Clinical Policy: Cell and Gene Therapies

Reference Number: WNC.CP.299
Last Review Date: 01/2025

Coding Implications
Revision Log

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

Note: 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.

Description[1] - This policy discusses medical necessity criteria for Cell & Gene Therapies.

Human gene therapy aims to manipulate gene expression or alter cellular properties for therapeutic purposes.

Gene therapy involves modifying a member's genetic makeup to combat or eradicate diseases. This can be achieved through various methods:

a. Replacement of a defective gene with a healthy version.
b. Deactivation of a malfunctioning gene.
c. Introduction of a new or modified gene to address a specific condition.

Gene therapy is currently under investigation for treating a range of illnesses, including cancer, genetic disorders, and infectious diseases.

Different types of gene therapy products are being explored, including:

a. Plasmid DNA: Circular DNA molecules engineered to transport therapeutic genes into human cells.
b. Viral vectors: Modified viruses utilized to deliver genetic material into cells after being rendered non-infectious.
c. Bacterial vectors: Modified bacteria employed as carriers to transport therapeutic genes into human tissues.
d. Human gene editing technology: Used to disrupt harmful genes or repair mutated ones; and
e. Patient-derived cellular gene therapy products: Cells extracted from the patient, genetically altered (often using viral vectors), and reintroduced into the patient.

Gene therapy products fall under the regulatory purview of the FDA's Center for Biologics Evaluation and Research (CBER). Prior to conducting clinical trials in the United States, investigational new drug applications (INDs) must be submitted for human clinical studies. The marketing approval of gene therapy products necessitates the submission and approval of a biologics license application (BLA).

Policy/Criteria[1]

I. WellCare of North Carolina® shall cover Cell & Gene Therapies when the member meets the following requirements:

A. The Cell or Gene Therapy has received approval from the United States Food & Drug Administration (U.S. FDA).
B. The Cell or Gene Therapy is administered per U.S. FDA approved guidelines regarding:
1. Indications and usage.
2. Dosage and administration.
3. Dosage forms and strengths; and
4. Warnings and precautions.
C. The administration of the Cell or Gene Therapy occurs at a Qualified Treatment Center (QTC) that has received approval for administering the Cell or Gene Therapy.

II. Medically necessary transportation

A. In addition to the specific criteria covered in Criteria I above, WellCare of North Carolina® may cover Medically Necessary transportation for medical appointments under WellCare of North Carolina® Non-Emergency Medical Transportation benefit. Please refer to Clinical Coverage Policy WNC.CP.262 "Non-Emergency Medical Transportation," available at WellCare NC Clinical Coverage Guidelines for prior authorization information.
B. Medicaid Transportation information, for WellCare of North Carolina members, is available at WellCare NC Medicaid Transportation Services.

III. WellCare of North Carolina® shall **not cover** Cell & Gene Therapies for **ANY** one of the following:
A. The Cell or Gene Therapy has not received approval from the U.S. FDA;
B. The Cell or Gene Therapy is being administered outside U.S. FDA guidelines regarding:
1. Indications and usage;
2. Dosage and administration; or
3. Dosage forms and strengths;
C. The Cell or Gene Therapy is being administered at a facility that has not been approved as a QTC for that therapy;
D. Repeat treatment in members who have received the same or another Cell or Gene Therapy previously;
E. When the member's psychosocial history limits the member's ability to comply with pre- and post-infusion medical care; or
F. When there is current member or caretaker non-compliance that would make compliance with a disciplined medical regime improbable.

IV. In addition to the specific criteria not covered above, WellCare of North Carolina® shall **not** cover:
A. Fertility preservation services associated with Cell & Gene Therapy administration.
B. Non-Emergency Medical Transportation (NEMT) for fertility preservation service appointments.

NOTE: *Centers for Medicare and Medicaid Services (CMS) will require participating manufacturers to provide payment for fertility preservation services for members who receive therapies administered under the CGT Access Model (refer to Background I. Definitions).*

Background[1]

I. Definitions

A. Fertility Preservation Services
Fertility preservation is the process of safeguarding or storing eggs, sperm, or reproductive tissue to enable a member to have biological children in the future.

B. Medical Noncompliance
Medical noncompliance, also known as nonadherence, refers to a member's failure to follow prescribed medications or a recommended treatment plan. This can also involve neglecting other health-improving measures, such as lifestyle changes or dietary adjustments.

C. Psychosocial History
A psychosocial history assessment is a detailed and comprehensive evaluation of a member's physical, mental, and emotional well-being, as well as their functional abilities within their community and self-perception. Typically conducted by social workers and medical professionals, this assessment gathers essential information about a member to understand their current and potential future behaviors. It plays a crucial role in health care programs, aiding in the development of an effective management and action plan for the medical team.

D. United States Food & Drug Administration (U.S. FDA)
The responsibility of safeguarding public health falls on the Food and Drug Administration (FDA). This entails guaranteeing the safety, effectiveness, and reliability of both human and veterinary drugs, biological products, and medical devices. Additionally, the FDA ensures the safety of the nation's food supply, cosmetics, and items emitting radiation.

E. Centers for Medicare and Medicaid Services (CMS) Cell and Gene Therapy (CGT) Access Model
The CMS Cell and Gene Therapy (CGT) Access Model is designed to enhance the lives of Medicaid beneficiaries with rare and severe conditions by improving access to potentially life-changing treatments. While these therapies have high initial costs, they offer the potential to lower long-term health care expenses by targeting the root causes of disease, lessening illness severity, and decreasing health care usage. At first, the model will prioritize gene therapy treatments for beneficiaries with sickle cell disease, a genetic blood disorder that predominantly impacts Black Americans.

F. State-Selected Model Drug
A State-Selected Model Drug in the context of the CMS Cell and Gene Therapy (CGT) Access Model refers to a specific cell or gene therapy chosen by a state to be included in the model. These therapies are typically high-cost treatments aimed at addressing rare or severe diseases. Under the CGT Access Model, states collaborate with the Centers for Medicare and Medicaid Services (CMS) to facilitate access to these transformative treatments. Providers administering these therapies must

participate in CMS-designated patient registries and follow specific guidelines, including patient counseling for CMS specified studies.

II. Prior Approval

A. WellCare of North Carolina shall require prior approval for Cell & Gene Therapies.
B. The provider shall obtain prior approval before rendering Cell & Gene Therapies. Refer to Description above.
C. All therapies that meet the description of Cell and Gene Therapies are subject to prior authorization.
D. Providers must use the product-specific CPT/HCPCS codes when requesting prior authorization (PA) for Cell and Gene Therapies, regardless of whether the administration will occur in an inpatient or outpatient hospital setting. The CPT/HCPCS codes included on the PA will be cross walked to ICD-10 PCS codes on inpatient claims.
E. Continued therapy is not authorized, as Cell & Gene Therapy is designed to be administered as a one-time, lifetime treatment.

III. Provider Qualifications and Occupational Licensing Entity Regulations

A. The Cell & Gene Therapy must be from a manufacturer enrolled in the Medicaid Drug Rebate Program.

IV. Provider Certifications

A. Cell & Gene Therapies are exclusively offered at Qualified Treatment Centers (QTC). Each QTC undergoes a meticulous selection process, focusing on their proficiency in specialties like sickle cell disease, transplantation, cellular, and genetic therapy. These centers are equipped with trained personnel to deliver Cell & Gene Therapies effectively. Providers must be qualified to administer Cell & Gene Therapies. Treatment centers must offer appropriate multidisciplinary care, including mental health, substance use disorder (SUD) treatment, pain management, and case management.
B. Providers must meet all participation requirements for Medicaid and be enrolled in North Carolina Medicaid to be reimbursed for Cell and Gene Therapies.

V. Cell & Gene Therapy (CGT) Access Model Requirements

A. A provider submitting a claim for administering a State-Selected Model Drug must be registered with the CMS-designated patient registry for the model and must also seek beneficiary consent for participation in a CMS-specified study.
B. A provider submitting a claim for a State-Selected Model Drug must follow the state's specified billing instructions.
C. Payment is contingent upon continued compliance with these Model requirements.

Coding Implications

ICD-10-PCS Codes	Description
XW133H9	Transfusion of Lovotibeglogene Autotemcel into Peripheral Vein, Percutaneous Approach, New Technology Group 9
XW143H9	Transfusion of Lovotibeglogene Autotemcel into Central Vein, Percutaneous Approach, New Technology Group 9
XW133J8	Transfusion of Exagamglogene Autotemcel into Peripheral Vein, Percutaneous Approach, New Technology Group 8
XW143J8	Transfusion of Exagamglogene Autotemcel into Central Vein, Percutaneous Approach, New Technology Group 8

HCPCS Code	Description
J3590	Unclassified biologics
J3392	Injection, exagamglogene autotemcel, per treatment
J3394	Injection, lovotibeglogene autotemcel, per treatment

National Drug Code (NDC)	Description
73554111101	Lyfgenia (lovotibeglogene autotemcel)
51167029001	Casgevy (exagamglogene autotemcel)
51167029009	Casgevy (exagamglogene autotemcel)

NOTE:

- Provider(s) shall file outpatient claims for Cell & Gene Therapy with the product-specific HCPCS code for the Cell & Gene Therapy. If the Cell & Gene Therapy has been approved by the U.S. FDA but has not yet been assigned a product specific HCPCS code, the provider shall use HCPCS J3590 (UNCLASSIFIED BIOLOGICS).
- Provider(s) shall include the prior authorization (PA) number and NDC on the claim.
- Provider(s) shall attach invoice from manufacturer of Cell & Gene Therapy.

Reviews, Revisions, and Approvals	Reviewed Date	Approval Date
Original approval date	11/24	11/24
Under Description change 'such as' to 'including' and removed 'furthermore' from last statement. Note below Criteria IV. Changed "a cell and gene therapy," to "therapies administered under the CGT Access Model (refer to Background I. Definitions)." Added Background I.E & I.F. Background II., added "Providers must use the product-specific CPT/HCPCS codes when requesting prior authorization (PA) for Cell and Gene Therapies, regardless of whether the administration will occur in an inpatient or outpatient hospital setting. The CPT/HCPCS codes included on the PA will be cross walked to ICD-10 PCS codes on inpatient claims. Continued therapy is not authorized, as Cell & Gene Therapy is designed to be administered as a one-time, lifetime treatment." Background Criteria V. added. "Cell & Gene Therapy (CGT) Access Model Requirements." ICD-10 code table, added 'XW133J8 and XW143J8'. HCPCS codes added 'J3392 J3394.' NDC codes added, '73554111101, 51167029001, 51167029009.' Added "and NDC" to Note listed under NDC table.	01/2025	01/2025

References

1. State of North Carolina Medicaid Clinical Coverage Policy No:1S-13 Cell and Gene Therapies. Program Specific Clinical Coverage Policies | NC Medicaid (ncdhhs.gov). Published January 1, 2025. Accessed January 14, 2025.

North Carolina Guidance

Eligibility Requirements

1. An eligible beneficiary shall be enrolled in the NC Medicaid Program (Medicaid is NC Medicaid program, unless context clearly indicates otherwise).
2. Provider(s) shall verify each Medicaid beneficiary's eligibility each time a service is rendered.
3. The Medicaid beneficiary may have service restrictions due to their eligibility category that would make them ineligible for this service.

EPSDT Special Provision: Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age

- 42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid beneficiary under 21 years of age if the service is medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed practitioner).

This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his or her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the beneficiary's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the beneficiary's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product, or procedure:

I. that is unsafe, ineffective, or experimental or investigational.
II. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure meets all EPSDT criteria, including to correct or improve or maintain the beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT and Prior Approval Requirements

- If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does NOT eliminate the requirement for prior approval.
- **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *NCTracks Provider Claims and Billing Assistance Guide*, and on the EPSDT provider page. The Web addresses are specified below:

NCTracks Provider Claims and Billing Assistance Guide:
https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html
EPSDT provider page: https://medicaid.ncdhhs.gov/

Provider(s) Eligible to Bill for the Procedure, Product, or Service
To be eligible to bill for the procedure, product, or service related to this policy, the provider(s) shall:

i. meet Medicaid qualifications for participation.
ii. have a current and signed Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement; and
iii. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

Compliance
Provider(s) shall comply with the following in effect at the time the service is rendered:

A. All applicable agreements, federal, state, and local laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements; and

B. All NC Medicaid's clinical (medical) coverage policies, guidelines, policies, provider manuals, implementation updates, and bulletins published by the Centers for Medicare and Medicaid Services (CMS), DHHS, DHHS division(s) or fiscal contractor(s).

Claims-Related Information
Provider(s) shall comply with the NC Tracks Provider Claims and Billing Assistance Guide, Medicaid bulletins, fee schedules, NC Medicaid's clinical coverage policies and any other relevant documents for specific coverage and reimbursement for Medicaid:

- Claim Type - as applicable to the service provided:
  Professional (CMS-1500/837P transaction)
  Institutional (UB-04/837I transaction)
  Unless directed otherwise, Institutional Claims must be billed according to the National Uniform Billing Guidelines. All claims must comply with National Coding Guidelines.
- International Classification of Diseases and Related Health Problems, Tenth Revisions, Clinical Modification (ICD-10-CM) and Procedural Coding System (PCS) - Provider(s) shall report the ICD-10-CM and Procedural Coding System (PCS) to the highest level of specificity that supports medical necessity. Provider(s) shall use the current ICD-10 edition and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for code description, as it is no longer documented in the policy.
- Code(s) - Provider(s) shall report the most specific billing code that accurately and completely describes the procedure, product or service provided. Provider(s) shall use the Current Procedural Terminology (CPT), Health Care Procedure Coding System (HCPCS), and UB-04 Data Specifications Manual (for a complete listing of valid revenue codes) and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for the code description, as it is no longer documented in the policy. If no such specific CPT or HCPCS code exists, then the provider(s) shall report the procedure, product or service using the appropriate unlisted procedure or service code.
  Unlisted Procedure or Service
  CPT: The provider(s) shall refer to and comply with the Instructions for Use of the CPT Codebook, Unlisted Procedure or Service, and Special Report as documented in the current CPT in effect at the time of service.
  HCPCS: The provider(s) shall refer to and comply with the Instructions for Use of HCPCS National Level II codes, Unlisted Procedure or Service and Special Report as documented in the current HCPCS edition in effect at the time of service.
- Modifiers - Providers shall follow applicable modifier guidelines.
- Billing Units - Provider(s) shall report the appropriate code(s) used which determines the billing unit(s).

- Co-payments -
  For Medicaid refer to Medicaid State Plan:
  https://medicaid.ncdhhs.gov/get-involved/nc-health-choice-state-plan

- Reimbursement - Provider(s) shall bill their usual and customary charges. For a schedule of rates, refer to: https://medicaid.ncdhhs.gov/.

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.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members/enrollees, and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members/enrollees and their representatives agree to be bound by such terms and conditions by providing services to members/enrollees and/or submitting claims for payment for such services.