

**EFFECTIVE DATE:** 06|01|2021

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## OVERVIEW

Clinical assessment and noninvasive imaging of chronic heart failure can be limited in accurately diagnosing patients with heart failure because symptoms and signs can poorly correlate with objective methods of assessing cardiac dysfunction. For management of heart failure, clinical signs and symptoms (eg, shortness of breath) are relatively crude markers of decompensation and occur late in the course of an exacerbation. Thus, circulating biomarkers have potential benefit in heart failure diagnosis and management.

In transplant recipients, despite the progress in immunosuppressant therapy, risk of rejection remains. Diagnosis of allograft rejection continues to rely on clinical monitoring and histologic confirmation by tissue biopsy. However, due to limitations of tissue biopsy, including a high degree of interobserver variability in the grading of results and its potential complications, less invasive alternatives have been investigated. Several laboratory-tested biomarkers of transplant rejection have been evaluated and are commercially available for use.

The following test are addressed in this policy:

- AlloMap (CareDx)
- AlloSure Heart (CareDx)
- AlloSure Kidney (CareDx)
- Heartsbreath (Menssana Research)
- myTAIHEART (TAI Diagnostics)
- Presage® ST2 Assay (Critical Diagnostics)

## MEDICAL CRITERIA

### Medicare Advantage Plans

#### AlloSure Heart

AlloSure® Heart may be considered medically necessary when all of the following criteria are met:

- It is used in conjunction with AlloMap®,
- To assess the probability of allograft rejection in heart transplant recipients with clinical suspicion of rejection,
- To inform clinical decision-making about the necessity of a heart biopsy in such patients at least 55 days post-transplant in conjunction with standard clinical assessment.

#### AlloSure Kidney

AlloSure® Kidney may be considered medically necessary when all of the following criteria are met:

- It is used to assess the probability of allograft rejection in kidney transplant recipients with clinical suspicion of rejection,
- To inform clinical decision-making about the necessity of renal biopsy in such patients at least 2 weeks post-transplant in conjunction with standard clinical assessment.

### Commercial Products

Not applicable

## **PRIOR AUTHORIZATION**

### **Medicare Advantage Plans**

Prior authorization is required for the following tests:

- AlloSure Heart
- AlloSure Kidney

### **Commercial Products**

Not applicable

### **Medicare Advantage Plans and Commercial Products**

There is no specific CPT coding for some of the services referenced in this policy. Therefore, an Unlisted CPT code should be used (see Coding Section for details). All Unlisted genetic testing CPT codes require prior authorization to determine what service is being rendered and if the service is covered or not medically necessary. See the Related Policies section.

Note: Laboratories are not allowed to obtain clinical authorization or participate in the authorization process on behalf of the ordering physician. Only the ordering physician shall be involved in the authorization, appeal or other administrative processes related to prior authorization/medical necessity.

In no circumstance shall a laboratory or a physician/provider use a representative of a laboratory or anyone with a relationship to a laboratory and/or a third party to obtain authorization on behalf of the ordering physician, to facilitate any portion of the authorization process or any subsequent appeal of a claim where the authorization process was not followed and/or a denial for clinical appropriateness was issued, including any element of the preparation of necessary documentation of clinical appropriateness. If a laboratory or a third party is found to be supporting any portion of the authorization process, BCBSRI will deem the action a violation of this policy and severe action will be taken up to and including termination from the BCBSRI provider network. If a laboratory provides a laboratory service that has not been authorized, the service will be denied as the financial liability of the participating laboratory and may not be billed to the member.

## **POLICY STATEMENT**

### **Medicare Advantage Plans**

The following test is covered:

- AlloMap

The following tests may be considered medically necessary when the medical criteria above are met:

- AlloSure Heart
- AlloSure Kidney

The following tests are not covered as the evidence is insufficient to determine the effects of the technology on health outcomes:

- Heartsbreath
- myTAIHEART
- Presage® ST2 Assay

### **Commercial Products**

The following tests are not medically necessary as the evidence is insufficient to determine the effects of the technology on health outcomes:

- AlloMap
- AlloSure Heart
- AlloSure Kidney
- Heartsbreath

- myTAIHEART
- Presage® ST2 Assay

## COVERAGE

Benefits may vary between groups and contracts. Please refer to the appropriate Benefit Booklet, Evidence of Coverage, or Subscriber Agreement for laboratory tests or not medically necessary/not covered benefits/coverage.

## BACKGROUND

The laboratory tests for heart transplant rejection currently evaluated in this policy include the Presage® ST2 Assay kit, which measures the soluble suppression of tumorigenicity-2 protein biomarker; the myTAIHEART assay, which uses cell-free DNA to measure a panel of single nucleotide polymorphisms; the Heartsbreath test, which measures breath markers of oxidative stress; and the AlloMap test, which uses gene expression profiling. Also included in this policy is the AlloSure test, which measures the donor-derived cell-free DNA for renal transplant rejection.

## HEART FAILURE

Heart failure is a major cause of morbidity and mortality worldwide. The term *heart failure* refers to a complex clinical syndrome that impairs the heart's ability to move blood through the circulatory system. The prevalence of heart failure in the U.S. between 2013 and 2016 was an estimated 6.2 million for Americans ≥20 years old, up from 5.7 million from between 2009 and 2012. Heart failure is the leading cause of hospitalization among people older than age 65 years, with direct and indirect costs estimated at \$37 billion annually in the U.S. Although survival has improved with treatment advances, absolute mortality rates of heart failure remain near 50% within 5 years of diagnosis.

### Physiology

Heart failure can be caused by disorders of the pericardium, myocardium, endocardium, heart valves or great vessels, or metabolic abnormalities. Individuals with heart failure may present with a wide range of left ventricular (LV) anatomy and function. Some have normal LV size and preserved ejection fraction; others have severe LV dilatation and depressed ejection fraction. However, most patients present with key signs and symptoms secondary to congestion in the lungs from impaired LV myocardial function. They include dyspnea, orthopnea, and paroxysmal dyspnea. Other symptoms include weight gain due to fluid retention, fatigue, weakness, and exercise intolerance secondary to diminished cardiac output.

### Diagnosis

Initial evaluation of a patient with suspected heart failure is typically based on clinical history, physical examination, and chest radiograph. Because people with heart failure may present with nonspecific signs and symptoms (eg, dyspnea), accurate diagnosis can be challenging. Therefore, noninvasive imaging procedures (eg, echocardiography, radionuclide angiography) are used to quantify pump function of the heart, thus identifying or excluding heart failure in patients with characteristic signs and symptoms. These tests can also be used to assess prognosis by determining the severity of the underlying cardiac dysfunction. However, clinical assessment and noninvasive imaging can be limited in accurately evaluating patients with heart failure because symptoms and signs can poorly correlate with objective methods of assessing cardiac dysfunction. Thus, invasive procedures (eg, cardiac angiography, catheterization) are used in select patients with presumed heart failure symptoms to determine the etiology (ie, ischemic vs. nonischemic) and physiologic characteristics of the condition.

### Treatment

Patients with heart failure may be treated using a number of interventions. Lifestyle factors such as the restriction of salt and fluid intake, monitoring for increased weight, and structured exercise programs are beneficial components of self-management. A variety of medications are available to treat heart failure. They include diuretics (eg, furosemide, hydrochlorothiazide, spironolactone), angiotensin-converting enzyme

inhibitors (eg, captopril, enalapril, lisinopril), angiotensin receptor blockers (eg, losartan, valsartan, candesartan), b-blockers (eg, carvedilol, metoprolol succinate), and vasodilators (eg, hydralazine, isosorbide dinitrate). Numerous device-based therapies also are available. Implantable cardioverter defibrillators reduce mortality in patients with an increased risk of sudden cardiac death. Cardiac resynchronization therapy improves symptoms and reduces mortality for patients who have disordered LV conduction evidenced by a wide QRS complex on electrocardiogram. Ventricular assist devices are indicated for patients with end-stage heart failure who have failed all other therapies and are also used as a bridge to cardiac transplantation in select patients.

### **Heart Failure Biomarkers**

Because of limitations inherent in standard clinical assessments of patients with heart failure, a number of objective disease biomarkers have been investigated to diagnose and assess heart failure patient prognosis, with the additional goal of using biomarkers to guide therapy.<sup>7</sup> They include a number of proteins, peptides, or other small molecules whose production and release into circulation reflect the activation of remodeling and neurohormonal pathways that lead to LV impairment. Examples include B-type natriuretic peptide (BNP), its analogue N-terminal pro B-type natriuretic peptide (NT-proBNP), troponin T and I, renin, angiotensin, arginine vasopressin, C-reactive protein, and norepinephrine.

BNP and NT-proBNP are considered the reference standards for biomarkers in assessing heart failure patients. They have had substantial impact on the standard of care for diagnosis of heart failure and are included in the recommendations of all major medical societies, including the American College of Cardiology Foundation and American Heart Association, European Society of Cardiology, and the Heart Failure Society of America. Although natriuretic peptide levels are not 100% specific for the clinical diagnosis of heart failure, elevated BNP or NT-proBNP levels in the presence of clinical signs and symptoms reliably identify the presence of structural heart disease due to remodeling and heightened risk for adverse events. Natriuretic peptides also can help in determining prognosis of heart failure patients, with elevated blood levels portending poorer prognosis.

In addition to diagnosing and assessing prognosis of heart failure patients, blood levels of BNP or NT-proBNP have been proposed as an aid for managing patients diagnosed with chronic heart failure. Levels of either biomarker rise in response to myocardial damage and LV remodeling, whereas they tend to fall as drug therapy ameliorates symptoms of heart failure. Evidence from a large number of randomized controlled trials (RCTs) that have compared BNP- or NT-proBNP-guided therapy with clinically guided adjustment of pharmacologic treatment of patients who had chronic heart failure has been assessed in recent systematic reviews and meta-analyses. However, these analyses have not consistently reported a benefit for BNP-guided management. Savarese et al (2013) published the largest meta-analysis to date, a patient-level meta-analysis that evaluated 2686 patients from 12 RCTs. This meta-analysis showed that NT-proBNP-guided management was associated with significant reductions in all-cause mortality and heart failure–related hospitalization compared with clinically guided treatment. Although BNP-guided management in this meta-analysis was not associated with significant reductions in these parameters, differences in patient numbers and characteristics may explain the discrepancy. Troughton et al (2014) conducted a second patient-level meta-analysis that included 11 RCTs with 2000 patients randomized to natriuretic peptide-guided pharmacologic therapy or usual care. The results showed that, among patients 75 years of age or younger with chronic heart failure, most of whom had impaired left ventricular ejection fraction, natriuretic peptide-guided therapy was associated with significant reductions in all-cause mortality compared with clinically guided therapy. Natriuretic-guided therapy also was associated with significant reductions in hospitalization due to heart failure or cardiovascular disease.

### **Suppression of Tumorigenicity-2 Protein Biomarker**

A protein biomarker, ST2, has elicited interest as a potential aid to predict prognosis and manage therapy of heart failure. This protein is a member of the interleukin-1 (IL-1) receptor family. It is found as a transmembrane isoform (ST2L) and a soluble isoform (sST2), both of which have circulating IL-33 as their primary ligand. ST2 is a unique biomarker that has pluripotent effects in vivo. Thus, binding between IL-33

and ST2L is believed to have an immunomodulatory function via T-helper type 2 lymphocytes and was initially described in the context of cell proliferation, inflammatory states, and autoimmune diseases. However, the IL-33/ST2L signaling cascade is also strongly induced through mechanical strain of cardiac fibroblasts or cardiomyocytes. The net result is mitigation of adverse cardiac remodeling and myocardial fibrosis, which are key processes in the development of heart failure. The soluble isoform of ST2 is produced by lung epithelial cells and cardiomyocytes and is secreted into circulation in response to exogenous stimuli, mechanical stress, and cellular stretch. This form of ST2 binds to circulating IL-33, acting as a "decoy," thus inhibiting the IL-33-associated antiremodeling effects of the IL-33/ST2L signaling pathway. Thus, on a biologic level, IL-33/ST2L signaling plays a role in modulating the balance of inflammation and neurohormonal activation and is viewed as pivotal for protection from myocardial remodeling, whereas sST2 is viewed as attenuating this protection. In the clinic, blood concentrations of sST2 appear to correlate closely with adverse cardiac structure and functional changes consistent with remodeling in patients with heart failure, including abnormalities in filling pressures, chamber size, and systolic and diastolic function.

An enzyme-linked immunosorbent-based assay is commercially available for determining sST2 blood levels (Presage ST2 Assay). The manufacturer claims a limit of detection of 1.8 ng/mL for sST2, and a limit of quantification of 2.4 ng/mL, as determined according to Clinical and Laboratory Standards Institute guideline EP-17-A. Mueller and Dieplinger (2013) reported a limit of detection of 2.0 ng/mL for sST2 in their study. In the same study, the assay had a within-run coefficient of variation of 2.5% and a total coefficient of variation less than 4.0%, demonstrated linearity within the dynamic range of the assay calibration curve, and exhibited no relevant interference or cross-reactivity.

The ST2 biomarker is not intended to diagnosis heart failure because it is a relatively nonspecific marker that is increased in many other disparate conditions that may be associated with acute or chronic manifestations of heart failure. Although the natriuretic peptides (BNP, NT-proBNP) reflect different physiologic aspects of heart failure compared with sST2, they are considered the reference standard biomarkers when used with clinical findings to diagnose, prognosticate, and manage heart failure and as such are the comparator to sST2.

## **HEART TRANSPLANT REJECTION**

Most cardiac transplant recipients experience at least a single episode of rejection in the first year after transplantation.

Acute cellular rejection is most likely to occur in the first 6 months after transplantation, with a significant decline in the incidence of rejection after this time. Although immunosuppressants are required on a life-long basis, dosing is adjusted based on graft function and the grade of acute cellular rejection determined by histopathology. Endomyocardial biopsies are typically taken from the right ventricle via the jugular vein periodically during the first 6 to 12 months posttransplant. The interval between biopsies varies among clinical centers. A typical schedule is weekly for the first month, once or twice monthly for the following 6 months, and several times (monthly to quarterly) between 6 months and 1 year posttransplant. Surveillance biopsies may also be performed after the first postoperative year (eg, on a quarterly or semiannual basis). This practice, although common, has not been demonstrated to improve transplant outcomes. Some centers no longer routinely perform endomyocardial biopsies after 1 year in patients who are clinically stable.

While the endomyocardial biopsy is the criterion standard for assessing heart transplant rejection, it is limited by a high degree of interobserver variability in the grading of results and potential morbidity that can occur with the biopsy procedure. Also, the severity of rejection may not always coincide with the grading of the rejection by biopsy. Finally, a biopsy cannot be used to identify patients at risk of rejection, limiting the ability to initiate therapy to interrupt the development of rejection. For these reasons, an endomyocardial biopsy is considered a flawed criterion standard by many. Therefore, noninvasive methods of detecting cellular rejection have been explored. It is hoped that noninvasive tests will assist in determining appropriate patient management and avoid overuse or underuse of treatment with steroids and other immunosuppressants that can occur with false-negative and false-positive biopsy reports. Two techniques are commercially available for the detection of heart transplant rejection.

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## **Noninvasive Heart Transplant Rejection Tests**

### **Heartsbreath Test**

The Heartsbreath test, a noninvasive test that measures breath markers of oxidative stress, has been developed to assist in the detection of heart transplant rejection. In heart transplant recipients, oxidative stress appears to accompany allograft rejection, which degrades membrane polyunsaturated fatty acids and evolving alkanes and methylalkanes that are, in turn, excreted as volatile organic compounds in breath. The Heartsbreath test analyzes the breath methylated alkane contour, which is derived from the abundance of C4 to C20 alkanes and monomethylalkanes and has been identified as a marker to detect grade 3 (clinically significant) heart transplant rejection.

### **AlloMap**

Another approach has focused on patterns of gene expression of immunomodulatory cells, as detected in the peripheral blood. For example, microarray technology permits the analysis of the expression of thousands of genes, including those with functions known or unknown. Patterns of gene expression can then be correlated with known clinical conditions, permitting a selection of a finite number of genes to compose a custom multigene test panel, which then can be evaluated using polymerase chain reaction techniques. AlloMap is a commercially available molecular expression test that has been developed to detect acute heart transplant rejection or the development of graft dysfunction. The test involves polymerase chain reaction–expression measurement of a panel of genes derived from peripheral blood cells and applies an algorithm to the results. The proprietary algorithm produces a single score that considers the contribution of each gene in the panel. The score ranges from 0 to 40. The AlloMap website states that a lower score indicates a lower risk of graft rejection; the website does not cite a specific cutoff for a positive test. All AlloMap testing is performed at the CareDx reference laboratory in California.

### **Presage ST2 Assay**

In addition to its use as a potential aid to predict prognosis and manage therapy of heart failure, elevated serum ST2 levels have also been associated with increased risk of antibody-mediated rejection following heart transplant. For this reason, ST2 has also been proposed as a prognostic marker post heart transplantation and as a test to predict acute cellular rejection (graft-versus-host disease). The Presage ST2 Assay, described above, is a commercially available sST2 test that has been investigated as a biomarker of heart transplant rejection.

### **myTAIHEART Biomarker**

Using proprietary myTAIHEART software, the myTAIHEART test uses multiplexed, high-fidelity amplification followed by allele-specific qPCR of a panel of 94 highly informative bi-allelic single nucleotide polymorphisms (SNPs) and two controls to quantitatively genotype cell free DNA in the patient's plasma after cardiac transplant, and accurately distinguish “donor specific” cell free DNA originating from the engrafted heart from “self-specific” cell free DNA originating from the recipient's native cells. The ratio of donor specific cell free DNA to total cell free DNA is reported as the donor fraction (%) and categorizes the patient as at low or increased risk of moderate (grade 2R) to severe (grade 3R) acute cellular rejection: low

donor fractions indicate less damage to the transplanted heart and a lower risk for rejection, while increased donor fractions indicate more damage to the transplanted heart and an increased risk for rejection. Testing with myTAIHEART does not require a donor specimen. The test is indicated for use in heart transplant recipients who are 2 months of age or older and  $\geq 8$  days post-transplant, restricted to use in single organ post-heart transplant patients, and is contraindicated in patients who:

- are pregnant
- currently have or in the past have had another transplanted organ (solid organ or allogeneic bone marrow)
- have post-transplant lymphoproliferative disease
- have cancer or have had cancer within the previous 2 years
- are on mechanical circulatory support
- are closely related to the transplant donor

Other laboratory-tested biomarkers of heart transplant rejection have been evaluated. They include brain natriuretic peptide, troponin, and soluble inflammatory cytokines. Most have had low accuracy in diagnosing rejection. Preliminary studies have evaluated the association between heart transplant rejection and micro-RNAs or high-sensitivity cardiac troponin in cross-sectional analyses but the clinical use has not been evaluated.

## **RENAL TRANSPLANT REJECTION**

Allograft dysfunction is typically asymptomatic and has a broad differential, including graft rejection. Diagnosis and rapid treatment are recommended to preserve graft function and prevent loss of the transplanted organ. For a primary kidney transplant, graft survival at 1 year is 94.7%; at 5 years, graft survival is 78.6%.

Surveillance of transplant kidney function relies on routine monitoring of serum creatinine, urine protein levels, and urinalysis. Allograft dysfunction may also be demonstrated by a drop in urine output or, rarely, as pain over the transplant site. With clinical suspicion of allograft dysfunction, additional noninvasive workup including ultrasonography or radionuclide imaging may be used. A renal biopsy allows a definitive assessment of graft dysfunction and is typically a percutaneous procedure performed with ultrasonography or computed tomography guidance. Biopsy of a transplanted kidney is associated with fewer complications than biopsy of a native kidney because the allograft is typically transplanted more superficially than a native kidney. Renal biopsy is a low-risk invasive procedure that may result in bleeding complications; loss of a renal transplant, as a complication of renal biopsy, is rare.

Kidney biopsies allow for diagnosis of acute and chronic graft rejection, which may be graded using the Banff Classification. Pathologic assessment of biopsies demonstrating acute rejection allows clinicians to further distinguish between acute cellular rejection and antibody-mediated rejection, which are treated differently.

## **NONINVASIVE RENAL TRANSPLANT REJECTION TESTS**

### **AlloSure**

Cell-free DNA (cfDNA), released by damaged cells, is normally present in healthy individuals. In patients who have received transplants, donor-derived cfDNA (dd-cfDNA) may be also present. It is proposed that allograft rejection, which is associated with damage to transplanted cells, may result in an increase in ddcfDNA. AlloSure is a commercially available, next-generation sequencing assay that quantifies the fraction of dd-cfDNA in renal transplant recipients, relative to total cfDNA, by measuring 266 single nucleotide variants. Separate genotyping of the donor or recipient is not required, but patients who receive a kidney transplant from a monozygotic (identical) twin are not eligible for this test. The fraction of dd-cfDNA relative to total cfDNA present in the peripheral blood sample is cited in the report.

For individuals who have chronic heart failure who receive the sST2 assay to determine prognosis and/or to guide management, the evidence includes correlational studies and 2 meta-analyses. Relevant outcomes are

overall survival, quality of life, and hospitalization. Most of the evidence is from reanalysis of existing randomized controlled trials and not from studies specifically designed to evaluate the predictive accuracy of sST2, and prospective and retrospective cross-sectional studies made up a large part of 1 meta-analysis. Studies have mainly found that elevated sST2 levels are statistically associated with elevated risk of mortality. A pooled analysis of study results found that sST2 significantly predicted overall mortality and cardiovascular mortality. Several studies, however, found that sST2 test results did not provide additional prognostic information compared with N-terminal pro B-type natriuretic peptide levels. Moreover, no comparative studies were identified on the use of the sST2 assay to guide management of patients diagnosed with chronic heart failure. The evidence is insufficient to determine the effects of the technology on health outcomes. For individuals who have heart transplantation who receive sST2 assay to determine prognosis and/or to predict acute cellular rejection, the evidence includes a small number of retrospective observational studies on the Presage ST2 Assay. Relevant outcomes are overall survival, morbid events, and hospitalization. No prospective studies were identified that provide high-quality evidence on the ability of sST2 to predict transplant outcomes. One retrospective study (n = 241) found that sST2 levels were associated with acute cellular rejection and mortality; another study (n = 26) found that sST2 levels were higher during an acute rejection episode than before rejection. The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals who have heart transplantation who receive myTAIHEART assay to determine acute cellular rejection, the evidence includes observational studies. A validation study using 158 matched endomyocardial biopsy-plasma pairs from 76 pediatric and adult heart transplant recipients (ages 2 months or older, and 8 days more post-transplant) found a donor-specific fraction cutoff (0.32%) that produced a 100% negative predictive value for Grade 2 or higher acute cellular rejection. A prospective observational blinded study (n=174; pediatric=101, adult=73) using biopsy-paired samples found that myTAIHEART level was associated with acute cellular and antibody-mediated rejection in both adult and pediatric heart transplant populations, and that an optimal donor fraction threshold (0.3%) ruled out the presence of either acute cellular rejection or antibody-mediated rejection. Both studies received industry funding. The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals who have a heart transplant who receive measurement of volatile organic compounds to assess cardiac allograft rejection, the evidence includes a diagnostic accuracy study. Relevant outcomes are overall survival, test validity, morbid events, and hospitalizations. The published study found that, for identifying grade 3 (now grade 2R) rejection, the negative predictive value of the breath test the study evaluated (97.2%) was similar to endomyocardial biopsy (96.7%) and the sensitivity of the breath test (78.6%) was better than that for biopsy (42.4%). However, the breath test had a lower specificity (62.4%) and a lower positive predictive value (5.6%) in assessing grade 3 rejection than a biopsy (specificity, 97%; positive predictive value, 45.2%). The breath test was also not evaluated for grade 4 rejection. This single study is not sufficient to determine the clinical validity of the test measuring volatile organic compounds and no studies on clinical utility were identified. The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals who have a heart transplant who receive gene expression profiling (GEP) to assess cardiac allograft rejection, the evidence includes 2 diagnostic accuracy studies and several randomized controlled trials evaluating clinical utility. Relevant outcomes are overall survival, test validity, morbid events, and hospitalizations. The 2 studies, Cardiac Allograft Rejection Gene Expression Observation (CARGO, CARGO II) examining the diagnostic performance of GEP for detecting moderate-to-severe rejection lacked a consistent threshold for defining a positive GEP test (ie, 20, 30, or 34) and reported a low number of positive cases. In the available studies, although the negative predictive values were relatively high (ie, at least 88%), the performance characteristics were only calculated based on 10 or fewer cases of rejection; therefore, performance data may be imprecise. Moreover, the positive predictive value in CARGO II was only 4.0% for patients who were at least 2 to 6 months posttransplant and 4.3% for patients more than 6 months posttransplant. The threshold indicating a positive test that seems to be currently accepted (a score of 34) was not prespecified; rather it evolved partway through the data collection period in the Invasive Monitoring

Attenuation through Gene Expression (IMAGE) study. In addition, the IMAGE study had several methodologic limitations (eg, lack of blinding); further, the IMAGE study failed to provide evidence that GEP offers incremental benefit over biopsy performed on the basis of clinical exam or echocardiography. Patients at the highest risk of transplant rejection are patients within 1 year of the transplant, and, for that subset, there remains insufficient data on which to evaluate the clinical utility of GEP. The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals with a renal transplant and clinical suspicion of allograft rejection who receive testing of dd-cfDNA to assess renal allograft rejection, the evidence includes small diagnostic accuracy studies. Relevant outcomes are OS, test validity, morbid events, and hospitalizations. One study examined the diagnostic performance of dd-cfDNA for detecting moderate-to-severe rejection; the NPV was moderately high (84%), and performance characteristics were calculated on 27 cases of active transplant rejection. The threshold indicating a positive test was not prespecified. A subsequent smaller single-center study that explored variation in clinical validity based on different rejection mechanisms found the strongest performance characteristics for AlloSure with antibody-mediated rejection. The evidence is insufficient to determine the effects of the technology on health outcomes.

### **Medicare Advantage Plans**

AlloMap®, an In Vitro Diagnostic Multivariate Index assay (IVDMIA) test service performed in a single laboratory, is FDA approved to aid in the identification of heart transplant recipients with stable allograft function who have a low probability of moderate/severe acute cellular rejection (ACR) at the time of testing in conjunction with standard clinical assessment.

AlloMap® is marketed by CareDx® for cardiac transplantation as a noninvasive means to assess allograft rejection status. AlloMap® has been characterized as a “rule-out” test for rejection that can be complemented by a cell-free DNA “rule-in” test. The utility of the combination of these 2 tests when used together was assessed and found that together these tests enhance the accuracy of assessing rejection status than either test alone.

A test that is able to provide information that will help to inform immunosuppression and rejection management while avoiding an invasive procedure and potentially expanding access to care has clinical utility.

The premise for AlloSure® is that rejection entails injury, including increased cell death in the allograft, leading to increased donor-derived cell-free DNA (dd-cfDNA) released into the bloodstream. The AlloSure® test for dd-cfDNA detected in the blood of transplant recipients has been developed as a noninvasive marker for diagnosis of graft rejection. The AlloSure® assay is a targeted next-generation sequencing assay that uses 266 single-nucleotide polymorphisms (SNPs) to accurately quantify dd-cfDNA in transplant recipients without separate genotyping of donor or recipient.<sup>7</sup> The assay quantifies the fraction of dd-cfDNA in both unrelated and related donor-recipient pairs and can be completed within 3 days of peripheral blood collection, a practical turnaround time for management of transplant recipients. AlloSure® assay results are reported as the percentage of dd-cfDNA in total cfDNA.

It is well accepted within the renal and cardiac transplant communities that immunosuppression management is an important component of post-transplant care to both optimize graft longevity while avoiding side effects and toxicity of immunosuppressive therapies. Graft assessment is an important decision tool used to help clinicians optimize immunosuppressive treatment. The gold standard for assessing rejection or a solid organ allograft rejection or injury has historically and remains a biopsy in conjunction with serologic criteria. However, given the invasive nature and risks associated with a biopsy, tests that can potentially mitigate the need for a biopsy while still providing clinicians with actionable information that can be used to help optimize immunosuppressive therapy are reasonable and necessary. Thus there is adequate evidence to support that the AlloSure® assay when used in combination provides incremental information to change clinician management in a way that will be expected to improve outcomes.

## CODING

The following CPT code is covered for Medicare Advantage Plans and not medically necessary for Commercial Products.

This code can be used for AlloMap:

**81595** Cardiology (heart transplant), mRNA, gene expression profiling by real-time quantitative PCR of 20 genes (11 content and 9 housekeeping), utilizing subfraction of peripheral blood, algorithm reported as a rejection risk score

The following CPT codes are not covered for Medicare Advantage Plans and not medically necessary for Commercial Products.

This code can be used for Presage® ST2 Assay:

**83006** Growth stimulation expressed gene 2 (ST2, Interleukin 1 receptor like-1)

This code can be used for myTAIHEART:

**0055U** Cardiology (heart transplant), cell-free DNA, PCR assay of 96 DNA target sequences (94 single nucleotide polymorphism targets and two control targets), plasma

There is no specific CPT code for AlloSure Heart or AlloSure Kidney, therefore Unlisted CPT code 81479 should be used. CPT code 81479 requires prior authorization for Medicare Advantage Plans and Commercial Products.

Effective 1/1/2021, there is no specific CPT code for the Heartsbreath test. Therefore, the most appropriate Unlisted CPT code should be used. For claims filed for dates of service prior to 1/1/2021 the following CPT code can be used:

**0085T** Breath test for heart transplant rejection

## RELATED POLICIES

Genetic Testing Services

Proprietary Laboratory Analyses (PLA)

## PUBLISHED

Provider Update, April 2021

Provider Update, June 2020

Provider Update, April 2019

## REFERENCES

1. Centers for Medicare& Medicaid Services. Local Coverage Determination (LCD): MolDX: Molecular Diagnostic Tests (MDT) (L35160)
2. Centers for Medicare& Medicaid Services. Local Coverage Article: Billing and Coding: MolDx: AlloMap (A54364)
3. Centers for Medicare& Medicaid Services. Local Coverage Determination (LCD): MolDX: Allosure® or Equivalent Cell-Free DNA Testing for Kidney and Heart Allografts (L38355)
4. Centers for Medicare& Medicaid Services. Local Coverage Article: Billing and Coding: MolDX: Allosure® or Equivalent Cell-Free DNA Testing for Kidney and Heart Allografts (A57380)
5. Centers for Medicare& Medicaid Services. National Coverage Determination (NCD) for HEARTSBREATH Test for Heart Transplant Rejection (260.10)
6. Yancy CW, Jessup M, Bozkurt B, et al. 2013 ACCF/AHA guideline for the management of heart failure: a report of the American College of Cardiology Foundation/American Heart Association Task Force on Practice Guidelines. J Am Coll Cardiol. Oct 15 2013; 62(16): e147-239. PMID 23747642

7. Roger VL, Go AS, Lloyd-Jones DM, et al. Heart disease and stroke statistics--2011 update: a report from the American Heart Association. *Circulation*. Feb 01 2011; 123(4): e18-e209. PMID 21160056
8. Virani SS, Alonso A, Benjamin EJ, et al. Heart Disease and Stroke Statistics-2020 Update: A Report From the American Heart Association. *Circulation*. Mar 03 2020; 141(9): e139-e596. PMID 31992061
9. Rohde LE, Beck-da-Silva L, Goldraich L, et al. Reliability and prognostic value of traditional signs and symptoms in outpatients with congestive heart failure. *Can J Cardiol*. May 15 2004; 20(7): 697-702. PMID 15197422
10. Marcus GM, Gerber IL, McKeown BH, et al. Association between phonocardiographic third and fourth heart sounds and objective measures of left ventricular function. *JAMA*. May 11 2005; 293(18): 2238-44. PMID 15886379
11. Stevenson LW, Perloff JK. The limited reliability of physical signs for estimating hemodynamics in chronic heart failure. *JAMA*. Feb 10 1989; 261(6): 884-8. PMID 2913385
12. Gaggin HK, Januzzi JL. Biomarkers and diagnostics in heart failure. *Biochim Biophys Acta*. Dec 2013; 1832(12): 2442-50. PMID 23313577
13. McMurray JJ, Adamopoulos S, Anker SD, et al. ESC guidelines for the diagnosis and treatment of acute and chronic heart failure 2012: The Task Force for the Diagnosis and Treatment of Acute and Chronic Heart Failure 2012 of the European Society of Cardiology. Developed in collaboration with the Heart Failure Association (HFA) of the ESC. *Eur J Heart Fail*. Aug 2012; 14(8): 803-69. PMID 22828712
14. Lindenfeld J, Albert NM, Boehmer JP, et al. HFSA 2010 Comprehensive Heart Failure Practice Guideline. *J Card Fail*. Jun 2010; 16(6): e1-194. PMID 20610207
15. Savarese G, Trimarco B, Dellegrattaglia S, et al. Natriuretic peptide-guided therapy in chronic heart failure: a meta-analysis of 2,686 patients in 12 randomized trials. *PLoS One*. 2013; 8(3): e58287. PMID 23472172
16. Troughton RW, Frampton CM, Brunner-La Rocca HP, et al. Effect of B-type natriuretic peptide-guided treatment of chronic heart failure on total mortality and hospitalization: an individual patient meta-analysis. *Eur Heart J*. Jun 14 2014; 35(23): 1559-67. PMID 24603309
17. Bhardwaj A, Januzzi JL. ST2: a novel biomarker for heart failure. *Expert Rev Mol Diagn*. May 2010; 10(4): 459-64. PMID 20465500
18. Chowdhury P, Kehl D, Choudhary R, et al. The use of biomarkers in the patient with heart failure. *Curr Cardiol Rep*. Jun 2013; 15(6): 372. PMID 23644993
19. Ciccone MM, Cortese F, Gesualdo M, et al. A novel cardiac bio-marker: ST2: a review. *Molecules*. Dec 11 2013; 18(12): 15314-28. PMID 24335613
20. Daniels LB, Bayes-Genis A. Using ST2 in cardiovascular patients: a review. *Future Cardiol*. Jul 2014; 10(4): 525-39. PMID 25301315
21. Dieplinger B, Mueller T. Soluble ST2 in heart failure. *Clin Chim Acta*. Mar 30 2015; 443: 57-70. PMID 25269091
22. Mueller T, Dieplinger B. The Presage((R)) ST2 Assay: analytical considerations and clinical applications for a high-sensitivity assay for measurement of soluble ST2. *Expert Rev Mol Diagn*. Jan 2013; 13(1): 13-30. PMID 23256700
23. Shah RV, Januzzi JL. ST2: a novel remodeling biomarker in acute and chronic heart failure. *Curr Heart Fail Rep*. Mar 2010; 7(1): 9-14. PMID 20425491
24. Xu D, Chan WL, Leung BP, et al. Selective expression of a stable cell surface molecule on type 2 but not type 1 helper T cells. *J Exp Med*. Mar 02 1998; 187(5): 787-94. PMID 9480988
25. Weinberg EO, Shimpo M, De Keulenaer GW, et al. Expression and regulation of ST2, an interleukin-1 receptor family member, in cardiomyocytes and myocardial infarction. *Circulation*. Dec 03 2002; 106(23): 2961-6. PMID 12460879
26. Stewart S, Winters GL, Fishbein MC, et al. Revision of the 1990 working formulation for the standardization of nomenclature in the diagnosis of heart rejection. *J Heart Lung Transplant*. Nov 2005; 24(11): 1710-20. PMID 16297770
27. CareDx. Overview: AlloMap Testing: Answering Unmet Needs in Heart Transplant Surveillance. n.d.; <http://www.allomap.com/providers/overview/>. Accessed August 31, 2020.
28. North PE, Ziegler E, Mahnke DK, et al. Cell-free DNA donor fraction analysis in pediatric and adult heart transplant patients by multiplexed allele-specific quantitative PCR: Validation of a rapid and highly

sensitive clinical test for stratification of rejection probability. PLoS One. 2020; 15(1): e0227385. PMID 31929557

29. Duong Van Huyen JP, Tible M, Gay A, et al. MicroRNAs as non-invasive biomarkers of heart transplant rejection. Eur Heart J. Dec 01 2014; 35(45): 3194-202. PMID 25176944
30. Patel PC, Hill DA, Ayers CR, et al. High-sensitivity cardiac troponin I assay to screen for acute rejection in patients with heart transplant. Circ Heart Fail. May 2014; 7(3): 463-9. PMID 24733367
31. Organ Procurement and Transplantation Network. National Data. 2018; <https://optn.transplant.hrsa.gov/data/view-data-reports/national-data/#>. Accessed August 31, 2020.

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