Hematopoietic Cell Transplantation for Acute Lymphoblastic Leukemia

**Description of Procedure or Service**

**Hematopoietic Cell Transplantation**

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

**Acute Lymphoblastic Leukemia (ALL)**

**Childhood ALL**

ALL is the most common cancer diagnosed in children and represents almost 25% of cancers in children younger than 15 years. Complete remission of disease is now typically achieved with pediatric chemotherapy regimens in approximately 95% of children with ALL, with up to 85% long-term survival rates. 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. The prognosis after 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 only 10% to 15% for those who relapse less than 3 years following treatment. Thus, HCT may be a strong consideration in those with short remissions. At present, the comparative outcomes with either autologous or allo-HCT are unknown.

ALL is a heterogeneous disease with different genetic alterations resulting in distinct biologic subtypes. Patients are stratified according to certain clinical and genetic risk factors that predict outcome, with risk-adapted therapy tailoring treatment based on the predicted risk of relapse. Two of the most important factors predictive of risk are patient age and white blood cell count (WBC) at diagnosis. Certain genetic characteristics of the leukemic cells strongly influence prognosis.

**Adult ALL**

ALL accounts for approximately 20% of acute leukemias in adults. Approximately 60%–80% of adults with ALL can be expected to achieve complete remission after induction chemotherapy; however, only 35%–40% can be expected to survive 2 years. Differences in the frequency of genetic abnormalities that characterize adult ALL versus childhood ALL help, in part, to explain the outcome differences between the two groups. For example, the “good prognosis” genetic abnormalities like hyperdiploidy and t(12;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 like the Philadelphia
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chromosome (t(9;22)) are seen in 25%–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 >30,000/µL (B-cell lineage) and >100,000/µL (T-cell lineage).

Note: For the purpose of this policy unless otherwise specified in the text, the term “allogeneic HCT” refers to the use of a myeloablative pretransplant conditioning regimen.

Conventional Preparative Conditioning for HCT

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 prior to undergoing bone marrow ablation. As a consequence, autologous HCT is typically performed as consolidation therapy when the patient’s disease is in complete remission. Patients who undergo autologous HCT are susceptible to chemotherapy-related toxicities and opportunistic infections prior to engraftment, but not GVHD.

The conventional (“classical”) practice of allogeneic 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 in this procedure is due to a combination of initial eradication of malignant cells and subsequent graft-versus-malignancy (GVM) effect that develops after engraftment of allogeneic stem cells within the patient’s bone marrow space. While the slower GVM 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 effects 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 allogeneic HCT, immune suppressant drugs are required to minimize graft rejection and GVHD, which also increases susceptibility of the patient to opportunistic infections.

Reduced-Intensity Conditioning for Allogeneic HCT

Reduced-intensity conditioning (RIC) refers to the pretransplant use of lower doses or less intense regimens of cytotoxic drugs or radiation 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 non-relapse mortality (NRM) 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 NRM 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 allogeneic HSCT 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 the purposes of this Policy, the term “reduced-intensity conditioning” will refer to all conditioning regimens intended to be non-myeloablative, as opposed to fully myeloablative (conventional) regimens.

Related Policies:
Cord Blood as a Source of Stem Cells

***Note: This Medical Policy is complex and technical. For questions concerning the technical language and/or specific clinical indications for its use, please consult your physician.

Policy
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BCBSNC will provide coverage for Hematopoietic Cell Transplantation for Acute Lymphoblastic Leukemia (ALL) when it is determined to be medically necessary because the medical criteria and guidelines shown below are met.

Some patients may be eligible for coverage under Clinical Trials. Refer to the policy on Clinical Trial Services.

Benefits Application

This medical policy relates only to the services or supplies described herein. Please refer to the Member's Benefit Booklet for availability of benefits. Member's benefits may vary according to benefit design; therefore member benefit language should be reviewed before applying the terms of this medical policy.

Some health benefit plans may exclude benefits for transplantation.

Refer to the Member’s Benefit Booklet for prior review requirements.

When Hematopoietic Cell Transplantation for Acute Lymphoblastic Leukemia is covered

Children

1) Allogeneic or autologous cell transplantation may be considered medically necessary as a treatment of childhood ALL in first complete remission but at high risk of relapse. (See Policy Guidelines for Relapse Risk Prognostic Factors.)

2) Autologous or allogeneic cell transplantation may be considered medically necessary as a treatment of childhood ALL in second or greater remission or refractory ALL.

3) Allogeneic HCT is considered medically necessary to treat relapsing ALL after a prior autologous HCT.

Adults

1) Autologous hematopoietic cell transplantation may be considered medically necessary as a treatment of adult ALL in first complete remission but at high risk of relapse. (See Policy Guidelines for Relapse Risk Prognostic Factors.)

2) Allogeneic hematopoietic cell transplantation may be considered medically necessary as a treatment of adult ALL in first complete remission for any risk level.

3) Allogeneic hematopoietic cell transplantation may be considered medically necessary as a treatment of adult ALL in second or greater remission, or in patients with relapsed or refractory ALL.

4) Reduced-intensity conditioning allogeneic hematopoietic HCT may be considered medically necessary as a treatment of ALL patients who are in complete marrow and extramedullary first or second remission, and who, for medical reasons would be unable to tolerate a standard myeloablative conditioning regimen. (See Policy Guidelines)

5) High dose chemotherapy with allogeneic cell support may be considered medically necessary as a treatment in adults with Progenitor-B cell ALL.

6) Allogeneic HCT is considered medically necessary to treat relapsing ALL after a prior autologous HCT.

When Hematopoietic Cell Transplantation for Acute Lymphoblastic Leukemia is not covered

Autologous hematopoietic HCT is investigational to treat adult ALL in second or greater remission or those with refractory disease.
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Policy Guidelines

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 outcome. Therapy may include hematopoietic cell transplantation (HCT).

For individuals who have childhood ALL in first complete remission at high risk of relapse, subsequent remission, or refractory ALL who receive autologous or allogeneic HCT, the evidence includes randomized controlled trials (RCTs) and systematic reviews. Relevant outcomes are overall survival, disease-specific survival, and treatment-related mortality and morbidity. For children in high risk ALL in first complete remission (CR1) or relapsed ALL, studies suggest 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, HCT is a treatment option. This conclusion is further supported by an evidence-based systematic review of the literature and position statement from the American Society for Blood and Marrow Transplantation. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

For individuals who have adult ALL in first complete remission, subsequent remission, or refractory ALL who receive autologous or allogeneic HCT, the evidence includes RCTs and systematic reviews. Relevant outcomes are overall survival, disease-specific survival, and treatment-related mortality and morbidity. Current evidence supports the use of autologous HCT for adults with high-risk ALL in first complete remission, or myeloablative allogeneic HCT (allo-HCT) for adults with any risk level ALL, whose health status is sufficient to tolerate the procedure. Reduced-intensity conditioning (RIC) 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 a meaningful improvement in the net health outcome.

For individuals who have relapse after a prior autologous HCT for ALL who receive allo-HCT, the evidence includes case series and systematic reviews. Relevant outcomes are overall survival, disease-specific survival, and treatment-related mortality and morbidity. Evidence Street Assessments have identified only small case series with short-term follow-up, which were considered inadequate evidence of benefit. The evidence is insufficient to determine the effects of the technology on health outcome.

Allo-HCT after failed autologous HCT has been shown to be of clinical benefit in other hematologic malignancies and is potentially curative. In addition, clinical input has supported use of allogeneic HCT to treat relapsing ALL after a failed prior autologous HCT, particularly with RIC regimens, in adults or children. Thus, this indication may be considered medically necessary.

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 sex, white blood cell count at presentation above 50,000/µL, hypodiploidy (<45 chromosomes), translocation involving chromosomes 9 and 22 (t[9;22]) or BCR/ABL fusion, translocation involving chromosomes 4 and 11 (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/µL or greater, or poor treatment response to induction therapy at 6 weeks with high risk having 1% or higher minimal residual disease measured by flow cytometry; (2) all children with T-cell phenotype; and (3) patients with either the t(9;22) or t(4;11) regardless of early response measures.
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**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/µL (B-cell lineage) or greater than 100,000/µL (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 patients for whom a conventional myeloablative allogeneic hematopoietic cell transplantation (HCT) could be curative may be considered candidates for reduced-intensity conditioning allogeneic HCT (see Background section). Such patients include those whose age (typically >60 years) or comorbidities (eg, liver or kidney dysfunction, generalized debilitation, prior intensive chemotherapy including autologous or allogeneic HCT, low Karnofsky Performance Status score) preclude use of a standard myeloablative conditioning regimen.

The ideal allogeneic donors are human leukocyte antigen (HLA) identical siblings, matched at the HLA-A, -B, and DR (antigen-D related) loci on each arm of chromosome 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 patients will have such a donor. The risk of morbidity (eg, graft-versus host disease [GVHD]) may be higher than with HLA matched donors; however, as medical treatments improve, the risks of GVHD with haploidentical donors are approaching those similar to HLA-matched donors.

**Billing/Coding/Physician Documentation Information**

This policy may apply to the following codes. Inclusion of a code in this section does not guarantee that it will be reimbursed. For further information on reimbursement guidelines, please see Administrative Policies on the Blue Cross Blue Shield of North Carolina web site at www.bcbsnc.com. They are listed in the Category Search on the Medical Policy search page.

*Applicable codes: 38205, 38206, 38230, 38232, 38240, 38241, 38242, 38243, S2150*

BCBSNC may request medical records for determination of medical necessity. When medical records are requested, letters of support and/or explanation are often useful, but are not sufficient documentation unless all specific information needed to make a medical necessity determination is included.

**Scientific Background and Reference Sources**

*Hematopoietic Stem Cell Transplantation for Acute Lymphoblastic Leukemia*

- TEC Assessment, January, 1998; Volume 12, No. 25
- TEC Assessment, August, 2000; Volume 15, No. 9
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Medical Director review 4/2017
Specialty Matched Consultant Advisory Panel- 4/2018

Policy Implementation/Update Information

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2/01 Original policy issued.


1/04 Benefits Application and Billing/Coding sections updated for consistency.

2/04 Individual CPT codes listed for CPT ranges 38240-38242 under Billing/Coding section.

7/29/04 Added code S2150 to the Billing/Coding section of the policy.

12/9/04 Specialty Matched Consultant Advisory Panel review 11/29/2004. No changes to criteria. Revised Description of Procedure or Service section. Reformatted When Bone Marrow Transplant for Acute Lymphocytic Leukemia is covered section. Wording revised under When Bone Marrow Transplant for acute Lymphocytic Leukemia is not covered. Added policy number to Policy Key Words section. "Hematopoietic" and "Opportunistic" added to Definitions. References added.

4/10/06 Specialty Matched Consultant Advisory Panel review 3/15/2006. Added to the "When covered" section an additional indication; "3. High dose chemotherapy with allogeneic stem cell support may be considered medically necessary as a treatment in young adults with Progenitor-B ALL". References added.

6/2/08 Specialty Matched Consultant Advisory Panel review 3/17/08. Added reference to the Clinical Trials policy to the "Policy" section. Removed from the "When Not Covered" section; "High dose chemotherapy and allogeneic stem cell support is considered investigational for children and adults, as a treatment of relapsing ALL after a prior course of high-dose chemotherapy and autologous stem cell support." References added. (btw)

6/22/10 Policy Number(s) removed. (amw)

7/6/10 Specialty Matched Consultant Advisory Panel review 5/24/2010. Policy name changed from Bone Marrow Transplant for Acute lymphocytic Leukemia to Hematopoietic Stem-Cell Transplantation for Lymphoblastic Leukemia. Removed reference to "Bone Marrow Transplant, high dose chemotherapy and stem cell support" and inserted "hematopoietic stem-cell transplantation" throughout policy as appropriate. Description extensively revised. Updated "high risk of relapse" criteria for both children and adults. Added under "When Covered" section; Adult", "2. Allogeneic hematopoietic stem-cell transplantation may be considered medically necessary as a treatment of adult ALL in first complete remission for any risk level." Added "4. Reduced-intensity conditioning allogeneic hematopoietic SCT may be considered medically necessary as a treatment of ALL in patients who are in complete marrow and extramedullary first or second remission, and who, for medical reasons would be unable to tolerate a standard myeloablative conditioning regimen. These include patients whose age (typically older than 60 years) or comorbidities (e.g., liver or kidney dysfunction, generalized debilitation, prior intensive chemotherapy, low Karnofsky Performance Status) preclude use of a standard myeloablative conditioning regimen." Revised the "When Not Covered" section to indicate; "Children 1. Allogeneic hematopoietic SCT is considered investigational to treat relapsing ALL after a prior autologous SCT. "Adults 1. Autologous hematopoietic SCT is investigational to treat adult ALL in second or greater remission or those with refractory disease. 2. Allogeneic hematopoietic SCT is investigational to treat relapsing ALL after a prior autologous SCT." "NOTE: The use of donor leukocyte infusions to treat relapse after allogeneic SCT for either children or adults is considered separately in the policy entitled, Donor Leukocyte Infusion. “Policy Guidelines” updated. References added. (btw)

5/24/11 Specialty Matched Consultant Advisory Panel review 4/27/11. Moved all “Notes” to the “Description” section. Revised the following statement in the “Benefits Application” section for consistency; “Some health benefit plans may exclude benefits for transplantation.”
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Moved the following statement from “Policy Guidelines” to “Benefit Applications”; “Refer to the Member’s Benefit Booklet for prior review requirements.” Moved information related to Relapse Risk Prognostic Factors and Reduced Intensity Conditioning to the “Policy Guideline” section. “Policy Guidelines” updated. References added. (btw)

2/21/12  New 2012 CPT code 38232 added to Billing/Coding section. (btw)

5/15/12  Specialty Matched Consultant Advisory Panel review 4/18/2012. Description section updated for format consistency. No change to policy intent. References added. (btw)

1/15/13  Added new CPT code, 38243, to Billing/Coding section. (btw)

4/30/13  Specialty Matched Consultant Advisory Panel review 4/17/2013. Removed the word “support” from #2 under Children in the When Covered section. No change to policy intent. (btw)

7/16/13  “Allogeneic HSCT is considered medically necessary to treat relapsing ALL after a prior autologous HSCT” added to the When Covered section for both children and adults. Reference added. (btw)


7/15/14  References updated. No changes to Policy Statements. (mco)

5/26/15  Specialty Matched Consultant Advisory Panel review 4/29/2015. Removed related policy “Donor Lymphocyte Infusion” from the Related Policy section since this policy has been archived. No change to policy. Reference added. (lpr)

5/31/16  Updated Description and Policy Guidelines sections. Reference added. Specialty Matched Consultant Advisory Panel review 4/27/2016. No change to policy statement. (lpr)

2/24/17  Policy Guidelines revised. Reference added. No change to policy intent. (lpr)

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5/26/17  Policy title changed from “Hematopoietic Stem Cell Transplantation for Acute Lymphoblastic Leukemia” to Hematopoietic Cell Transplantation for Acute Lymphoblastic Leukemia.” Specialty Matched Consultant Advisory Panel review 4/26/2017. Under “When Not Covered Section” removed “Children” and statement #1: Allogeneic hematopoietic SHCT is considered investigational to treat relapsing ALL after a prior autologous SHCT. Also removed “Adults” and statement #2: Allogeneic hematopoietic SHCT is considered investigational to treat relapsing ALL after a prior autologous SHCT. Updated Policy Guidelines. Reference added. Medical Director review 4/2017. (lpr)

5/11/18  Specialty Matched Consultant Advisory Panel review 4/25/2018. Reference added. No change to policy statement. (lpr)

Medical policy is not an authorization, certification, explanation of benefits or a contract. Benefits and eligibility are determined before medical guidelines and payment guidelines are applied. Benefits are determined by the group contract and subscriber certificate that is in effect at the time services are rendered. This document is solely provided for informational purposes only and is based on research of current medical literature and review of common medical practices in the treatment and diagnosis of disease. Medical practices and knowledge are constantly changing and BCBSNC reserves the right to review and revise its medical policies periodically.