

# CONCERT GENETIC TESTING: IMMUNE, AUTOIMMUNE, AND RHEUMATOID DISORDERS

---

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

## OVERVIEW

Immunodeficiency disorders typically result from the use of a drug or from a long-lasting significant disorder (e.g., cancer), however a subset of immunodeficiency disorders are inherited. Immunodeficiency disorders impair the immune system's ability to defend the body against foreign substances, such as bacteria, viruses, and cancer cells. As a result, infections or cancers can develop. Individuals with immunodeficiency can also have an autoimmune disorder, such as rheumatoid arthritis.

There are two types of immunodeficiency disorders: primary and secondary. Primary disorders are relatively rare and usually present at birth, genetic in origin, and hereditary; however, some primary immunodeficiency disorders are not recognized until adulthood. Secondary disorders are more common and generally develop later in life as a result of the use of certain drugs or from conditions such as diabetes or HIV infection.

## POLICY REFERENCE TABLE

Below is a list of higher volume tests and the associated laboratories for each coverage criteria section. This list is not all inclusive.

### Coding Implications

This clinical policy references Current Procedural Terminology (CPT<sup>®</sup>). CPT<sup>®</sup> is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2022, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for

informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

<a href="#">Coverage Criteria Sections</a>	Example Tests (Labs)	Common CPT Codes	Common ICD Codes	<a href="#">Ref</a>
<b><a href="#">Known Familial Variant Analysis for Immune, Autoimmune, and Rheumatoid Disorders</a></b>				
<a href="#">Known Familial Variant Analysis for Immune, Autoimmune, and Rheumatoid Disorders</a>	Targeted Mutation Analysis for a Known Familial Variant	81403		12
<b><a href="#">Periodic Fever Syndromes</a></b>				
<a href="#">Periodic Fever Syndromes Multigene Panel</a>	Periodic Fever Syndromes Panel (Invitae)	81404, 81479	M04.1, R50.9, A68.9	11
	Periodic Fever Syndromes Panel (PreventionGenetics)			
	Periodic Fever Syndromes Panel (7 genes) (GeneDx)			
<b><a href="#">Rheumatoid Arthritis Biomarker Activity Panels</a></b>				
<a href="#">Rheumatoid Arthritis Biomarker Activity Panels</a>	Vectra® (LabCorp)	81490	M05.00 through M06.9	1, 2
	Vectra® with CV Risk (LabCorp)			
<b><a href="#">Genetic Algorithmic Rheumatoid Arthritis Tests</a></b>				
<a href="#">Genetic Rheumatoid Arthritis for Tumor Necrosis Factor inhibitor (TNFi) Treatment</a>	PrismRA (Scipher Medicine)	81599, 81479	M05, M06, M08	10
<b><a href="#">HLA Typing for Ankylosing Spondylitis, Rheumatoid Arthritis, and Autoimmune Disorders</a></b>				
<a href="#">HLA Typing for Ankylosing Spondylitis, Rheumatoid Arthritis,</a>	HLA-B27 DNA Typing (Quest Diagnostics)	81374	M04.8, M04.9, M05, M06, M45	7, 8, 9
	HLA-B51 Behcet’s Disease Association Test (Quest Diagnostics)			

<a href="#">and Autoimmune Disorders</a>	HLA DRB1 Typing, High Resolution (Quest Diagnostics)	81382		
<b><a href="#">Other Covered Immune, Autoimmune, and Rheumatoid Disorders</a></b>				
<a href="#">Other Covered Immune Disorders</a>	See below	81400 through 81408		3, 4, 5, 6

## OTHER RELATED POLICIES

This policy document provides coverage criteria for Genetic Testing for Immune, Autoimmune, and Rheumatoid Disorders. Please refer to:

- ***Genetic Testing: Multisystem Inherited Disorders, Intellectual Disability, and Developmental Delay*** for coverage criteria related to genetic disorders that affect multiple organ systems
- ***Genetic Testing: General Approach to Genetic Testing*** for coverage criteria related to immune disorders not specifically addressed in the policy reference table.

## CRITERIA

It is the policy of health plans affiliated with Centene Corporation® that the specific genetic testing noted below is **medically necessary** when meeting the related criteria:

### KNOWN FAMILIAL VARIANT ANALYSIS FOR IMMUNE, AUTOIMMUNE, AND RHEUMATOID DISORDERS

- I. Targeted mutation analysis for a known familial variant (81403) for an immune, autoimmune, and rheumatoid disorder is considered **medically necessary** when:
  - A. The member/enrollee has a [close relative](#) with a known pathogenic or likely pathogenic variant causing the condition.
- II. Targeted mutation analysis for a known familial variant (81403) for an immune, autoimmune, and rheumatoid disorder is considered **investigational** for all other indications.

[back to top](#)

## PERIODIC FEVER SYNDROME

### Periodic Fever Syndromes Multigene Panel

- I. Genetic testing for periodic fever syndromes, also called hereditary recurrent fever syndromes, (e.g., Familial Mediterranean Fever, tumor necrosis factor receptor-associated periodic fever [TRAPS]) via multigene panel (81404, 81479) is considered **medically necessary** when:
  - A. The member/enrollee has three or more episodes of [unexplained fever](#) in a six-month period, occurring at least seven days apart, **AND**
  - B. Common causes of fever have been ruled out, including viral or bacterial infection.
- II. Genetic testing for periodic fever syndromes, also called hereditary recurrent fever syndromes, (e.g., Familial Mediterranean Fever, tumor necrosis factor receptor-associated periodic fever [TRAPS]) via multigene panel (81404, 81479) is considered **investigational** for all other indications.

[back to top](#)

## RHEUMATOID ARTHRITIS BIOMARKER ACTIVITY PANELS

### Rheumatoid Arthritis Biomarker Activity Panels

- I. The use of [multibiomarker disease](#) activity scores for rheumatoid arthritis (81490) is considered **investigational**.

[back to top](#)

## GENETIC ALGORITHMIC RHEUMATOID ARTHRITIS TESTS

### Tumor Necrosis Factor Inhibitor (TNFi) Treatment

- I. The use of genetic algorithmic rheumatoid arthritis tests to determine appropriateness of TNFi treatment (ie, PrismRA) (81599, 81479) is considered **investigational**.

[back to top](#)

## **HLA TYPING FOR ANKYLOSING SPONDYLITIS, RHEUMATOID ARTHRITIS, AND AUTOIMMUNE DISORDERS**

- I. The use of HLA-B27 typing (81374, 81382) to confirm or establish the diagnosis of ankylosing spondylitis, or another spondyloarthropathies, is considered **medically necessary** when:
  - A. The member/enrollee has clinical or radiographic features of ankylosing spondylitis, or another spondyloarthropathy, **AND**
  - B. HLA-B27 results are needed to establish a diagnosis of ankylosing spondylitis, or another spondyloarthropathy.
- II. The use of HLA typing (81374, 81382) for ankylosing spondylitis, rheumatoid arthritis, and autoimmune disorders is considered **investigational** for all other indications.

[back to top](#)

## **OTHER COVERED IMMUNE, AUTOIMMUNE, AND RHEUMATOID DISORDERS**

The following is a list of conditions that have a known genetic association. Due to their relative rareness, it may be appropriate to cover these genetic tests to establish or confirm a diagnosis.

- I. Genetic testing to establish or confirm one of the following immune, autoimmune, or rheumatoid disorders to guide management is considered **medically necessary** when the member/enrollee demonstrates clinical features\* consistent with the disorder (the list is not meant to be comprehensive, see II below):
  - A. [Agammaglobulinemia: X-Linked and Autosomal Recessive](#)
  - B. [Autoimmune Lymphoproliferative Syndrome \(ALPS\)](#)
  - C. [Chronic Granulomatous Disease \(CGD\)](#)
  - D. Common Variable Immune Deficiency (CVID)
  - E. Complement Deficiencies
  - F. Congenital Neutropenia Syndromes (e.g., *ELANE*-Related Neutropenia)
  - G. Familial Hemophagocytic Lymphohistiocytosis (HLH)

- H. [Hyper IgE Syndrome \(HIES\)](#)
  - I. [Hyper IgM Syndromes](#)
  - J. Leukocyte Adhesion Deficiency (LAD)
  - K. NEMO Deficiency Syndrome
  - L. [Severe Combined Immune Deficiency \(SCID\) and Combined Immune Deficiency](#)
  - M. WHIM Syndrome (Warts, Hypogammaglobulinemia, Infections, and Myelokathexis)
  - N. [Wiskott-Aldrich Syndrome](#)
- II. Genetic testing to establish or confirm the diagnosis of all other immune, autoimmune, or rheumatoid disorders not specifically discussed within this or another medical policy will be evaluated by the criteria outlined in *General Approach to Genetic Testing* (see policy for coverage criteria).

\*Clinical features for a specific disorder may be outlined in resources such as [GeneReviews](#), [OMIM](#), [National Library of Medicine](#), [Genetics Home Reference](#), or other scholarly source.

[back to top](#)

## NOTES AND DEFINITIONS

1. **Close relatives** include first, second, and third degree blood relatives on the same side of the family:
  - a. **First-degree relatives** are parents, siblings, and children
  - b. **Second-degree relatives** are grandparents, aunts, uncles, nieces, nephews, grandchildren, and half siblings
  - c. **Third-degree relatives** are great grandparents, great aunts, great uncles, great grandchildren, and first cousins
2. **Multibiomarker disease activity (MBDA)** tests for rheumatoid arthritis are an approach that uses serum biomarkers to measure rheumatoid arthritis disease activity.
3. **Unexplained fever** (or fever of unknown origin [FUO]) is defined as a temperature higher than 38.3 C (100.9 F) that lasts for more than three weeks with no obvious source despite appropriate investigation. The four categories of potential etiology of FUO are classic, nosocomial, immune deficient, and human immunodeficiency virus-related. The four subgroups of the differential diagnosis of FUO are infections, malignancies, autoimmune conditions, and miscellaneous.

[back to top](#)

## **BACKGROUND AND RATIONALE**

### **Known Familial Variant Analysis for Immune, Autoimmune, and Rheumatoid Disorders**

#### *Genetic Support Foundation*

The Genetic Support Foundation’s Genetics 101 information on inheritance patterns says the following about testing for familial pathogenic variants:

Genetic testing for someone who may be at risk for an inherited disease is always easier if we know the specific genetic cause. Oftentimes, the best way to find the genetic cause is to start by testing someone in the family who is known or strongly suspected to have the disease. If their testing is positive, then we can say that we have found the familial pathogenic (harmful) variant. We can use this as a marker to test other members of the family to see who is also at risk.

### **Periodic Fever Syndromes Multigene Panel**

#### *Soon and Laxer (2017)*

A 2017 clinical review by Soon and Laxer addressing recurrent fever in childhood stated the following: “Recurrent or periodic fever syndromes are defined by 3 or more episodes of unexplained fever in a 6-month period, occurring at least 7 days apart.” (page 756) The authors recommend that: “Once infections, immunodeficiency, malignancy, inflammatory bowel disease, and adverse drug reactions have been ruled out, autoinflammatory diseases—including periodic fever syndromes—should be considered.” (p. 758)

### **Rheumatoid Arthritis Biomarker Activity Panels**

#### *American College of Rheumatology*

In its 2019 guidelines on the treatment of rheumatoid arthritis, The American College of Rheumatology updated guidelines on the treatment of rheumatoid arthritis (2019). In this update, the following 11 measures of disease activity were identified as fulfilling a minimum standard for regular use in most clinical settings:

Disease Activity Score (DAS)

Routine Assessment of Patient Index Data 3 (RAPID3)  
Routine Assessment of Patient Index Data 5 (RAPID5)  
Clinical Disease Activity Index (CDAI)  
Disease Activity Score with 28 joints (DAS28-ESR/CRP)  
Patient Derived DAS28, Hospital Universitario La Princesa Index (HUPI)  
Multibiomarker Disease Activity Score (MBDA score, Vectra DA)  
Rheumatoid Arthritis Disease Activity Index (RADAI)  
Rheumatoid Arthritis Disease Activity Index 5 (RADAI-5)  
Simplified Disease Activity Index (SDAI)

Although the original Vectra DA test is included in this list, the current commercially available version of the test that is now called Vectra, which includes the leptin-adjusted MBDA score (now called the "adjusted MBDA score") that was not addressed in the 2019 ACR guideline. This is because evidence on Vectra with the adjusted MBDA score was published subsequent to the ACR review end date.

*ter Haar, et. al 2015*

An expert committee of pediatric and adult rheumatologists convened and created a set of recommendations for the management of autoinflammatory disease, using the European League Against Rheumatism standard operating procedure, that included the following regarding genetic evaluation:

- Management of patients with AID should ideally be guided by a multidisciplinary team in a tertiary centre with expertise in AID, with access to genetic counselling (Expert opinion, based on level 4 evidence). (p. 1637)

### **Genetic Algorithmic Rheumatoid Arthritis Tests - Genetic Rheumatoid Arthritis for Tumor Necrosis Factor Inhibitor (TNFi) Treatment**

Neither the 2015 nor the 2021 recommendations for the treatment of rheumatoid arthritis by the American College of Rheumatology include recommendations for genetic testing to determine the effectiveness of TNFi therapy. The peer-reviewed published clinical utility studies show there is the possibility of management changes and improved outcomes based on results of PrismRA. However, these studies have flaws, such as concern for investigator group bias, lack of blinding that could affect results, and only a single study that provides real world evidence showing changed management based on PrismRA results alone.

At the present time, Genetic Algorithmic Rheumatoid Arthritis Tests for Anti-Tumor Necrosis Factor Inhibitor (TNFi) Treatment tests such as PrismRA have insufficient evidence in peer-



reviewed publications to effectively result in improved health outcomes compared to the current standard of care.

## **HLA Typing for Ankylosing Spondylitis, Rheumatoid Arthritis, and Autoimmune Disorders**

*Rudwaleit et al 2009*

“Refinement of the candidate criteria resulted in new ASAS [Assessment of SpondyloArthritis International Society] classification criteria that are defined as: the presence of sacroiliitis by radiography or by magnetic resonance imaging (MRI) plus at least one SpA feature ("imaging arm") or the presence of HLA-B27 plus at least two SpA features ("clinical arm").” (p. 777)

*Akgul and Ozgocmen, 2011*

“HLA B-27 positivity is extremely relevant to the early diagnosis of SpA [spondyloarthropathies]. Five to 10% of the population are HLA B-27 positive and in patients with AS [ankylosing spondylitis] and SpA the positivity of HLA B-27 changes to 70% to 95% and nearly 70%, respectively.” (p. 109)

*Yu and van Tubergen, UpToDate, 2020*

“HLA-B27 can be useful to increase the confidence of a diagnosis of axSpA [axial spondyloarthritis] in patients in whom plain radiographs or magnetic resonance imaging (MRI) also exhibit abnormalities consistent with axSpA. HLA-B27 can also be used as a screening tool in primary care in patients presenting with chronic back pain or IBP [inflammatory back pain] suspected by the primary clinician as having a significant probability for axSpA, depending upon the availability and the costs of local HLA-B27 testing. Several diagnostic criteria sets include HLA-B27, including the Amor criteria, and ASAS [Assessment of SpondyloArthritis International Society] axial and peripheral spondyloarthritis criteria.”

[back to top](#)

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Policy developed	03/23	03/23

## REFERENCES

1. England BR, Tjong BK, Bergman MJ, et al. 2019 Update of the American College of Rheumatology Recommended Rheumatoid Arthritis Disease Activity Measures. *Arthritis Care Res (Hoboken)*. 2019;71(12):1540-1555. doi:10.1002/acr.24042
2. ter Haar NM, Oswald M, Jeyaratnam J, et al. Recommendations for the management of autoinflammatory diseases. *Ann Rheum Dis*. 2015;74(9):1636-1644. doi:10.1136/annrheumdis-2015-207546
3. Immune Deficiency Foundation. “Specific PI Diagnoses”. 2020. <https://primaryimmune.org/specific-pi-diagnoses>. Accessed February 22, 2021.
4. Adam MP, Ardinger HH, Pagon RA, et al., editors. GeneReviews<sup>®</sup> [Internet]. Seattle (WA): University of Washington, Seattle; 1993-2023. Available from: <https://www.ncbi.nlm.nih.gov/books/NBK1116/>
5. Online Mendelian Inheritance in Man, OMIM<sup>®</sup>. McKusick-Nathans Institute of Genetic Medicine, Johns Hopkins University (Baltimore, MD). World Wide Web URL: <https://omim.org/>
6. MedlinePlus [Internet]. Bethesda (MD): National Library of Medicine (US). Available from: <https://medlineplus.gov/genetics/>.
7. Rudwaleit M, van der Heijde D, Landewe R, et al. The development of Assessment of SpondyloArthritis international Society classification criteria for axial spondyloarthritis (part II): validation and final selection. *Ann Rheum Dis*. Jun 2009;68(6):777-83. doi:10.1136/ard.2009.108233
8. Akgul O, Ozgocmen S. Classification criteria for spondyloarthropathies. *World J Orthop*. 2011;2(12):107-115. doi:10.5312/wjo.v2.i12.07
9. Yu D, van Tubergen A. Diagnosis and differential diagnosis of axial spondyloarthritis (ankylosing spondylitis and nonradiographic axial spondyloarthritis) in adults. In: Romain PL, ed. UpToDate. UpToDate; 2021. Accessed December 15, 2021. <https://uptodate.com/contents/diagnosis-and-differential-diagnosis-of-axial-spondyloarthritis-ankylosing-spondylitis-and-nonradiographic-axial-spondyloarthritis-in-adults>
10. Concert Genetics. Evidence Review for Coverage Determination for Genetic Algorithmic Rheumatoid Arthritis Tests for TNFi treatment. V1.2.2022
11. Soon GS, Laxer RM. Approach to recurrent fever in childhood. *Can Fam Physician*. 2017;63(10):756-762.
12. Genetic Support Foundation. Genetics 101 Inheritance Patterns: Familial Pathogenic Variant. Accessed 10/4/2022. <https://geneticsupportfoundation.org/genetics-101/#>

[back to top](#)

## **Important Reminder**

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited.

Providers, members/enrollees and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members/enrollees and their representatives agree to be bound by such terms and conditions by providing services to members/enrollees and/or submitting claims for payment for such services.

**Note: For Medicaid members/enrollees**, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

**Note: For Medicare members/enrollees**, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at <http://www.cms.gov> for additional information.

©2023 Centene Corporation. All rights reserved. All materials are exclusively owned by Centene Corporation and are protected by United States copyright law and international copyright law. No part of this publication may be reproduced, copied, modified, distributed, displayed, stored in a retrieval system, transmitted in any form or by any means, or otherwise published without the prior written permission of Centene Corporation. You may not alter or remove any trademark, copyright or other notice contained herein. Centene<sup>®</sup> and Centene Corporation<sup>®</sup> are registered trademarks exclusively owned by Centene Corporation.

