Mesenchymal Stem Cell Therapy
For Orthopedic Conditions

Policy Number: 2018M0203A
Effective Date: May 14, 2018

Last Review Date: April 27, 2018
Next Review Date: May 14, 2020

Important Information - Please Read Before Using This Policy

UCare has developed medical policies to assist in the determination of coverage of a clinical service (such as a procedure, therapy, diagnostic test, medical device, etc.), when coverage requires determination of medical necessity. Clinical services referenced in UCare’s medical policies may not be covered by every UCare plan. Coverage is determined by federal and state regulation and by member contract materials, such as the Evidence of Coverage (EOC), Member Contract, or Member Handbook. This medical policy alone does not guarantee coverage.

Coverage is subject to the benefits or restrictions of the member’s specific plan, which will supersede this medical policy when applicable. Please refer to the end of this document to read “How Coverage Is Determined in Specific UCare Plans.”

UCare’s medical policies are periodically reviewed and updated using published clinical evidence. In addition to medical policies, UCare uses tools for determination of medical necessity that are developed by external sources, including but not limited to McKesson InterQual Criteria and Hayes Inc. Knowledge Center. This medical policy does not constitute the practice of medicine or medical advice. Treating health care providers are solely responsible for determining what care to provide to patients. Members should always consult their provider before making any decisions about medical care.

Administrative Procedure

Prior authorization is NOT applicable for Mesenchymal Stem Cell Therapy for orthopedic conditions because UCare considers the procedure investigational. CPT® codes are listed below in the codes section.

UCare prior authorization form is available here:
https://www.UCare.org/providers/Eligibility-Authorizations/Pages/EligibilityAuth.aspx
Definitions and Scope of this Policy

This policy addresses the use of Mesenchymal Stem Cell (MSC) therapy for regeneration in orthopedic conditions.

Mesenchymal Stem cells: are a type of cell that may develop into other types of cells (for example bone, tendon, articular cartilage, ligaments, or muscle). They may be autologous or purchased commercially.

Mesenchymal Stem Cell Therapy: Infusion or implantation of MSCs into various anatomic sites to promote healing or regeneration of damaged cartilage or bone.

Orthopedic indications: regeneration of cartilage, bone, or spine.

Osteoarthritis: degeneration of joint cartilage and the underlying bone.

Regeneration of bone, cartilage, or spine: the process of stimulating repair or replacement of damaged bone, cartilage or spine.

Medical Necessity Criteria

Mesenchymal stem cell therapy for orthopedic conditions
UCare considers mesenchymal stem cell therapy investigational and not medically necessary for orthopedic conditions including but not limited to the following:
- Avascular necrosis of the femoral head.
- Bone fractures and nonunions.
- Osteoarthritis
- Osteochondral defects
- Osteonecrosis
- Repair and regeneration of musculoskeletal tissue.
- Spinal fusion procedures.
- Orthopedic diseases of the spine.

Applicable Codes

The Current Procedural Terminology (CPT®) codes and HCPCS codes listed in this policy are for reference purposes only. Listing of a service or device code in this policy does not imply that the service described by this code is a covered or non-covered health service. The inclusion of a code does not imply any right to reimbursement or guarantee claims payment. Other medical policies
and coverage determination guidelines may apply.

<table>
<thead>
<tr>
<th>CPT® Code Ranges Applicable To This Policy</th>
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<tbody>
<tr>
<td>20930 Allograft, morselized, or placement of osteopromotive material, for spine surgery only</td>
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<tr>
<td>20999 Unlisted procedure, musculoskeletal system, general (specified as MSC implant)</td>
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<tr>
<td>21899 Unlisted procedure, neck or thorax</td>
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<tr>
<td>22899 Unlisted procedure, spine</td>
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<tr>
<td>23929 Unlisted procedure, shoulder</td>
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<tr>
<td>26989 Unlisted procedure, hands or fingers</td>
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<tr>
<td>27299 Unlisted procedure, pelvis or hip joint</td>
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<tr>
<td>27599 Unlisted procedure, femur or knee</td>
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<tr>
<td>27899 Unlisted procedure, leg or ankle</td>
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<tr>
<td>28899 Unlisted procedure, foot or toes</td>
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<tr>
<td>29999 Unlisted procedure, arthroscopy</td>
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<tr>
<td>38205 Blood derived hematopoietic progenitor cell harvesting for transplantation, per collection allogeneic.</td>
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<tr>
<td>38206 Blood-derived hematopoietic progenitor cell harvesting for transplantation, per collection; autologous</td>
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<tr>
<td>38220 Bone marrow aspiration</td>
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<tr>
<td>38230 Bone marrow harvesting for transplantation; allogeneic</td>
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<tr>
<td>38232 Bone marrow harvesting for transplantation; autologous</td>
</tr>
<tr>
<td>38241 Bone Marrow or blood-derived peripheral stem cell transplantation; autologous</td>
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<tr>
<td>HCPCS None</td>
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</tbody>
</table>

CPT® is a registered trademark of the American Medical Association.

How Coverage Is Determined In Specific UCare Plans

- **Commercial: UCare Choices/Fairview UCare Choices:**
  Coverage is determined by the Member Contract. If there is a conflict between this medical policy and the individual Member Contract, the provisions of the Member Contract will govern.

- **Medicare Advantage: UCare for Seniors (HMO Point-of-Service) and EssentiaCare (Preferred Provider Organization):**
  Coverage is determined by guidance from the Centers for Medicare & Medicaid Services (CMS) National Coverage Determination (NCD) or applicable CMS Local Coverage Determination (LCD) and the applicable UCare Evidence of Coverage (EOC). This medical policy applies in the absence of CMS guidance and/or EOC language.
Medicaid – MinnesotaCare: Prepaid Medical Assistance Program (PMAP), UCare Connect (non-SNP/non-integrated), Minnesota Senior Care Plus (MSC+), and MinnesotaCare Coverage is determined by the applicable Evidence of Coverage (also known as the “Member Handbook”) and guidance from the Minnesota Department of Human Services (DHS) Minnesota Health Care Programs (MHCP) Provider Manual. This medical policy applies if DHS coverage criteria are not available.

Medicare Advantage – Dual Eligible Special Needs Plan: UCare Connect + Medicare and Minnesota Senior Health Options (MSHO)
Medicare coverage is determined by the applicable Member Handbook (MSHO) or Evidence of Coverage (UCare Connect + Medicare) and guidance from the Centers for Medicare & Medicaid Services (CMS). This medical policy applies in the absence of CMS guidance and/or EOC language.

Medicaid coverage is determined by the applicable Member Handbook (MSHO) or Evidence of Coverage (UCare Connect + Medicare), and guidance from the DHS MHCP Provider Manual. This medical policy applies if coverage criteria have not been determined by DHS.

Revision History
4/27/2018