MASSACHUSETTS

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Medical Policy

Hematopoietic Cell Transplantation for Plasma Cell Dyscracias, Including Multiple Myeloma and POEMS Syndrome

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Policy Number: 075

BCBSA Reference Number: 8.01.17
NCD/LCD: National Coverage Determination (NCD) for Stem Cell Transplantation Formerly 110.8.1 (110.23)

Related Policies

- Hematopoietic Cell Transplantation for Waldenström Macroglobulinemia, #322
- Placental/Umbilical Cord Blood as a Source of Stem Cells, #285

Policy

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

MULTIPLE MYELOMA

A single or second (salvage) autologous hematopoietic cell transplantation may be **MEDICALLY NECESSARY** to treat multiple myeloma.

Tandem autologous-autologous hematopoietic cell transplantation may be **MEDICALLY NECESSARY** to treat multiple myeloma in patients who fail to achieve at least a near-complete or very good partial response after the first transplant in the tandem sequence.

Definition of near-complete response and very good partial response

- A near complete response, as defined by the European Group for Blood and Marrow Transplant (EBMT) is the disappearance of M protein at routine electrophoresis, but positive immunofixation.
- A very good partial response has been defined as a 90% decrease in the serum paraprotein level.

Tandem transplantation with an initial round of autologous hematopoietic cell transplantation followed by a non-marrow-ablative conditioning regimen and allogeneic hematopoietic cell transplantation (i.e., reduced-intensity conditioning transplant) may be **MEDICALLY NECESSARY** to treat newly diagnosed multiple myeloma patients.

Allogeneic hematopoietic cell transplantation, myeloablative or nonmyeloablative, as upfront therapy of newly diagnosed multiple myeloma or as salvage therapy, is **INVESTIGATIONAL**.

POEMS syndrome
Autologous hematopoietic cell transplantation may be considered **MEDICALLY NECESSARY** to treat disseminated POEMS syndrome.*

*Patients with disseminated POEMS syndrome may have diffuse sclerotic lesions or disseminated bone marrow involvement.

Allogeneic and tandem hematopoietic cell transplantation are **INVESTIGATIONAL** to treat POEMS syndrome.

Medicare HMO Blue℠ and Medicare PPO Blue℠ Members

Medical necessity criteria and coding guidance can be found through the link below.

National Coverage Determinations (NCDs)

National Coverage Determination (NCD) for Stem Cell Transplantation Formerly 110.8.1 (110.23)

Note: To review the specific NCD, please remember to click "accept" on the CMS licensing agreement at the bottom of the CMS webpage.

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**.
Medicare HMO Blue℠	Prior authorization is **required**.
Medicare PPO Blue℠	Prior authorization is **required**.

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

38206	Blood-derived hematopoietic progenitor cell harvesting for transplantation, per collection; autologous
38232	Bone marrow harvesting for transplantation; autologous
38241	Bone marrow or blood-derived peripheral stem-cell transplantation; autologous

HCPCS Codes

HCPCS codes:	Code Description
S2150	Bone marrow or blood-derived peripheral stem-cell (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-up; medical/surgical, diagnostic, emergency, and rehabilitative services; and the number of days of pre- and post-transplant care in the global definition

ICD-10-PCS Procedure Codes

ICD-10-PCS procedure codes:	Code Description
30233G0	Transfusion of Autologous Bone Marrow into Peripheral Vein, Percutaneous Approach
30233G0	Transfusion of Autologous Bone Marrow into Peripheral Vein, Percutaneous Approach
30233G0	Transfusion of Autologous Bone Marrow into Peripheral Vein, Percutaneous Approach
30233X0	Transfusion of Autologous Cord Blood Stem Cells into Peripheral Vein, Percutaneous Approach
30233Y0	Transfusion of Autologous Hematopoietic Stem Cells into Peripheral Vein, Percutaneous Approach
30233Y0	Transfusion of Autologous Hematopoietic Stem Cells into Peripheral Vein, Percutaneous Approach
30243G0	Transfusion of Autologous Bone Marrow into Central Vein, Percutaneous Approach
30243G0	Transfusion of Autologous Bone Marrow into Central Vein, Percutaneous Approach
30243G0	Transfusion of Autologous Bone Marrow into Central Vein, Percutaneous Approach
30243X0	Transfusion of Autologous Cord Blood Stem Cells into Central Vein, Percutaneous Approach
30243Y0	Transfusion of Autologous Hematopoietic Stem Cells into Central Vein, Percutaneous Approach
30243Y0	Transfusion of Autologous Hematopoietic Stem Cells into Central Vein, Percutaneous Approach
30263G0	Transfusion of Autologous Bone Marrow into Central Artery, Percutaneous Approach
30263G0	Transfusion of Autologous Bone Marrow into Central Artery, Percutaneous Approach
30263G0	Transfusion of Autologous Bone Marrow into Central Artery, Percutaneous Approach
30263X0	Transfusion of Autologous Cord Blood Stem Cells into Central Artery, Percutaneous Approach
30263Y0	Transfusion of Autologous Hematopoietic Stem Cells into Central Artery, Percutaneous Approach
3E03305	Introduction of Other Antineoplastic into Peripheral Vein, Percutaneous Approach
3E03305	Introduction of Other Antineoplastic into Peripheral Vein, Percutaneous Approach
3E03305	Introduction of Other Antineoplastic into Peripheral Vein, Percutaneous Approach
3E03305	Introduction of Other Antineoplastic into Peripheral Vein, Percutaneous Approach
3E04305	Introduction of Other Antineoplastic into Central Vein, Percutaneous Approach

3E04305	Introduction of Other Antineoplastic into Central Vein, Percutaneous Approach
3E04305	Introduction of Other Antineoplastic into Central Vein, Percutaneous Approach
3E04305	Introduction of Other Antineoplastic into Central Vein, Percutaneous Approach
3E05305	Introduction of Other Antineoplastic into Peripheral Artery, Percutaneous Approach
3E05305	Introduction of Other Antineoplastic into Peripheral Artery, Percutaneous Approach
3E05305	Introduction of Other Antineoplastic into Peripheral Artery, Percutaneous Approach
3E05305	Introduction of Other Antineoplastic into Peripheral Artery, Percutaneous Approach
3E06305	Introduction of Other Antineoplastic into Central Artery, Percutaneous Approach
3E06305	Introduction of Other Antineoplastic into Central Artery, Percutaneous Approach
3E06305	Introduction of Other Antineoplastic into Central Artery, Percutaneous Approach
3E06305	Introduction of Other Antineoplastic into Central Artery, Percutaneous Approach

The following CPT, HCPCS and ICD Procedure codes are considered investigational for <u>Commercial Members: Managed Care (HMO and POS), PPO, Indemnity, Medicare HMO Blue and Medicare PPO Blue:</u>

CPT Codes

CPT codes:	Code Description
38205	Blood-derived hematopoietic progenitor cell harvesting for transplantation, per collection; allogeneic
38230	Bone marrow harvesting for transplantation; allogeneic
38240	Bone marrow or blood-derived peripheral stem-cell transplantation; allogeneic

HCPCS Codes

HCPCS codes:	Code Description
S2140	Cord blood harvesting for transplantation, allogeneic
S2142	Cord blood-derived stem-cell transplantation, allogeneic

ICD-10-PCS Procedure Codes

ICD-10-PCS procedure codes:	Code Description
30233G1	Transfusion of Nonautologous Bone Marrow into Peripheral Vein, Percutaneous Approach
30233G1	Transfusion of Nonautologous Bone Marrow into Peripheral Vein, Percutaneous Approach
30233G1	Transfusion of Nonautologous Bone Marrow into Peripheral Vein, Percutaneous Approach
30233X1	Transfusion of Nonautologous Cord Blood Stem Cells into Peripheral Vein, Percutaneous Approach
30233Y1	Transfusion of Nonautologous Hematopoietic Stem Cells into Peripheral Vein, Percutaneous Approach
30233Y1	Transfusion of Nonautologous Hematopoietic Stem Cells into Peripheral Vein, Percutaneous Approach
30243G1	Transfusion of Nonautologous Bone Marrow into Central Vein, Percutaneous Approach
30243G1	Transfusion of Nonautologous Bone Marrow into Central Vein, Percutaneous Approach
30243G1	Transfusion of Nonautologous Bone Marrow into Central Vein, Percutaneous Approach

30243X1	Transfusion of Nonautologous Cord Blood Stem Cells into Central Vein, Percutaneous Approach
30243Y1	Transfusion of Nonautologous Hematopoietic Stem Cells into Central Vein, Percutaneous Approach
30243Y1	Transfusion of Nonautologous Hematopoietic Stem Cells into Central Vein, Percutaneous Approach
30263G1	Transfusion of Nonautologous Bone Marrow into Central Artery, Percutaneous Approach
30263G1	Transfusion of Nonautologous Bone Marrow into Central Artery, Percutaneous Approach
30263G1	Transfusion of Nonautologous Bone Marrow into Central Artery, Percutaneous Approach
30263X1	Transfusion of Nonautologous Cord Blood Stem Cells into Central Artery, Percutaneous Approach
30263Y1	Transfusion of Nonautologous Hematopoietic Stem Cells into Central Artery, Percutaneous Approach
30263Y1	Transfusion of Nonautologous Hematopoietic Stem Cells into Central Artery, Percutaneous Approach

Description

Multiple Myeloma

MM is a systemic malignancy of plasma cells that represents approximately 10% of all hematologic cancers. It is treatable but rarely curable. At diagnosis, most patients have the generalized disease, and the selection of treatment is influenced by patient age, general health, prior therapy, and the presence of disease complications.[1,2,3]

The disease is staged by estimating tumor mass, based on various clinical parameters such as hemoglobin, serum calcium, number of lytic bone lesions, and the presence or absence of renal failure. MM usually evolves from an asymptomatic premalignant stage (termed *monoclonal gammopathy of undetermined significance*). Treatment is usually reserved for patients with symptomatic disease (usually progressive myeloma), whereas asymptomatic patients are observed because there is little evidence that early treatment of asymptomatic MM prolongs survival compared with therapy delivered at the time of symptoms or end-organ damage.[1,2] In some patients, an intermediate asymptomatic but more advanced premalignant stage is recognized and referred to as smoldering MM. The overall risk of disease progression from smoldering to symptomatic MM is 10% per year for the first five years, approximately 3% per year for the next five years, and 1% for the next ten years.[1,2]

POEMS Syndrome

POEMS syndrome (also known as osteosclerotic myeloma, Crow-Fukase syndrome, or Takatsuki syndrome) is a rare, paraneoplastic disorder secondary to a plasma cell dyscrasia.[4,5] This complex, multiorgan disease was first described in 1938, but the acronym POEMS was coined in 1980, reflecting hallmark characteristics of the syndrome: polyneuropathy, organomegaly, endocrinopathy, M protein, and skin changes.[6] No single test establishes the presence of POEMS syndrome. Its pathogenesis is undefined, although some evidence has suggested it is mediated by an imbalance of proinflammatory cytokines including interleukin (IL)-1β, IL-6, and tumor necrosis factor α; vascular endothelial growth factor may also be involved.[5,7] However, specific criteria have been established, and the syndrome may entail other findings in the constellation of signs and symptoms, as shown in Table 1. Both major criteria and at least one of the minor criteria are necessary for diagnosis.[7]

Table 1. Criteria and Associations for POEMS Syndrome

Major Criteria	Minor Criteria	Known Associations	Possible Associations
Polyneuropathy			
	Sclerotic bone lesions	Clubbing	Pulmonary hypertension
Monoclonal plasma-proliferative disorder			
	Castleman disease	Weight loss	Restrictive lung disease
	Organomegaly (splenomegaly, hepatomegaly, lymphadenopathy)	Thrombocytosis	Thrombotic diatheses
	Edema (edema, pleural effusion, ascites)	Polycythemia	Arthralgias
	Endocrinopathy (adrenal, thyroid, pituitary, gonadal, parathyroid, pancreatic)	Hyperhidrosis	Cardiomyopathy (systolic dysfunction)
	Skin changes (hyperpigmentation, hypertrichosis, plethora, hemangiomata, white nails)		Fever
	Papilledema		Low vitamin B_{12} levels
			Diarrhea

The prevalence of POEMS syndrome is unclear. A national survey in Japan showed a prevalence of about 0.3 per 100000.[8] Other large series had been described in the United States[5,7,9] and India.[10] In general, patients with POEMS have superior overall survival compared with that of MM (nearly 14 years in a large series).[7] However, given the rarity of POEMS, no randomized controlled trials of therapies have been reported.[11] Numerous approaches have included ionizing radiation, plasmapheresis, intravenous immunoglobulin, interferon-α, corticosteroids, alkylating agents, azathioprine, tamoxifen, trans-retinoic acid, and high-dose chemotherapy with autologous hematopoietic cell transplantation (HCT) support.[5,7] Optimal treatment involves eliminating the plasma cell clone (eg, by surgical excision or local radiotherapy for an isolated plasmacytoma) or systemic chemotherapy in patients with disseminated disease (eg, medullary disease or multiple plasmacytomas). Given the underlying plasma cell dyscrasia of POEMS syndrome, newer approaches to MM, including bortezomib, lenalidomide, and thalidomide, are also under investigation.[5,12]

HCT is a procedure in which hematopoietic stem cells are infused to restore bone marrow function in cancer patients who receive bone marrow-toxic doses of cytotoxic 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]). They can be harvested from bone marrow, peripheral blood, or umbilical cord blood shortly after delivery of neonates. Although cord blood is an allogeneic source, the stem cells in it are antigenically “naive” and thus are associated with a lower incidence of rejection or graft-versus-host disease. Cord blood is discussed in detail in policy #285.

Immunologic compatibility between infused hematopoietic stem cells and the recipient is not an issue in autologous HCT. However, immunologic compatibility between donor and patient is a critical factor for achieving a good outcome of allo-HCT. Compatibility is established by typing of human leukocyte antigen (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 six. Depending on the disease being treated, an acceptable donor will match the patient at all or most of the HLA loci (except umbilical cord blood).

Conditioning for HCT

Conventional Conditioning

The conventional (“classical”) practice of allo-HCT involves administration of cytotoxic agents (eg, cyclophosphamide, busulfan) with or without total body irradiation at doses sufficient to destroy endogenous hematopoietic capability in the recipient. The beneficial treatment effect of this procedure is due to a combination of initial eradication of malignant cells and subsequent graft-versus-malignancy effect mediated by non-self-immunologic effector cells that develop after engraftment of allogeneic stem cells within the patient’s bone marrow space. While the slower graft-versus-malignancy effect is

considered to be the potentially curative component, it may be overwhelmed by extant disease without the use of pretransplant conditioning. However, intense conditioning regimens are limited to patients who are sufficiently fit medically to tolerate substantial adverse 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 allo-HCT, immunosuppressant drugs are required to minimize graft rejection and graft-versus-host disease, which also increases susceptibility to opportunistic infections.

The success of autologous HCT is predicated on the ability of cytotoxic chemotherapy with or without radiotherapy to eradicate cancerous cells from the blood and bone marrow. This permits subsequent engraftment and repopulation of bone marrow space with presumably normal hematopoietic stem cells obtained from the patient before undergoing bone marrow ablation. 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 before engraftment, but not graft-versus-host disease.

Reduced-Intensity Conditioning Allo-HCT
RIC refers to the pretransplant use of lower doses or less intense regimens of cytotoxic drugs or radiotherapy that are used in traditional full-dose myeloablative conditioning treatments. The goal of RIC is to reduce disease burden and to minimize as much as possible associated treatment-related morbidity and non-relapse 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 non-relapse mortality and relapse due to residual disease. RIC regimens can be viewed as a continuum in effects, 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, which may be supplemented with donor lymphocyte infusions to eradicate residual malignant cells.

For our purposes, the term *reduced-intensity conditioning* will refer to all conditioning regimens intended to be nonmyeloablative as opposed to fully myeloablative (traditional) regimens.

MM treatment overview
In the prechemotherapy era, the median survival for a patient diagnosed with MM was approximately seven months. After the introduction of chemotherapy (eg, the alkylating agent melphalan in the 1960s), prognosis improved, with a median survival of 24 to 30 months and 10-year survival of 3%. In a large group of patients with newly diagnosed MM, there was no difference in overall survival reported during a 24-year period from 1971-1994, with a trend toward improvement during 1995-2000, and a statistically significant benefit in overall survival during 2001-2006.[2] These data suggested that autologous HCT was responsible for the trends during 1994-2000, while novel agents have contributed to the improvement since 2001.[2]

The introduction of novel agents and better prognostic indicators has been the major advances in the treatment of this disease.[13,14] Novel agents such as the proteasome inhibitor bortezomib and the immunomodulatory derivatives thalidomide and lenalidomide first showed efficacy in relapsed and refractory myeloma and now have been integrated into first-line regimens.[13,14,15] With the introduction of these novel treatments, it is now expected that most patients with MM will respond to initial therapy, and only a small minority will have refractory disease.[16]

Summary
Multiple myeloma (MM) is a systemic malignancy of plasma cells that represents approximately 10% of all hematologic cancers. POEMS syndrome, characterized by polyneuropathy, organomegaly, endocrinopathy, M protein, and skin changes, is a rare, paraneoplastic disorder secondary to a plasma

cell dyscrasia. Plasma cell dyscrasias are treatable but rarely curable. In some cases, autologous or allogeneic hematopoietic cell transplantation (HCT) is considered as therapy.

Newly Diagnosed MM
For individuals who have newly diagnosed MM who receive autologous HCT as initial treatment, the evidence includes several prospective, randomized controlled trials (RCTs) that compared conventional chemotherapy with high-dose chemotherapy plus autologous HCT. The relevant outcomes include overall survival (OS) and treatment-related morbidity. In general, the evidence has suggested OS rates are improved with autologous HCT compared with conventional chemotherapy in this setting. Limitations of the published evidence include patient heterogeneity, variability in treatment protocols, short follow-up periods, inconsistency in reporting important health outcomes, and inconsistency in reporting or collecting outcomes. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

For individuals who have newly diagnosed MM who receive tandem autologous HCT, the evidence includes several RCTs. The relevant outcomes include OS and treatment-related morbidity. Compared with single autologous HCT, a number of RCTs have demonstrated tandem autologous HCT improved OS and recurrence-free survival in newly diagnosed MM. The available RCTs compare reduced-intensity conditioning allogeneic HCT (allo-HCT) following a first autologous HCT with single or tandem autologous transplants. The RCTs were based on genetic randomization (ie, patients with a human leukocyte antigen-identical sibling who were offered reduced-intensity conditioning allo-HCT following autologous HCT), whereas other patients underwent either one or two autologous transplants. Although the body of evidence has shown inconsistencies regarding OS and disease-free survival rates, some studies have shown a survival benefit with tandem autologous HCT followed by reduced-intensity conditioning allo-HCT, although at the cost of higher transplant-related mortality compared with conventional treatments. Factors across studies that may account for differing trial results include different study designs, nonuniform preparative regimens, different patient characteristics (including risk stratification), and criteria for advancing to a second transplant. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

For individuals who have newly diagnosed MM who receive allo-HCT with as initial or salvage treatment, the evidence includes nonrandomized studies. The relevant outcomes include OS and treatment-related morbidity. Studies have reported on patients with both myeloablative conditioning and reduced-intensity conditioning. Limitations of the published evidence include patient sample heterogeneity, variability in treatment protocols, short follow-up periods, inconsistency in reporting important health outcomes, and inconsistency in reporting or collecting outcomes. Nonmyeloablative allo-HCT as first-line therapy is associated with lower transplant-related mortality but a greater risk of relapse; convincing evidence is lacking that allo-HCT improves survival better than autologous HCT. The evidence is insufficient to determine the effects of the technology on health outcomes.

Relapsed or Refractory MM
For individuals who have relapsed MM after failing an autologous HCT who receive autologous HCT, the evidence includes an RCT, a retrospective study, a systematic review summarizing data from four series of patients who relapsed after a first autologous HCT, and a review summarizing recent studies on a second autologous HCT in relapsed myeloma. The relevant outcomes include OS and treatment-related morbidity. Despite some limitations of the published evidence, including patient sample heterogeneity, variability in treatment protocols, and short follow-up periods, the available trial evidence has suggested OS rates are improved with autologous HCT compared with conventional chemotherapy in this setting. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

For individuals who have refractory, multiple myeloma after failing the first HCT who receive tandem autologous HCT, the evidence includes three RCTs and a review. The relevant outcomes include OS and treatment-related morbidity. The evidence has shown tandem autologous HCT improves OS rates in this

setting. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

POEMS Syndrome
For individuals who have POEMS syndrome who receive HCT, the evidence includes case reports and series. The relevant outcomes include OS and treatment-related morbidity. No RCTs of HCT of any type have been performed in patients with POEMS syndrome of any severity, nor is it likely such studies will be performed because of the rarity of this condition. Available case reports and series are subject to selection bias and are heterogeneous concerning treatment approaches and peritransplant support. However, for patients with disseminated POEMS syndrome, a chain of evidence and contextual factors related to the disease and MM would suggest improvement in health outcomes with autologous HCT. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

Policy History

Date	Action
3/2019	BCBSA National medical policy review. Description, summary and references updated. Policy statements unchanged.
1/2019	Outpatient prior authorization is required for all commercial products including Medicare Advantage. Effective 1/1/2019.
2/2018	New references added from BCBSA National medical policy. Title clarified.
1/2018	Clarified coding information.
12/2016	Coverage clarified for Medicare Advantage based on National Coverage Determination (NCD) for Stem Cell Transplantation Formerly 110.8.1 (110.23). 12/14/2016
11/2015	New references added from BCBSA National medical policy.
4/2015	BCBSA National medical policy review. Policy clarified.
1/2015	Clarified coding information.
5/2014	Updated Coding section with ICD10 procedure and diagnosis codes, effective 10/2015.
2/2014	BCBSA National medical policy review. New medically necessary and investigational indications described; policy title changed. Effective 2/1/2014.
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.
12/2011	Minor change to policy statements (added phrase “in the tandem sequence” to the medically necessary tandem autologous-autologous statement).
7/2011	Medical Policy Group – Hematology and Oncology. No changes to policy statements.
9/2010	Medical Policy Group – Hematology and Oncology. No changes to policy statements.
9/1/2010	Medical Policy 075 effective 9/1/2010.

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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