-159815--,00.html. If there is a discrepancy between this policy and the Michigan Medicaid Provider Manual located at: http://www.michigan.gov/mdch/0,1607,7-132-2945_5100-87572--,00.html, the Michigan Medicaid Provider Manual will govern. If there is a discrepancy or lack of guidance in the Michigan Medicaid Provider Manual, the Priority Health contract with Michigan Medicaid will govern. For Medical Supplies/DME/Prosthetics and Orthotics, please refer to the Michigan Medicaid Fee Schedule to verify coverage.***

IV. DESCRIPTION

Umbilical cord blood stem cells can be used as an alternative to a conventional allogeneic bone marrow transplant for a variety of marrow - based disorders, such as leukemia, aplastic anemia and certain inherited metabolic disorders. Compatibility testing may be done on Chorionic Villous Sampling (CVS) specimens, amniocytes obtained by amniocentesis, or on the cord blood itself.

V. CODING INFORMATION

ICD-10 Diagnosis Codes*:*
Not specified

CPT/HCPCS Codes:
No prior auth

59899	Unlisted procedure, maternity care and delivery
38999	Unlisted procedure, hemic or lymphatic system
59000	Amniocentesis; diagnostic
59012	Cordocentesis (intrauterine), any method
59015	Chorionic villus sampling, any method
86812	HLA typing; A, B, or C (eg, A10, B7, B27), single antigen
86813	HLA typing; A, B, or C, multiple antigens
86816	HLA typing; DR/DQ, single antigen
86817	HLA typing; DR/DQ, multiple antigens
86821	HLA typing; lymphocyte culture, mixed (MLC)

**Not in fee schedule

88240 Cryopreservation, freezing and storage of cells, each cell line
88241 Thawing and expansion of frozen cells, each aliquot
Auth required (see medical policy 91066 Stem Cell or Bone Marrow Transplantation)
38205 Blood-derived hematopoietic progenitor cell harvesting for transplantation, per collection; allogeneic
38207 Transplant preparation of hematopoietic progenitor cells; cryopreservation and storage
38209 Transplant preparation of hematopoietic progenitor cells; thawing of previously frozen harvest, with washing, per donor

("S" codes not payable for Priority Health Medicaid or Medicare)
S2140 Cord blood harvesting for transplantation, allogeneic
S2142 Cord blood-derived stem-cell transplantation, allogeneic

VI. REFERENCES

Umbilical Cord Blood Compatibility Testing, Coverage Policy Bulletin, Number 0190, Aetna U.S. Healthcare, www.aetna.com/cpb

Umbilical Cord Blood Banking, Cigna Medical Coverage Policy @https://cignaforhcp.cigna.com/web/ (Retrieved March 25, 2016 , March 13, 2017 & March 28, 2018)

Stem Cells for Hematopoietic Cell Transplant, Aetna Clinical Policy Bulletin @ http://www.aetna.com/cpb/medical/data/100_199/0190.html (Retrieved March 13, 2017 & March 28, 2018)