



IEHP UM Subcommittee Approved Authorization Guideline			
Guideline	Bone Marrow Transplant in the Treatment of Multiple Sclerosis	Guideline #	UM_NEU 01
		Original Effective Date	01/26/2008
Section	Neurology	Revision Date	12/15/2021

COVERAGE POLICY

Bone Marrow Transplant in the Treatment of Multiple Sclerosis is experimental and investigational and therefore not covered.

COVERAGE LIMITATIONS AND EXCLUSIONS

N/A

ADDITIONAL INFORMATION

N/A

CLINICAL/REGULATORY RESOURCE

Medicare: No National Coverage Determinations or Local Coverage Determinations pertaining to this treatment.

Medi-Cal: No guidelines regarding this treatment.

Apollo Medical Review Criteria Guidelines for Managing Care: Multiple sclerosis is not listed as an indication for treatment with stem cells from bone marrow or cord blood.

Aetna: Hematopoietic cell transplantation (autologous or allogeneic) is considered experimental and investigational for multiple sclerosis.

American Society for Blood and Marrow Transplantation: Multiple sclerosis is not a recommended indication for allogeneic hematopoietic stem cell transplant and is recommended for only clinical studies for autologous hematopoietic stem cell transplant.

DEFINITION OF TERMS

N/A

REFERENCES

1. Aetna Medical Policy Bulletin 0606.2021. Hematopoietic Cell Transplantation for Autoimmune Diseases and Miscellaneous Indications. http://www.aetna.com/cpb/medical/data/600_699/0606.html. Accessed December 9, 2021.
2. Apollo Medical Review Criteria Guidelines for Managing Care, 20th edition, 2021. HO 105 Stem Cell Transplantation; Bone Marrow or Cord Blood.

3. Majhail, Navneet S, Stephanie H Farnia, Paul A Carpenter, Richard E Champlin, Stephen Crawford, David I Marks, James L Omel, Paul J Orchard, Jeanne Palmer, Wael Saber, Bipin N Savani, Paul A Veys, Christopher N Bredeson, MD, MSc, Sergio A Giral, Charles F LeMaistre. 2015. Indications for Autologous and Allogeneic Hematopoietic Cell Transplantation: Guidelines from the American Society for Blood and Marrow Transplantation, Biol Blood Marrow Transplant 21(11): 1863-1869.

DISCLAIMER

IEHP Clinical Authorization Guidelines (CAG) are developed to assist in administering plan benefits, they do not constitute a description of plan benefits. The Clinical Authorization Guidelines (CAG) express IEHP's determination of whether certain services or supplies are medically necessary, experimental and investigational, or cosmetic. IEHP has reached these conclusions based upon a review of currently available clinical information (including clinical outcome studies in the peer-reviewed published medical literature, regulatory status of the technology, evidence-based guidelines of public health and health research agencies, evidence-based guidelines and positions of leading national health professional organizations, views of physicians practicing in relevant clinical areas, and other relevant factors). IEHP makes no representations and accepts no liability with respect to the content of any external information cited or relied upon in the Clinical Authorization Guidelines (CAG). IEHP expressly and solely reserves the right to revise the Clinical Authorization Guidelines (CAG), as clinical information changes.