

## Corporate Medical Policy

### Genetic Testing for PTEN Hamartoma Tumor Syndrome AHS – M2087

**File Name:** genetic\_testing\_for\_PTEN\_hamartoma\_tumor\_syndrome  
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**Last Review:** 07/2020

#### Description of Procedure or Service

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Phosphatase and tensin homolog (PTEN) hamartoma tumor syndromes (PHTS) are primarily characterized by hamartomatous tumors (disorganized growths of native cells in native tissues) caused by PTEN germline mutations. PHTS include Cowden syndrome (CS), Bannayan-Riley-Ruvalcaba syndrome (BRRS), *PTEN*-related Proteus syndrome (PS), and Proteus-like syndrome (PLS) (Charis Eng, 2016; Stanich & Lindor, 2018).

##### Related Policies

Molecular Panel Testing of Cancers for Diagnosis, Prognosis, and Identification of Targeted Therapy AHS-M2109

General Genetic Testing, Germline Disorders AHS-M2145

General Genetic Testing, Somatic Disorders AHS-M2146

**\*\*\*Note: This Medical Policy is complex and technical. For questions concerning the technical language and/or specific clinical indications for its use, please consult your physician.**

#### Policy

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**BCBSNC will provide coverage for genetic testing for PTEN hamartoma tumor syndrome when it is determined the medical criteria or reimbursement guidelines below are met.**

#### Benefits Application

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This medical policy relates only to the services or supplies described herein. Please refer to the Member's Benefit Booklet for availability of benefits. Member's benefits may vary according to benefit design; therefore member benefit language should be reviewed before applying the terms of this medical policy.

#### When Genetic Testing for PTEN Hamartoma Tumor Syndrome is covered

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1. Reimbursement for genetic counseling for PTEN mutation testing is allowed and recommended.
2. Genetic testing for a *PTEN* mutation is considered medically necessary to confirm the diagnosis when a patient has clinical signs of Cowden Syndrome/*PTEN* hamartoma tumor syndrome.
  - a. Three or more major criteria, but one must include macrocephaly, Lhermitte-Duclos disease, or gastrointestinal hamartomas; OR
  - b. Two major and three minor criteria

##### Major Criteria:

- i. Breast Cancer
- ii. Endometrial cancer (epithelial)

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- iii. Thyroid Cancer (follicular)
- iv. Gastrointestinal hamartomas (including ganglioneuromas, but excluding hyperplastic polyps;  $\geq 3$ )
- v. Lhermitte-Duclos disease (adult)
- vi. Macrocephaly (megalcephaly) (i.e.  $\geq 97$ th percentile, 58 cm in adult woman, 60 cm in adult men)
- vii. Macular pigmentation of glans penis
- viii. Multiple mucocutaneous lesions (any of the following):
  - Multiple trichilemmomas ( $\geq 3$ , at least one biopsy proven)
  - Acral keratoses ( $\geq 3$  palmoplantar keratotic pits and/or acral hyperkeratotic papules) 4 – GT63
  - Mucocutaneous neuromas ( $\geq 3$ )
  - Oral papillomas (particularly on tongue and gingiva), multiple ( $\geq 3$ ) OR biopsy proven OR dermatologist diagnosed

### Minor Criteria:

- i. Autism spectrum disorder
  - ii. Colon cancer
  - iii.  $\geq 3$  esophageal glycogenic acanthoses
  - iv. Lipomas ( $\geq 3$ )
  - v. Intellectual disability (i.e.,  $IQ \leq 75$ )
  - vi. Renal cell carcinoma
  - vii. Testicular lipomatosis
  - viii. Thyroid cancer (papillary or follicular variant of papillary)
  - ix. Thyroid structural lesions (e.g. adenoma, multinodular goiter)
  - x. Vascular anomalies (including multiple intracranial developmental venous anomalies)
3. Genetic testing for a *PTEN* mutation is considered medically necessary in individuals not meeting the clinical diagnostic criteria for Cowden Syndrome/*PTEN* hamartoma tumor syndrome with a personal history of any one of the following:
- a. Adult Lhermitte-Duclos disease (cerebellar tumors)
  - b. Autism spectrum disorder and macrocephaly
  - c. Two or more biopsy-proven trichilemmomas
  - d. Two or more major criteria (one must be macrocephaly)
  - e. Three major criteria without macrocephaly
  - f. One major and  $\geq 3$  minor criteria
  - g.  $\geq 4$  minor criteria
4. Genetic testing for a *PTEN* mutation is considered medically necessary in individuals with a personal history of Bannayan-Riley-Ruvalcaba syndrome (BRRS)
5. Genetic Testing for a *PTEN* mutation is considered medically necessary in at-risk individuals with a relative with a clinical diagnosis of Cowden Syndrome/*PTEN* Hamartoma Tumor syndrome for whom testing has not been performed AND with either one of the following criteria:
- a. Any one major criterion, OR  
Two minor criteria
6. Reimbursement is allowed for genetic testing for a *PTEN* mutation in a first-degree relative of a proband with a known *PTEN* mutation.

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7. Reimbursement is allowed for genetic testing for a PTEN mutation in individuals with PTEN pathogenic/likely pathogenic variant detected by tumor profiling on any tumor type in the absence of germline analysis.
8. Reimbursement is allowed for comprehensive multi-gene panel testing if familial pathogenic/likely pathogenic variant is not known.

## **When Genetic Testing for PTEN Hamartoma Tumor Syndrome is not covered**

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Genetic testing for a PTEN mutation is considered investigational for all other indications.

See “**Note**” below in the Billing/Coding/Physician Documentation Information section.

### Policy Guidelines

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#### **Background**

Tumor suppressor genes serve several purposes within the body; these genes are able to regulate cell division, restore DNA errors, and tell cells when to die (a process known as apoptosis). Communication of these processes occurs via various cell signaling pathways. In particular, the tumor suppressor gene known as phosphatase and tensin homolog (*PTEN*) is an important phosphatase regulator of the phosphatidylinositol 3-kinase (PI3K)/AKT signaling pathway and the mechanistic target of rapamycin (mTOR) signaling pathway (Sansal & Sellers, 2004; Stanich & Lindor, 2018). The PI3K/AKT and mTOR signaling pathways are critical for cell proliferation, cell cycle progression, and apoptosis.

Loss of function of the *PTEN* gene contributes to an increased risk of both benign and malignant tumors and is implicated in increased lifetime risks of breast, thyroid, uterine, renal, and other cancers; patients may also display clinical features such as cognitive changes, skin changes, macrocephaly (enlarged head) and intestinal polyposis (Ngeow & Eng, 2020). Further, loss of *PTEN* gene functionality results in a spectrum of autosomal dominant disorders known *PTEN* hamartoma tumor syndromes (PHTS); this includes Cowden syndrome (CS), Bannayan-Riley-Ruvalcaba syndrome (BRRS), *PTEN*-related Proteus syndrome (PS), and Proteus-like syndrome (PLS) (Charis Eng, 2016). Autism spectrum disorders (ASDs) with macrocephaly and adult Lhermitte-Duclos disease (LDD) have also been associated with PHTS (Pilarski, 2019; Stanich & Lindor, 2018).

A diagnosis of PHTS is established by identification of a germline pathogenic variant in *PTEN* via molecular genetic testing. A single-gene sequence analysis will detect up to 80% of CS cases, 60% of BRRS cases, 50% PLS cases, and 20% of PS cases. Deletion and duplication analysis or promoter region analysis may also detect additional cases, but further research is required. In addition to single gene analysis, gene panels or further comprehensive testing may assist with clinical management (C. Eng, 2016). All types of mutations have been reported including missense, nonsense, splice site, insertions, and deletions; therefore, *PTEN* mutation testing usually requires sequence analysis of the entire coding region and deletion/duplication analysis (Charis Eng, 2016; Marsh et al., 1999). Mutations have also been reported in the *PTEN* promoter, and a test for mutations in this region of the gene has become clinically available (Stanich & Lindor, 2018). Mingo et al. (2018) recently found that the pathogenicity of frequent *PTEN* mutations targeting the N-terminus “may be related, at least in part, with the retention of *PTEN* in the nucleus. This could be important for the implementation of precision therapies for patients with alterations in the *PTEN* pathway.” Germline *PTEN* mutations are found in approximately 20 to 34% of individuals who meet clinical criteria for CS or who meet criteria for genetic testing (Pilarski, 2019; Pilarski, Stephens, Noss, Fisher, & Prior, 2011; Tan et al., 2011). This number seems to be highly variable as Giorgianni et al. (2013) state that approximately 80% of CS patients have a *PTEN* mutation at locus 10q23.2.

*Cowden Syndrome (CS)*

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CS is defined by multiple hamartomas with a high risk for benign and malignant tumors in the thyroid, breast, and endometrium. Besides multiple hamartomas in a variety of tissues, patients typically exhibit macrocephaly as well as characteristic dermatologic manifestations, such as trichilemmomas (benign tumors originating from hair follicles) and papillomatous papules (wart-like growths) (Garofola & Gross, 2020). For individuals with CS, the lifetime risk of developing breast cancer is as high as 85%; for thyroid cancer, which is usually follicular carcinoma, the lifetime risk is as high as 35%; finally, for endometrial cancer, the risk may reach as high as 28% (Charis Eng, 2016). The estimated prevalence of CS is 1 in 200,000 to 250,000, though it is likely underreported (Stanich & Lindor, 2018). Of all PHTS, only CS has been documented to confer a predisposition to cancer; however, it has been suggested that any patients with *PTEN* mutations should be assumed to have cancer risks similar to CS (Stanich & Lindor, 2018).

## *Bannayan-Riley-Ruvalcaba Syndrome (BRRS)*

BRRS is characterized by hamartomas along with macrocephaly, lipomas, and pigmented penile macules. It is also associated with high birth weight, developmental delay or deficiency, proximal muscle myopathy, joint hypermobility, high palate, and scoliosis (Stanich & Lindor, 2018). Similar mutations in the *PTEN* gene are found in both CS and BRRS, which are now considered phenotypically distinct presentations of a similar genetic abnormality (Lachlan, Lucassen, Bunyan, & Temple, 2007; Marsh et al., 1999).

## *PTEN-related Proteus Syndrome (PS)*

PS is characterized by hamartomatous overgrowth of multiple tissues with hyperostoses (excessive bone growth), vascular malformations, dysregulation of fatty tissues, connective tissue nevi, and epidermal nevi. Phenotypic features of PS are usually present at birth and progress over an individual's lifetime (Hobert & Eng, 2009).

## *Proteus-like Syndrome (PLS)*

PLS is undefined but typically refers to individuals with similar clinical features to PS who do not meet the diagnostic criteria (Charis Eng, 2016; Hobert & Eng, 2009). Overall, limited information is available on PLS. Stanich and Lindor (2018) report that PLS cases typically exhibit “a distinct type of epidermal nevus (also referred to as segmental overgrowth, lipomatosis, arteriovenous malformation, and epidermal nevus (SOLAMEN) syndrome or type 2 segmental Cowden syndrome).”

## *Autism Spectrum Disorders (ASDs)*

ASDs are a collection of disorders presenting with common abnormalities associated with social and communication behaviors. A few studies have been published which research the relationship between *PTEN* mutations and ASDs. Schaefer and Mendelsohn (2013) completed a literature review of at least seven different studies and determined that 15 of 318 (5%) individuals with an ASD diagnosis had a pathogenic *PTEN* mutation; further, macrocephaly was present in all 15 cases.

## *Lhermitte-Duclos Disease (LDD)*

LDD is a rare disease characteristic of benign tumor development in the granule cells of the cerebellum. It has been reported that “Most LDD patients appear to have a germline loss of the *PTEN* allele and go on to lose the remaining *PTEN* allele at some point, thereby allowing abnormal growth of the granule cells (Giorgianni et al., 2013).” LDD often develops in conjunction with CS, but may also develop singularly (Stanich & Lindor, 2018).

## *Clinical Validity and Utility*

Yehia et al. (2018) conducted a four-year multicenter study; all participants had suspected BRRS or Cowden/Cowden-like (CS/CS-like) syndromes without *PTEN* mutations. Exome sequencing and

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targeted analysis was completed on 59 genes supported by the American College of Medical Genetics and Genomics (ACMG), as well as on 24 additional genes known to be associated with inherited cancer syndromes. “Pathogenic or likely pathogenic cancer susceptibility gene alterations were found in seven of the 87 (8%) CS/CS-like and BRRS patients and included *MUTYH*, *RET*, *TSC2*, *BRCA1*, *BRCA2*, *ERCC2* and *HRAS* (Yehia et al., 2018).”

Ngeow et al. (2015) estimated the cost effectiveness of each *PTEN* mutation detected in CS-like patients using the PTEN Cleveland Clinic (CC) score. This is a risk assessment tool which helps to estimate an individual’s risk of having a *PTEN* mutation. Several questions are answered through an online survey, and a total risk score between 0 and 100 is provided (CC, 2020). The authors found that the cost to detect one *PTEN* mutation was between \$3720 to \$4573 at a CC score of 15 (CC15). The authors also concluded that “In sensitivity analyses, CC15 is robustly the most cost-effective strategy for probands who are younger than 60 years (Ngeow et al., 2015).”

Isik et al. (2020) researched the genotype to phenotype correlation of patients with *PTEN* mutations. A total of 10 molecularly confirmed PHTS patients participated in this study; these participants originated from seven different families. The authors note that “Macrocephaly was the most common clinical finding, involving all patients. This was followed by skin lesions, neurodevelopmental delay, and pathologic cranial magnetic resonance imaging findings (Isik et al., 2020).” Further, sequencing of the *PTEN* gene identified seven different *PTEN* variants; four variants were located in exon five. The authors conclude by highlighting the importance of screening for *PTEN* mutations in patients with macrocephaly, particularly due to an increased risk of cancer.

## Guidelines and Recommendations

### The International Cowden Consortium Operational Criteria for the Diagnosis of Cowden Syndrome Ver 2000 (Pilarski et al., 2013; Pilarski & Eng, 2004)

#### Pathognomonic criteria

##### Mucocutaneous lesions

- Trichilemmomas, facial
- Acral keratoses
- Papillomatous papules
- Mucosal lesions

#### Major criteria

- Breast carcinoma
- Thyroid carcinoma (non-medullary), especially follicular thyroid carcinoma
- Macrocephaly (megalencephaly) (say,  $\geq 97$ th centile)
- Lhermitte-Duclos disease (LDD)
- Endometrial carcinoma

#### Minor criteria

- Other thyroid lesions (eg, adenoma or multinodular goitre)
- Mental retardation (say,  $IQ \leq 75$ )
- GI hamartomas
- Fibrocystic disease of the breast
- Lipomas
- Fibromas
- Genito-urinary tumours (eg, renal cell carcinoma, uterine fibroids) or malformation

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According to the International Cowden Consortium, an operational diagnosis of Cowden Syndrome is made if the individual meets any of the following:

- (1) Mucocutaneous lesions alone if:
  - (a) there are 6 or more facial papules, of which 3 or more must be trichilemmoma, or
  - (b) cutaneous facial papules and oral mucosal papillomatosis, or
  - (c) oral mucosal papillomatosis and acral keratoses, or
  - (d) palmoplantar keratoses, 6 or more
- (2) 2 major criteria but one must include macrocephaly or LDD
- (3) 1 major and 3 minor criteria
- (4) 4 minor criteria

According to the International Cowden Consortium, an operational diagnosis of Cowden Syndrome in a family where one person is diagnostic for Cowden syndrome is made if any of the following criteria are met:

- (1) The pathognomonic mucocutaneous lesion
- (2) Any one major criterion with or without minor criteria
- (3) Two minor criteria

In 2013, Pilarski et al published revised evidence-based criteria covering the spectrum of PTEN-related clinical disorders. The revised guidelines define the operational diagnosis of PTEN Hamartoma Tumor syndrome in an individual who meets either one of the following:

- Three or more major criteria, but one must include macrocephaly, Lhermitte-Duclos disease, or gastrointestinal hamartomas; or
- Two major and three minor criteria

The operational diagnosis in a family where one individual meets the revised PTEN Hamartoma Tumor syndrome clinical diagnostic criteria or has a PTEN mutation is as follows (Pilarski et al., 2013):

- Any two major criteria with or without minor criteria; or
- One major and two minor criteria; or
- Three minor criteria

Pilarski et al (2013) defined the major and minor criteria as follows:

## Major Criteria:

- Breast Cancer
- Endometrial cancer (epithelial)
- Thyroid Cancer (follicular)
- Gastrointestinal hamartomas (including ganglioneuromas, adenomas, hyperplastic polyps;  $\geq 3$ )
- Lhermitte-Duclos disease (adult)
- Macrocephaly (megalcephaly) (i.e.  $\geq 97$ th percentile, 58 cm in adult woman, 60 cm in adult men)
- Macular pigmentation of glans penis
- Multiple mucocutaneous lesions (any of the following):

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- Multiple trichilemmomas ( $\geq 3$ , at least one biopsy proven)
- Acral keratoses ( $\geq 3$  palmoplantar keratotic pits and/or acral hyperkeratotic papules) 4 – GT63
- Mucocutaneous neuromas ( $\geq 3$ )
- Oral papillomas (particularly on tongue and gingiva), multiple ( $\geq 3$ ) OR biopsy proven OR dermatologist diagnosed

## Minor Criteria:

- Autism spectrum disorder
- Colon cancer
- $\geq 3$  esophageal glycogenic acanthoses
- Lipomas ( $\geq 3$ )
- Intellectual disability (i.e.,  $IQ \leq 75$ )
- Renal cell carcinoma
- Testicular lipomatosis
- Thyroid cancer (papillary or follicular variant of papillary)
- Thyroid structural lesions (e.g. adenoma, multinodular goiter)
- Vascular anomalies (including multiple intracranial developmental venous anomalies)

## **National Comprehensive Cancer Network (NCCN) (NCCN, 2019, 2020)**

The NCCN guidelines for Cowden Syndrome/PTEN Hamartoma Tumor syndrome recommend testing in individuals who meet any of the following criteria:

- “Individual from a family with a known PTEN pathogenic variant/likely pathogenic variant
- Individuals with a personal history of Bannayan-Riley-Ruvalcaba syndrome (BRRS)
- Individuals meeting the clinical diagnostic criteria for CS/PHTS
- Individuals not meeting the clinical diagnostic criteria for Cowden Syndrome/PTEN hamartoma tumor syndrome with a personal history:
  - Adult Lhermitte-Duclos disease (cerebellar tumors)
  - Autism spectrum disorder and macrocephaly
  - Two or more biopsy-proven trichilemmomas
  - Two or more major criteria (one must be macrocephaly)
  - Three major criteria without macrocephaly
  - One major and  $\geq 3$  minor criteria
  - $\geq 4$  minor criteria
- At-risk individuals with a relative with a clinical diagnosis of Cowden Syndrome/PTEN Hamartoma Tumor syndrome for whom testing has not been performed. The at-risk individual must have the following:
  - Any one major criterion, OR
  - Two minor criteria
- *PTEN* pathogenic/likely pathogenic variant detected by tumor profiling on any tumor type in the absence of germline analysis

## Major Criteria

- Breast cancer
- Endometrial cancer (epithelial)
- Thyroid cancer (follicular)

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- GI hamartomas (including ganglioneuromas<sup>aa</sup>, but excluding hyperplastic polyps;  $\geq 3$ )
- Lhermitte-Duclos disease (adult)
- Macrocephaly (megalencephaly) (ie,  $\geq 97\%$ , 58 cm in adult women, 60 cm in adult men)
- Macular pigmentation of glans penis
- Multiple mucocutaneous lesions<sup>cc</sup> (any of the following):
  - Multiple trichilemmomas ( $\geq 3$ , at least one biopsy proven)
  - Acral keratoses ( $\geq 3$  palmoplantar keratotic pits and/or acral hyperkeratotic papules)
  - Mucocutaneous neuromas ( $\geq 3$ )
  - Oral papillomas (particularly on tongue and gingiva), multiple ( $\geq 3$ ) OR biopsy proven OR dermatologist diagnosed

## Minor Criteria

- Autism spectrum disorders
- Colon cancer
- Esophageal glycogenic acanthoses ( $\geq 3$ )
- Lipomas ( $\geq 3$ )
- Intellectual disability (ie,  $\text{IQ} \leq 75$ )
- Papillary or follicular variant of papillary thyroid cancer
- Thyroid structural lesions (eg, adenoma nodule(s), goiter)
- Renal cell carcinoma
- Single GI hamartoma or ganglioneuroma
- Testicular lipomatosis
- Vascular anomalies (including multiple intracranial developmental venous anomalies)

If an individual has two or more major criteria, such as breast cancer and non-medullary thyroid cancer, but does not have macrocephaly, one of the major criteria may be included as one of the three minor criteria to meet testing criteria.

This should prompt a careful evaluation of personal and family history of the individual to determine the yield of germline sequencing. Somatic *PTEN* pathogenic/likely pathogenic variants are common in many tumor types in absence of germline pathogenic/likely pathogenic variant.

Multiple polyp types are often seen in patients with PHTS, and less commonly may include adenomas, hyperplastic polyps, and other histologies.

The literature available on mucocutaneous lesions is not adequate to accurately specify the number or extent of mucocutaneous lesions required to be a major criterion for CS/PHTS. Clinical judgment should be used.

Insufficient evidence exists in the literature to include fibrocystic disease of the breast, fibromas, and uterine fibroids as diagnostic criteria (NCCN, 2020).”

“Operational diagnosis in an individual (either of the following):

1. Three or more major criteria, but one must include macrocephaly, Lhermitte-Duclos disease, or GI hamartomas; or
2. Two major and three minor criteria.

Operational diagnosis in a family where one individual meets revised PTEN hamartoma tumor syndrome clinical diagnostic criteria or has a *PTEN* pathogenic/likely pathogenic variant:



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1. Any two major criteria with or without minor criteria; or
2. One major and two minor criteria; or
3. Three minor criteria (NCCN, 2020)”

## **ClinGen PTEN Expert Panel (Mester et al., 2018)**

This expert panel was convened by the ClinGen Hereditary Cancer Clinical Domain Working Group to develop PTEN-specific genetic variant interpretations. A total of 42 variants were included in the following categories: benign/likely benign (BEN/LBEN), pathogenic/likely pathogenic (PATH/LPATH), uncertain significance (VUS), and conflicting (CONF) ClinVar assertions.

The following variants were considered BEN/LBEN: 9C>G, 903G>A, 1026C>A, 1311T>C, 18A>G, 75G>A, 132C>T, 360A>G, 1104T>G, 79+35C>T, 165-13\_165-10delGTTT, 254-39G>T, 801+23G>A, and 1026+32T>G.

The following variants were considered PATH/LPATH: 50\_51delAA, 511C>T, 892C>T, 964A>T, 987\_990delTAAA, 80-1G>C, 165-1G>A, 493-2A>G, 801+1delG, 802-2A>T, 1026+1G, 103A>G, 389G>A, 407G>A, 517C>T, and 737C>T.

The following variants were considered VUS or CONF: 1170C>T, 209+3A>T, 235G>A, 304\_306dupAAA, 1052\_1054delTAG, 1171C>T, 764G>A, 44G>A, 78C>T, 209+4\_209+7delAGTA, 521A>G (Mester et al., 2018).

## **American College of Medical Genetics (ACMG) (Schaefer & Mendelsohn, 2013)**

In 2013, the ACMG published guidelines for identifying the etiology of autism spectrum disorders (ASDs). These guidelines state that “*PTEN* testing [should] be reserved for patients with ASDs with a head circumference above the 98th percentile (Schaefer & Mendelsohn, 2013).” The authors then suggest that of all ASD-related genetic evaluations, about 5% of testing will be due to *PTEN* mutations.

## **National Organization for Rare Disorders (NORD) (NORD, 2018)**

The NORD states that “Sotos syndrome is a rare genetic disorder characterized by excessive growth that occurs prior to and after birth (prenatally and postnatally). The overlap of neurodevelopmental disabilities and macrocephaly in both PHTS and Sotos syndrome indicates the need for genetic testing to avoid misdiagnosis (NORD, 2018).” Genetic counseling is also suggested.

## **American College of Gastroenterology (ACG) (Syngal et al., 2015)**

In 2015, the ACG published guidelines on genetic testing and management of hereditary gastrointestinal cancer syndromes. These guidelines clearly state that the “Genetic evaluation of a patient with possible CS should include testing for *PTEN* mutations... CS is caused by mutations in the *PTEN* gene. Once a disease-causing mutation is identified in a patient with CS or related conditions, other family members should undergo mutation-specific testing to determine whether the disease is present or absent so that appropriate surveillance can be undertaken” (Syngal et al., 2015). Further, the ACG also notes that “Surveillance in affected or at-risk CS patients should include

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screening for colon, stomach, small bowel, thyroid, breast, uterine, kidney, and skin (melanoma) cancers (conditional recommendation, low quality of evidence) (Syngal et al., 2015).”

## Applicable Federal Regulations

No FDA-approved tests were found regarding the assessment of hamartomas. Additionally, many labs have developed specific tests that they must validate and perform in house. These laboratory-developed tests (LDTs) are regulated by the Centers for Medicare and Medicaid (CMS) as high-complexity tests under the Clinical Laboratory Improvement Amendments of 1988 (CLIA '88). As an LDT, the U. S. Food and Drug Administration has not approved or cleared this test; however, FDA clearance or approval is not currently required for clinical use.

## Billing/Coding/Physician Documentation Information

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This policy may apply to the following codes. Inclusion of a code in this section does not guarantee that it will be reimbursed. For further information on reimbursement guidelines, please see Administrative Policies on the Blue Cross Blue Shield of North Carolina web site at [www.bcbsnc.com](http://www.bcbsnc.com). They are listed in the Category Search on the Medical Policy search page.

**Note:** For 5 or more gene tests being run on the same platform, such as multi-gene panel next generation sequencing, please refer to Laboratory Procedures Reimbursement Policy AHS - R2162

*Applicable service codes: 81321, 81322, 81323, 81445, 96040, S0265*

BCBSNC may request medical records for determination of medical necessity. When medical records are requested, letters of support and/or explanation are often useful, but are not sufficient documentation unless all specific information needed to make a medical necessity determination is included.

## Scientific Background and Reference Sources

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# Genetic Testing for PTEN Hamartoma Tumor Syndrome AHS – M2087

Medical Director review 7/2019

Specialty Matched Consultant Advisory Panel review 7/2020

Medical Director review 7/2020

## Policy Implementation/Update Information

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- 1/1/2019 BCBSNC will provide coverage for genetic testing for PTEN hamartoma tumor syndrome when it is determined to be medically necessary because criteria and guidelines are met. Medical Director review 1/1/2019. Policy noticed 1/1/2019 for effective date 4/1/2019 (jd)
- 8/13/2019 Specialty Matched Consultant Advisory Panel review. 7/2019. Medical Director review 7/2019. (jd)
- 9/10/2019 Reviewed by Avalon 2<sup>nd</sup> Quarter 2019 CAB. Added Related Policies to the Description section. Reference to “Note” added to the When Not Covered section. Policy guidelines and references updated. “Note” “5 or more gene tests being run on the same platform, such as multi-gene panel next generation sequencing, please refer to Laboratory Procedures Reimbursement Policy AHS - R2162” added to the Billing/Coding section and code table removed. Medical Director review 8/2019. (jd)
- 10/29/19 Wording in the Policy, When Covered, and/or Not Covered section(s) changed from Medical Necessity to Reimbursement language, where needed. (hb)
- 7/28/20 Updated Related Policies. The following changes were made to the When Covered section: Added Item 1 reimbursement language for genetic counseling; item 2, iv. under Major Criteria, removed “adenomas” and added “but excluding”; added items 6-7 reimbursement language, and reformatted as applicable. Updated policy guidelines and references. The following codes were added to the Billing/Coding section: 96040, S0265, and Note added as follows: **Note:** For 5 or more gene tests being run on the same platform, such as multi-gene panel next generation sequencing, please refer to Laboratory Procedures Reimbursement Policy AHS - R2162”. Specialty Matched Consultant Advisory Panel review 7/2020. Medical Director review 7/2020. (jd)

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