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MEDICAL POLICY – 8.01.15

Hematopoietic Cell Transplantation for Chronic Lymphocytic Leukemia and Small Lymphocytic Lymphoma

BCBSA Ref. Policy:	8.01.15
Effective Date:	Apr. 1, 2025
Last Revised:	Mar. 10, 2025
Replaces:	8.01.514

RELATED MEDICAL POLICIES:

8.01.529 Hematopoietic Cell Transplantation for Non-Hodgkin Lymphomas

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Introduction

Chronic lymphocytic leukemia (CLL) and small lymphocytic lymphoma (SLL) are two types of cancer that affect the white blood cells and the bone marrow. Many individuals initially do not have any obvious symptoms of these diseases, and they may be discovered during an annual physical exam or by doing routine blood tests. Other individuals may have symptoms and go to their doctor because they are worried and don't feel well. A variety of medications can be used to treat these cancers, and the choice of treatment may depend on how bad a person's symptoms are and how aggressive their cancer is. In some cases, a hematopoietic cell transplant may be used to treat these diseases. This policy discusses when a hematopoietic cell transplant may be medically necessary to treat CLL and SLL.

Note: The Introduction section is for your general knowledge and is not to be taken as policy coverage criteria. The rest of the policy uses specific words and concepts familiar to medical professionals. It is intended for providers. A provider can be a person, such as a doctor, nurse, psychologist, or dentist. A provider also can be a place where medical care is given, like a hospital, clinic, or lab. This policy informs them about when a service may be covered.

Policy Coverage Criteria

Transplant	Medical Necessity
Allogeneic hematopoietic cell transplantation	**Allogeneic hematopoietic cell transplantation is considered medically necessary to treat chronic lymphocytic leukemia or small lymphocytic lymphoma in individuals with markers of poor-risk disease (see Table1 below).**

Transplant	Investigational
Autologous hematopoietic cell transplantation	**Autologous hematopoietic cell transplantation is considered investigational to treat chronic lymphocytic leukemia or small lymphocytic lymphoma.**

Additional Information

Staging and Prognosis of Chronic Lymphocytic Leukemia or Small Lymphocytic Leukemia

Two scoring systems are used to determine stage and prognosis of individuals with chronic lymphocytic leukemia (CLL) or small lymphocytic leukemia (SLL). As outlined in Table 1 below, the Rai and Binet staging systems classify individuals into three risk groups with different prognoses and are used to make therapeutic decisions.

Because prognosis of individuals varies within the different Rai and Binet classifications, other prognostic markers are used in conjunction with staging to determine clinical management.

The National Comprehensive Cancer Network guideline on CLL/SLL stated the following as unfavorable prognostic factors: DNA sequencing with mutated TP53 or ≤2% immunoglobulin heavy-chain variable (IGHV) mutation; interphase cytogenetics with del17p or deletion of 11q (del11q); or complex karyotype (≥3 unrelated chromosome abnormalities in more than 1 cell on karyotype).

Table 1. Rai and Binet Classification for CLL or SLL

Rai Stage	Risk	Description	Median Survival, y	Binet Stage	Description	Median Survival, y
0	Low	Lymphocytosis	>10	A	≤3 lymphoid areas, normal hemoglobin and platelets	>10

Rai Stage	Risk	Description	Median Survival, y	Binet Stage	Description	Median Survival, y
I	Int	Lymphocytosis + lymphadenopathy	7 to 9	B	≥3 lymphoid areas, normal hemoglobin and platelets	7
II	Int	Lymphocytosis + splenomegaly ± lymphadenopathy	7 to 9			
III	High	Lymphocytosis + anemia ± lymphadenopathy or splenomegaly	1.5 to 5	C	Any number of lymphoid areas, anemia, thrombocytopenia	5
IV	High	Lymphocytosis + thrombocytopenia ± anemia, splenomegaly, or lymphadenopathy	1.5 to 5			

CLL: chronic lymphocytic leukemia; Int: Intermediate; SLL: small lymphocytic lymphoma.

Documentation Requirements

The individual's medical records submitted for review for all conditions should document that medical necessity criteria are met. The record should include clinical documentation of the following:

- Diagnosis/condition
- History and physical examination documenting the severity of the condition
- Markers of poor-risk disease

Coding

Code	Description
CPT	
38230	Bone marrow harvesting for transplantation; allogeneic
38240	Hematopoietic progenitor cell (HPC); allogeneic transplantation per donor
HCPCS	

Note: CPT codes, descriptions and materials are copyrighted by the American Medical Association (AMA). HCPCS codes, descriptions and materials are copyrighted by Centers for Medicare Services (CMS).

Related Information

Benefit Application

The following considerations may supersede this policy:

- State mandates requiring coverage for autologous hematopoietic bone marrow transplantation offered as part of clinical trials of autologous bone marrow transplantation approved by the National Institutes of Health.
- Some plans may participate in voluntary programs offering coverage for individuals participating in National Institutes of Health -approved clinical trials of cancer chemotherapies, including autologous hematopoietic bone marrow transplantation.

Evidence Review

Description

Risk stratification of individuals with chronic lymphocytic leukemia (CLL)/small lymphocytic lymphoma (SLL) guides therapy decisions, which may include hematopoietic cell transplantation (HCT) for those with poor-risk features.

Background

Chronic Lymphocytic Leukemia and Small Lymphocytic Lymphoma

Chronic lymphocytic leukemia (CLL) and small lymphocytic lymphoma (SLL) are neoplasms of hematopoietic origin characterized by the accumulation of lymphocytes with a mature, generally well-differentiated morphology. In CLL, these cells accumulate in blood, bone marrow, lymph nodes, and spleen; in SLL they are generally confined to lymph nodes. The Revised European-

American/World Health Organization Classification of Lymphoid Neoplasms considers B-cell CLL and SLL a single disease entity.

CLL and SLL share many common features and are often referred to as blood and tissue counterparts of each other, respectively. Both tend to present as asymptomatic enlargement of the lymph nodes, tend to be indolent, but can undergo transformation to a more aggressive form of disease (e.g., Richter transformation). The median age at diagnosis of CLL is approximately 72 years, but it may present in younger individuals, often as poor-risk disease with significantly reduced life expectancy.

Treatment regimens used for CLL are generally the same as those used for SLL, and treatment outcomes are comparable for both diseases. Both low- and intermediate-risk CLL and SLL demonstrate relatively good prognoses, with median survivals of six to 10 years; however, the median survival of high-risk CLL or SLL may only be two years. Although typically responsive to initial therapy, CLL and SLL are rarely cured by conventional therapy, and nearly all individuals ultimately die of their disease. This natural disease history prompted investigation of HCT as a possible curative regimen.

Hematopoietic Cell Transplantation

Hematopoietic cell transplantation (HCT) is a procedure in which hematopoietic stem cells are infused to restore bone marrow function in cancer individuals who receive bone-marrow–toxic doses of drugs with or without whole body radiotherapy. Hematopoietic stem cells may be obtained from the transplant recipient (autologous HCT) or a donor (allogeneic HCT [allo-HCT]). These cells can be harvested from bone marrow, peripheral blood, or umbilical cord blood shortly after the 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 individual is critical for achieving a good outcome of allo-HCT. 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 HLA-A, -B, and -DR loci on each arm of chromosome 6. Depending on the disease being treated, an acceptable donor will match the individual at all or most of the HLA loci.

Conditioning for HCT

Conventional Conditioning for HCT

The conventional practice of allo-HCT involves administration of cytotoxic agents (e.g., cyclophosphamide, busulfan) with or without total body irradiation at doses sufficient to destroy endogenous hematopoietic capability in the recipient. The beneficial treatment effect in this procedure is due to a combination of initial eradication of malignant cells and subsequent graft-versus-malignancy effect that develops after engraftment of allogeneic stem cells within the individual's bone marrow space. The slower graft-versus-malignancy effect is considered the potentially curative component, but it may be overwhelmed by extant disease without the use of pretransplant conditioning. However, intense conditioning regimens are limited to individuals 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 increases the susceptibility of the individual to opportunistic infections.

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 individual before undergoing bone marrow ablation. As a consequence, autologous HCT is typically performed as consolidation therapy when the individual's disease is in complete remission. Individuals 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

Use of a myeloablative or reduced-intensity pretransplant conditioning regimen, should be individualized based on factors that include age, the presence of comorbidities, and disease burden.

Some individuals for whom a conventional myeloablative allotransplant could be curative may be considered candidates for reduced-intensity conditioning (RIC) allogeneic hematopoietic cell transplantation (allo-HCT). These include those individuals whose age (typically >60 years) or comorbidities (e.g., liver or kidney dysfunction, generalized debilitation, prior intensive chemotherapy, low Karnofsky Performance Status score) preclude use of a standard myeloablative conditioning regimen. An individual who relapses following a conventional

myeloablative allo-HCT could undergo a second myeloablative procedure if a suitable donor is available and his or her medical status would permit it. However, this type of individual would likely undergo RIC before a second allo-HCT if complete remission could be reinduced with chemotherapy.

The ideal allogeneic donors are human leukocyte antigen (HLA)-identical siblings, matched at the HLA-A, -B, and -DR loci on each arm of chromosome 6. Related donors mismatched at a single locus are also considered suitable donors. A matched, unrelated donor identified through the National Marrow Donor Registry is typically the next option considered. Recently, haploidentical donors—typically a parent or a child of the individual—with whom there is usually sharing of only three of the six major histocompatibility antigens, have been under investigation as a stem cell source. Most individuals 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.

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 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 near totally myeloablative to minimally myeloablative with lymphoablation, with intensity tailored to specific diseases and an individual's condition. Individuals 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 policy, the term "reduced-intensity conditioning" will refer to all conditioning regimens intended to be non-myeloablative, as opposed to fully myeloablative (conventional) regimens.

Summary of Evidence

For individuals who have chronic lymphocytic leukemia (CLL)/small lymphocytic lymphoma (SLL) and markers of poor-risk disease who receive allogeneic HCT (allo-HCT), the evidence includes single-arm prospective and registry-based studies. Relevant outcomes are overall survival, disease-specific survival, change in disease status, and treatment-related mortality and morbidity. Data have suggested that allo-HCT can provide long-term disease control and overall

survival in individuals with poor-risk CLL/SLL. High rates of treatment-related morbidity discourage this approach in lower risk disease, particularly among older individuals whose health status typically precludes the use of myeloablative conditioning. The evidence is sufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who have CLL/SLL who receive autologous HCT, the evidence includes randomized controlled trials and a systematic review. Relevant outcomes are overall survival, disease-specific survival, change in disease status, and treatment-related mortality and morbidity. Autologous HCT is feasible in younger individuals but is not curative, particularly in those with poor-risk CLL. Studies of autologous HCT published to date have not shown improvement in overall survival in individuals with CLL/SLL, and results must be considered in the context of improved outcomes with the use of newer chemoimmunotherapy agents. Furthermore, evidence from the European Intergroup randomized controlled trial has suggested quality of life issues are important in selecting individuals for autologous HCT and may dictate the management course for individuals who are otherwise candidates for this approach. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

Ongoing and Unpublished Clinical Trials

A search of **ClinicalTrials.gov** in November 2024 did not identify any ongoing or unpublished trials that would likely influence this review.

Practice Guidelines and Position Statements

The purpose of the following information is to provide reference material. Inclusion does not imply endorsement or alignment with the policy conclusions.

Guidelines or position statements will be considered for inclusion if they were issued by, or jointly by, a US professional society, an international society with US representation, or National Institute for Health and Care Excellence (NICE). Priority will be given to guidelines that are informed by a systematic review, include strength of evidence ratings, and include a description of management of conflict of interest.

American Society for Blood and Marrow Transplantation

In 2015, the American Society for Blood and Marrow Transplantation published guidelines on indications for allogeneic (allo-HCT) and autologous hematopoietic cell transplantation (HCT) for chronic lymphocytic leukemia (CLL).[17] Recommendations described the current consensus on use of HCT in and out of the clinical trial setting. Treatment recommendations are shown in **Table 2**.

Table 2: 2015 Recommendations for Allogeneic and Autologous HCT for CLL

Adult Indications	Allogeneic HCT	Autologous HCT
High risk, first or greater remission	C	N
T cell, prolymphocytic leukemia	R	R
B cell, prolymphocytic leukemia	R	R
Transformation to high-grade lymphoma	C	C

C: standard of care, clinical evidence available, CLL: chronic lymphocytic leukemia; HCT: hematopoietic cell transplantation; N: Not generally recommended; R: standard of care, rare indication.

In 2016, the Society published clinical practice recommendations with additional detail on allo-HCT for CLL.[18] Recommendations are shown in **Table 3**.

Table 3: 2016 Recommendations for Allogeneic HCT for CLL

Indications	Allogeneic HCT
High-risk CLL	Not recommended in the first-line consolidation setting
	Not recommended for patients who relapse after first-line therapy and demonstrate sensitive disease after second line therapy (not BCR inhibitors)
	Recommended for patients who relapse after first-line therapy, have refractory disease after second-line therapy (not BCR inhibitors) and show an objective response to BCR inhibitors or to a clinical trial
	Recommended for patients who relapse after first-line therapy, have refractory disease after second-line therapy (including BCR inhibitors but not BCL-2 inhibitors) and show an objective response to BCL-2 inhibitors or to a clinical trial

Indications	Allogeneic HCT
	Recommended when there is a lack of response or there is progression after BCL-2 inhibitors
Richter transformation	Recommended after achieving an objective response to anthracycline-based chemotherapy
Purine analogue relapsed and/or refractory disease	Not recommended

BCR: B cell receptor; BCL-2: B cell lymphoma 2; CLL: chronic lymphocytic leukemia; HCT: hematopoietic cell transplantation.

American Society for Transplantation and Cellular Therapy

In 2020, the American Society for Transplantation and Cellular Therapy (ASTCT) published guidelines on indications for HCT and immune effector cell therapy.[19], Recommendations for CLL are shown in **Table 4**.

Table 4. 2020 Recommendations for Allogeneic Hematopoietic Cell Transplantation for Chronic Lymphocytic Leukemia

Adult Indications	Allogeneic HCT	Autologous HCT
High-risk, first or greater remission	S	N
T cell, prolymphocytic leukemia	S	R
B cell, prolymphocytic leukemia	R	R
Transformation to high-grade lymphoma	C	S

C: standard of care, clinical evidence available; HCT: hematopoietic cell transplantation; N: not generally recommended; R: standard of care, rare indication; S: standard of care

National Comprehensive Cancer Network Guidelines

Current National Comprehensive Cancer Network (NCCN) guidelines (v.1.2025) for CLL and small lymphocytic lymphoma (SLL) state the following regarding HCT:[20]:

- "Given the favorable outcome of patients with del(17p) or TP53 mutation treated with covalent BTKi as first-line therapy and the availability of venetoclax as an effective treatment option for relapsed or refractory CLL, allogeneic HCT is not considered as a reasonable treatment option for relapsed/refractory CLL after initial purine analogue-based therapy."
- "Allogeneic HCT can be considered for CLL/SLL refractory to small-molecule therapy in individuals without significant comorbidities."
- In individuals with histologic transformation (Richter's) and progression, allogeneic HCT can be considered for certain individuals with disease responding to initial chemotherapy. In addition, "autologous HCT may also be appropriate for individuals with disease responding to initial therapy but who are not candidates for allogeneic HCT due to age, comorbidities, or lack of a suitable donor."

Medicare National Coverage

There is no national coverage determination.

Regulatory Status

The US Food and Drug Administration regulates human cells and tissues intended for implantation, transplantation, or infusion through the Center for Biologics Evaluation and Research, under the Code of Federal Regulation title 21, parts 1270 and 1271. Hematopoietic cells are included in these regulations.

References

1. Giné E, Moreno C, Esteve J, et al. The role of stem-cell transplantation in chronic lymphocytic leukemia risk-adapted therapy. Best Pract Res Clin Haematol. Sep 2007; 20(3): 529-43. PMID 17707838
2. Gribben JG. Role of allogeneic hematopoietic stem-cell transplantation in chronic lymphocytic leukemia. J Clin Oncol. Oct 20 2008; 26(30): 4864-5. PMID 18794537
3. Kharfan-Dabaja MA, Anasetti C, Santos ES. Hematopoietic cell transplantation for chronic lymphocytic leukemia: an evolving concept. Biol Blood Marrow Transplant. Apr 2007; 13(4): 373-85. PMID 17382245
4. Gladstone DE, Fuchs E. Hematopoietic stem cell transplantation for chronic lymphocytic leukemia. Curr Opin Oncol. Mar 2012; 24(2): 176-81. PMID 22234253

5. Delgado J, Milligan DW, Dreger P. Allogeneic hematopoietic cell transplantation for chronic lymphocytic leukemia: ready for prime time?. Blood. Sep 24 2009; 114(13): 2581-8. PMID 19641189

6. Dreger P. Allotransplantation for chronic lymphocytic leukemia. Hematology Am Soc Hematol Educ Program. 2009: 602-9. PMID 20008245

7. Brown JR, Kim HT, Li S, et al. Predictors of improved progression-free survival after nonmyeloablative allogeneic stem cell transplantation for advanced chronic lymphocytic leukemia. Biol Blood Marrow Transplant. Oct 2006; 12(10): 1056-64. PMID 17084369

8. Delgado J, Thomson K, Russell N, et al. Results of alemtuzumab-based reduced-intensity allogeneic transplantation for chronic lymphocytic leukemia: a British Society of Blood and Marrow Transplantation Study. Blood. Feb 15 2006; 107(4): 1724-30. PMID 16239425

9. Dreger P, Brand R, Hansz J, et al. Treatment-related mortality and graft-versus-leukemia activity after allogeneic stem cell transplantation for chronic lymphocytic leukemia using intensity-reduced conditioning. Leukemia. May 2003; 17(5): 841-8. PMID 12750695

10. Khouri IF, Saliba RM, Admirand J, et al. Graft-versus-leukaemia effect after non-myeloablative haematopoietic transplantation can overcome the unfavourable expression of ZAP-70 in refractory chronic lymphocytic leukaemia. Br J Haematol. May 2007; 137(4): 355-63. PMID 17456058

11. Schetelig J, Thiede C, Bornhauser M, et al. Evidence of a graft-versus-leukemia effect in chronic lymphocytic leukemia after reduced-intensity conditioning and allogeneic stem-cell transplantation: the Cooperative German Transplant Study Group. J Clin Oncol. Jul 15 2003; 21(14): 2747-53. PMID 12860954

12. Sorror ML, Storer BE, Sandmaier BM, et al. Five-year follow-up of patients with advanced chronic lymphocytic leukemia treated with allogeneic hematopoietic cell transplantation after nonmyeloablative conditioning. J Clin Oncol. Oct 20 2008; 26(30): 4912-20. PMID 18794548

13. Dreger P, Döhner H, Ritgen M, et al. Allogeneic stem cell transplantation provides durable disease control in poor-risk chronic lymphocytic leukemia: long-term clinical and MRD results of the German CLL Study Group CLL3X trial. Blood. Oct 07 2010; 116(14): 2438-47. PMID 20595516

14. Reljic T, Kumar A, Djulbegovic B, et al. High-dose therapy and autologous hematopoietic cell transplantation as front-line consolidation in chronic lymphocytic leukemia: a systematic review. Bone Marrow Transplant. Aug 2015; 50(8): 1144. PMID 26242579

15. Michallet M, Dreger P, Sutton L, et al. Autologous hematopoietic stem cell transplantation in chronic lymphocytic leukemia: results of European intergroup randomized trial comparing autografting versus observation. Blood. Feb 03 2011; 117(5): 1516-21. PMID 21106985

16. de Wreede LC, Watson M, van Os M, et al. Improved relapse-free survival after autologous stem cell transplantation does not translate into better quality of life in chronic lymphocytic leukemia: lessons from the randomized European Society for Blood and Marrow Transplantation-Intergroup study. Am J Hematol. Feb 2014; 89(2): 174-80. PMID 24123244

17. Majhail NS, Farnia SH, Carpenter PA, et al. Indications for Autologous and Allogeneic Hematopoietic Cell Transplantation: Guidelines from the American Society for Blood and Marrow Transplantation. Biol Blood Marrow Transplant. Nov 2015; 21(11): 1863-1869. PMID 26256941

18. Kharfan-Dabaja MA, Kumar A, Hamadani M, et al. Clinical Practice Recommendations for Use of Allogeneic Hematopoietic Cell Transplantation in Chronic Lymphocytic Leukemia on Behalf of the Guidelines Committee of the American Society for Blood and Marrow Transplantation. Biol Blood Marrow Transplant. Dec 2016; 22(12): 2117-2125. PMID 27660167

19. Kanate AS, Majhail NS, Savani BN, et al. Indications for Hematopoietic Cell Transplantation and Immune Effector Cell Therapy: Guidelines from the American Society for Transplantation and Cellular Therapy. Biol Blood Marrow Transplant. Jul 2020; 26(7): 1247-1256. PMID 32165328

20. National Comprehensive Cancer Network (NCCN). NCCN clinical practice guidelines in oncology: chronic lymphocytic leukemia/small lymphocytic lymphoma. Version 1.2025. **https://www.nccn.org/professionals/physician_gls/pdf/cll.pdf**. Accessed February 5, 2025.

History

Date	Comments
03/10/14	New Policy. Policy replaces 8.01.514. Policy updated with literature review through December, 2013; reference 11 added. In new policy, policy statement regarding autologous HCT changed from medically necessary to investigational. Policy statement regarding allogeneic HCT changed to medically necessary only in patients with markers of poor-risk disease as defined in Policy Guidelines.
04/18/14	Update Related Policies. Delete 8.01.20 and replace with 8.01.529.
06/27/14	Update Related Policies. Remove 8.01.35 and add 8.01.532.
12/03/14	Update Related Policies. Remove 8.01.17.
03/10/15	Annual Review. Policy updated with literature review through December 22, 2014; no new references added; no change to policy statements. ICD-9 and ICD-10 diagnosis codes removed; not utilized in adjudication. HCPCS Q and J code ranges removed.
07/01/16	Annual Review, approved June 14, 2016. Literature review. No change to policy statement.
11/04/16	Coding update. Removed codes that are transplant benefit related.
04/01/17	Annual Review, approved March 14, 2017. Policy updated with literature review through November 9, 2016; references 22-23 added. Policy statements unchanged.
10/24/17	Policy moved to new format; no change to policy statements.
04/01/18	Annual Review, approved March 13, 2018. Policy updated with literature review through November 2017; Note added that American Society for Blood and Marrow Transplantation guidelines were updated - allo-HSCT no longer recommended for high-risk CLL as consolidation in first remission or immune-chemotherapy sensitive first relapse. No references added; reference 24 updated. Policy statements unchanged.
04/01/19	Annual Review, approved March 5, 2019. Policy updated with literature review through December 2018, reference 24 updated, Policy statements unchanged.
04/01/20	Delete policy, approved March 10, 2020. This policy will be deleted effective July 2, 2020 and replaced with InterQual criteria for dates of service on or after July 2, 2020. Removed CPT code 38242 effective April 1, 2020; code does not match criteria.

Date	Comments
06/10/20	Interim Review, approved June 9, 2020, effective June 10, 2020. This policy is reinstated immediately and will no longer be deleted or replaced with InterQual criteria on July 2, 2020.
08/01/20	Annual Review, approved July 2, 2020. Policy updated with literature review through November 1, 2019, no references added, Policy statements unchanged.
09/01/20	Coding update. Removed CPT codes 38232, 38241 and HCPCS S2140, S2142 and S2150.
04/01/21	Annual Review, approved March 2, 2021. Policy updated with literature review through November 17, 2020; no references added. Policy statements unchanged.
5/1/21	Update Related Policies. Removed policy 7.01.50 as it was archived.
04/01/22	Annual Review, approved March 7, 2022. Policy updated with literature review through November 29, 2021; no references added. Policy statements unchanged.
04/01/23	Annual Review, approved March 6, 2023. Policy updated with literature review through December 2, 2022; no references added. Minor editorial refinements to policy statements; intent unchanged. Changed the wording from "patient" to "individual" throughout the policy for standardization.
04/01/24	Annual Review, approved March 25, 2024. Policy updated with literature review through November 27, 2023; references added. Policy statements unchanged.
04/01/25	Annual Review, approved March 10, 2025. Policy updated with literature review through November 25, 2024; no references added. Policy statements unchanged.

Scope: Medical policies are systematically developed guidelines that serve as a resource for Company staff when determining coverage for specific medical procedures, drugs or devices. Coverage for medical services is subject to the limits and conditions of the member benefit plan. Members and their providers should consult the member benefit booklet or contact a customer service representative to determine whether there are any benefit limitations applicable to this service or supply. This medical policy does not apply to Medicare Advantage.