Medical Policy

Multigene Expression Assay for Predicting Recurrence in Colon Cancer

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Policy Number: 239
BCBSA Reference Number: 2.04.61
NCD/LCD: N/A
Oncotype DX Colon Cancer Assay Coding and Billing Guidelines (M0002, V15)

Related Policies
None

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

Gene expression assays for determining the prognosis of stage 2 or stage 3 colon cancer following surgery are considered INVESTIGATIONAL.

Medicare HMO BlueSM and Medicare PPO BlueSM Members

Coding guidance for Medicare Advantage members living in Massachusetts or Medicare Advantage members living outside of Massachusetts can be found through the link below.

Oncotype DX Colon Cancer Assay Coding and Billing Guidelines (M0002, V15)

For medical necessity criteria and coding guidance for Medicare Advantage members living outside of Massachusetts, please see the Centers for Medicare and Medicaid Services website for information regarding your specific jurisdiction at https://www.cms.gov.

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) This is not a covered service.
Commercial PPO and Indemnity This is not a covered service.
Medicare HMO Blue℠ Prior authorization is not required.
Medicare PPO Blue℠ Prior authorization is not 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 following CPT codes are considered investigational for Commercial Members: Managed Care (HMO and POS), PPO and Indemnity:

<table>
<thead>
<tr>
<th>CPT codes:</th>
<th>Code Description</th>
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<tbody>
<tr>
<td>81525</td>
<td>Oncology (colon), mRNA, gene expression profiling by real-time RT-PCR of 12 genes (7 content and 5 housekeeping), utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as a recurrence score</td>
</tr>
</tbody>
</table>

**Description**

**COLON CANCER**

According to estimates by the National Cancer Institute, in 2018 over 140,000 new cases of colorectal cancer will be diagnosed in the United States, and over 50,600 people will die of this cancer. Five-year survival estimates are around 65%.

**Treatment**

Of patients with stage II colon cancer, 75% to 80% are cured by surgery alone, and the absolute benefit of chemotherapy for the overall patient population is small. Patients most likely to benefit from chemotherapy are difficult to identify by standard clinical and pathologic risk factors. Genomic tests are intended to facilitate identifying stage II patients most likely to experience recurrence after surgery and most likely to benefit from additional treatment.

Colorectal cancer is classified as stage II (also called Dukes B) when it has spread outside the colon and/or rectum to nearby tissue but is not detectable in lymph nodes (stage III disease, also called Dukes C) and has not metastasized to distant sites (stage IV disease). Primary treatment is surgical resection of primary cancer and colonic anastomosis. After surgery, the prognosis is good, with survival rates of 75% to 80% at 5 years. A Cochrane review by Figueredo et al (2008), assessing 50 studies of adjuvant therapy vs surgery alone in stage II patients, found a small though statistically significant absolute benefit of chemotherapy for disease-free survival but not for overall survival. Therefore, adjuvant chemotherapy with 5-fluorouracil or capecitabine is recommended only for resected patients, with high-risk stage II disease (ie, those with poor prognostic features).

However, the clinical and pathologic features used to identify high-risk disease are not well-established, and patients for whom benefits of adjuvant chemotherapy would most likely outweigh harms cannot be identified with certainty. The current diagnostic system relies on a variety of factors, including tumor substage IIB (T4A tumors that invade the muscularis propria and extend into pericolorectal tissues) or IIC (T4B tumors that invade or are adherent to other organs or structures), obstruction or bowel perforation at initial diagnosis, an inadequately low number of sampled lymph nodes at surgery (≤12), histologic...
features of aggressiveness, a high preoperative carcinoembryonic antigen level, and indeterminate or positive resection margins.

Of interest, a review by Vilar and Gruber (2010) has noted that microsatellite instability and mismatch repair deficiency in colon cancer may represent confounding factors to be considered in treatment. These factors may identify a minority (15%-20%) of the population with improved disease-free survival who may derive no benefit or may exhibit deleterious effects from adjuvant 5-fluorouracil plus leucovorin–based treatments. Patient microsatellite instability and mismatch repair status may be critically important in how to study, interpret, and use a particular gene expression profile test.

Summary
For individuals who have stage II or III colon cancer who receive GEP testing, the evidence includes development and validation studies and decision-impact studies. Relevant outcomes are disease-specific survival, test accuracy and validity, and change in disease status. The available evidence has shown that GEP testing for colon cancer can improve risk prediction, particularly the risk of recurrence in patients with stage II or III colon cancer. However, the degree of difference in risk conferred by the test is small. Evidence to date does not permit conclusions on whether GEP classification is sufficient to modify treatment decisions in stage II or III patients. Studies showing management changes as a consequence of testing have not demonstrated whether such changes improve outcomes. The evidence is insufficient to determine the effects of the technology on health outcomes.

Policy History

<table>
<thead>
<tr>
<th>Date</th>
<th>Action</th>
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<tbody>
<tr>
<td>9/2017</td>
<td>New references added from BCBSA National medical policy.</td>
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<tr>
<td>10/2016</td>
<td>New references added from BCBSA National medical policy.</td>
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<tr>
<td>6/2015</td>
<td>Local Coverage Determination (LCD): Molecular Diagnostic Tests (MDT) (L33541) added.</td>
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<td>10/2014</td>
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<td>12/2013</td>
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<tr>
<td>2/2013</td>
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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

References


