

Hematopoietic Cell Transplantation for Solid Tumors of Childhood

Policy # 00064

Original Effective Date: 01/28/2002

Current Effective Date: 08/01/2026

Applies to all products administered or underwritten by Blue Cross and Blue Shield of Louisiana and its subsidiary, HMO Louisiana, Inc. (collectively referred to as the "Company"), unless otherwise provided in the applicable contract. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

Investigational or experimental services are not covered. This includes any drug, device, procedure, or service provided under the investigational arm of a clinical trial or clinical study. These services are excluded from coverage under benefits.

Note: Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma is addressed separately in medical policy 00063.

When Services May Be Eligible for Coverage

Coverage for eligible medical treatments or procedures, drugs, devices or biological products may be provided only if:

- *Benefits are available in the member's contract/certificate, and*
- *Medical necessity criteria and guidelines are met.*

Based on review of available data, the Company may consider autologous hematopoietic cell transplantation (HCT) for the following conditions to be **eligible for coverage:****

- Initial treatment of high-risk neuroblastoma; **OR**
- Recurrent or refractory neuroblastoma; **OR**
- Initial treatment of high-risk Ewing's sarcoma; **OR**
- Recurrent or refractory Ewing's sarcoma; **OR**
- Metastatic retinoblastoma.

Based on review of available data, the Company may consider tandem autologous hematopoietic cell transplantation (HCT) for high-risk neuroblastoma to be **eligible for coverage.****

When Services Are Considered Not Medically Necessary

The use of autologous hematopoietic cell transplantation (HCT) or tandem autologous HCT when coverage criteria are not met, including as initial treatment of low- or intermediate-risk neuroblastoma, initial treatment of low- or intermediate-risk Ewing's sarcoma, is considered to be **not medically necessary.****

When Services Are Considered Investigational

Coverage is not available for investigational medical treatments or procedures, drugs, devices or biological products.

Hematopoietic Cell Transplantation for Solid Tumors of Childhood

Policy # 00064

Original Effective Date: 01/28/2002

Current Effective Date: 08/01/2026

Based on review of available data, the Company considers autologous hematopoietic cell transplantation (HCT) for other solid tumors of childhood including, but not limited, to the following to be **investigational**.*

- Rhabdomyosarcoma (RMS); **OR**
- Wilm's tumor; **OR**
- Osteosarcoma; **OR**
- Retinoblastoma without metastasis.

Based on review of available data, the Company considers tandem autologous hematopoietic cell transplantation (HCT) for the treatment of all other types of pediatric solid tumors (except high-risk neuroblastoma as noted above) to be **investigational**.*

Based on review of available data, the Company considers allogeneic (myeloablative or nonmyeloablative) hematopoietic cell transplantation (HCT) for treatment of pediatric solid tumors to be **investigational**.*

Based on review of available data, the Company considers salvage allogeneic hematopoietic cell transplantation (HCT) for pediatric solid tumors that relapse after autologous transplant or fail to respond to be **investigational**.*

Policy Guidelines

This policy addresses peripheral neuroblastoma arising from the peripheral nervous system (ie, neuroblastoma, ganglioneuroblastoma, ganglioneuroma).

Hematopoietic cell transplantation refers to any source of stem cells, ie, autologous, allogeneic, syngeneic, or umbilical cord blood.

Relapse is defined as tumor recurrence after a prior complete response.

Primary refractory disease is defined as a tumor that does not achieve a complete remission after initial standard-dose chemotherapy.

Background/Overview

Solid Tumors of Childhood

Solid tumors of childhood arise from mesodermal, ectodermal, and endodermal cells of origin. Some common solid tumors of childhood are neuroblastoma, Ewing sarcoma/Ewing sarcoma family of tumors (ESFT), Wilms tumor, rhabdomyosarcoma, osteosarcoma, and retinoblastoma.

General Treatment

The prognosis for pediatric solid tumors has improved more recently, mostly due to the application of multiagent chemotherapy and improvements in local control therapy (including aggressive surgery and advancements in radiotherapy). However, patients with metastatic, refractory, or recurrent disease continue to have poor prognoses, and these “high-risk” patients are candidates for

Policy # 00064

Original Effective Date: 01/28/2002

Current Effective Date: 08/01/2026

more aggressive therapy, including autologous hematopoietic cell transplantation (HCT), to improve event-free survival (EFS) and overall survival (OS).

Descriptions of pediatric-onset solid tumors addressed herein are as follows.

Peripheral Neuroblastoma

Neuroblastoma is the most common extracranial solid tumor of childhood, with approximately 90% of cases presenting in children younger than 5 years of age. These tumors originate where sympathetic nervous system tissue is present, within the adrenal medulla or paraspinal sympathetic ganglia, but have diverse clinical behavior depending on a variety of risk factors.

Patients with neuroblastoma are stratified into prognostic risk groups (low, intermediate, high) that determine treatment plans. Risk variables include age at diagnosis, clinical stage of disease, tumor histology, and certain molecular characteristics, including the presence of the *MYCN* oncogene. Tumor histology is categorized as favorable or unfavorable, according to the degree of tumor differentiation, the proportion of tumor stromal component, and index of cellular proliferation. It is well-established that *MYCN* amplification is associated with rapid tumor progression and a poor prognosis, even in the setting of other coexisting favorable factors. Loss of heterozygosity (LOH) at chromosome arms 1p and 11q frequently occurs in neuroblastoma. Although 1p LOH is associated with *MYCN* amplification, 11q is usually found in tumors without this abnormality. Some recent studies have shown that 1p LOH and unbalanced 11q LOH are strongly associated with outcome in patients with neuroblastoma, and both are independently predictive of worse progression-free survival (PFS) in patients with low- and intermediate-risk disease. Although the use of these LOH markers in assigning treatment in patients is evolving, they may prove useful to stratify treatment.

In the early 1990s, a uniform clinical staging system based on surgical resectability and distant spread, the International Neuroblastoma Staging System, was adopted by pediatric cooperative groups (see Table 1).

Table 1. International Neuroblastoma Staging System

Stage	Description
1	Localized tumor with complete gross excision, with or without microscopic residual disease; lymph nodes negative for tumor
2A	Localized tumor with incomplete gross excision; lymph nodes negative for tumor
2B	Localized tumor with or without complete gross excision, with ipsilateral lymph nodes positive for tumor
3	Unresectable unilateral tumor infiltrating across the midline, with or without regional lymph node involvement; or localized unilateral tumor with contralateral regional lymph node involvement; or midline tumor with bilateral extension by infiltration or by lymph node involvement

Hematopoietic Cell Transplantation for Solid Tumors of Childhood

Policy # 00064

Original Effective Date: 01/28/2002

Current Effective Date: 08/01/2026

4	Any primary tumor with dissemination to distant lymph nodes, bone, bone marrow, liver, skin, and/or other organs, except as defined for stage 4S
4S	Localized primary tumor as defined for stage 1, 2A, or 2B, with dissemination limited to skin, liver, and/or bone marrow (marrow involvement less than 10%), limited to children younger than 1 year of age

The low-risk group includes patients younger than 1 year of age with stage 1, 2, or 4S disease with favorable histopathologic findings and no *MYCN* oncogene amplification. High-risk neuroblastoma is characterized by age older than 1 year, disseminated disease, *MYCN* oncogene amplification, and unfavorable histopathologic findings.

The International Neuroblastoma Risk Group (2009) proposed a revised staging system, which incorporated pretreatment imaging parameters instead of surgical findings (see Table 2).

Table 2. International Neuroblastoma Risk Group Staging System

Stage	Description
L1	Localized tumor not involving vital structures as defined by the list of Image-Defined Risk Factors and confined to 1 body compartment
L2	Locoregional tumor with presence of 1 or more Image-Defined Risk Factors
M	Distant metastatic disease (except stage MS)
MS	Metastatic disease in children younger than 18 months with metastases confined to skin, liver, and/or bone marrow

Treatment

In general, most patients with the low-stage disease have excellent outcomes with minimal therapy; and with International Neuroblastoma Staging System stage-1 disease, most patients can be treated by surgery alone. Most infants, even with disseminated disease, have favorable outcomes with chemotherapy and surgery.

For intermediate-risk disease, moderately intensive multiagent chemotherapy is the mainstay of therapy. Surgery is needed to obtain a diagnosis, and the extent of resection necessary to obtain an optimal outcome is not established. Patients at high-risk have historically had very low (<15%) long-term OS. Current therapy for high-risk disease typically includes an aggressive multimodal approach with chemotherapy, surgical resection, and radiotherapy.

Treatment of recurrent disease is determined by the risk group at diagnosis and the extent of disease and age of the patient at recurrence.

Ewing Sarcoma Family of Tumors

ESFT encompasses a group of tumors that share some degree of neuroglial differentiation and a characteristic underlying molecular pathogenesis (chromosomal translocation). The translocation

Hematopoietic Cell Transplantation for Solid Tumors of Childhood

Policy # 00064

Original Effective Date: 01/28/2002

Current Effective Date: 08/01/2026

usually involves chromosome 22 and results in fusion of the *EWS* gene with 1 of the members of the ETS (E26 transformation-specific) family of transcription factors, either FLI1 (90% to 95%) or ERG (5% to 10%). These fusion products function as oncogenic aberrant transcription factors. Detection of these fusions is considered to be specific for the ESFT and helps further validate diagnosis. Included in ESFT are “classic” Ewing sarcoma of bone, extraosseous Ewing, peripheral primitive neuroectodermal tumor, and Askin tumors (chest wall).

Most commonly diagnosed in adolescence, ESFT can be found in bone (most commonly) or soft tissue; however, the spectrum of ESFT has also been described in various organ systems. Ewing is the second most common primary malignant bone tumor. The most common primary sites are the pelvic bones, the long bones of the lower extremities, and the bones of the chest wall.

Treatment

Current therapy for Ewing sarcoma typically includes induction chemotherapy, followed by local control with surgery and/or radiotherapy (dependent on tumor size and location), followed by adjuvant chemotherapy. Multiagent chemotherapy, surgery, and radiotherapy have improved PFS rates in patients with the localized disease to 60% to 70%. The presence of metastatic disease is the most unfavorable prognostic feature, and the outcome for patients presenting with metastatic disease is poor, with 20% to 30% PFS. Other adverse prognostic factors that may categorize a patient as having “high-risk” Ewing are tumor location (eg, patients with pelvic primaries have worse outcomes), larger tumor size, and older age of the patient. However, “high-risk” Ewing has not always been consistently defined in the literature.

Rhabdomyosarcoma

Rhabdomyosarcoma, the most common soft tissue sarcoma of childhood, shows skeletal muscle differentiation. The most common primary sites are the head and neck (eg, parameningeal), genitourinary tract, and extremities.

Treatment

Specific treatment is based on tumor location, resection, and node status, and may involve surgery, radiotherapy, and chemotherapy. Five-year survival rates for rhabdomyosarcoma increased between 1975 and 2017 from 53% to 71% in children younger than 15 years and from 30% to 52% in patients 15 to 19 years of age.

Approximately 15% of children present with metastatic disease, and despite the introduction of new drugs and intensified treatment, the 5-year survival is 20% to 30% for this “high-risk” group. Similarly, postrelapse mortality is very high. The prognosis of the metastatic disease is affected by tumor histology, age at diagnosis, the site of metastatic disease, and the number of metastatic sites.

Wilms Tumor

Wilms tumor is the most common primary malignant renal tumor of childhood. In the United States, Wilms tumor is staged using the National Wilms Tumor Study system, which is based on surgical evaluation before chemotherapy (see Table 3).

Policy # 00064

Original Effective Date: 01/28/2002

Current Effective Date: 08/01/2026

Table 3. National Wilms Tumor Study Staging

Stage	Description
I	(a) Tumor is limited to the kidney and completely excised; (b) The tumor was not ruptured before or during removal; (c) The vessels of the renal sinus are not involved beyond 2 mm (d) There is no residual tumor apparent beyond the margins of excision
II	(a) Tumor extends beyond the kidney but is completely excised (b) No residual tumor is apparent at or beyond the margins of excision (c) Tumor thrombus in vessels outside the kidney is stage II if the thrombus is removed en bloc with the tumor
III	Residual tumor confined to the abdomen: (a) Lymph nodes in the renal hilum, the periaortic chains, or beyond are found to contain tumor (b) Diffuse peritoneal contamination by the tumor (c) Implants are found on the peritoneal surfaces (d) Tumor extends beyond the surgical margins either microscopically or grossly (e) Tumor is not completely respectable because of local infiltration into vital structures
IV	Presence of hematogenous metastases or metastases to distant lymph nodes
V	Bilateral renal involvement at the time of initial diagnosis

Adapted from Metzger and Dome (2005).

Treatment

In the United States, National Wilms Tumor Study and Children's Oncology Group protocols are based on primary resection for unilateral tumors, followed by escalating levels of chemotherapy and radiotherapy depending on tumor stage and other prognostic factors. Tumor histology, tumor stage, molecular and genetic markers (eg, LOH at chromosome 16q), and age (>2 years) are all associated with increased risks of recurrence and death. Wilms tumors are highly sensitive to chemotherapy and radiotherapy, and current cure rates exceed 85%. Between 10% and 15% of patients with favorable histology and 50% of patients with anaplastic tumors, experience tumor progression or relapse.

Similar risk-adapted strategies are being tested for the 15% of patients who experience a relapse. Success rates after relapse range from 25% to 45%. For patients with adverse prognostic factors (histologically anaplastic tumors, relapse <6 to 12 months after nephrectomy, second or subsequent relapse, relapse within the radiation field, bone or brain metastases), the EFS rate is less than 15%.

Osteosarcoma

Osteosarcoma is a primary malignant bone tumor and the most common bone cancer in children and adolescents; it is characterized by infiltration of bone or osteoid by the tumor cells. Peak incidence occurs around puberty, most commonly in long bones such as the femur or humerus. Osteosarcomas are characterized by variants in the *TP53* tumor suppressor gene.

Hematopoietic Cell Transplantation for Solid Tumors of Childhood

Policy # 00064

Original Effective Date: 01/28/2002

Current Effective Date: 08/01/2026

The prognosis of osteosarcoma has greatly improved, with 5-year survival rates increasing between 1975 and 2020 from 40% to 72% in children younger than 15 years and from 56% to 71% in 15- to 19-year olds. Prognostic factors for patients with localized disease include site and size of the primary tumor, the presence of metastases at the time of diagnosis, resection adequacy, and tumor response to neoadjuvant chemotherapy.

Treatment

For patients with recurrent osteosarcoma, the most important prognostic factor is surgical respectability. There is a 5-year survival rate of 20% to 45% in patients who had a complete resection of metastatic pulmonary tumors and a 20% survival rate for patients with metastatic tumors at other sites.

Retinoblastoma

Retinoblastoma is the most common primary tumor of the eye in children. It may occur as a heritable (25% to 30%) or nonheritable (70% to 75%) tumor. Cases may be unilateral or bilateral, with bilateral tumors almost always being the heritable type.

Treatment

Treatment options depend on the extent of disease. Retinoblastoma is usually confined to the eye, and with current therapy, has a high cure rate. However, once disease spreads beyond the eye, survival rates drop significantly; 5 year disease-free survival is reported to be less than 10% in those with the extraocular disease, and stage 4B disease (ie, disease metastatic to the central nervous system) has been lethal in virtually all cases reported.

The strategy for nonmetastatic disease depends on the disease extent but may include focal therapies (eg, laser photocoagulation, cryotherapy, plaque radiotherapy), intravitreal chemotherapy, intra-arterial chemotherapy, systemic chemotherapy, enucleation, or a combination. For metastatic disease, intensive multimodal therapy with high-dose chemotherapy (HDC), with or without radiotherapy, is standard care.

Hematopoietic Cell Transplantation

HCT is a procedure in which hematopoietic stem cells are infused to restore bone marrow function in cancer patients who receive bone-marrow-toxic doses of drugs, with or without whole body radiotherapy. Hematopoietic stem cells may be obtained from the transplant recipient (autologous HCT) or a donor (allogeneic HCT). They can be harvested from bone marrow, peripheral blood, or umbilical cord blood shortly after delivery of neonates. Although cord blood is an allogeneic source, the stem cells in it are antigenically “naive” and thus are associated with a lower incidence of rejection or graft-versus-host disease.

Immunologic compatibility between infused hematopoietic stem cells and the recipient is not an issue in autologous HCT; however, immunologic compatibility between donor and patient is critical for achieving a good outcome of allogeneic HCT. Compatibility is established by typing of human leukocyte antigens using cellular, serologic, or molecular techniques. Human leukocyte antigens refer to the tissue type expressed at class I and class II loci on chromosome 6. Depending

Policy # 00064

Original Effective Date: 01/28/2002

Current Effective Date: 08/01/2026

on the disease being treated, an acceptable donor (except umbilical cord blood) will match the patient at all or most human leukocyte antigens loci.

FDA or Other Governmental Regulatory Approval

U.S. Food and Drug Administration (FDA)

The U.S. Food and Drug Administration regulates human cells and tissues intended for implantation, transplantation, or infusion through the Center for Biologics Evaluation and Research, under Code of Federal Regulation, title 21, parts 1270 and 1271. Hematopoietic stem cells are included in these regulations.

Rationale/Source

This medical policy was developed through consideration of peer-reviewed medical literature generally recognized by the relevant medical community, U.S. Food and Drug Administration approval status, nationally accepted standards of medical practice and accepted standards of medical practice in this community, technology evaluation centers, reference to regulations, other plan medical policies, and accredited national guidelines.

Hematopoietic cell transplantation (HCT) is a procedure in which hematopoietic stem cells are infused to restore bone marrow function in cancer patients who receive bone-marrow-toxic doses of drugs, with or without whole body radiotherapy. Stem cells may be obtained from the transplant recipient (autologous HCT) or harvested from a donor (allogeneic HCT). Stem cells may be harvested from bone marrow, peripheral blood, or umbilical cord blood shortly after delivery of neonates.

Summary of Evidence

For individuals who have high-risk or relapsed peripheral neuroblastoma who receive single or tandem autologous HCT, the evidence includes randomized controlled trials (RCTs), systematic reviews with meta-analyses of those trials, and observational studies. Relevant outcomes are overall survival (OS), disease-specific survival (DSS), and treatment-related mortality (TRM) and morbidity. In the pooled analysis, patients with high-risk neuroblastoma treated with first-line therapy with single autologous HCT with myeloablative conditioning had significantly improved event-free survival (EFS) compared with standard therapy. Similarly, nonrandomized comparative studies, single-arm studies, and case series evaluating tandem autologous HCT showed improvements in EFS for children with high-risk neuroblastoma. A recent RCT found that tandem autologous HCT resulted in statistically significantly better EFS compared with single HCT. The evidence is sufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who have high-risk Ewing sarcoma who receive single or tandem autologous HCT, the evidence includes an RCT, single-arm studies, and case series. Relevant outcomes are OS, DSS, and TRM and morbidity. Although early nonrandomized studies were promising, more recent prospective nonrandomized study results have been inconsistent regarding whether HCT extends survival compared with typical conventional therapy. An RCT comparing consolidation with high-

Hematopoietic Cell Transplantation for Solid Tumors of Childhood

Policy # 00064

Original Effective Date: 01/28/2002

Current Effective Date: 08/01/2026

dose chemotherapy (HDC) plus autologous HCT to standard chemotherapy plus whole lung irradiation in patients with Ewing sarcoma with pulmonary and/or pleural metastases did not find a significant improvement in EFS in the group that received HCT. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who have rhabdomyosarcoma (RMS) who receive single autologous HCT, the evidence includes a systematic review and nonrandomized comparative studies. Relevant outcomes are OS, DSS, and TRM and morbidity. Available studies have not demonstrated improvements in OS or EFS with autologous HCT. Additional research is needed to demonstrate a benefit with autologous HCT for pediatric RMS. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who have Wilms tumor who receive single autologous HCT, the evidence includes retrospective studies and a meta-analysis. Relevant outcomes are OS, DSS, and TRM and morbidity. In the meta-analysis, overall 4-year survival rates were similar between patients receiving HCT and receiving chemotherapy. There was a trend suggesting that patients with lung-only stage 3 or 4 relapse might benefit from autologous HCT. However, the overall body of evidence is limited. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who have osteosarcoma who receive single autologous HCT, the evidence includes case series, a prospective single-arm study, and a retrospective study. Relevant outcomes are OS, DSS, and TRM and morbidity. An interim analysis of the prospective single-arm study showed that patients receiving autologous HCT were experiencing lower EFS rates than historical controls, resulting in all patients being enrolled in the standard of care chemotherapy. Conversely, a retrospective study found favorable EFS and OS rates with HDC plus autologous HCT in patients with nonmetastatic osteosarcoma with low-degree necrosis after neoadjuvant chemotherapy. The overall body of evidence is limited. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who have localized retinoblastoma who receive single autologous HCT, there are no studies. Relevant outcomes are OS, DSS, and TRM and morbidity. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who have metastatic retinoblastoma who receive single autologous HCT, the evidence includes small case series and case reports, and prospective and retrospective studies. Relevant outcomes are OS, DSS, and TRM and morbidity. Results from the limited data have suggested that autologous HCT may prolong EFS and OS, particularly in patients without central nervous system involvement (stage 4A disease). Given the poor prognosis for this indication with conventional therapies, the incremental improvement with autologous HCT might be considered a significant benefit. However, the overall body of evidence is limited. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

Policy # 00064

Original Effective Date: 01/28/2002

Current Effective Date: 08/01/2026

Supplemental Information

Clinical Input From Physician Specialty Societies and Academic Medical Centers

While the various physician specialty societies and academic medical centers may collaborate with and make recommendations during this process, through the provision of appropriate reviewers, input received does not represent an endorsement or position statement by the physician specialty societies or academic medical centers, unless otherwise noted.

2017 Input

Clinical input was sought to help determine whether the use of autologous hematopoietic cell transplantation (HCT) for individuals with advanced-stage Wilms tumor, osteosarcoma, and retinoblastoma would provide a clinically meaningful improvement in net health outcome and whether the use is consistent with generally accepted medical practice. In response to requests, clinical input was received from 2 respondents, including 2 physicians with academic medical center affiliation.

For individuals who have advanced-stage Wilms tumor who receive autologous HCT, clinical input does not support a clinically meaningful improvement in net health outcome and does not indicate this use is consistent with generally accepted medical practice.

For individuals who have osteosarcoma who receive autologous HCT, clinical input does not support a clinically meaningful improvement in net health outcome and does not indicate this use is consistent with generally accepted medical practice.

For individuals who have metastatic retinoblastoma who receive autologous HCT, clinical input supports this use provides a clinically meaningful improvement in net health outcome and indicates this use is consistent with generally accepted medical practice.

2011 Input

Clinical input was sought to help determine whether the use of single autologous HCT for individuals with high-risk Ewing sarcoma would provide a clinically meaningful improvement in net health outcome and whether the use is consistent with generally accepted medical practice. In response to requests, clinical input was received from 3 academic medical centers and 2 Blue Distinction Centers for Transplants.

For individuals who have high-risk Ewing sarcoma who receive single autologous HCT, clinical input supports this use provides a clinically meaningful improvement in net health outcome and indicates this use is consistent with generally accepted medical practice. One reviewer did not consider autologous HCT for low- to intermediate-risk Ewing sarcoma investigational but did state that the results of the Euro-EWING's phase 3 trial were awaited.

Practice Guidelines and Position Statements

Guidelines or position statements will be considered for inclusion in 'Supplemental Information' if they were issued by, or jointly by, a US professional society, an international society with US

Policy # 00064

Original Effective Date: 01/28/2002

Current Effective Date: 08/01/2026

representation, or National Institute for Health and Care Excellence (NICE). Priority will be given to guidelines that are informed by a systematic review, include strength of evidence ratings, and include a description of management of conflict of interest.

American Society for Transplantation and Cellular Therapy

In 2020, the American Society for Transplantation and Cellular Therapy published consensus guidelines for clinically appropriate indications for HCT based on best prevailing evidence. Indications for HCT in pediatric patients with the solid tumors types addressed in this review are outlined in Table 4.

Table 4. Indications for Hematopoietic Cell Transplant in Pediatric Patients with Solid Tumors

Indication and Disease Status	Allogeneic HCT ^a	Autologous HCT ^a
Ewing sarcoma, high risk or relapse	D	S
Soft tissue sarcoma, high risk or relapse	D	D
Neuroblastoma, high risk or relapse	D	S ^b
Wilms tumor, relapse	N	C
Osteosarcoma, high risk	N	C

Adapted from Kanate et al (2020).

HCT: hematopoietic cell transplantation.

^a “Standard of care (S): This category includes indications that are well defined and are generally supported by evidence in the form of high quality clinical trials and/or observational studies (eg, through CIBMTR or EBMT).” “Standard of care, clinical evidence available (C): This category includes indications for which large clinical trials and observational studies are not available. However, HCT/immune effector cell therapy (IECT) has been shown to be an effective therapy with acceptable risk of morbidity and mortality in sufficiently large single- or multi-center cohort studies. HCT/IECT can be considered as a treatment option for individual patients after careful evaluation of risks and benefits. As more evidence becomes available, some indications may be reclassified as ‘Standard of Care’.” “Developmental; (D): Developmental indications include diseases where pre-clinical and/or early phase clinical studies show HCT/IECT to be a promising treatment option. HCT/IECT is best pursued for these indications as part of a clinical trial. As more evidence becomes available, some indications may be reclassified as ‘Standard of Care, Clinical Evidence Available’ or ‘Standard of Care’.” “Not generally recommended (N): HCT/IECT is not currently recommended for these indications where evidence do not support the routine use of HCT/IECT. However, this recommendation does not preclude investigation of HCT/IECT as a potential treatment and may be pursued for these indications within the context of a clinical trial.

^b Tandem autologous HCT recommended.

Hematopoietic Cell Transplantation for Solid Tumors of Childhood

Policy # 00064

Original Effective Date: 01/28/2002

Current Effective Date: 08/01/2026

National Comprehensive Cancer Network

Current National Comprehensive Cancer Network (NCCN) guidelines or comments on HCT related to the cancers addressed in this review are summarized in Table 5. Other tumor types are not addressed in Network guidelines.

Table 5. National Comprehensive Cancer Network Guidelines

Guideline	Tumor Type	Year	NCCN Comments
Bone cancer	Osteosarcoma	v1.2026	"The safety and efficacy of HDT/HCT in patients with locally advanced, metastatic, or relapsed osteosarcoma have also been evaluated. In the Italian Sarcoma Group study, treatment with carboplatin and etoposide was followed by stem cell rescue, combined with surgery-induced complete response in chemosensitive disease. Transplant-related mortality was 3.1%. The 3-year OS and DFS rates were 20% and 12%, respectively. The efficacy of this approach in patients with high-risk disease is yet to be determined in prospective randomized studies."
Bone cancer	Ewing sarcoma	v1.2026	"High dose therapy followed by hematopoietic cell transplant (HDT/HCT) has been evaluated in patients with localized as well as metastatic disease. HDT/HCT has been associated with potential survival benefit in patients with non-metastatic disease. However, studies that have evaluated HDT/HCT in patients with primary metastatic disease have shown conflicting results.... HDT/HCT has been associated with improved long-term survival in patients with relapsed or progressive Ewing sarcoma in small, single-institution studies. The role of this approach is yet to be determined in prospective randomized studies."
Soft tissue sarcoma	Rhabdomyosarcoma	v1.2025	HCT not addressed
Wilms tumor (nephroblastoma)	Wilms tumor	v2.2025	HCT not addressed

Hematopoietic Cell Transplantation for Solid Tumors of Childhood

Policy # 00064

Original Effective Date: 01/28/2002

Current Effective Date: 08/01/2026

Neuroblastoma	Neuroblastoma	v1.2025	"For patients who are candidates for consolidation therapy, the Panel recommends tandem transplantation with two consecutive rounds of high-dose chemotherapy with autologous stem cell rescue for the majority of patients with high-risk disease."
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DFS: disease-free survival; HCT: hematopoietic cell transplantation; HDT: high-dose therapy; NCCN: National Comprehensive Cancer Network; OS: overall survival.

National Ewing Sarcoma Tumor Board

The National Ewing Sarcoma Tumor Board published consensus recommendations for systemic therapies in the management of relapsed Ewing sarcoma. Regarding HCT, the board states that "high-dose therapy with autologous stem cell rescue (HDT) has been attempted for the treatment of patients with ES, in both the upfront and relapsed settings. Although HDT has been incorporated into the treatment of patients with high-risk neuroblastoma and high-risk medulloblastoma, its role in the treatment of patients with ES remains controversial".

U.S. Preventive Services Task Force Recommendations

Not applicable.

Medicare National Coverage

There is no national coverage determination. In the absence of a national coverage determination, coverage decisions are left to the discretion of local Medicare carriers.

Ongoing and Unpublished Clinical Trials

Some currently ongoing trials that might influence this policy are listed in Table 6.

Table 6. Summary of Key Trials

NCT No.	Trial Name	Planned Enrollment	Completion Date
<i>Ongoing</i>			
<i>Peripheral neuroblastoma</i>			
NCT02605421	Tandem Myeloablative Consolidation Therapy and Autologous Stem Cell Rescue for High-Risk Neuroblastoma	12	Dec 2026
NCT01704716	High Risk Neuroblastoma Study 1 of SIOP-Europe (SIOPEN)	3300	Sep 2026
NCT06172296	A Phase 3 Study of Dinutuximab Added to Intensive Multimodal Therapy for Children With Newly Diagnosed High-Risk Neuroblastoma	478	Dec 2029

Hematopoietic Cell Transplantation for Solid Tumors of Childhood

Policy # 00064

Original Effective Date: 01/28/2002

Current Effective Date: 08/01/2026

<i>Unpublished</i>			
NCT00638898	Pilot Study of High-Dose Chemotherapy With Busulfan, Melphalan, and Topotecan Followed by Autologous Hematopoietic Stem Cell Transplant in Advanced Stage and Recurrent Tumors	25	Dec 2024
NCT01505569	Alkylator-Intense Conditioning Followed by Autologous Transplantation for Patients With High Risk or Relapsed Solid or CNS Tumors	44	Feb 2024
NCT01526603	High Dose Chemotherapy and Autologous Peripheral Blood Stem Cell (PBSC) Rescue for Neuroblastoma: Standard of Care Considerations	13	May 2023

NCT: national clinical trial.

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Policy # 00064

Original Effective Date: 01/28/2002

Current Effective Date: 08/01/2026

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Policy # 00064

Original Effective Date: 01/28/2002

Current Effective Date: 08/01/2026

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Policy # 00064

Original Effective Date: 01/28/2002

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Original Effective Date: 01/28/2002

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Hematopoietic Cell Transplantation for Solid Tumors of Childhood

Policy # 00064

Original Effective Date: 01/28/2002

Current Effective Date: 08/01/2026

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Hematopoietic Cell Transplantation for Solid Tumors of Childhood

Policy # 00064

Original Effective Date: 01/28/2002

Current Effective Date: 08/01/2026

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Policy History

Original Effective Date: 01/28/2002

Current Effective Date: 08/01/2026

12/06/2001	Medical Policy Committee review
01/28/2002	Managed Care Advisory Council approval
05/07/2004	Medical Director review
05/18/2004	Medical Policy Committee review. Format revision. High-Dose Chemotherapy and Hematopoietic Stem Cell Support for Pediatric Solid Tumors policy separated from current HDC with Hematopoietic Stem Cell Support policy. No substance change to policy.
06/28/2004	Managed Care Advisory Council approval
05/03/2005	Medical Director review. Format revision. No substance change to policy.
05/17/2005	Medical Policy Committee review. Policy statement language changed from, “may consider HDC and autologous or syngeneic SCS to treat recurrent or refractory Ewing’s sarcoma to be eligible for coverage” to; “Based on review of available data, the Company may consider HDC and autologous or syngeneic SCS to consolidate remissions of poor-risk Ewing’s sarcoma, or as salvage therapy for those with residual, recurrent or refractory disease to be eligible for coverage.” Patient selection criteria added.
05/23/2005	Managed Care Advisory Council approval
08/02/2006	Medical Director review
08/09/2006	Medical Policy Committee approval. Format revisions, FDA and other governmental regulatory approval added. References updated. Coverage eligibility unchanged.
06/13/2007	Medical Director review
06/20/2007	Medical Policy Committee approval. Policy updated with literature review. Policy statement added to indicate that multiple cycle high-dose chemotherapy and hematopoietic stem-cell support is considered to be investigational for the treatment of neuroblastoma.
07/02/2008	Medical Director review
07/16/2008	Medical Policy Committee approval
06/04/2009	Medical Director review
06/17/2009	Medical Policy Committee approval. Changed title from “High-Dose Chemotherapy with Stem Cell Support for Solid Tumors of Childhood” to “High-Dose Chemotherapy with Hematopoietic Stem Cell Support for Solid Tumors of Childhood”. Changed “poor-risk Ewing’s sarcoma” to “high-risk Ewing’s sarcoma” in the “When Services May Be Eligible for Coverage” section and under the “Patient Selection Criteria.” Extensive changes made to

Hematopoietic Cell Transplantation for Solid Tumors of Childhood

Policy # 00064

Original Effective Date: 01/28/2002

Current Effective Date: 08/01/2026

	“Background/Overview, FDA, Rationale and References” sections of the policy. No change to coverage eligibility.
06/03/2010	Medical Policy Committee review
06/16/2010	Medical Policy Implementation Committee approval. Changed title from “High-Dose Chemotherapy with Hematopoietic Stem Cell Support for Support for Solid Tumors of Childhood” to “Hematopoietic Stem Cell Transplantation for Solid Tumors of Childhood”. Changed all “high-dose chemotherapy with stem cell support” verbiage to “hematopoietic stem cell transplantation” throughout the coverage section of the policy. Coverage eligibility unchanged.
06/02/2011	Medical Policy Committee review
06/15/2011	Medical Policy Implementation Committee approval. Investigational statement modified to specify that “tandem autologous-autologous hematopoietic stem cell transplantation for treatment of pediatric solid tumors” is investigational. Added that allogeneic (myeloablative or nonmyeloablative) hematopoietic stem cell transplantation for treatment of pediatric solid tumors is investigational.
06/14/2012	Medical Policy Committee review
06/20/2012	Medical Policy Implementation Committee approval. Policy updated and reformatted.
03/04/2013	Coding updated
06/06/2013	Medical Policy Committee review
06/25/2013	Medical Policy Implementation Committee approval. The coverage statements were modified to state specifically that tandem autologous HSCT for high-risk neuroblastoma is considered to be eligible for coverage, but is investigational for all other indications.
06/05/2014	Medical Policy Committee review
06/18/2014	Medical Policy Implementation Committee approval. No change to coverage.
08/03/2015	Coding update: ICD10 Diagnosis code section added; ICD9 Procedure code section removed.
09/03/2015	Medical Policy Committee review
09/23/2015	Medical Policy Implementation Committee approval. No change to coverage.
09/08/2016	Medical Policy Committee review
09/21/2016	Medical Policy Implementation Committee approval. No change to coverage.
01/01/2017	Coding update: Removing ICD-9 Diagnosis Codes
07/06/2017	Medical Policy Committee review
07/19/2017	Medical Policy Implementation Committee approval. Changed “hematopoietic stem cell transplantation” to “hematopoietic cell transplantation” per NCCN terminology change. Based on clinical input, “metastatic retinoblastoma” added to first medically necessary statement. In first investigational statement, “retinoblastoma” changed to “retinoblastoma without metastases.”
07/05/2018	Medical Policy Committee review
07/11/2018	Medical Policy Implementation Committee approval. No change to coverage.
07/03/2019	Medical Policy Committee review
07/18/2019	Medical Policy Implementation Committee approval. Coverage eligibility unchanged.

Hematopoietic Cell Transplantation for Solid Tumors of Childhood

Policy # 00064

Original Effective Date: 01/28/2002

Current Effective Date: 08/01/2026

07/02/2020	Medical Policy Committee review
07/08/2020	Medical Policy Implementation Committee approval. Coverage eligibility unchanged.
07/01/2021	Medical Policy Committee review
07/14/2021	Medical Policy Implementation Committee approval. Coverage eligibility unchanged.
07/07/2022	Medical Policy Committee review
07/13/2022	Medical Policy Implementation Committee approval. Coverage eligibility unchanged.
07/06/2023	Medical Policy Committee review
07/12/2023	Medical Policy Implementation Committee approval. Coverage eligibility unchanged.
07/02/2024	Medical Policy Committee review
07/10/2024	Medical Policy Implementation Committee approval. Coverage eligibility unchanged.
07/03/2025	Medical Policy Committee review
07/09/2025	Medical Policy Implementation Committee approval. Coverage eligibility unchanged.
05/01/2026	Coding update.
07/02/2026	Medical Policy Committee review
07/08/2026	Medical Policy Implementation Committee review.
07/16/2026	Medical Quality Management Committee approval. Added “When Services Are Considered Not Medically Necessary” and “The use of autologous hematopoietic cell transplantation (HCT) or tandem autologous HCT when coverage criteria are not met, including as initial treatment of low- or intermediate-risk neuroblastoma, initial treatment of low- or intermediate-risk Ewing’s sarcoma, is considered to be not medically necessary.”

Next Scheduled Review Date: 07/2027

Coding

The five character codes included in the Louisiana Blue Medical Policy Coverage Guidelines are obtained from Current Procedural Terminology (CPT®)‡, copyright 2025 by the American Medical Association (AMA). CPT is developed by the AMA as a listing of descriptive terms and five character identifying codes and modifiers for reporting medical services and procedures performed by physician.

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Hematopoietic Cell Transplantation for Solid Tumors of Childhood

Policy # 00064

Original Effective Date: 01/28/2002

Current Effective Date: 08/01/2026

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Codes used to identify services associated with this policy may include (but may not be limited to) the following:

Code Type	Code
CPT	38204, 38205, 38206, 38207, 38208, 38209, 38210, 38211, 38212, 38213, 38214, 38215, 38230, 38232, 38240, 38241 Delete code effective 05/01/2026: 38242
HCPCS	S2140, S2142, S2150
ICD-10 Diagnosis	All related Diagnoses

*Investigational – A medical treatment, procedure, drug, device, or biological product is Investigational if the effectiveness has not been clearly tested and it has not been incorporated into standard medical practice. Any determination we make that a medical treatment, procedure, drug, device, or biological product is Investigational will be based on a consideration of the following:

- A. Whether the medical treatment, procedure, drug, device, or biological product can be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA) and whether such approval has been granted at the time the medical treatment, procedure, drug, device, or biological product is sought to be furnished; or
- B. Whether the medical treatment, procedure, drug, device, or biological product requires further studies or clinical trials to determine its maximum tolerated dose, toxicity, safety, effectiveness, or effectiveness as compared with the standard means of treatment or diagnosis, must improve health outcomes, according to the consensus of opinion among experts as shown by reliable evidence, including:
 1. Consultation with technology evaluation center(s);
 2. Credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community; or
 3. Reference to federal regulations.

**Medically Necessary (or “Medical Necessity”) - Health care services, treatment, procedures, equipment, drugs, devices, items or supplies that a Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

- A. In accordance with nationally accepted standards of medical practice;
- B. Clinically appropriate, in terms of type, frequency, extent, level of care, site and duration, and considered effective for the patient's illness, injury or disease; and
- C. Not primarily for the personal comfort or convenience of the patient, physician or other health care provider, and not more costly than an alternative service or sequence of services

Hematopoietic Cell Transplantation for Solid Tumors of Childhood

Policy # 00064

Original Effective Date: 01/28/2002

Current Effective Date: 08/01/2026

at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, “nationally accepted standards of medical practice” means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of Physicians practicing in relevant clinical areas and any other relevant factors.

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NOTICE: If the Patient’s health insurance contract contains language that differs from the BCBSLA Medical Policy definition noted above, the definition in the health insurance contract will be relied upon for specific coverage determinations.

NOTICE: Medical Policies are scientific based opinions, provided solely for coverage and informational purposes. Medical Policies should not be construed to suggest that the Company recommends, advocates, requires, encourages, or discourages any particular treatment, procedure, or service, or any particular course of treatment, procedure, or service.

NOTICE: Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage.

NOTICE: If an authorization for an ongoing course of treatment has been provided to a member and the member changes from one health plan to another health plan (e.g., a member moves from carrier A to Louisiana Blue), Louisiana Blue may honor the previous health plan’s authorization for the same service under the same type of in-network benefit for a 90-day transition period. Documentation of the authorization for the ongoing course of treatment from the previous health plan must be provided to us by the member or their provider and the services provided for the course of treatment must otherwise be a covered service under the Louisiana Blue health plan. This provision does not apply to medications covered under the plan’s pharmacy benefit.