Hematopoietic Stem-Cell Transplantation for Breast Cancer

Policy Number:  8.01.27
Origination:  7/2002
Last Review:  7/2014
Next Review:  7/2015

Policy
Blue Cross and Blue Shield of Kansas City (Blue KC) will not provide coverage for hematopoietic stem cell support for breast cancer. This is considered not medically necessary or investigational.

When Policy Topic is covered
Not Applicable

When Policy Topic is not covered
Single or tandem autologous hematopoietic stem-cell transplantation is considered not medically necessary to treat any stage of breast cancer.

Allogeneic stem cell transplantation is investigational to treat any stage of breast cancer.

Considerations
Clinical trials for conditions other than those allowed in this policy may be available in the research setting. However, these trials are considered investigational and/or experimental and therefore contract exclusions.

Note: There are some state mandates in place that require insurance carriers to cover certain clinical trials under very specific guidelines. Please contact your BCBSKC representative for more information.

Description of Procedure or Service
The use of high-dose chemotherapy (HDC) and hematopoietic stem-cell transplantation (HSCT), instead of standard dose chemotherapy, has been used in an attempt to prolong survival in women with high-risk nonmetastatic and metastatic breast cancer.

Background
Hematopoietic Stem Cell Transplantation
Hematopoietic stem cell transplantation (HSCT) 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. Hematopoietic stem cells may be obtained from the transplant recipient (autologous HSCT) or from a donor (allogeneic HSCT). 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 “naïve” and thus are associated with a lower incidence of rejection or graft-versus-host disease (GVHD). Cord blood is discussed in greater detail in a separate policy.

Immunologic compatibility between infused hematopoietic stem cells and the recipient is not an issue in autologous HSCT. However, immunologic compatibility between donor and patient is a critical factor for achieving a good outcome of allogeneic HSCT. Compatibility is established by typing of human leukocyte antigens (HLA) using cellular, serologic, or molecular techniques. HLA refers to the tissue
type expressed at the Class I and Class II loci on chromosome 6. Depending on the disease being treated, an acceptable donor will match the patient at all or most of the HLA loci (with the exception of umbilical cord blood).

**Conventional Preparative Conditioning for HSCT**

The success of autologous HSCT 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 HSCT is typically performed as consolidation therapy when the patient’s disease is in complete remission. Patients who undergo autologous HSCT are susceptible to chemotherapy-related toxicities and opportunistic infections prior to engraftment, but not GVHD.

The conventional (“classical”) practice of allogeneic HSCT 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 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 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 HSCT, 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 HSCT**

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 traditional 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 (traditional) regimens.

**HSCT in Solid Tumors in Adults**

HSCT is an established treatment for certain hematologic malignancies; however, its use in solid tumors in adults continues to be largely experimental. Initial enthusiasm for the use of autologous transplant with the use of high-dose chemotherapy and stem cells for solid tumors has waned with the realization that dose intensification often fails to improve survival, even in tumors with a linear-dose response to chemotherapy. With the advent of reduced-intensity allogeneic transplant, interest has shifted to exploring the generation of alloreactivity to metastatic solid tumors via a graft-versus-tumor effect of donor-derived T cells.

**Rationale**
This policy was created in 1999 and is based on a search of the MEDLINE database through January 5, 2014.

History of Hematopoietic Stem-Cell Transplant for Breast Cancer

In the late 1980s/early 1990s, initial results of phase II trials for breast cancer and autologous hematopoietic stem-cell transplant (HSCT) were promising, showing high response rates in patients with metastatic disease who underwent high-dose consolidation, with a subset of up to 30% remaining disease-free for prolonged periods. In the early 1990s, larger prospective comparisons of conventional-dose chemotherapy to high-dose therapy with HSCT were initiated but accrued slowly, with up to a decade from initiation to the reporting of results. The first results from randomized trials at a single institution in early stage and metastatic disease showed survival benefits but were ultimately shown to have been based on fraudulent data. In the interim, however, the treatment became almost standard of care, while many patients received high-dose therapy off protocol, further reducing accrual to ongoing randomized trials. The results of the randomized trials were presented beginning in 1999 and showed little survival benefit; subsequently, the number of HSCT procedures performed for breast cancer decreased from thousands every year to only a few.

Autologous HSCT

The PBT-1 trial randomly assigned patients with a complete response (CR) or partial response (PR) to induction therapy for previously untreated metastatic breast cancer to autologous HSCT (n=101) or to conventional-dose maintenance chemotherapy (n=83) for up to 2 years. Of 553 patients enrolled and given initial induction therapy, only 310 achieved a PR (n=252) or CR (n=58), and only 199 were randomized. Of 72 partial responders assigned to the HSCT arm after initial induction therapy, only 5 (7%) were converted to CR. Median survival (24 vs 26 months, respectively) and overall survival (OS) at 3 years (32% vs 38%, respectively) did not differ between arms. There also were no statistically significant differences between arms in time to progression or progression-free survival (PFS) at 3 years. While treatment duration was substantially shorter for those randomly assigned to HSCT, acute morbidity was markedly more severe than after conventional-dose maintenance.

During 2003 and 2004, 4 trials reported final outcomes analyses from randomized comparisons of autologous HSCT versus conventional-dose chemotherapy for adjuvant therapy of high-risk nonmetastatic breast cancer. Two of the studies involved women with at least 4 positive axillary lymph nodes, and the other 2 involved at least 10 positive lymph nodes. The 4 studies pooled included 2337 patients.

Evidence from these trials did not support the conclusion that autologous HSCT improved outcomes when compared with conventional-dose adjuvant therapy, as no OS difference was seen in any of the studies. An editorial that accompanied one of the trials briefly reviewed and commented on factors contributing to the diffusion of autologous HSCT into routine practice of the treatment of certain breast cancer patients, without adequate testing in randomized controlled trials (RCTs).

A Cochrane systematic review and meta-analysis published in July 2005 pooled data from 6 RCTs on metastatic breast cancer reported through November 2004 (n=438 randomly assigned to autologous HSCT, 412 to conventional-dose therapy). The relative risk (RR) for treatment-related mortality was significantly higher in the arm randomly assigned to HSCT (15 vs 2 deaths; RR=4.07; 95% confidence interval [CI], 1.39 to 11.88). Treatment-related morbidity also was more severe among those randomly assigned to HSCT. OS did not differ significantly between groups at 1, 3, or 5 years after treatment. Statistically significant differences in event-free survival (EFS) at 1 year (RR=1.76; 95% CI, 1.40 to 2.21) and 5 years (RR=2.84; 95% CI, 1.07 to 7.50) favored the HSCT arms. Only 1 of the 6 included trials that had followed up all patients for at least 5 years. Reviewers recommended further follow-up for patients randomized in the other 5 trials. They also concluded that, in the interim, patients with metastatic breast cancer should not receive HSCT outside of a clinical trial because available data showed greater treatment-related mortality and toxicity without improved OS.
A second Cochrane systematic review and meta-analysis, also published in July 2005, included data from 13 RCTs on patients with high-risk (poor prognosis) early breast cancer (n=2535 randomly assigned to HSCT, 2529 to conventional-dose therapy).(9) Treatment-related mortality was significantly greater among those randomly assigned to high-dose chemotherapy/autologous SCT (65 vs 4 deaths; RR=8.58; 95% CI, 4.13 to 17.80, respectively). Treatment-related morbidity also was more common and more severe in the high-dose arms. There were no significant differences between arms in OS rates at any time after treatment. EFS was significantly greater in the HSCT group at 3 years (RR=1.12; 95% CI, 1.06 to 1.19, respectively) and 4 years (RR=1.30; 95% CI, 1.16 to 1.45, respectively) after treatment. However, the 2 groups did not differ significantly with respect to EFS at 5 and 6 years after treatment. Quality-of-life scores were significantly worse in the HSCT arms than in controls soon after treatment, but differences were no longer statistically significant by 1 year. Reviewers concluded that available data were insufficient to support routine use of HSCT for patients with poor-prognosis early breast cancer.

Hanrahan et al, with a median follow-up of 12 years, demonstrated no recurrence-free or OS advantage for patients with high-risk primary breast cancer treated with autologous HSCT after standard dose chemotherapy (n=39) versus standard chemotherapy alone (n=39). (10) Coombes et al reported on autologous HSCT as adjuvant therapy for primary breast cancer in women free of metastatic disease, with a median follow-up of 68 months.(11) A total of 281 patients were randomly assigned to receive standard chemotherapy or HDC with HSCT. They found no significant difference in relapse-free survival or OS (OS hazard ratio [HR], 1.18; 95% CI, 0.80 to 1.75; p=0.40).

A systematic review and meta-analysis published in 2007 included RCTs comparing autologous HSCT with standard-dose chemotherapy in women with early, poor prognosis breast cancer, which included 13 trials to September 2006 with 5064 patients.(12) Major conclusions were that, at 5 years, EFS approached statistical significance for the high-dose group, but no OS differences were seen. There were more transplant-related deaths in the high-dose group. The end conclusion was that there was insufficient evidence to support routine use of autologous HSCT for treating early, poor prognosis breast cancer.

Crump et al reported the results of a randomized trial of women who had not previously been treated with chemotherapy and had metastatic breast cancer or locoregional recurrence after mastectomy.(13) After initial response to induction therapy, 112 women were allocated to standard chemotherapy and 112 to autologous HSCT. After a median follow-up of 48 months, 79 deaths were observed in the high-dose group and 77 in the standard chemotherapy group. No difference in OS was observed between the 2 groups after a median follow-up of 48 months, with a median OS of 24 months in the HSCT group (95% CI, 21 to 35 months) and 28 months for the standard chemotherapy group (95% CI, 22 to 33 months; HR=0.9; 95% CI, 0.6 to 1.2; p=0.43).

Biron et al reported the results of a phase III, open, multicenter, prospective trial of women with metastatic breast cancer (and/or local or regional relapse beyond curative treatment by surgery or radiation).(14) After a CR or at least 50% PR to induction therapy, 88 women were randomly assigned to HSCT and 91 to no further treatment. No OS difference was seen between the 2 groups, with 3-year survival of 33.6% in the high-dose group and 27.3% in the observation group (p=0.8).

Zander et al reported survival data after 6 years of follow-up(15) on a trial that had previously been reported after 3.8 years of follow-up.(8) Women with surgically resected breast cancer and axillary lymph node dissection with 10 or more positive axillary lymph nodes but no evidence of metastatic disease were randomly assigned to standard chemotherapy (n=152) or HSCT (n=150). No difference in OS was observed; the estimated 5-year OS rate in the standard arm was 62% (95% CI, 54% to 70%) and 64% (95% CI, 56% to -72%) in the high-dose transplant group.

Nieto and Shpall performed a meta-analysis of all randomized trials published or updated since 2006, focusing on those that compared HDC with standard-dose chemotherapy for high-risk primary breast cancer.(16) The meta-analysis of 15 randomized trials involving patients with high-risk primary breast
cancer or metastatic disease (n=6102) detected an absolute 13% EFS benefit in favor of HDC and autologous HSCT (p<0.001) at a median follow-up of 6 years. The absolute differences in disease-specific and OS did not reach statistical significance (7% and 5%, respectively). Subset analyses suggested that HDC could be particularly effective in patients with triple negative tumors (hormone receptor and HER2-negative). The authors concluded that HDC remains a valid research strategy in certain subpopulations with high-risk primary breast cancer, for example those with triple negative tumors.

Berry et al performed a meta-analysis with individual patient data from 15 randomized trials comparing autologous HSCT with HDC (n=3118) to standard chemotherapy (n= 3092) for patients with high-risk primary breast cancer. (17) A survival analysis was adjusted for trial, age, number of positive lymph nodes, and hormone receptor status. HSCT was associated with a nonsignificant 6% reduction in risk of death (HR=0.94; 95% CI, 0.87 to 1.02; p=0.13) and a significant reduction in the risk of recurrence (HR=0.87; 95% CI, 0.81 to 0.93; p<0.001). Toxic death was higher in the HSCT group with 72 (6%) of 1207 deaths in these trial arms compared with 17 (1.4%) of 1261 deaths in the standard therapy arms. In a subgroup analysis, the authors investigated whether age, number of positive lymph nodes, tumor size, histology, hormone receptor status, or HER2 status impacted survival when comparing HSCT versus standard treatment. The authors found that HER2-negative patients receiving HSCT had a 21% reduction in the risk of death and HER2-negative and hormone receptor negative patients receiving HSCT had a 33% reduction in the risk of death. In their discussion, the authors state that this relationship could be spurious due to the amount of missing data on HER2 status and suggest that HSCT is unlikely to show much benefit in these subgroups of patients.

A meta-analysis by Wang et al included aggregate data from 14 trials (N=5747) published since March 2010.(18) Clinical trials of patients receiving HSCT as a first-line treatment for primary breast cancer were eligible for inclusion. A higher treatment-related mortality was found among the patients who received HSCT compared with standard chemotherapy (RR=3.42; 95% CI, 1.32 to 8.86). OS did not differ significantly between groups with an HR of 0.91 (95% CI, 0.82 to 1.00) for the HSCT compared to standard treatment. Risk of secondary, nonbreast cancer was higher in the HSCT group (RR=1.28; 95% CI, 0.82 to 1.98). Disease free survival was better in the HSCT group compared with chemotherapy alone (RR=0.89; 95% CI, 0.79 to 0.99). Patients receiving HSCT had a greater risk of dying during remission than patients treated with nonmyeloablative chemotherapy because of the toxicity of the regimen. This increase in treatment-related mortality may help explain why there was no observed OS benefit for patients receiving HSCT when disease-free survival was observed to be superior to standard chemotherapy.

In 2013, the Italian Group of Bone Marrow and Hematopoietic Stem-Cell Transplantation and Cellular Therapy (GITMO) published registry data on 415 patients with metastatic breast cancer who received high-dose chemotherapy and autologous HSCT between 1990 and 2005.(19) More than 95% of the transplants performed used peripheral blood stem cells. Sixteen percent of patients received a tandem transplant. Estrogen-receptor (ER) status was known in 328 patients, 65% of whom were ER positive. Her-2 expression data were insufficient for subset analysis. After a median follow-up of 27 months (range, 0-172 months), PFS at 5 and 10 years was 23% and 14% and OS was 47% and 32%, respectively. The authors reported statistically significant survival benefit in patient subgroups including those with ER-positive tumors and those without visceral metastases; however, these are established positive prognostic factors compared with factors for patients with ER-negative tumors and visceral metastases, respectively. In addition, the authors did not report which patients received hormonal therapy, nor was it known if/which patients received targeted HER-2 therapy, and it is unclear what impact on survival therapies other that HSCT may have had.

In 2013, GITMO published registry data on the use of adjuvant HDC with autologous HSCT in 1183 patients with high-risk primary breast cancer (3 or more involved lymph nodes), treated between 1990 and 2005.(20) Data on ER and HER-2 status were available in 85% and 48% of patients, respectively. The majority of patients with hormone receptor-positive tumors received tamoxifen after HSCT. The median lymph node involvement at surgery was 15 (range, 4-63). More than 95% of the patients
received peripheral blood-mobilized stem cells. After a median follow-up of 7.1 years, disease free survival was 9.6 years, with 65% of patients free of disease at 5 years. Median OS was not reached, with 75% of patients alive at 5 years posttransplantation. Subgroup analysis showed significantly better OS in endocrine responsive tumors and in patients who received multiple transplant procedures. Transplant-related mortality was 0.8% and late cardiac and secondary tumor-related mortality were approximately 1% overall.

**Tandem Autologous Transplantation**

Kroger et al reported on the comparison of single versus tandem autologous HSCT in 187 patients with chemotherapy-sensitive metastatic breast cancer. Only 52 of 85 patients completed the second HDC cycle in the tandem arm, mostly due to withdrawal of consent (most common reason), adverse effects, progressive disease, or death. The rate of CR was 33% in the single-dose arm versus 37% in the tandem arm (p=0.48). Although there was a trend toward improved PFS after tandem HSCT, median OS tended to be greater after single versus tandem HDC (29 vs 23.5 months, respectively; p=0.4). The authors concluded that tandem HSCT cannot be recommended for patients with chemotherapy-sensitive metastatic breast cancer because of a trend for shorter OS and higher toxicity compared with single HSCT.

Schmid et al published results of 93 patients without prior chemotherapy for metastatic breast cancer who were randomly assigned to standard-dose chemotherapy or double HDC with autologous HSCT. The primary study objective was to compare CR rates. Objective response rates for the patients in the high-dose group were 66.7% versus 64.4% for the standard group (p=0.82). There were no significant differences between the 2 treatments in median time to progression, duration of response, or OS (OS, 26.9 months vs 23.4 months for the double high-dose arm vs the standard arm, respectively; p=0.60).

**Allogeneic HSCT**

To date, allogeneic HSCT for breast cancer has mostly been used in patients who have failed multiple lines of conventional chemotherapy.

Ueno et al reported the results of allogeneic HSCT in 66 women with poor-risk metastatic breast cancer from 15 centers who underwent transplantation between 1992 and 2000. Thirty-nine (59%) received myeloablative and 27 (41%) RIC regimens. A total of 17 (26%) patients had received a prior autologous HSCT. Median follow-up time for survivors was 40 months (range, 3-64 months). Treatment-related mortality was lower in the RIC group (7% vs 29% at 100 days; p=0.03). PFS at 1 year was 23% in the myeloablative group versus 8% in the RIC group (p=0.09). OS rates after myeloablative conditioning versus the RIC group were 51% (95% CI, 36% to 67%) versus 26% (95% CI, 11% to 45%; p=0.04) at 1 year, 25% (95% CI, 13% to 40%) versus 15% (95% CI, 3% to 34%; p=0.33) at 2 years, and 19% (95% CI, 8% to 33%) versus 7% (95% CI, <1 to 25%; p=0.21) at 3 years, respectively.

Fleskens et al reported the results of a phase II study of 15 patients with metastatic breast cancer treated with HLA-matched reduced-intensity allogeneic HSCT. Median patient age was 49.5 years (range, 39.7-60.8 years), and all patients had been extensively pretreated and had undergone at least 1 palliative chemotherapy regimen for metastatic disease. Treatment-related mortality was 2 of 15 (13%). One-year PFS was 20%, and 1- and 2-year OS was 40% and 20%, respectively. The authors noted no objective tumor responses but concluded that the relatively long PFS suggests a graft-versus-tumor effect.

**Clinical Trials**

The National Cancer Institute clinical trials database (as of January 2014) identified 1 ongoing phase III trial for HSCT for breast cancer. The open label, randomized study is investigating the effect of high-
dose alkylating chemotherapy compared with standard chemotherapy as part of a multimodality treatment approach in patients with oligometastatic breast cancer harboring homologous recombination deficiency. The primary outcome measure is EFS. The estimated enrollment is 86 with an estimated study completion date of July 2019 (NCT01646034).

Summary

Randomized trials of autologous hematopoietic stem cell transplantation (HSCT) versus standard dose chemotherapy for patients with high-risk nonmetastatic or metastatic breast cancer have not shown a survival advantage with HSCT, with greater treatment-related mortality and toxicity. Therefore, autologous HSCT is considered not medically necessary for this indication.

Nonrandomized studies using reduced-intensity or myeloablative allogeneic HSCT for metastatic breast cancer have suggested a possible graft-versus-tumor effect, but remains investigational for this indication.

Practice Guidelines and Position Statements


Medicare National Coverage

There is no national coverage determination (NCD). In the absence of an NCD, coverage decisions are left to the discretion of local Medicare carriers.

References


**Billing Coding/Physician Documentation Information**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>38204</td>
<td>Management of recipient hematopoietic progenitor cell donor search and cell acquisition</td>
</tr>
<tr>
<td>38205</td>
<td>Blood-derived hematopoietic progenitor cell harvesting for transplantation, per collection; allogenic</td>
</tr>
<tr>
<td>38206</td>
<td>Blood-derived hematopoietic progenitor cell harvesting for transplantation, per collection; autologous</td>
</tr>
<tr>
<td>38207</td>
<td>Transplant preparation of hematopoietic progenitor cells; cryopreservation and storage</td>
</tr>
<tr>
<td>38208</td>
<td>Transplant preparation of hematopoietic progenitor cells; thawing of previously frozen harvest, without washing</td>
</tr>
</tbody>
</table>
Transplant preparation of hematopoietic progenitor cells; thawing of previously frozen harvest, with washing

Transplant preparation of hematopoietic progenitor cells; specific cell depletion within harvest, T-cell depletion

Transplant preparation of hematopoietic progenitor cells; tumor cell depletion

Transplant preparation of hematopoietic progenitor cells; red blood cell removal

Transplant preparation of hematopoietic progenitor cells; platelet depletion

Transplant preparation of hematopoietic progenitor cells; plasma (volume) depletion

Transplant preparation of hematopoietic progenitor cells; cell concentration in plasma, mononuclear, or buffy coat layer

Bone marrow; aspiration only

Bone marrow; biopsy, needle or trocar

Bone marrow harvesting for transplantation; allogeneic

Bone marrow harvesting for transplantation; autologous

Bone marrow or blood-derived peripheral stem cell transplantation; allogeneic

Bone marrow or blood-derived peripheral stem cell transplantation; autologous

Bone marrow or blood-derived peripheral stem cell transplantation; allogeneic donor lymphocyte infusions

HLA typing; A, B, or C (e.g., A10, B7, B27), single antigen

HLA typing; A, B, or C, multiple antigens

HLA typing; DR/DQ, single antigen

HLA typing; DR/DQ, multiple antigens

HLA typing; lymphocyte culture, mixed (MLC)

HLA typing; lymphocyte culture, primed (PLC)

Cryopreservation, freezing and storage of cells, each cell line

Thawing and expansion of frozen cells, each aliquot

Chemotherapy administration by other than infusion technique only (e.g., subcutaneous, intramuscular, push), per visit

Chemotherapy administration by infusion technique only, per visit

Chemotherapy administration by both infusion technique and other technique(s) (e.g., subcutaneous, intramuscular, push), per visit

Cord blood harvesting for transplantation, allogeneic

Cord blood-derived stem

Bone marrow or blood-derived stem cells (peripheral or umbilical), allogeneic or autologous, harvesting, transplantation, and related complications; including: pheresis and cell preparation/storage; marrow ablative therapy; drugs, supplies, hospitalization with outpatient follow

Additional Policy Key Words

N/A

Policy Implementation/Update Information

7/1/02 New policy.

8/1/03 No policy statement changes. Changed from the Medical section to the Surgery and Transplant sections.

7/1/04 No policy statement changes.

7/1/05 No policy statement changes.

4/1/06 Considerations section revised to include general criteria.

10/1/06 Policy statement revised to change to investigational for all breast cancer indications.

7/1/07 No policy statement changes.

7/1/08 No policy statement changes.

7/1/09 Terminology in policy statements modified; however, intent of policy statements remains unchanged. “High-dose chemotherapy” removed from title.

7/1/10 Policy statement for single or tandem autologous transplant changed to “not medically necessary.”
7/1/11 No policy statement changes.
1/1/12 Coding updated.
7/1/12 No policy statement changes.
7/1/13 No policy statement changes.
7/1/14 No policy statement changes.

State and Federal mandates and health plan contract language, including specific provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage. The medical policies contained herein are for informational purposes. The medical policies do not constitute medical advice or medical care. Treating health care providers are independent contractors and are neither employees nor agents Blue KC and are solely responsible for diagnosis, treatment and medical advice. No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic, photocopying, or otherwise, without permission from Blue KC.