MASSACHUSETTS

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Medical Policy

Hematopoietic Cell Transplantation for Acute Lymphoblastic Leukemia

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Policy Number: 076

BCBSA Reference Number: 8.01.32 (For Plan internal use only)

Related Policies

None

Policy

Commercial Members: Managed Care (HMO and POS), PPO, and Indemnity

Childhood Acute Lymphoblastic Leukemia (ALL)

Autologous or allogeneic hematopoietic cell transplantation (HCT) may be considered **MEDICALLY NECESSARY** to treat childhood acute lymphoblastic leukemia (ALL) in first complete remission but at high risk of relapse.*

Autologous or allogeneic HCT may be considered **MEDICALLY NECESSARY** to treat childhood ALL in second or greater remission or refractory ALL.

Allogeneic HCT is considered **MEDICALLY NECESSARY** to treat relapsing ALL after a prior autologous HCT.

Relapse Risk Prognostic Factors

Childhood Acute Lymphoblastic Leukemia

*Adverse prognostic factors in children include the following: age younger than 1 year or more than 9 years, male gender, white blood cell (WBC) count at presentation above 50,000/ìL, hypodiploidy (<45 chromosomes), t(9;22) or *BCR/ABL* fusion, t(4;11) or *MLL/AF4* fusion, and ProB or T-lineage immunophenotype. Several risk stratification schema exist, but, in general, the following findings help define children at high risk of relapse: (1) poor response to initial therapy including poor response to prednisone prophase defined as an absolute blast count of 1000/ìL or greater, or poor treatment response to induction therapy at 6 weeks with high risk having ≥1% minimal residual disease measured

by flow cytometry, (2) all children with T- cell phenotype, and (3) individuals with either the t(9;22) or t(4;11) regardless of early response measures.

Adult Acute Lymphoblastic Leukemia

Autologous HCT may be considered **MEDICALLY NECESSARY** to treat adult ALL in first complete remission but at high risk of relapse.*

Allogeneic HCT may be considered **MEDICALLY NECESSARY** to treat adult ALL in first complete remission for any risk level.*

Allogeneic HCT may be considered **MEDICALLY NECESSARY** to treat adult ALL in second or greater remissions, or in patients with relapsed or refractory ALL.

Autologous HCT is **INVESTIGATIONAL** to treat adult ALL in second or greater remission or those with refractory disease.

Allogeneic HCT is considered **MEDICALLY NECESSARY** to treat relapsing ALL after a prior autologous HCT.

Reduced-intensity conditioning allogeneic HCT may be considered **MEDICALLY NECESSARY** as a treatment of ALL in individuals who are in complete marrow and extramedullary first or second remission, and who, for medical reasons (see below) would be unable to tolerate a standard myeloablative conditioning regimen.

Adult Acute Lymphoblastic Leukemia
*Risk factors for relapse are less well-defined in adults, but a patient with any of the following may be considered at high risk for relapse: age older than 35 years, leukocytosis at presentation of greater than 30,000/ìL (B-cell lineage) or greater than 100,000/ìL (T-cell lineage), “poor prognosis” genetic abnormalities like the Philadelphia chromosome (t[9;22]), extramedullary disease, and time to attain complete remission longer than 4 weeks.

Reduced-Intensity Conditioning
Some individuals for whom a conventional myeloablative allogeneic HSCT could be curative may be considered candidates for RIC allogeneic HCT (see Description section). These include those whose age (typically >60 years) or comorbidities (eg, liver or kidney dysfunction, generalized debilitation, prior intensive chemotherapy including autologous or allogeneic HSCT, low Karnofsky Performance Status) preclude use of a standard myeloablative conditioning regimen.

The ideal allogeneic donors are HLA-identical siblings, matched at the HLA-A, B, and DR loci (6 of 6). Related donors mismatched at 1 locus are also considered suitable donors. A matched, unrelated donor identified through the National Marrow Donor Registry is typically the next option considered. Recently, there has been interest in haploidentical donors, typically a parent or a child of the patient, where usually there is sharing of only 3 of the 6 major histocompatibility antigens. Most individuals will have such a donor; however, the risk of GVHD and overall morbidity of the procedure may be severe, and experience with these donors is not as extensive as that with matched donors.

Prior Authorization Information

Inpatient

- For services described in this policy, precertification/preauthorization **IS REQUIRED** for all products if the procedure is performed **inpatient**.

Outpatient

- For services described in this policy, see below for products where prior authorization **might be required** if the procedure is performed **outpatient**.

	Outpatient
Commercial Managed Care (HMO and POS)	Prior authorization is **required**.
Commercial PPO and Indemnity	Prior authorization is **required**.

Requesting Prior Authorization Using Authorization Manager
Providers will need to use Authorization Manager to submit initial authorization requests for services. Authorization Manager, available 24/7, is the quickest way to review authorization requirements, request authorizations, submit clinical documentation, check existing case status, and view/print the decision letter. For commercial members, the requests must meet medical policy guidelines.

To ensure the service request is processed accurately and quickly:
- Enter the facility's NPI or provider ID for where services are being performed.
- Enter the appropriate surgeon's NPI or provider ID as the servicing provider, *not* the billing group.

Authorization Manager Resources
Refer to our Authorization Manager page for tips, guides, and video demonstrations.

CPT Codes / HCPCS Codes / ICD Codes

Inclusion or exclusion of a code does not constitute or imply member coverage or provider reimbursement. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage as it applies to an individual member.

Providers should report all services using the most up-to-date industry-standard procedure, revenue, and diagnosis codes, including modifiers where applicable.

The following codes are included below for informational purposes only; this is not an all-inclusive list.

The above medical necessity criteria MUST be met for the following codes to be covered for Commercial Members: Managed Care (HMO and POS), PPO, Indemnity, Medicare HMO Blue and Medicare PPO Blue:

CPT Codes

CPT codes:	Code Description
38240	Bone marrow or blood-derived peripheral stem-cell transplantation; allogeneic
38241	Bone marrow or blood-derived peripheral stem-cell transplantation; autologous

HCPCS Codes

HCPCS codes:	Code Description
S2142	Cord blood-derived stem-cell transplantation, allogeneic
S2150	Bone marrow or blood-derived peripheral stem-cell harvesting and transplantation, allogeneic or autologous, including pheresis, high-dose chemotherapy, and the number of days of post-transplant care in the global definition (including drugs; hospitalization; medical surgical, diagnostic and emergency services)

ICD-10-PCS Procedure Codes

ICD-10-PCS procedure codes:	Code Description
30233G0	Transfusion of Autologous Bone Marrow into Peripheral Vein, Percutaneous Approach

30233G1	Transfusion of Nonautologous Bone Marrow into Peripheral Vein, Percutaneous Approach
30243G0	Transfusion of Autologous Bone Marrow into Central Vein, Percutaneous Approach
30243G1	Transfusion of Nonautologous Bone Marrow into Central Vein, Percutaneous Approach
30263G0	Transfusion of Autologous Bone Marrow into Central Artery, Percutaneous Approach
30263G1	Transfusion of Nonautologous Bone Marrow into Central Artery, Percutaneous Approach
3E03305	Introduction of Other Antineoplastic into Peripheral Vein, Percutaneous Approach
3E04305	Introduction of Other Antineoplastic into Central Vein, Percutaneous Approach
3E05305	Introduction of Other Antineoplastic into Peripheral Artery, Percutaneous Approach
3E06305	Introduction of Other Antineoplastic into Central Artery, Percutaneous Approach
30233Y0	Transfusion of Autologous Hematopoietic Stem Cells into Peripheral Vein, Percutaneous Approach
30243Y0	Transfusion of Autologous Hematopoietic Stem Cells into Central Vein, Percutaneous Approach
30233Y1	Transfusion of Nonautologous Hematopoietic Stem Cells into Peripheral Vein, Percutaneous Approach
30243Y1	Transfusion of Nonautologous Hematopoietic Stem Cells into Central Vein, Percutaneous Approach
30263Y1	Transfusion of Nonautologous Hematopoietic Stem Cells into Central Artery, Percutaneous Approach
30233X1	Transfusion of Nonautologous Cord Blood Stem Cells into Peripheral Vein, Percutaneous Approach
30243X1	Transfusion of Nonautologous Cord Blood Stem Cells into Central Vein, Percutaneous Approach
30263X1	Transfusion of Nonautologous Cord Blood Stem Cells into Central Artery, Percutaneous Approach

Description

Acute Lymphoblastic Leukemia

Acute lymphoblastic leukemia (ALL) is a heterogeneous disease with different genetic variations resulting in distinct biologic subtypes. Patients are stratified by certain clinical and genetic risk factors that predict an outcome, with risk-adapted therapy tailoring treatment based on the predicted risk of relapse.[1] Two of the most important factors predictive of risk are patient age and white blood cell count at diagnosis.[1] Certain genetic characteristics of leukemic cells strongly influence prognosis. Clinical and biologic factors predicting clinical outcomes and relapse risk are summarized in the Policy Guidelines section.[2]

Childhood Acute Lymphoblastic Leukemia

Acute lymphoblastic leukemia is the most common cancer diagnosed in children; it represents nearly 25% of cancer diagnoses in children younger than 15 years.[3] Remission of disease is now typically achieved with pediatric chemotherapy regimens in 98% of children with ALL, with long-term survival rates of up to 85%. Survival rates have improved with the identification of effective drugs and combination chemotherapy through large randomized trials, integration of presymptomatic central nervous system prophylaxis, and intensification and risk-based stratification of treatment.[2] The prognosis after the first relapse is related to the length of the original remission. For example, leukemia-free survival is 40% to 50% for children whose first remission was longer than 3 years compared with 10% to 15% for those who relapse less than 3 years after treatment. Thus, hematopoietic cell transplantation (HCT) may be a strong consideration in those with short remissions. At present, comparative outcomes with autologous or allogeneic HCT (allo-HCT) are unknown.

Adult Acute Lymphoblastic Leukemia

In adults, ALL accounts for 20% of acute leukemias. Between 60% and 80% of adults with ALL can be expected to achieve a complete response after induction chemotherapy; however, patients who experience a relapse after remission usually die within 1 year[4]. Differences in the frequency of genetic abnormalities that characterize adult ALL versus childhood ALL help, in part, to explain differences in outcomes between the 2 groups. For example, the "good prognosis" genetic abnormalities, such as hyperdiploidy and translocation of chromosomes 12 and 21, are seen much less commonly in adult ALL, whereas they are some of the most common in childhood ALL. Conversely, "poor prognosis" genetic abnormalities such as the Philadelphia chromosome (translocation of chromosomes 9 and 22) are seen in 25% to 30% of adult ALL but infrequently in childhood ALL. Other adverse prognostic factors in adult ALL include age greater than 35 years, poor performance status, male sex, and leukocytosis at presentation of greater than 30,000/μL (B-cell lineage) or greater than 100,000/μL (T-cell lineage).

Hematopoietic Cell Transplantation

Hematopoietic cell transplantation is a procedure in which hematopoietic stem cells are intravenously infused to restore bone marrow and immune function in cancer patients who receive bone marrow-toxic doses of cytotoxic 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. Cord blood transplantation is discussed in detail in policy #285.

Immunologic compatibility between infused hematopoietic stem cells and the recipient is not an issue in autologous HCT. In allogeneic stem cell transplantation, immunologic compatibility between donor and patient is a critical factor for achieving a successful outcome. Compatibility is established by typing of human leukocyte antigens (HLA) using cellular, serologic, or molecular techniques. HLA refers to the gene complex expressed at the HLA-A, -B, and -DR (antigen-D related) loci on each arm of chromosome 6. An acceptable donor will match the patient at all or most of the HLA loci.

Conditioning for Hematopoietic Cell Transplantation

Conventional Conditioning

The conventional ("classical") practice of allo-HCT involves administration of cytotoxic agents (e.g., cyclophosphamide, busulfan) with or without existing disease in the absence of pretransplant conditioning. Intense conditioning regimens are limited to patients whose health status is sufficient to tolerate the procedure of body irradiation at doses sufficient to cause bone marrow ablation in the recipient. The beneficial treatment effect of this procedure is due to a combination of the initial eradication of malignant cells and subsequent graft-versus-malignancy effect mediated by non-self-immunologic effector cells. While the slower graft-versus-malignancy effect is considered the potentially curative component, it may be overwhelmed by substantial adverse effects. These include opportunistic infections secondary to loss of endogenous bone marrow function and organ damage or failure caused by cytotoxic drugs. Subsequent to graft infusion in allo-HCT, immunosuppressant drugs are required to minimize graft rejection and graft-versus-host disease (GVHD), which increases susceptibility to opportunistic infections.

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

Reduced-Intensity Conditioning Allogeneic Hematopoietic Cell Transplantation

Reduced-intensity conditioning (RIC) allogeneic HCT refers to the pretransplant use of lower doses of cytotoxic drugs or less intense regimens of radiotherapy than are used in traditional full-dose myeloablative conditioning treatments. Although the definition of RIC is variable, with numerous versions employed, all regimens seek to balance the competing effects of relapse due to residual disease and

non-relapse mortality. The goal of RIC is to reduce disease burden and to minimize associated treatment-related morbidity and non-relapse mortality in the period during which the beneficial graft-versus-malignancy effect of allogeneic transplantation develops. These RIC regimens range from nearly total 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. In this review, the term reduced-intensity conditioning will refer to all conditioning regimens intended to be nonmyeloablative.

Summary

Description

Acute lymphoblastic leukemia (ALL) is a heterogeneous disease with different genetic variations resulting in distinct biologic subtypes. Patients are stratified to risk-adapted therapy according to certain clinical and genetic risk factors that predict an outcome. Therapy may include hematopoietic cell transplantation (HCT).

Summary of Evidence

For individuals who have childhood acute lymphoblastic leukemia (ALL) in first complete remission (CR1) at high-risk of relapse, remission, or refractory ALL who receive autologous hematopoietic cell transplantation (HCT) , the evidence includes randomized controlled trials (RCTs) and systematic reviews. Relevant outcomes are overall survival (OS) , disease-specific survival (DSS) , and treatment-related mortality (TRM) and morbidity. For children with high-risk ALL in CR1 or with relapsed ALL, studies have suggested that HCT is associated with fewer relapses but higher death rates due to treatment-related toxicity. However, for a subset of high-risk patients in second complete remission or beyond or with relapsed disease, autologous HCT is a treatment option. This conclusion is further supported by an evidence-based systematic review and position statement from the American Society for Blood and Marrow Transplantation (ASBMT). The evidence is sufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who have childhood ALL in CR1 at high-risk of relapse, remission, or refractory ALL who receive allogeneic HCT (allo-HCT), the evidence includes RCTs and systematic reviews. Relevant outcomes are OS, DSS, and TRM and morbidity. For children with high-risk ALL in CR1 or with relapsed ALL, studies have suggested that allo-HCT is associated with fewer relapses but higher death rates due to treatment-related toxicity. However, for a subset of high-risk patients in second complete remission or beyond or with relapsed disease, allo-HCT is a treatment option. This conclusion is further supported by an evidence-based systematic review and position statement from the ASBMT. The evidence is sufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who have adult ALL in CR1, subsequent remission, or refractory ALL who receive autologous HCT, the evidence includes RCTs and systematic reviews. Relevant outcomes are OS, DSS, and TRM and morbidity. Current evidence supports the use of autologous HCT for adults with high-risk ALL in CR1, whose health status is sufficient to tolerate the procedure. The evidence is sufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who have adult ALL in CR1 or subsequent remission or refractory ALL who receive allo-HCT, the evidence includes RCTs, systematic reviews, and observational studies. Relevant outcomes are OS, DSS, and TRM and morbidity. Current evidence supports the use of myeloablative allo-HCT for adults with any risk level ALL, whose health status is sufficient to tolerate the procedure. Reduced-intensity conditioning allo-HCT may be considered for patients who demonstrate complete marrow and extramedullary first or second remission and who could be expected to benefit from a myeloablative allo-HCT, but for medical reasons would not tolerate a myeloablative conditioning regimen. The evidence is sufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who have relapsed after a prior autologous HCT for adult or childhood ALL who receive allo-HCT, the evidence includes case series. Relevant outcomes are OS, DSS, and TRM and morbidity.

Evidence reviews have identified only small case series with short-term follow-up, which was considered inadequate evidence of benefit. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

Policy History

Date	Action
3/2025	Annual policy review. References updated. Policy statements unchanged.
3/2024	Annual policy review. Description, summary, and references updated. Policy statements unchanged.
9/2023	Policy clarified to include prior authorization requests using Authorization Manager.
3/2023	Annual policy review. Minor editorial refinements to policy statements; intent unchanged.
2/2022	Annual policy review. Description, summary, and references updated. Policy statements unchanged.
3/2021	Annual policy review. Description, summary, and references updated. Policy statements unchanged.
1/2021	Medicare information removed. See MP #132 Medicare Advantage Management for local coverage determination and national coverage determination reference.
4/2020	Bone marrow harvesting codes were removed. Outpatient prior authorization is not required.
3/2020	Annual policy review. Description, summary, and references updated. Policy statements unchanged.
3/2019	Annual policy review. Description, summary, and references updated. Policy statements unchanged.
1/2019	Outpatient prior authorization is required for all commercial products. Effective 1/1/2019.
2/2018	Annual policy review. New references added.
1/2018	Clarified coding information.
5/2017	Annual policy review. New references added
6/2017	Annual policy review. New references added
2/2017	Annual policy review. New references added
5/2016	Annual policy review. “Hematopoietic stem cell transplantation (HSCT)” was replaced with “hematopoietic cell transplantation (HCT)” in the policy statements and title. 5/1/2016
8/2015	Added coding language.
7/2015	Annual policy review. New references added
5/2014	Updated Coding section with ICD10 procedure and diagnosis codes. Effective 10/2015.
4/2014	Investigational indications for autologous hematopoietic stem-cell transplantation clarified; medically necessary indications for allogeneic hematopoietic stem-cell transplantation clarified.
11/2013	Annual policy review. New medically necessary indications described. Effective 11/1/2013.
12/2012	Updated to add new CPT code 38243.
11/2011-4/2012	Medical policy ICD 10 remediation: Formatting, editing and coding updates. No changes to policy statements.
7/2011	Reviewed - Medical Policy Group - Hematology and Oncology. No changes to policy statements.
9/2010	Reviewed - Medical Policy Group - Hematology and Oncology. No changes to policy statements.
9/1/2010	Medical policy 076 effective 9/1/2010 describing covered and non-covered indications.

Information Pertaining to All Blue Cross Blue Shield Medical Policies

Click on any of the following terms to access the relevant information:

Medical Policy Terms of Use
Managed Care Guidelines
Indemnity/PPO Guidelines
Clinical Exception Process
Medical Technology Assessment Guidelines

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