Hematopoietic Cell Transplantation for Hodgkin Lymphoma

Policy # 00057
Original Effective Date: 01/28/2008
Current Effective Date: 06/08/2020

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 Non-Hodgkin Lymphomas is addressed separately in medical policy 00062.

When Services Are 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) in patients with primary refractory or relapsed Hodgkin lymphoma (HL) to be **eligible for coverage.****

Based on review of available data, the Company may consider allogenic hematopoietic cell transplantation (HCT), using either myeloablative or reduced-intensity conditioning (RIC) regimens in patients with primary refractory or relapsed Hodgkin lymphoma (HL) to be **eligible for coverage.****

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 tandem autologous hematopoietic cell transplantation (HCT) to be **eligible for coverage.****

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Patient Selection Criteria
Coverage eligibility will be for tandem autologous HCT will be considered when any of the following criteria are met:

- In patients with primary refractory Hodgkin lymphoma (HL); or
- In patients with relapsed disease with poor risk features who do not attain a complete remission (CR) after cytoreductive chemotherapy prior to transplantation (see Policy Guidelines).

When Services Are Considered Investigational

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

The use of tandem autologous hematopoietic cell transplantation (HCT) when patient selection criteria are not met is considered to be **investigational.***

Based on review of available data, the Company considers a second autologous cell transplantation for relapsed lymphoma after a prior autologous hematopoietic cell transplantation (HCT) to be **investigational.***

Based on review of available data, the Company considers other uses of hematopoietic cell transplantation (HCT) in patients with Hodgkin lymphoma (HL), including, but not limited to, initial therapy for newly diagnosed disease to consolidate a first complete remission (CR) to be **investigational.***

Policy Guidelines

In the Morschhauser et al (2008) study of risk-adapted salvage treatment with single or tandem autologous hematopoietic cell transplantation for first relapse or refractory Hodgkin lymphoma, poor-risk relapsed Hodgkin lymphoma was defined as 2 or more of the following risk factors at first relapse: time to relapse less than 12 months, stage III or IV at relapse, and relapse within previously irradiated sites. The primary refractory disease was defined as disease regression less than 50% after 4 to 6 cycles of doxorubicin-containing chemotherapy or disease progression during induction or within 90 days after the end of first-line treatment.

Some patients for whom a conventional myeloablative allotransplant could be curative may be considered candidates for reduced-intensity conditioning allogeneic hematopoietic cell transplantation. They include those with malignancies that are effectively treated with myeloablative allogeneic transplantation, but whose age (typically >55 or >60 years) or comorbidities (eg, liver or kidney dysfunction, generalized debilitation, prior intensive chemotherapy, low Karnofsky Performance Status score) preclude the use of a standard myeloablative conditioning regimen.

The ideal allogeneic donors are human leukocyte antigen–identical matched siblings. Related donors mismatched at a single locus are also considered suitable donors. A matched, unrelated donor identified through the National Marrow Donor Program is typically the next option considered. Recently, there has been interest in haploidentical donors, typically a parent or a child of the patient, with whom usually there is sharing of only 3 of the 6 major histocompatibility antigens. Most patients will have such a donor; however, the risk of graft-versus-host disease and overall morbidity of the procedure may be severe, and experience with these donors is not as extensive as that with matched donors.

Background/Overview

Hodgkin Lymphoma

HL is a relatively uncommon B-cell lymphoma. In 2017, the estimated number of new cases in the United States was approximately 8260 and 1070 estimated deaths. The disease has a bimodal distribution, with most patients diagnosed between the ages of 15 and 30 years, with a second peak in adults aged 55 years and older.

The 2008 World Health Organization classification divided HL into 2 main types; these classifications did not change in the 2016 update:

1. Classical" HL
    - Nodular sclerosis
    - Mixed cellularity
    - Lymphocyte depleted
    - Lymphocyte-rich
2. Nodular lymphocyte-predominant HL.

In Western countries, "Classical" HL accounts for 95% of cases of HL and, for nodular lymphocyte-predominant HL, only 5%. "Classical" HL is characterized by the presence of neoplastic Reed-Sternberg cells in a background of numerous non-neoplastic inflammatory cells. Nodular lymphocyte-predominant HL lacks Reed-Sternberg cells but is characterized by the presence of lymphocytic and histiocytic cells termed "popcorn cells".

Staging

The Ann Arbor staging system for HL recognizes that the disease is thought typically to arise in a single lymph node and spread to contiguous lymph nodes with eventual involvement of extranodal sites. The staging system attempts to distinguish patients with localized HL who can be treated with extended field radiation from those who require systemic chemotherapy.

Each stage is subdivided into A and B categories. "A" indicates no systemic symptoms are present and "B" indicates the presence of systemic symptoms, which include unexplained weight loss of more than 10% of body weight, unexplained fevers, or drenching night sweats (see Table 1).

Table 1. Ann Arbor Staging System for Hodgkin Lymphoma

Stage	Area of Concern
I	Single lymph node region (I) or localized involvement of a single extralymphatic organ or site (IE)
II	2 or more lymph node regions on the same side of the diaphragm (II) or localized involvement of a single associated extralymphatic organ or site and its regional lymph node(s) with or without involvement of other lymph node regions on the same side of the diaphragm (IIE). The number of lymph node regions involved should be indicated by a subscript (eg, II_2).
III	Involvement of lymph node regions or structures on both sides of the diaphragm. These patients are further subdivided as follows: • III-1: disease limited to spleen or upper abdomen • II-2: periaortic or pelvic node involvement
IV	Disseminated (multifocal) involvement of 1 or more extralymphatic organs, with or without associated lymph node involvement, or isolated extralymphatic organ involvement with distant (nonregional) nodal involvement

Patients with HL are generally classified into three groups: early-stage favorable (stage I-II with no B symptoms or large mediastinal lymphadenopathy), early-stage unfavorable (stage I-II with a large mediastinal mass, with or without B symptoms; stage IB-IIB with the bulky disease), and advanced-stage disease (stage III-IV).

Treatment

Patients with nonbulky stage IA or IIA disease are considered to have the clinically early-stage disease. These patients are candidates for chemotherapy, combined modality therapy, or radiotherapy alone. Patients with obvious stage III or IV disease, bulky disease (defined as a 10-cm mass or mediastinal disease with a transverse diameter >33% of the transthoracic diameter), or the presence of B symptoms will require combination chemotherapy with or without additional radiotherapy.

HL is highly responsive to conventional chemotherapy, and up to 80% of newly diagnosed patients can be cured with chemotherapy and/or radiotherapy. Patients who prove refractory or who relapse after first-line therapy have a significantly worse prognosis. Primary refractory HL is defined as disease regression of less than 50% after 4 to 6 cycles of anthracycline-containing chemotherapy, disease progression during induction therapy, or progression within 90 days after the completion of the first-line treatment.

In patients with relapse, the results of salvage therapy vary depending on a number of prognostic factors, as follows: the length of the initial remission, stage at recurrence, and the severity of anemia at the time of relapse. Early and late relapse are defined as less or more than 12 months from the time of remission, respectively. Approximately 70% of patients with late first relapse can be salvaged by autologous hematopoietic cell transplantation (HCT) but not more than 40% with early first relapse.

Only 25% to 35% of patients with primary progressive or poor-risk recurrent HL achieve durable remission after autologous HCT, with most failures being due to disease progression after transplant. Most relapses after transplant occur within 1 to 2 years, and once relapse occurs posttransplant, median survival is less than 12 months.

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 from a donor (allogeneic HCT [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.

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 antigen (HLA) using cellular, serologic, or molecular techniques. HLA refers to the tissue type expressed at the HLA-A, -B, and -DR (antigen-D related) 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).

Conditioning for HCT

Conventional Conditioning
The conventional ("classical") practice of allo-HCT involves administration of cytotoxic agents (eg, cyclophosphamide, busulfan) with or without total body irradiation at doses sufficient to destroy endogenous hematopoietic capability in the recipient. The beneficial treatment effect in this procedure is due to a combination of initial eradication of malignant cells and subsequent graft-versus-malignancy effect 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 graft-versus-malignancy effect is considered to be 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 events that include pre-engraftment 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 graft-versus-host disease, which also increase susceptibility to opportunistic infections.

The success of autologous HCT is predicated on the ability of cytotoxic chemotherapy with or without radiotherapy 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. Patients who undergo autologous HCT are susceptible to chemotherapy-related toxicities and opportunistic infections before engraftment, but not graft-versus-host disease.

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 but also to minimize as much as possible associated treatment-related morbidity and nonrelapse mortality in the period during which the beneficial graft-versus-malignancy 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 nearly 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, the term RIC refers to all conditioning regimens intended to be nonmyeloablative, as opposed to fully myeloablative (conventional) regimens.

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

Hodgkin lymphoma (HL) results from a clonal expansion of a B-cell lineage, characterized by the presence of Reed-Sternberg cells on pathology. Standard treatment is based on the stage at presentation and may involve chemotherapy with or without radiotherapy. Hematopoietic cell transplantation (HCT) has been used for HL, particularly in the setting of relapse or refractory disease.

Autologous HCT

For individuals who have HL who receive autologous HCT as first-line therapy, the evidence includes randomized controlled trials (RCTs). The relevant outcomes are overall survival (OS), disease-specific survival (DSS), change in disease status, morbid events, and treatment-related mortality (TRM) and morbidity. RCTs of autologous HCT as first-line treatment have reported that this therapy does not provide additional benefit compared with conventional chemotherapy. The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals who have relapsed or refractory HL who receive autologous HCT, the evidence includes RCTs, a meta-analysis, nonrandomized comparative studies, and case series. The relevant outcomes are OS, DSS, change in disease status, morbid events, and TRM and morbidity. Two RCTs in patients with relapsed or refractory disease have reported a benefit in progression-free survival and a trend toward a benefit in OS. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

For individuals who have relapsed HL after an autologous HCT who receive a second autologous HCT, the evidence includes case series. The relevant outcomes are OS, DSS, change in disease status, morbid events, and TRM and morbidity. No RCTs or nonrandomized comparative studies were identified. In a case series, TRM at 100 days was 11%; at a median follow-up of 72 months, the mortality rate was 73%. The evidence is insufficient to determine the effects of the technology on health outcomes.

Allogeneic HCT

For individuals who have HL who receive allo-HCT as first-line therapy, the evidence includes no published studies. The relevant outcomes are OS, DSS, change in disease status, morbid events, and

TRM and morbidity. No studies specifically addressing allo-HCT as first-line treatment for HL were identified. The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals who have relapsed or refractory HL who receive allo-HCT, the evidence includes a number of case series and a meta-analysis. The relevant outcomes are OS, DSS, change in disease status, morbid events, and TRM and morbidity. A 2016 meta-analysis identified 38 case series evaluating allo-HCT for relapsed or refractory HL. The pooled analysis found a 6-month OSl rate of 83% and a 3-year overall survival rate of 50%. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

For individuals who have relapsed HL after autologous HCT who receive allo-HCT, the evidence includes case series and a meta-analysis. The relevant outcomes are OS, DSS, change in disease status, morbid events, and TRM and morbidity. A 2016 meta-analysis of 38 case series found that a previous autologous HCT followed by allo-HCT was significantly associated with higher 1- and 2-year OS rates and significantly higher recurrence-free survival rates at 1 year compared with no previous autologous HCT. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

For individuals who have relapsed or refractory HL who receive reduced-intensity conditioning with allo-HCT, the evidence includes case series, cohort studies, and a systematic review. The relevant outcomes are OS, DSS, change in disease status, morbid events, and TRM and morbidity. A 2015 systematic review cited a number of studies, including some with comparison groups, showing acceptable outcomes after reduced-intensity conditioning with allo-HCT in patients with relapsed or refractory HL. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

Tandem Autologous HCT

For individuals who have HL who receive tandem autologous HCT, the evidence includes nonrandomized comparative studies and case series. The relevant outcomes are OS, DSS, change in disease status, morbid events, and TRM and morbidity. One prospective, nonrandomized study reported that, in patients with poor prognostic markers, response to tandem autologous HCT might be higher than for single autologous HCT. This study was not definitive due to potential selection bias; RCTs are needed to determine the impact of tandem autologous HCT on health outcomes in

this population. The evidence is insufficient to determine the effects of the technology on health outcomes.

Clinical input obtained from academic medical centers in 2009 supported the use of tandem autologous HCT in specific situations, including primary refractory HL and relapsed disease with poor-risk features, not in remission. Tandem autologous HCT may be considered medically necessary for these situations.

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.

In response to requests, input was received from 2 academic medical centers while this policy was under review in 2009. Both reviewers agreed with the policy statements, except the use of a second autologous hematopoietic cell transplantation (HCT) after a prior autologous HCT, which both thought would be medically necessary for certain circumstances. Data to support the use of a second autologous HCT are extremely limited, and the policy statement for this use of HCT remains investigational.

Practice Guidelines and Position Statements

National Comprehensive Cancer Network Guidelines

Current National Comprehensive Cancer Network guidelines for Hodgkin lymphoma (HL; v.3.2018) include a recommendation for autologous HCT in patients with biopsy-proven refractory disease who have undergone second-line systemic therapy and Deauville stages 1, 2, 3, or 4 according to restaging based on findings from positron emission tomography or computed tomography.

American Society for Blood and Marrow Transplantation
In 2015, guidelines were published by the American Society for Blood and Marrow Transplantation on indications for autologous and allogeneic HCT. Recommendations described the current consensus on the use of HCT in and out of the clinical trial setting. The Society recommendations on HL are provided in Table 2.

Table 2. Recommendations for Use of HCT to Treat Hodgkin Lymphoma

Indication	Allogeneic HCT	Autologous HCT
Adult		
First complete response (PET negative)	N	N
First complete response (PET positive)	N	C
Primary refractory, sensitive	C	S
Primary refractory, resistant	C	N
First relapse, sensitive	S	S
First relapse, resistant	C	N
Second or greater relapse	C	S
Relapse after autologous transplant	C	N
Pediatric		
First complete response	N	N
Primary refractory, sensitive	C	C
Primary refractory, resistant	C	N
First relapse, sensitive	C	C
First relapse, resistant	C	N
Second or greater relapse	C	C

C: clinical evidence available; HCT: hematopoietic cell transplantation; N: not generally recommended; PET: positron emission tomography; S: standard of care.

The Society (2015) also published guidelines on the role of cytotoxic therapy with HCT in patients with Hodgkin Lymphoma. Select recommendations are shown in Table 3.

Table 3. Recommendations on Use of Cytotoxic Therapy with HCT to Treat Hodgkin Lymphoma

Recommendation	GOR	Highest LOE
Autologous HCT		
Autologous HCT should not be offered as first-line therapy for advanced disease	A	1+
Autologous HCT should be offered as first-line therapy for patients who fail to achieve CR	B	2++
Autologous HCT should be offered as salvage therapy over nontransplantation (except localized disease or in patients with low-stage disease)	A	1+
Autologous HCT should be offered to pediatric patients with primary refractory disease or high-risk relapse who respond to salvage therapy	B	2++
Tandem autologous HCT is not routinely recommended in standard-risk patients	C	2+
Allogeneic HCT		
Allo-HCT should be used for relapse after ASCT instead of conventional therapy	B	2++
RIC is the recommended regimen intensity	B	2++
All donor sources can be considered	A	1+
There are limited data for tandem autologous HCT/allo-HCT	D	4
Allo-HCT is preferred over autologous HCT as second HCT (except in late relapse)	C	2+

allo: allogeneic; CR: Complete response; GOR: grade of recommendation; HCT: hematopoietic cell transplantation; LOE: level of evidence; RIC: reduced-intensity conditioning.

American College of Radiology

The American College of Radiology (2016) issued an Appropriateness Criteria on recurrent HL. The criteria stated that while salvage therapy followed by autologous HCT is standard of care for relapsed HL, alternative therapies may be considered in select patients. For example, there is evidence that in patients with small isolated relapses occurring more than three years after initial presentation, a course of radiotherapy or combined modality therapy without autologous HCT may be considered. Also, radiotherapy may be considered as part of combined modality therapy for patients with local relapse after treatment with chemotherapy alone or for relapses outside of the original site of disease.

U.S. Preventive Services Task Force Recommendations
Not applicable.

Medicare National Coverage
Autologous HCT is considered reasonable and necessary and is covered under Medicare (NCD 110.23 [formerly 110.8.1]) for patients with "[a]dvanced Hodgkin's disease who have failed conventional therapy and have no HLA [human leukocyte antigen]-matched donor."

Ongoing and Unpublished Clinical Trials
Some currently unpublished trials that might influence this review are listed in Table 4.

Table 4. Summary of Key Trials

NCT No.	Trial Name	Planned Enrollment	Completion Date
Ongoing			
NCT00574496	Combination Chemotherapy Followed by Donor Stem Cell Transplant in Treating Patients With Relapsed or High-Risk Primary Refractory Hodgkin Lymphoma	30	Nov 2019
NCT01203020	Once Daily Targeted Intravenous (IV) Busulfex as Part of Reduced-toxicity Conditioning for Patients With Refractory Lymphomas Undergoing Allogeneic Transplantation	32	Dec 2018

NCT: national clinical trial.

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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 Hodgkin's Disease policy developed separately from current HDC with Hematopoietic Stem Cell Support policy.
06/28/2004	Managed Care Advisory Council approval
05/03/2005	Medical Director review
05/17/2005	Medical Policy Committee review. Coverage eligibility unchanged.
05/23/2005	Managed Care Advisory Council approval
05/03/2006	Medical Director review
05/17/2006	Medical Policy Committee approval. Format revision, including addition of FDA and or other governmental regulatory approval and rationale/source. Coverage eligibility unchanged.
04/04/2007	Medical Director review
04/18/2007	Medical Policy Committee approval. No change in coverage eligibility.
04/02/2008	Medical Director review
04/16/2008	Medical Policy Committee approval. No change to coverage eligibility.
04/02/2009	Medical Director review
04/15/2009	Medical Policy Committee approval. Title changed to match BCBSA. No change to coverage.
04/08/2010	Medical Policy Committee approval

04/21/2010	Medical Policy Implementation Committee approval. Added tandem autologous HSCT to be eligible for coverage with criteria. Added reduced-intensity allogeneic HSCT to treat Hodgkin Lymphoma to be eligible for coverage with criteria. Added that a second autologous stem-cell transplantation for relapsed lymphoma after a prior autologous HSCT to be investigational. Updated background/overview, rationale and references.
04/07/2011	Medical Policy Committee review
04/13/2011	Medical Policy Implementation Committee approval. Coverage eligibility unchanged.
04/12/2012	Medical Policy Committee review
04/25/2012	Medical Policy Implementation Committee approval. Coverage eligibility unchanged.
05/02/2013	Medical Policy Committee review
05/22/2013	Medical Policy Implementation Committee approval. Coverage eligibility unchanged.
05/01/2014	Medical Policy Committee review
05/21/2014	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. Removed statement on reduced intensity allogenic HCT, added coverage statement for allogenic HCT, using either myeloablative or reduced-intensity conditioning regimens in patients with primary refractory or relapsed Hodgkin lymphoma. Added a policy guidelines section.
05/03/2018	Medical Policy Committee review

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05/16/2018	Medical Policy Implementation Committee approval. Coverage eligibility unchanged.
05/02/2019	Medical Policy Committee review
05/15/2019	Medical Policy Implementation Committee approval. Coverage eligibility unchanged.
05/07/2020	Medical Policy Committee review
05/13/2020	Medical Policy Implementation Committee approval. Coverage eligibility unchanged.

Next Scheduled Review Date: 05/2021

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 2019 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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CPT is a registered trademark of the American Medical Association.

Hematopoietic Cell Transplantation for Hodgkin Lymphoma

Policy # 00057
Original Effective Date: 01/28/2008
Current Effective Date: 06/08/2020

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	C81.00-C81.99

*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.

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.