Molina Clinical Policy
Hematopoietic Stem Cell Transplantation for Acute Lymphoblastic Leukemia (ALL): Policy No. 118

Last Approval: 6/14/2023
Next Review Due By: June 2024

DISCLAIMER

This Molina Clinical Policy (MCP) is intended to facilitate the Utilization Management process. Policies are not a supplementation or recommendation for treatment; Providers are solely responsible for the diagnosis, treatment, and clinical recommendations for the Member. It expresses Molina's determination as to whether certain services or supplies are medically necessary, experimental, investigational, or cosmetic for purposes of determining appropriateness of payment. The conclusion that a particular service or supply is medically necessary does not constitute a representation or warranty that this service or supply is covered (e.g., will be paid for by Molina) for a particular Member. The Member's benefit plan determines coverage – each benefit plan defines which services are covered, which are excluded, and which are subject to dollar caps or other limits. Members and their Providers will need to consult the Member's benefit plan to determine if there are any exclusion(s) or other benefit limitations applicable to this service or supply. If there is a discrepancy between this policy and a Member's plan of benefits, the benefits plan will govern. In addition, coverage may be mandated by applicable legal requirements of a State, the Federal government or CMS for Medicare and Medicaid Members. CMS's Coverage Database can be found on the CMS website. The coverage directive(s) and criteria from an existing National Coverage Determination (NCD) or Local Coverage Determination (LCD) will supersede the contents of this MCP and provide the directive for all Medicare members. References included were accurate at the time of policy approval and publication.

OVERVIEW

Acute Lymphoblastic Leukemia (ALL)

Acute leukemias comprise a heterogeneous group of neoplastic disorders that arise from malignant transformation of blood-forming, or hematopoietic, stem cells. Malignant transformation typically involves chromosomal rearrangements (translocations), deletions, or additions, which disturb the normal control of cell division, allowing affected cells to multiply without restraint. Clones, or leukemic cells, arising from such transformation particularly influence the development of white blood cells (WBCs), or leukocytes, and rapidly proliferate in the bone marrow, ultimately replacing normal cells and causing anemia, thrombocytopenia, and granulocytopenia. After release into the blood stream, leukemic cells can infiltrate any organ or site and often spread to the liver, spleen, lymph nodes, central nervous system (CNS), and gonads, where they continue to grow and divide, resulting in small tumors, inflammation, and/or organ damage and failure. One of two major types of acute leukemia, ALL involves stem cells that normally become lymphoblasts, the precursors of leukocytes known as lymphocytes. It is an aggressive type of leukemia characterized by the presence of too many lymphoblasts or lymphocytes in the bone marrow and peripheral blood; ALL can spread to the lymph nodes, spleen, liver, CNS, and other organs. Without treatment, ALL usually progresses quickly. (Stock & Estrov 2022; [1-2]DynaMed 2022).

In 2023, there were an estimated 6,540 new cases and 1,390 deaths from ALL in the United States. ([1] NCI 2023). ALL occurs in both children and adults, and it is the most common type of cancer in children. ALL is believed to arise from malignant transformation of B- or T-cell progenitor cells. The disease is characterized by the accumulation of lymphoblasts in the marrow or in various extramedullary sites. The World Health Organization (WHO) classifies ALL as either B lymphoblastic leukemia or T lymphoblastic leukemia. B lymphoblastic leukemia is subdivided by the presence or absence of specific recurrent genetic abnormalities (t(9;22)), MLL rearrangement, t(12;21), hyperdiploidy, hypodiploidy, t(5;14), and t(1;19). Current treatment decisions rely on the immunophenotype (early-pre-B ALL, pre-B ALL, B-cell ALL, or T-cell ALL) and cytogenetics of affected cells. ([1-2] NCI 2023).

Stem Cell Transplantation

Stem cell transplantation refers to transplantation of hematopoietic stem cells (HSCs) from a donor into a patient. HSCs are immature cells that can develop into any of the three types of blood cells (red cells, white cells or platelets). HSCs are created in the bone marrow and are found in the bone marrow and peripheral blood. There is also a high concentration of HSCs in umbilical-cord blood. HSCT is a treatment method to rescue the patients from treatment-induced aplasia after high-dose chemotherapy and/or radiotherapy has been administered to eliminate the patient's immune system. HSCT can be either autologous (using the person's own stem cells) or allogeneic (using stem cells from a donor). In allogeneic HSCT, it is preferable for donors to have a human leukocyte antigen (HLA) type that is identical to the recipient. Matching is performed on the basis of variability at three of more loci of the HLA gene (e.g., HLA-A, HLA-B, HLA-DRB1). As HLA variability increases, transplant-related morbidity and mortality, including graft rejection and graft-versus-host disease, also increase. In general, transplants in first remission have a better chance of a good outcome than transplants received later or when the disease is not in remission. For adults, a transplant in first complete remission or early disease offers a higher likelihood of 5-year survival compared to transplants for

patients in second remission or with advanced disease. For children, the likelihood of 5-year survival is increased for patients who receive a transplant in early or intermediate disease or first or second complete remission compared to patients with advanced disease at the time of transplant. (Horton & Steuber 2022; Holmberg et al. 2022; [1-3] Larson 2022; [1]NMDP date unknown).

COVERAGE POLICY

All transplants require prior authorization from the Corporate Transplant Department. Solid organ transplant requests will be reviewed by the Corporate Senior Medical Director or qualified clinical designee. All other transplants will be reviewed by the Corporate Senior Medical Director or covering Medical Director. If the criteria are met using appropriate NCD and/or LCD guidelines, State regulations, and/or MCP policies the Corporate Senior Medical Director's designee can approve the requested transplant.

Office visits with participating Providers do NOT require prior authorization. Providers should see the Member in office visits as soon as possible and without delay. Failure to see the Member in office visits may be considered a serious quality of care concern.

Transplant Evaluation

(NCCN 2022; [1-2] NCI 2023; CMS 2016; AMR 2019; Bredeson et al. 2016; DeFilipp et al. 2019; ECOG date unknown; McNeer et al. 2019; [2-5] NMDP date unknown)

Please see *MCP-323 Pre-Transplant Evaluation* for additional criteria and information.

Components of the transplant evaluation include:

1. History and physical examination; **AND**
2. Psychosocial evaluation and clearance:
   a. No behavioral health disorder by history or psychosocial issues:
      - If history of behavioral health disorder, no severe psychosis or personality disorder;
      - Mood/anxiety disorder must be excluded or treated;
      - Member has understanding of surgical risk and post procedure compliance and follow-up required.

   AND
   b. Adequate family and social support.

AND

3. EKG; **AND**
4. Chest x-ray; **AND**
5. Cardiac clearance in the presence of any of the following:
   a. Chronic smokers; **OR**
   b. Members > 50 years age; **OR**
   c. Those with a clinical or family history of heart disease or diabetes.

AND

6. Pulmonary clearance if evidence of pulmonary artery hypertension or chronic pulmonary disease; **AND**
7. Neurological exam and clearance for transplant including **ONE** of the following:
   a. Normal neurologic exam; **OR**
   b. Non-life limiting neurological impairment that does not preclude transplant and not caused by hematologic malignancy (e.g., diabetic peripheral neuropathy); **OR**
   c. Abnormal neurological exam with positive findings including **ONE** of the following:
      - Lumbar puncture normal cytology; **OR**

- Lumbar puncture with cytological exam abnormal, however central nervous system disease treated prior to clearance.

AND

8. A Performance Status that includes **ONE** of the following:
   a. Karnofsky score 70-100%; **OR**
   b. Eastern Cooperative Oncology Group (ECOG) grade 0-2.

AND

9. Lab studies that include:
   a. Complete blood count; kidney profile (blood urea nitrogen, creatinine); electrolytes; calcium; phosphorous; albumin; liver function tests; and coagulation profile (prothrombin time, and partial thromboplastin time);*
   b. Serologic screening for: Human Immunodeficiency Virus (HIV); Epstein Barr virus (EBV); Hepatitis B virus (HBV); Hepatitis C virus (HCV); cytomegalovirus (CMV); rapid plasma reagin (RPR) and/or fluorescent treponemal antibody (FTA):*
      - If HIV positive **ALL** of the following must be met:
        i. CD4 count >200 cells/mm-3 for >6 months; **AND**
        ii. Human Immunodeficiency Virus 1 (HIV-1) ribonucleic acid undetectable; **AND**
        iii. On stable anti-retroviral therapy >3 months; **AND**
        iv. No other complications from Acquired AIDS (e.g., opportunistic infection, including aspergillus, tuberculosis, coccidioides mycosis, resistant fungal infections, Kaposi's sarcoma, or other neoplasm).
   c. Urine drug screen (UDS) if Member is current or gives a history of past drug abuse.

AND

10. Colonoscopy (if indicated or if Member is age ≥ 50) with complete workup and treatment of abnormal results as indicated; an initial screening colonoscopy after initial negative screening requires a follow-up colonoscopy every 10 years).*

AND

11. Gynecological examination with Pap smear for women ages ≥ 21 to ≤ 65 years of age or if indicated (not indicated in women who have had a total abdominal hysterectomy or a total vaginal hysterectomy) within the last three years with complete workup and treatment of abnormal results as indicated.*

Within the last 12 months:

1. Dental examination or oral exam showing good dentition and oral care or no abnormality on panorex or plan for treatment of problems pre- or post-transplant; **AND**
2. Mammogram (if indicated or > age 40) with complete workup and treatment of abnormal results as indicated;* **AND**
3. Prostate Specific Antigen (PSA) if history of prostate cancer or previously elevated PSA with complete workup and treatment of abnormal results as indicated.*

* Participating Centers of Excellence may waive these criteria.

Criteria for Allogeneic HSCT

Ablative or non-myeloablative allogeneic HSCT from an HLA-matched donor (e.g., at least six out of eight match of the HLA-A, HLA-B, HLA-C and HLA-DRB1 markers) or from cord blood when there are no matched sibling or unrelated donors (e.g., at least four out of six match of the HLA-A, HLA-B and HLA-DRB-1 markers) **may be considered medically necessary** for the treatment of ALL when **ALL** of the following are met:

1. All transplant criteria are met; **AND**

2. Complete first remission (CR-1) defined by bone marrow biopsy including **BOTH** of the following:
   a. Bone marrow is normocellular with no more than 5% blasts; **AND**
   b. No signs or symptoms of the disease

AND

3. Any of the following high-risk factors for relapse:
   a. Age: children who are < 1 year or > 9 years & adults who are < 35 years; **OR**
   b. Any of the following chromosome abnormalities: t(4;11), t(1;19), t(8;14), deletion of(7q), trisomy 8, 11q23 (MLL) translocation; **OR**
   c. B-cell immunophenotype (i.e., presence of Mature B cell phenotype (Burkitt's lymphoma); **OR**
   d. Extramedullary disease outside the bone marrow especially affecting central nervous system; **OR**
   e. Failure to achieve a complete remission within 6 weeks of the start of induction therapy; **OR**
   f. High white blood cell count (WBC) > 50,000 at diagnosis; **OR**
   g. Hypodiploidy: defined as less than 45 chromosomes; **OR**
   h. Minimal residual disease (MRD) positivity following induction; **OR**
   i. Positive Philadelphia chromosome: (t(9;22) or BCR-ABL positive).

OR

4. Second or subsequent complete remission (CR-2) following complete first remission (CR-1) defined by bone marrow biopsy as **BOTH** of the following:
   a. Bone marrow is normocellular with no more than 5% blasts; **AND**
   b. No signs or symptoms of the disease.

OR

5. Any stage of relapse;

AND

6. The requesting transplant recipient should not have any of the following absolute contraindications:
   a. Cardiac, pulmonary, and nervous system disease that cannot be corrected and is a prohibitive risk for surgery; **OR**
   b. Malignant neoplasm with a high risk for reoccurrence, non-curable malignancy (excluding localized skin cancer); **OR**
   c. Systemic and/or uncontrolled infection; **OR**
   d. AIDS (CD4 count < 200cells/mm3); **OR**
   e. Unwilling or unable to follow post-transplant regimen:
      - Documented history of non-compliance
      - Inability to follow through with medication adherence or office follow-up

   OR
   f. Chronic illness with one year or less life expectancy; **OR**
   g. Limited, irreversible rehabilitation potential; **OR**
   h. Active untreated substance abuse issues, requires documentation supporting free from addiction for minimally 6 months if previous addiction was present; **OR**
   i. No adequate social/family support.

AND

7. The requesting transplant recipient should be evaluated carefully and potentially treated if any of the relative contraindications below are present. (Irreversible lung disease patients require consultation and clearance by a Pulmonologist prior to consideration of transplantation).
   a. Smoking, documentation supporting free from smoking for 6 months; **OR**
   b. Active peptic ulcer disease; **OR**
   c. Active gastroesophageal reflux disease; **OR**

d. Cerebrovascular accident (CVA) with long term impairment that is not amendable to rehabilitation or a patient with CVA/transient ischemic attack within past 6 months; **OR**
e. Obesity with body mass index of >30 kg/m^2 may increase surgical risk; **OR**
f. Chronic liver disease such as Hepatitis B/C/D, or cirrhosis which increases the risk of death from sepsis and hepatic failure requires consultation by a gastroenterologist or hepatologist; **OR**
g. Gall bladder disease requires ultrasound of the gall bladder with treatment prior to transplantation.

Criteria for Autologous HSCT

Autologous HSCT **may be considered medically necessary** in adults and children only if the Member has acute lymphocytic/lymphoblastic leukemia and **ALL** of the following:

1. All transplant criteria are met; **AND**
2. Does not have an allogeneic donor or has medical contraindications to an allogeneic transplantation procedure; **AND**
3. Is in morphologic and cytogenetic first complete remission (CR1) at the time of stem cell harvest; **AND**
4. Is at high risk for relapse (see criteria under #1 above); **AND**
5. Should not have any of the absolute contraindications and should be evaluated for any relative contraindications listed above.

Criteria for Subsequent HSCT

Autologous or Allogeneic HSCT (ablative or non-myeloablative) **may be authorized** after the first prior autologous HSCT has occurred only one time for Members with ALL who meet **ALL** of the *above* criteria for transplant and have **ANY** of the following:

1. Bone marrow relapse as defined as the reappearance of leukemia cells in the bone marrow or peripheral blood after a complete remission as indicated by a peripheral blast count of 5,000 or greater; **OR**
2. Primary graft failure indicated by no signs of engraftment* by 42 days after the transplant; **OR**
3. Failure to engraft*; **AND**
4. A suitable allogeneic donor has been identified.

* Engraftment is defined as the first 3 consecutive days on which the absolute neutrophil count (ANC) exceeds 5 x 10^9/L or > ANC500 at any time after transplantation ([5] NMDP date unknown).

Continuation of Therapy

When extension of a previously approved transplant authorization is requested, review using updated clinical information is appropriate.

1. If Molina Healthcare has authorized prior requests for transplantation **ALL** of the following information is required for medical review:
   a. Presence of no absolute contraindication as listed above.
   b. History and physical within the last 12 months.
   c. Kidney profile within the last 12 months.
   d. Cardiac update if history of cardiac disease within two years (≥ 50 years of age).
   e. Psychosocial evaluation or update within the last 12 months.
   f. Per initial and updated history and physical, any other clinically indicated tests and/or scans as determined by transplant center physician or Molina Medical Director.

2. If authorized prior requests for transplantation were obtained from another insurer, **ALL** of the following information is required for medical review:
   a. Authorization letter/documentation from previous insurer.
   b. Presence of no absolute contraindication as listed above.
   c. History and physical within the last 12 months.
   d. Cardiac update if history of cardiac disease within two years (≥ 50 years of age).

e. Psychosocial evaluation or update within the last 12 months.
f. Per initial and updated history and physical, any other clinically indicated tests and/or scans as determined by transplant center physician or Molina Medical Director.

For Members with Significant or Daily Cannabis Use

1. Documentation of compliance with a physician prescribed and managed program of abstinence, and a reasonable expectation that the Member will be abstinent from cannabis use during the transplant and immediate post-transplant time period. Daily cannabis use is an absolute contraindication for both transplant and pre-transplant evaluation unless there is a state mandate applicable for medical cannabis use and transplants, and there is documentation of Member compliance with a physician prescribed plan of care for prescribed cannabis use.
2. If the Member's cannabis use follows a formal, State-based program for managed medical cannabis, the request should include:
   - Documentation of the Plan of Care for medical cannabis (including the medical decision making that supports the use of medical cannabis); **AND**
   - Transplant Provider agreement with the Plan of Care (including agreement to be accountable for managing the Member's use of medical cannabis).

Limitations and Exclusions

The items below **are not considered medically necessary.** This list includes, but is not limited to:

1. Allogeneic (ablative or non-myeloablative) HSCT or autologous HSCT when the above criteria are not met.
2. A second or repeat allogeneic (ablative or non-myeloablative) transplant due to persistent, progressive disease.
3. HSCT collection, storage and freezing for a future unplanned transplant.
4. Autologous HSCT in adults who have refractory ALL or are in second or greater remission.
5. A tandem/sequential HSCT for the treatment of ALL is considered experimental, investigational, or unproven.

DOCUMENTATION REQUIREMENTS. Molina Healthcare reserves the right to require that additional documentation be made available as part of its coverage determination; quality improvement; and fraud; waste and abuse prevention processes. Documentation required may include, but is not limited to, patient records, test results and credentials of the provider ordering or performing a drug or service. Molina Healthcare may deny reimbursement or take additional appropriate action if the documentation provided does not support the initial determination that the drugs or services were medically necessary, not investigational, or experimental, and otherwise within the scope of benefits afforded to the member, and/or the documentation demonstrates a pattern of billing or other practice that is inappropriate or excessive.

SUMMARY OF MEDICAL EVIDENCE

The use of HSCT is considered a standard option for patients with higher-risk ALL. Patterns of use of HSCT vary between institutions and there is no consensus regarding patient selection, timing of transplantation, and other aspects of the procedure. Outcomes for HSCT for ALL in children and adults in the United States consists of registry data obtained from transplant centers that perform adult and pediatric transplantation and is available from the United Network for Organ Sharing database. Registry data demonstrates graft survival rates and outcomes for stem cell transplantation based on demographic and clinical information. ([1] NMDP date unknown).

National and Specialty Organizations

Several professional society organizations have recommended that allogeneic HSCT is the preferred method of treatment for individuals with ALL who are in first complete remission (CR1) with HLA matched sibling donor, after relapse, and second complete remission (CR2) (NCCN 2022; [1-2]NCI 2023; Bredeson et al. 2016; DeFilipp et al. 2019; [3-5] NMDP date unknown).

The **National Marrow Donor Program (NMDP)** recommends that adolescent and young adults ages 15-39 years with ALL be referred for consultation for HSCT when one of the following characteristics are present: primary induction failure, presence of MRD after initial therapy, first relapse, CR2 and beyond, if not previously evaluated; and high/very high-risk CR1 including: Philadelphia chromosome positive or Philadelphia-like, iAMP21, 11q23 rearrangement, B-cell

with poor-risk cytogenetics. The NMDP recommends that infants and children up to age 15 years at diagnosis ALL be referred for consultation for HSCT when one of the following characteristics is present: infant at time of diagnosis, primary induction failure, presence of MRD after initial therapy, first relapse, CR2 and beyond, if not previously evaluated; and high/very high-risk CR1 including: Philadelphia chromosome positive slow-TKI responders or with IKZF1 deletions, Philadelphia-like, iAMP21 and11q23 rearrangement. ([3] NMDP date unknown).

The **National Comprehensive Cancer Network (NCCN)** (2022) published guidelines recommend allogenic transplant for patients with PH-positive ALL; however, options are limited for those who relapse after transplant. Participation in clinical trials for adults with relapsed/refractory disease after an initial CR for individuals with Ph-negative ALL is recommended. In lieu of an appropriate trial, re-induction, salvage chemotherapy or allogeneic HSCT are recommended treatment options.

CODING & BILLING INFORMATION

CPT (Current Procedural Terminology) Codes

CPT	Collection Codes
38205	Blood-derived hematopoietic progenitor cell harvesting for transplantation, per collection; allogeneic
38206	Blood-derived hematopoietic progenitor cell harvesting for transplantation, per collection; autologous
38230	Bone marrow harvesting for transplantation; allogeneic
38232	Bone marrow harvesting for transplantation; autologous
	Cell Processing Services
38207	Transplant preparation of hematopoietic progenitor cells; cryopreservation and storage
38208	Transplant preparation of hematopoietic progenitor cells; thawing of previously frozen harvest, without washing, per donor
38209	Transplant preparation of hematopoietic progenitor cells; thawing of previously frozen harvest, with washing, per donor
38210	Transplant preparation of hematopoietic progenitor cells; specific cell depletion within harvest, T-cell depletion
38211	Transplant preparation of hematopoietic progenitor cells; tumor cell depletion
38212	Transplant preparation of hematopoietic progenitor cells; red blood cell removal
38213	Transplant preparation of hematopoietic progenitor cells; platelet depletion
38214	Transplant preparation of hematopoietic progenitor cells; plasma (volume) depletion
38215	Transplant preparation of hematopoietic progenitor cells; cell concentration in plasma, mononuclear, or buffy coat layer
	Cell infusion codes
38240	Hematopoietic progenitor cell (HPC); allogeneic transplantation per donor
38241	Hematopoietic progenitor cell (HPC); autologous transplantation
38242	Allogeneic lymphocyte infusions
38243	Hematopoietic progenitor cell (HPC); HPC boost
	Histocompatibility and Biopsy Codes
38221	Diagnostic bone marrow; biopsy(ies)
38222	Diagnostic bone marrow; biopsy(ies) and aspiration(s)
86812	HLA typing; A, B, or C (eg, A10, B7, B27), single antigen
86813	HLA typing; A, B, or C, multiple antigens
86816	HLA typing; DR/DQ, single antigen
86817	HLA typing; DR/DQ, multiple antigens

HCPCS (Healthcare Common Procedure Coding System) Codes

HCPCS	Description
S2140	Cord blood harvesting for transplantation, allogeneic
S2142	Cord blood derived stem-cell transplantation, allogeneic
S2150	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-up; medical/surgical, diagnostic, emergency, and rehabilitative services; and the number of days of pre-and post-transplant care in the global definition

CODING DISCLAIMER. Codes listed in this policy are for reference purposes only and may not be all-inclusive. Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement. Listing of a service or device code in this policy does not guarantee coverage. Coverage is determined by the benefit document. Molina adheres to Current Procedural Terminology (CPT®), a registered trademark of the American Medical Association (AMA). All CPT codes and descriptions are copyrighted by the AMA; this information is included for informational purposes only. Providers and facilities are expected to utilize industry standard coding practices for all submissions. When improper billing and coding is not followed, Molina has the right to reject/deny the claim and recover claim payment(s). Due to changing industry practices, Molina reserves the right to revise this policy as needed.

APPROVAL HISTORY

6/14/2023	Policy reviewed; "Pre-Transplant Evaluation" changed to "Transplant Evaluation," new criteria 7b, clarification edit to criteria #8 that only one of the sub-criteria need to be met, removed abnormal serology statement under criteria 9b, criteria 10 changed to age 45 years, added an asterisk to criteria 11 to denote it may be waived by a participating Center of Excellence. Grammatical edits to Disclaimer section and "Documentation Requirements" under Coverage Policy section. Replaced "marijuana" with "cannabis." Supplemental Information section removed. Overview, Summary of Medical Evidence, and References sections updated. Added codes 38221, 38222, 86812, 86813, 86816, 86817 and code descriptions updated for other codes. Removed ICD-10 codes. Policy reviewed in May 2023 by an Advanced Medical Reviews (AMR) practicing, board-certified physician in the areas of Medical Oncology and Hematology.
6/8/2022	Policy reviewed, no changes to criteria; included section on marijuana use; updated references.
6/9/2021	Policy reviewed; updated guidelines and references.
6/17/2020	Policy reviewed; updated guidelines and references.
6/18/2019	Policy reviewed; updated the high-risk criteria for relapse (section revised based on updated guidelines - criteria added: minimal residual disease [MRD] positivity following induction, and failure to achieve a complete remission within 6 weeks of the start of induction therapy). Recommendation and Summary of Medical Evidence sections condensed for ease of application. Guideline and Reference sections also updated. Policy reviewed in March 2019 by a practicing, board-certified physician in the areas of Internal Medicine, Hematology, and Oncology.
9/13/2018	Policy reviewed; updated guidelines and references.
6/22/2017	Policy reviewed, no changes.
12/14/2016	Policy reviewed, no changes.
7/29/2015	Policy reviewed; revised the pre-transplant criteria, minor revision to the criteria (to include any stage of relapse); Guideline and Reference sections also updated.
10/31/2012	New policy.

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