Hematopoietic Cell Transplantation for Chronic Myeloid Leukemia

Policy # 00053
Original Effective Date: 01/28/2002
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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.

Note: Hematopoietic Cell Transplantation for Acute Myeloid Leukemia is addressed separately in medical policy 00049.

Note: Allogeneic Hematopoietic Cell Transplantation for Myelodysplastic Syndromes and Myeloproliferative Neoplasms is addressed separately in medical policy 00061.

Note: Hematopoietic Cell Transplantation for Non-Hodgkin Lymphomas is addressed separately in medical policy 00062.

Note: BCR-ABL1 Testing in Chronic Myelogenous Leukemia and Acute Lymphoblastic Leukemia is addressed separately in medical policy 00428.

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 allogeneic hematopoietic cell transplantation (allo-HCT) using a myeloablative conditioning regimen as a treatment of chronic myeloid leukemia (CML) to be **eligible for coverage**.

Based on review of available data, the Company may consider allo-HCT using a reduced-intensity conditioning (RIC) regimen as a treatment of CML in patients who meet clinical criteria for an allogeneic HCT, but who are not considered candidates for a myeloablative conditioning allo-HCT, to be **eligible for coverage.**

When Services Are Considered Investigational
Note: Coverage is not available for investigational medical treatments or procedures, drugs, devices or biological products.

Based on review of available data, the Company considers autologous HCT as a treatment of CML to be **investigational.***

Based on review of available data, the Company considers RIC allo-HCT as a treatment of CML in patients who do not qualify for myeloablative allo-HCT to be **investigational.***

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Policy Guidelines

Some patients for whom a conventional myeloablative allotransplant could be curative may be considered candidates for RIC allogeneic HCT. They include those patients whose age (typically >60 years) or comorbidities (e.g., liver or kidney dysfunction, generalized debilitation, prior intensive chemotherapy, low Karnofsky Performance Status score) preclude use of a standard myeloablative conditioning regimen.

For patients who qualify for a myeloablative allo-HCT on the basis of clinical status, either a myeloablative or a RIC regimen may be considered medically necessary.

Background/Overview

CHRONIC MYELOID LEUKEMIA

CML is a hematopoietic stem cell disorder characterized by the presence of a chromosomal abnormality called the Philadelphia chromosome, which results from a reciprocal translocation between the long arms of chromosomes 9 and 22. This cytogenetic change results in constitutive activation of BCR-ABL, a tyrosine kinase that stimulates unregulated cell proliferation, inhibits cell apoptosis, creates genetic instability, and upsets interactions between CML cells and the bone marrow stroma only in malignant cells. CML accounts for about 15% of newly diagnosed cases of leukemia in adults and occurs in 1 to 2 cases per 100,000 adults.

The natural history of the disease consists of an initial (indolent) chronic phase, lasting a median of 3 years, which typically transforms into an accelerated phase, followed by a “blast crisis,” which is usually the terminal event. Most patients present in chronic phase, often with nonspecific symptoms secondary to anemia and splenomegaly. CML diagnosis is based on the presence of the Philadelphia chromosome abnormality by routine cytogenetics, or by detection of abnormal BCR-ABL products by fluorescence in situ hybridization or molecular studies, in the setting of persistent unexplained leukocytosis. Conventional-dose chemotherapy regimens used for chronic phase disease can induce multiple remissions and delay the onset of blast crisis to a median of 4 to 6 years. However, successive remissions are invariably shorter and more difficult to achieve than their predecessors.

Treatment

Historically, the only curative therapy for CML in blast phase has been allo-HCT, which was used more widely earlier in the disease process given the lack of other therapies for chronic phase CML. Drug therapies for chronic phase CML were limited to nonspecific agents including busulfan, hydroxyurea, and interferon-α.

Imatinib mesylate (Gleevec®‡), a selective inhibitor of the abnormal BCR-ABL tyrosine kinase protein, is considered the treatment of choice for newly diagnosed CML. While imatinib can be highly effective in suppressing CML, it is not curative and is ineffective in 20% to 30% of patients, initially or due to development of *BCR-ABL* variants that cause resistance to the drug. Even so, the overall survival (OS) of patients who present in chronic phase is greater than 95% at 2 years and 80% to 90% at 5 years.

For CML, two other tyrosine kinase inhibitors ([TKIs]; dasatinib, nilotinib) have received marketing approval from the U.S. Food and Drug Administration (FDA) as first-line therapies or following failure or patient intolerance of imatinib. Two additional TKIs (bosutinib, ponatinib) have been approved for use in patients resistant or intolerant to prior therapy.

For patients on imatinib who have disease progression, the therapeutic options include increasing the imatinib dose, changing to another TKI, or allo-HCT. Detection of *BCR-ABL* variants may be important in determining an alternative TKI; the presence of the *T315I* variant is associated with resistance to all TKIs and should indicate the need for allo-HCT or experimental therapy. TKIs have been associated with long-term remissions; however, if disease progression occurs on TKI therapy, allo-HCT is generally indicated and offers the potential for cure.

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 (allo-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 (GVHD).

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 with allo-HCT. Compatibility is established by typing of human leukocyte antigens (HLAs) using cellular, serologic, or molecular techniques. HLA refers to the tissue type expressed at the HLA-A, -B, and -DR loci on each arm of chromosome 6. Depending on the disease being treated, an acceptable donor will match the patient at all or most of the HLA loci (except umbilical cord blood).

Conventional Conditioning for HCT
The conventional practice of allo-HCT involves administration of cytotoxic agents (e.g., cyclophosphamide, busulfan) with or without total body irradiation at doses sufficient to destroy endogenous hematopoietic capability in the recipient. The beneficial treatment effect of this procedure is due to a combination of initial eradication of malignant cells and subsequent graft-versus-malignancy (GVM) effect that is mediated by non-self-immunologic effector cells that develop after engraftment of allogeneic stem cells within the patient's bone marrow space. While the slower GVM effect is considered the potentially curative component, it may be overwhelmed by extant disease without the use of pretransplant conditioning. However, intense conditioning regimens are limited to patients who are sufficiently fit medically to tolerate substantial adverse effects that include preengraftment opportunistic infections secondary to loss of endogenous bone marrow function and organ damage and failure caused by the cytotoxic drugs. Furthermore, in any allo-HCT, immunosuppressant drugs are required to minimize graft rejection and GVHD, which also increase susceptibility to opportunistic infections. The immune reactivity between donor T cells and malignant cells that is responsible for the GVM effect also leads to acute and chronic GVHD.

The success of autologous HCT is predicated on the ability of cytotoxic chemotherapy with or without radiation to eradicate cancerous cells from the blood and bone marrow. This permits subsequent engraftment and repopulation of bone marrow space with presumably normal hematopoietic stem cells obtained from the patient before undergoing bone marrow ablation. As a consequence, autologous HCT is typically performed when the patient's disease is in complete remission. Patients who undergo autologous HCT are susceptible to chemotherapy-related toxicities and opportunistic infections before engraftment, but not GVHD.

Reduced-Intensity Conditioning for Allo-HCT
RIC refers to the pretransplant use of lower doses or less intense regimens of cytotoxic drugs or radiotherapy than are used in conventional full-dose myeloablative conditioning treatments. The goal of RIC is to reduce disease burden and to minimize as much as possible associated treatment-related morbidity and nonrelapse mortality in the period during which the beneficial GVM effect of allogeneic transplantation develops. Although the definition of RIC remains arbitrary, with numerous versions employed, all seek to balance the competing effects of nonrelapse mortality and relapse due to residual disease. RIC regimens can be viewed as a continuum in effects, from near totally myeloablative, to minimally myeloablative with lymphoablation, with intensity tailored to specific diseases and patient condition. Patients who undergo RIC with allo-HCT initially demonstrate donor cell engraftment and bone marrow mixed chimerism. Most will subsequently convert to full-donor chimerism, which may be supplemented with donor lymphocyte infusions to eradicate residual malignant cells. For this evidence review, RIC will refer to all conditioning regimens intended to be nonmyeloablative, as opposed to fully myeloablative (conventional) regimens.

For CML, RIC regimens were initially administered to extend the use of allo-HCT to the estimated 70% of CML patients ineligible for myeloablative conditioning regimens because of advanced age or comorbidities. The use of RIC and allo-HCT are of particular interest for the treatment of CML, given the relatively pronounced susceptibility of this malignancy to the graft-versus-leukemia effect of allogeneic hematopoietic progenitor cells following their engraftment in the host.

FDA or Other Governmental Regulatory Approval

U.S. Food and Drug Administration (FDA)
The U.S. FDA 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.

Centers for Medicare and Medicaid Services (CMS)
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.

Rationale/Source

Evidence reviews assess the clinical evidence to determine whether the use of a technology improves the net health outcome. Broadly defined, health outcomes are length of life, quality of life, and ability to

function—including benefits and harms. Every clinical condition has specific outcomes that are important to patients and to managing the course of that condition. Validated outcome measures are necessary to ascertain whether a condition improves or worsens; and whether the magnitude of that change is clinically significant. The net health outcome is a balance of benefits and harms.

To assess whether the evidence is sufficient to draw conclusions about the net health outcome of a technology, 2 domains are examined: the relevance and the quality and credibility. To be relevant, studies must represent one or more intended clinical use of the technology in the intended population and compare an effective and appropriate alternative at a comparable intensity. For some conditions, the alternative will be supportive care or surveillance. The quality and credibility of the evidence depend on study design and conduct, minimizing bias and confounding that can generate incorrect findings. The randomized controlled trial is preferred to assess efficacy; however, in some circumstances, nonrandomized studies may be adequate. Randomized controlled trials are rarely large enough or long enough to capture less common adverse events and long-term effects. Other types of studies can be used for these purposes and to assess generalizability to broader clinical populations and settings of clinical practice. The following is a summary of the key literature to date.

ALLOGENEIC HEMATOPOIETIC CELL TRANSPLANTATION

In the pre–TKI era, allo-HCT was the standard of care for CML. Evidence in support of allo-HCT includes a 2015 randomized controlled trial comparing primary HCT from a matched family donor (n=166) with best available drug treatment (n=261), which enrolled patients from 1997 to 2004. There were no differences in 10-year OS between groups (0.76 for HCT patients vs 0.69 for drug treatment patients). Those with low transplant risk treated with HCT had improved survival compared with those treated with medical therapy, but, after patients entered blast crisis, survival did not differ between groups.

The advent of TKI therapy has altered the treatment paradigm for CML such that most patients are treated initially with a TKI until the disease progresses. While progression may occur within months of starting a TKI, progression may be delayed for years, as shown by the results of the IRIS trial and other studies. With the addition of three other TKIs (nilotinib, dasatinib, bosutinib) plus the possibility of effective dose escalation with imatinib to override resistance, it is possible to maintain a typical CML patient past the upper age limit (usually 50-55 years) at which a myeloablative allo-HCT is considered an option.

Nonrandomized Studies

Several nonrandomized studies have compared treatment using TKI therapy with allo-HCT in CML patients. Liu et al (2013) evaluated outcomes for CML patients who underwent HCT after imatinib failure. They retrospectively evaluated 105 patients with newly diagnosed chronic phase CML seen at a single institution from 1999 to 2011. Sixty-six patients received first-line imatinib therapy, 26 (treated before 2003) received interferon followed by imatinib, and 13 received first-line allo-HCT with curative intent. Twenty-two (21%) patients received allo-HCT overall, including 13 as first-line therapy and 9 following imatinib failure. Compared with those who received first-line allo-HCT, those who underwent HCT following imatinib failure had higher European Group for Blood and Marrow Transplantation risk score (p=0.03). Among those receiving allo-HCT (n=22; median follow-up, 134 months; range, 6-167 months), patients with imatinib

failure and disease progression had a significantly worse OS (p=0.015) compared with those receiving allo-HCT as first-line therapy. Patients receiving first-line allo-HCT had a 3-year OS rate of 91.7% (95% confidence interval, 29 to 38 months); 1 patient in this group died of relapse and 1 of chronic GVHD.

Xu et al (2015) retrospectively compared second-generation TKI therapy with allo-HCT in 93 patients in accelerated-phase CML. The second-generation TKI therapy group included 33 subjects, most of whom had been previously treated with another TKI (31 with imatinib, 2 with nilotinib). Of 60 patients treated with allo-HCT, 10 were treated with HCT for the first time, and 50 had been previously treated with imatinib. Median OS was significantly shorter with second-generation TKI treatment (22 months) than with allo-HCT (82 months). Median progression-free survival and event-free survival rates were similarly shorter with second-generation TKI treatment than with allo-HCT.

Zhang et al (2016) retrospectively compared imatinib (n=292) with allo-HCT (n=141) in patients who had CML. Survival rates were significantly longer in the imatinib group than in the allo-HCT group: 5-year EFS rates were 84% and 75% (p<0.05) and 5-year OS rates were 92% and 79%, both respectively. Findings were similar for patients with chronic phase and advanced phase disease.

Several studies have compared outcomes for CML patients treated with allo-HCT in the pre- and current TKI eras. While these studies have generally reported no worsening in treatment outcomes for allo-HCT following TKI therapy, they are limited by their underlying differences in treatment regimens from different eras. In a retrospective analysis by Shen et al (2015), of the 106 patients who underwent allo-HCT and who either did (n=36) or did not (n=70) receive prior treatment with TKIs, no significant differences were reported in 10-year relapse-free survival or OS rates. However, TKI-treated patients had a higher incidence of 0.5-year transplant-related mortality. In another retrospective analysis comparing patients treated using allo-HCT in the pre-TKI era (1989-2001; n=39) with those treated in the TKI era (2002-2013; n=30), Chamseddine et al (2015) reported longer 3-year OS and leukemia-free survival among patients treated in the TKI era.

Case Series
A number of case series, primarily involving a single center, have reported outcomes for patients treated with allo-HCT following TKI treatment failure. In a 2015 series of 51 patients given allo-HCT, 32 of whom were treated for TKI resistance or intolerance, 8-year OS and event-free survival rates were 68% and 46%, respectively. Another 2015 prospective series of 28 patients who underwent allo-HCT after the failure of at least 2 TKIs reported deep molecular remission in 18 subjects. However, all 6 patients transplanted in blast crisis died. In a smaller series, Zhao et al (2014) reported on outcomes for 12 patients with CML who experienced disease progression on imatinib and received dasatinib or nilotinib followed by allo-HCT at a single center. After a median follow-up of 28 months (range, 12-37 months) after allo-HCT, 8 (66.7%) of 12 patients were alive, including 7 with complete molecular remission.

In addition to being used prior to allo-HCT, TKI therapy may be used after HCT to prevent or treat disease relapse. Egan et al (2015) retrospectively analyzed patients at a single institution who underwent allo-HCT for CML and Philadelphia chromosome–positive acute lymphoblastic leukemia and had detectable BCR-

ABL transcripts by polymerase chain reaction, as well as ribonucleic acid (RNA) available for sequencing of the ABL kinase domain, in both the pre- and post-HCT settings to evaluate the impact of pre-HCT variants in the ABL kinase domain on post-HCT relapse. Among 95 patients with CML with available polymerase chain reaction transcripts, 10 (10.5%) were found to have pre-HCT *ABL* kinase variants known to confer resistance to TKIs. Of those with CML, 88.4% underwent myeloablative chemotherapy, and 11.6% underwent nonmyeloablative chemotherapy. Twenty-nine CML patients received post-HCT TKIs—19 (65.5%) for prophylaxis and 10 (34.5%) for treatment of refractory or relapsed disease. In 9 (64.2%) of the 14 patients with pre-HCT variants (which included both CML and Philadelphia chromosome–positive acute lymphoblastic leukemia), the same variants conferring TKI resistance was also detectable after allo-HCT. Among the 14 with pre-HCT variants, 8 (57.1%) received a TKI in the post-HCT setting, and 7 (50%) demonstrated post-HCT refractory disease or relapse. Of the 7 with relapsed disease, 6 had been given a predictably ineffective TKI within the first 100 days after allo-HCT, based on variant analysis conducted by the authors.

HCT With Nonmyeloablative Conditioning

Techniques for allo-HCT have continued to develop, with important advancements in the use of nonmyeloablative or RIC preparative regimens. Overall, among 9 studies evaluated in a 2007 review, outcomes with RIC allogeneic transplants were similar to those with conventional allotransplants, with OS rates ranging from 35% at 2.5 years to 85% at 5 years among patients in chronic phase at transplant. Among the studies assessed in this review, treatment-related mortality or nonrelapse mortality ranged from 0% to 29% at 1 year. In the largest retrospective study, the European Group for Blood and Marrow Transplantation (2005) evaluated 186 patients. The OS rate was 54% at 3 years using a variety of RIC regimens in patients in chronic phase 1 (n=118), chronic phase 2 (n=26), acute phase (n=30), and blast crisis (n=12). Among patients transplanted in the first chronic phase, the OS rate was 69% at 3 years.

RIC regimens have many of the same limitations as standard-intensity conditioning: relapse, GVHD, and mortality from treatment-related causes other than myelotoxicity. However, in the absence of prospective, comparative, randomized trials, only indirect comparisons can be made between the relative clinical benefits and harms associated with myeloablative and RIC regimens with allo-HCT. Comparison of study results is further compromised by heterogeneity across patients, treatments, and outcome measures. Nonetheless, clinical evidence has suggested outcomes in CML are similar between myeloablative and RIC allo-HCT.

Section Summary: Allogeneic Hematopoietic Cell Transplantation

Allo-HCT is accepted as a standard treatment in CML, although the use of targeted TKI therapy has allowed many patients who would previously have required allo-HCT to forestall or avoid transplantation altogether. Direct comparisons between myeloablative and nonmyeloablative conditioning (RIC) regimens are not available, but the available evidence has suggested that allo-HCT following nonmyeloablative conditioning regimens can lead to short- and medium-term survival rates that are on the order of those seen after myeloablative conditioning regimens. Although research into the optimal timing of allo-HCT in the setting of TKI therapy is limited, the available evidence has suggested that pretreatment with TKIs does not worsen outcomes after allo-HCT and may improve outcomes.

AUTOLOGOUS HCT

A major limitation in the use of autologous HCT in patients with CML is a high probability that leukemic cells will be infused back into the patient. However, it is recognized that many CML patients still have normal marrow stem cells. Techniques used to isolate and expand this normal clone of cells have included ex vivo purging, long-term culture, and immunophenotype selection. Even without such techniques, there are isolated case reports of partial cytogenetic remissions after autologous HCT, and a 1997 study suggested that patients undergoing such therapy may have improved survival compared with historical controls.

In the pre-TKI era, there was active research into the use of autologous HCT for CML. McGlave et al (1994) reported on outcomes for 200 consecutive autologous transplants using purged or unpurged marrow from 8 different transplant centers over 7 years. Of the 200 patients studied, 125 were alive at a median follow-up of 42 months. Of the 142 transplanted in chronic phase, median survival had not been reached at the time of publication, while the median survival was 35.9 months for those transplanted during an accelerated phase. Other data consist of small, single-institution case series using a variety of techniques to enrich the population of normal stem cells among the harvested cells.

Additional reports of small, uncontrolled studies with a total of 182 patients (range, 15-41 patients) given autologous HCT for CML included patient populations that varied across the studies. Some (2000, 2001) focused on newly diagnosed patients or those in the first year since diagnosis. Others (1999, 2000) have focused on patients who did not respond to or relapsed after initial treatment using interferon alfa. Finally, some have focused on patients transplanted in the late chronic phase (2000) or after transformation to accelerated phase or blast crisis (1999). Although some patients achieved complete or partial molecular remission and long-term disease-free survival, these studies do not permit conclusions free from the influence of selection bias. All autotransplanted patients included in these reports were treated before imatinib mesylate, or newer TKIs became available.

Section Summary: Autologous HCT

No controlled studies have evaluated autologous HCT for treatment of CML. The available data consists of case reports and case series. In the largest series (N=200 patients), median survival was 36 months for patients transplanted during an accelerated phase and median survival data were not available for patients transplanted in chronic phase. Controlled studies are needed to permit conclusions about the impact of autologous HCT on health outcomes in patients with CML.

SUMMARY OF EVIDENCE

For individuals who have CML who receive allo-HCT, the evidence includes systematic reviews, randomized controlled trials, and multiple prospective and retrospective series. Relevant outcomes are OS, disease-specific survival, and treatment-related morbidity and mortality. The introduction of TKIs has significantly changed the clinical use of HCT for CML. TKIs have replaced HCT as initial therapy for patients with chronic phase CML. However, a significant proportion of cases fail to respond to TKIs, develops resistance to them, or cannot tolerate TKIs and proceed to allo-HCT. Also, allo-HCT represents the only potentially curative option for those patients in the accelerated or blast phase CML. Currently, available evidence has suggested that TKI pretreatment does not lead to worse outcomes if HCT is needed.

Myeloablative conditioning regimens before HCT are used in younger (<60 years) patients without significant comorbidities. However, for patients with more comorbidities and/or more advanced age for whom myeloablative conditioning regimens would be prohibitively high-risk, evidence has suggested that reasonable outcomes can be obtained after HCT. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

For individuals who have CML who receive autologous HCT, the evidence includes case series. Relevant outcomes are OS, disease-specific survival, and treatment-related morbidity and mortality. In the largest series (N=200 patients), median survival was 36 months for patients transplanted during an accelerated phase; median survival data were not available for patients transplanted in chronic phase. Controlled studies are needed to permit conclusions on the impact of autologous HCT on health outcomes in patients with CML. The evidence is insufficient to determine the effects of the technology on health outcomes.

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Policy History

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12/06/2001	Medical Policy Committee review
03/25/2002	Managed Care Advisory Council approval
06/24/2002	Format revision. No substance change to policy.
05/07/2004	Medical Director review
05/18/2004	Medical Policy Committee review. Format revision. High-Dose Chemotherapy and Hematopoietic Stem Cell Support for Treatment of Chronic Myelogenous Leukemia policy developed separately from current HDC with Hematopoietic Stem Cell Support policy. No substance change to policy.
06/28/2004	Managed Care Advisory Council approval

Policy # 00053
Original Effective Date: 01/28/2002
Current Effective Date: 05/16/2018

06/07/2005	Medical Director review
06/21/2005	Medical Policy Committee review. Policy revised to consider eligibility for autologous SCS cases where no allogeneic donor match is available and patient has undergone treatment with Gleevec.
07/15/2005	Managed Care Advisory Council approval
07/07/2006	Format revision, including addition of FDA and or other governmental regulatory approval and rationale/source. Coverage eligibility unchanged.
07/11/2007	Medical Director review
07/18/2007	Medical Policy Committee approval. Rationale updated. Coverage eligibility unchanged.
10/01/2008	Medical Director review
10/22/2008	Medical Policy Committee approval. Autologous stem cell transplants are now considered investigational.
10/01/2009	Medical Policy Committee review
10/14/2009	Medical Policy Implementation Committee approval. No change to coverage eligibility.
10/14/2010	Medical Policy Committee review
10/20/2010	Medical Policy Implementation Committee approval. Coverage eligibility updated.
10/06/2011	Medical Policy Committee review
10/19/2011	Medical Policy Implementation Committee approval. Coverage eligibility unchanged.
10/11/2012	Medical Policy Committee review
10/31/2012	Medical Policy Implementation Committee approval. Coverage eligibility unchanged.
03/04/2013	Coding updated
10/03/2013	Medical Policy Committee review
10/16/2013	Medical Policy Implementation Committee approval. Coverage eligibility unchanged.
05/07/2015	Medical Policy Committee review
05/20/2015	Medical Policy Implementation Committee approval. Coverage eligibility unchanged.
08/03/2015	Coding update: ICD10 Diagnosis code section added; ICD9 Procedure code section removed.
05/05/2016	Medical Policy Committee review
05/18/2016	Medical Policy Implementation Committee approval. Coverage eligibility unchanged.
01/01/2017	Coding update: Removing ICD-9 Diagnosis Codes
05/04/2017	Medical Policy Committee review
05/17/2017	Medical Policy Implementation Committee approval. “Stem” removed from title and policy statements.
05/03/2018	Medical Policy Committee review
05/16/2018	Medical Policy Implementation Committee approval. Coverage eligibility unchanged. Policy Guidelines moved from the coverage section to the Policy Guidelines section.

Next Scheduled Review Date: 05/2019

Coding

The five character codes included in the Blue Cross Blue Shield of Louisiana Medical Policy Coverage Guidelines are obtained from Current Procedural Terminology (CPT®)‡, copyright 2017 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.

The responsibility for the content of Blue Cross Blue Shield of Louisiana Medical Policy Coverage Guidelines is with Blue Cross and Blue Shield of Louisiana and no endorsement by the AMA is intended or should be implied. The AMA disclaims responsibility for any consequences or liability attributable or related to any use, nonuse or interpretation of information contained in Blue Cross Blue Shield of Louisiana Medical Policy Coverage Guidelines. Fee schedules,

Hematopoietic Cell Transplantation for Chronic Myeloid Leukemia

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relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein. Any use of CPT outside of Blue Cross Blue Shield of Louisiana Medical Policy Coverage Guidelines should refer to the most current Current Procedural Terminology which contains the complete and most current listing of CPT codes and descriptive terms. Applicable FARS/DFARS apply.

CPT is a registered trademark of the American Medical Association.
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, 38242, 38243
HCPCS	S2140, S2142, S2150
ICD-10 Diagnosis	C92.10 C92.11 C92.12

*****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 the Blue Cross and Blue Shield Association technology assessment program (TEC) or other nonaffiliated 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 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.

‡ Indicated trademarks are the registered trademarks of their respective owners.

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