MEDICAL POLICY

POLICY TITLE	MOLECULAR PANEL TESTING OF CANCERS TO IDENTIFY TARGETED THERAPIES
POLICY NUMBER	MP 2.259

CLINICAL BENEFIT	☐ MINIMIZE SAFETY RISK OR CONCERN. ☒ MINIMIZE HARMFUL OR INEFFECTIVE INTERVENTIONS. ☐ ASSURE APPROPRIATE LEVEL OF CARE. ☐ ASSURE APPROPRIATE DURATION OF SERVICE FOR INTERVENTIONS. ☒ ASSURE THAT RECOMMENDED MEDICAL PREREQUISITES HAVE BEEN MET. ☐ ASSURE APPROPRIATE SITE OF TREATMENT OR SERVICE.
Effective Date:	**10/1/2024**

I. POLICY

This policy applies if there is not a specific Medical Policy that outlines criteria for medical necessity. If a specific policy does exist, then the criteria for medical necessity in that policy may supersede the guidelines in this policy. (See cross references)

Gene panel testing (e.g., next generation sequencing) to identify targeted therapies may be considered **medically necessary** when all the following are met:

- No other genetic panel testing for targeted therapies has been performed on the individual's tumor (except when recurrent neoplastic disease following remission occasioned a new biopsy); **AND**
- 5 or more targets have been requested, at least 5 of which are supported by NCCN Biomarker Compendium at a 2A level or higher **OR**
- Testing is required to comply with FDA label requirements as a cleared or approved companion diagnostic device at https://www.fda.gov/medical-devices/in-vitro-diagnostics/list-cleared-or-approved-companion-diagnostic-devices-in-vitro-and-imaging-tools

All other indications for gene panel testing for targeted oncologic therapies are considered **not medically necessary**. There is insufficient evidence to support a general conclusion concerning the health outcomes or benefits associated with this procedure.

The National Comprehensive Cancer Network (NCCN) is a nonprofit alliance of cancer centers throughout the United States. NCCN develops the Clinical Practice Guidelines in Oncology which are recommendations aimed to help health care professionals diagnose, treat and

manage patients with cancer. Guidelines evolve continuously as new treatments and diagnostics emerge and may be used by Capital Blue Cross when determining medical necessity according to this policy.

POLICY GUIDELINES

NCCN Drugs & Biologics Compendium
https://www.nccn.org/professionals/drug_compendium/content/

Cross-reference:

MP 2.241 Molecular Analysis (Including liquid biopsy (for Targeted Therapy or Immunotherapy of Non-Small Cell Lung Cancer
MP 2.267 Circulating Tumor DNA and Circulating Tumor Cells for Cancer Management (Liquid Biopsy)
MP 2.275 Molecular Markers in Fine Needle Aspirates of the Thyroid
MP 2.307 Genotype-Guided Tamoxifen Treatment
MP 2.323 General Approach to Evaluating the Utility of Genetic Panels
MP 2.316 Somatic Biomarker Testing (including liquid biopsy) for Target Treatment and Immunotherapy in Metastatic Colorectal Cancer (KRAS, NRAS, BRAF, MMR/MSI, HER2 and TMB)
MP 2.325 Genetic Cancer Susceptibility Panels Using Next Generation Sequencing
MP 2.354 Laboratory and Genetic Testing for Use of 5-Fluoruracil in Patients with Cancer
MP 2.364 Somatic Genetic Testing to Select Individuals with Melanoma or Glioma for Targeted Therapy or Immunotherapy

II. PRODUCT VARIATIONS TOP

This policy is only applicable to certain programs and products administered by Capital Blue Cross please see additional information below, and subject to benefit variations as discussed in Section VI below.

FEP PPO: Refer to FEP Medical Policy Manual. The FEP Medical Policy manual can be found at:
https://www.fepblue.org/benefit-plans/medical-policies-and-utilization-management-guidelines/medical-policies.

III. DESCRIPTION/BACKGROUND TOP

Companion Diagnostics

As defined by the FDA, “A companion diagnostic is a medical device, often an in vitro diagnostic (IVD), which provides information that is essential for the safe and effective use of a corresponding drug or biological product”.

A companion diagnostic device can be in vitro diagnostic (IVD) device or an imaging tool that provides information that is essential for the safe and effective use of a corresponding therapeutic product.

The FDA mentions that companion diagnostics can:

- identify patients who are most likely to benefit from a particular therapeutic product
- identify patients likely to be at increased risk for serious side effects as a result of treatment with a particular therapeutic product; **or**
- monitor response to treatment with a particular therapeutic product for the purpose of adjusting treatment to achieve improved safety or effectiveness.

Targeted Cancer Therapy

Much of the variability in clinical response may result from genetic variations. Within each broad type of cancer, there may be a large amount of variability in the genetic underpinnings of the cancer. Targeted cancer treatment refers to the identification of genetic abnormalities present in the cancer of a particular patient, and the use of drugs that target the specific genetic abnormality. The use of genetic markers allows cancers to be further classified by “pathways” defined at the molecular level. An expanding number of genetic markers have been identified. These may be categorized into 3 classes: (1) genetic markers that have a direct impact on care for the specific cancer of interest, (2) genetic markers that may be biologically important but are not currently actionable, and (3) genetic markers of uncertain importance.

Regulatory Status

Clinical laboratories may develop and validate tests in-house and market them as a laboratory service; laboratory-developed tests must meet the general regulatory standards of the Clinical Laboratory Improvement Amendments. Laboratories that offer laboratory-developed tests must be licensed by the Clinical Laboratory Improvement Amendments for high-complexity testing.

IV. RATIONALE

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SUMMARY OF EVIDENCE

Gene panel testing using next generation sequencing may be appropriate for those individuals who are diagnosed with cancers to identify appropriate targeted therapies. Those gene panel testing should be a NCCN recommendation or have FDA approval as a companion diagnostic test. Those expanded molecular panel testing not meeting those requirements, the evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

V. DEFINITIONS

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NA

VI. BENEFIT VARIATIONS

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The existence of this medical policy does not mean that this service is a covered benefit under the member's health benefit plan. Benefit determinations should be based in all cases on the applicable health benefit plan language. Medical policies do not constitute a description of benefits. A member's health benefit plan governs which services are covered, which are excluded, which are subject to benefit limits, and which require preauthorization. There are different benefit plan designs in each product administered by Capital Blue Cross. Members and providers should consult the member's health benefit plan for information or contact Capital Blue Cross for benefit information.

VII. DISCLAIMER

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Capital Blue Cross' medical policies are developed to assist in administering a member's benefits, do not constitute medical advice and are subject to change. Treating providers are solely responsible for medical advice and treatment of members. Members should discuss any medical policy related to their coverage or condition with their provider and consult their benefit information to determine if the service is covered. If there is a discrepancy between this medical policy and a member's benefit information, the benefit information will govern. If a provider or a member has a question concerning the application of this medical policy to a specific member's plan of benefits, please contact Capital Blue Cross' Provider Services or Member Services. Capital Blue Cross considers the information contained in this medical policy to be proprietary and it may only be disseminated as permitted by law.

VIII. CODING INFORMATION

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Note: This list of codes may not be all-inclusive, and codes are subject to change at any time. The identification of a code in this section does not denote coverage as coverage is determined by the terms of member benefit information. In addition, not all covered services are eligible for separate reimbursement.

Investigational; therefore, not covered when used to bill for expanded cancer mutation panels for selecting targeted cancer treatment:

Procedure Codes								
0009U	0036U	0211U	0249U	0391U	0409U	0485U	81479	

Covered when medically necessary:

Procedure Codes								
0037U	0239U	0242U	0244U	0250U	0326U	0334U	0448U	0473U
81479								

IX. REFERENCES

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X. POLICY HISTORY

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MP 2.259	**12/03/2020 Administrative Update.** New code 0239U added as covered with criteria. Effective 1/1/2021
	02/01/2021 Administrative Update. New codes 0242U and 0244U added as covered with criteria. Effective 4/1/2021.
	06/15/2021 Administrative Update. Added new codes 0249U and 0250U
	09/07/2021 Administrative Update. New ICD-10 code C56.3 added. Effective 10/1/2021
	09/17/2021 Consensus Review. No changes to policy statement. NCCN language added. FEP language updated. Added additional Cross-Referenced policies. Background, Rationale and References updated.
	06/10/2022 Administrative Update. Added new code 0326U.
	09/12/2022 Administrative Update. Added New Codes 0339U & 0334U.
	12/21/2022 Consensus Review. No change to policy statement. 0339U was not previously added to policy. Removed 0111U. References updated.
	06/13/2023 Administrative Update. Added new code 0391U Effective 7/1/23.
	08/07/2023 Minor Review. Multiple updates to criteria around NCCN and FDA approvals. Coding, references, background and rationale update.
	09/07/2023 Administrative Update. New code 0409U effective 10/1/23
	01/19/2024 Administrative Update. Clinical benefit added.
	03/15/2024 Administrative Update. Added code 0448U for 4/1/24
	06/10/2024 Administrative Update. Added code 0473U. Effective 7/1/2024.
	09/19/2024 Administrative Update. Added code 0485U. Effective 10/1/2024

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