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Medical Benefit		Effective Date: 01/01/15	Next Review Date: 05/18
Preauthorization	Yes	Review Dates: 09/12, 09/13, 09/14, 09/15, 09/16, 05/17	

Preauthorization is required.

The following protocol contains medical necessity criteria that apply for this service. The criteria are also applicable to services provided in the local Medicare Advantage operating area for those members, unless separate Medicare Advantage criteria are indicated. If the criteria are not met, reimbursement will be denied and the patient cannot be billed. Please note that payment for covered services is subject to eligibility and the limitations noted in the patient's contract at the time the services are rendered.

Populations	Interventions	Comparators	Outcomes
Individuals: • With abnormal iron indices or clinical signs of iron overload	Interventions of interest are: • Genetic testing for hereditary hemochromatosis	Comparators of interest are: • Standard diagnostic workup without genetic testing	Relevant outcomes include: • Test accuracy • Test validity • Change in disease status
Individuals: • Who are asymptomatic with a first-degree relative with known hereditary hemochromatosis	Interventions of interest are: • Genetic testing for hereditary hemochromatosis	Comparators of interest are: • No testing	Relevant outcomes include: • Test accuracy • Test validity • Change in disease status
Individuals: • Who are asymptomatic, for general population screening	Interventions of interest are: • Genetic testing for hereditary hemochromatosis	Comparators of interest are: • No testing	Relevant outcomes include: • Test accuracy • Test validity • Change in disease status

Description

Hereditary hemochromatosis (HH), a common genetic disorder of iron metabolism, can lead to inappropriate iron absorption, toxic accumulation of iron, and organ damage. Genetic testing is available to assess mutations in the *HFE* gene, which are responsible for most clinically significant cases of hereditary hemochromatosis.

Summary of Evidence

The evidence for genetic testing for hereditary hemochromatosis (HH) in individuals who have abnormal iron indices, clinical signs of iron overload, or are first-degree relatives of persons with hereditary hemochromatosis includes studies of analytic validity and clinical validity. Relevant outcomes are test accuracy, test validity, and change in disease status. These studies have established high analytic validity of genetic testing. Studies have demonstrated that current genetic testing detects the large majority of HH disease, but that among those with positive tests (HH homozygotes), penetrance for clinical disease is low. There is no direct evidence of the clinical utility of genetic testing, but along with prior knowledge regarding the effectiveness of treatment for clinical iron overload, there is a strong chain of indirect evidence that supports definitive genetic diagnosis of persons with

early signs of HH and of first-degree relatives of persons with HH. The evidence is sufficient to determine qualitatively that the technology results in a meaningful improvement in the net health outcome.

The evidence for genetic testing for HH in individuals in the general population includes, in addition to the above studies of analytic and clinical validity, observational studies of screening in population samples. Relevant outcomes are test accuracy, test validity, and change in disease status. These studies establish population prevalence of genetic HH, and serve as partial evidence to estimate penetrance of disease. Results of these studies provide information regarding the chain of indirect evidence that might support general population screening. Low prevalence of HH homozygosity and incomplete penetrance of clinical disease do not support a chain of evidence that would support general population screening. The evidence is insufficient to determine the effects of the technology on health outcomes.

Policy

Genetic testing for *HFE* gene mutations may be considered **medically necessary** in a patient with abnormal serum iron indices indicating iron overload. (See Policy Guidelines)

Genetic testing for *HFE* gene mutations may be considered **medically necessary** in individuals with a family history of hemochromatosis in a first-degree relative. (See Policy Guidelines)

Genetic testing for hereditary hemochromatosis in screening of the general population is considered **investigational**.

Policy Guidelines

Serum Iron Indices in the Diagnosis of Hereditary Hemochromatosis

Elevated fasting transferrin saturation (the ratio of serum iron to total iron-binding capacity) is the most sensitive initial phenotypic screening test. A minimum cut-off value of 45% will detect almost all affected C282Y homozygotes.

Serum ferritin reflects body iron stores and generally rises later in the progression of iron overload. In the absence of other causes of hyperferritinemia (alcohol abuse, the metabolic syndrome, inflammatory states [e.g., infection, cancer, active rheumatoid arthritis], acute and chronic hepatitis), serum ferritin is a good marker of the degree of iron overload.

The negative predictive value of a normal transferrin saturation and serum ferritin is 97%. In this situation, no further testing is recommended.

2011 Practice Guidelines by the American Association for the Study of Liver Diseases (AASLD) recommend *HFE* gene mutation testing in patients with abnormal serum iron indices (i.e., serum ferritin and transferrin saturation), even in the absence of symptoms.

Genetic Testing in an Individual with a Family History of Hereditary Hemochromatosis

The 2011 practice guidelines by the AASLD recommend screening (iron studies [serum ferritin and transferrin saturation] and *HFE* mutation analysis) of first-degree relatives of patients with *HFE*-related HH to detect early disease and prevent complications. For children of an identified proband, *HFE* testing of the other parent is generally recommended because if results are normal, the child is an obligate heterozygote and need not undergo further testing because there is no increased risk of iron overload.

If C282Y homozygosity or compound heterozygosity is found in adult relatives of a proband, and if serum ferritin levels are increased, then therapeutic phlebotomy can be initiated. If ferritin level is normal in these patients,

then yearly follow-up with iron studies is indicated. When identified, C282Y heterozygotes and H63D heterozygotes can be reassured that they are not at risk for developing progressive or symptomatic iron overload. Some H63D homozygotes can develop mild iron overload.

Genetic Counseling

Genetic counseling is primarily aimed at patients who are at risk for inherited disorders, and experts recommend formal genetic counseling in most cases when genetic testing for an inherited condition is considered. The interpretation of the results of genetic tests and the understanding of risk factors can be very difficult and complex. Therefore, genetic counseling will assist individuals in understanding the possible benefits and harms of genetic testing, including the possible impact of the information on the individual's family. Genetic counseling may alter the utilization of genetic testing substantially and may reduce inappropriate testing. Genetic counseling should be performed by an individual with experience and expertise in genetic medicine and genetic testing methods.

Background

Iron Overload Syndromes

Iron overload syndromes may be hereditary, secondary to some other disease (e.g., iron-loading anemias, parenteral iron overload, chronic liver disease, or dysmetabolic iron overload syndrome), or due to other miscellaneous conditions (e.g., neonatal iron overload, aceruloplasminemia, congenital atransferrinemia).

Iron overload, if left untreated, can lead to secondary tissue damage in a wide range of organs resulting in chronic liver disease (hepatic fibrosis, cirrhosis, hepatocellular carcinoma), endocrine dysfunction (diabetes, hypogonadism), arthralgia or arthritis (typically involving the second and third metacarpophalangeal joints), and cardiomyopathy (with either symptomatic cardiac failure or arrhythmias).

Hereditary hemochromatosis (HH), an autosomal recessive disorder, is the most common identified genetic disorder in white people, with an estimated prevalence of one in 250. However, fully expressed disease with end-organ manifestations is seen in less than 10% of affected individuals. Factors that influence phenotypic expression of *HFE* (high iron-related HH [i.e., the clinical appearance of iron overload]) are not clearly defined. Low clinical penetrance may be due to a complex interplay of genetic status and other factors such as age, sex, environmental influences, and comorbid diseases.

HH leads to inappropriate iron absorption from the intestine and progressive increase in intracellular iron concentrations. Untreated HH leads to premature death, usually by liver complications. Treatment by removing excess iron with serial phlebotomy is simple and effective, and if started before irreversible end-organ damage, restores normal life expectancy.

Diagnosis of HH

Patients with hemochromatosis may present with nonspecific systemic symptoms or specific organ-related symptoms, or they may be asymptomatic. Clinical diagnosis of hemochromatosis is based on documentation of increased iron stores as demonstrated by abnormal serum iron indices, specifically elevated transferrin saturation and elevated serum ferritin concentration. Liver biopsy has been used to confirm diagnosis but is now generally limited to determining the degree of hepatic fibrosis and cirrhosis during disease management. Most patients with a diagnosis of hemochromatosis will exhibit a familial pattern, thereby confirming the diagnosis of HH. However the familial pattern may not be obvious due to the large percentage of undiagnosed patients in some families, and further evaluation of family members may be required to establish whether a familial pattern is present.

General population screening for HH has been proposed because of the high prevalence of disease, absence of or nonspecific early clinical findings, specificity of findings once they appear, low cost of diagnosis and treat-

ment, and high cost and low success rate of late diagnosis and treatment. However, because penetrance is low, and the natural history of asymptomatic individuals is unpredictable, support for population-based screening is lacking. A U.S. Preventive Services Task Force (USPSTF) review of the literature suggested that up to 38% to 50% of C282Y homozygotes may develop iron overload, with up to 10% to 33% eventually developing hemochromatosis-associated morbidity.¹ The American Academy of Family Physicians, Centers for Disease Control and Prevention, and USPSTF recommend against population-based general screening.¹

Treatment of HH

The main treatment modality for patients with HH is periodic phlebotomy. While there has never been a randomized controlled trial of phlebotomy versus no phlebotomy in the treatment of HH, there is evidence from nonrandomized studies that initiation of phlebotomy before the development of cirrhosis and/or diabetes will significantly reduce HH-associated morbidity and mortality.²⁻⁴

Genetics of HH

Most patients with HH have mutations in the *HFE* gene, located on the short arm of chromosome 6. The *HFE* gene was identified and cloned in 1996. The most common mutation in the *HFE* gene is C282Y, a missense mutation that changes cysteine at position 282 in the HFE protein to tyrosine. Homozygosity for the C282Y mutation is associated with 60% to 90% of all cases of HH. Additionally, 3% to 8% of affected individuals are heterozygous for this mutation. Penetrance for elevated serum iron indices among C282Y homozygotes is variable. However, penetrance for characteristic clinical end points (i.e., end-organ damage) is quite low. There is no test that can predict whether a C282Y homozygote will develop clinical symptoms. A specific variant in *PCSK7*, which is associated with iron metabolism, has been investigated as a possible predictor of cirrhosis risk in HH patients homozygous for the *HFE* C282Y mutation.⁵

Another significant mutation is referred to as H63D, which changes histidine at position 63 to aspartic acid. Homozygosity for H63D is insufficient to cause clinically significant iron overload in the absence of modifying factors. However, compound heterozygosity for C282Y/H63D has been associated with increased hepatic iron concentrations; approximately 1% to 2% of patients with this genotype will develop clinical evidence of iron overload, usually in the presence of another liver disease.⁶

The clinical significance of a third *HFE* mutation, S65C (serine at position 65 changed to cysteine), appears to be minimal. This rare variant displays very low penetrance. Compound heterozygosity for C282Y/S65C may confer a low risk for mild HH. Individuals who are heterozygous for S65C and either the wild-type (normal) or H63D alleles do not seem to be at an increased risk for HH. Other mutations in *HFE* and in non-*HFE* genes (e.g., transferrin receptor 2 [*TFR2*]) resulting in iron overload syndromes are rare.⁷⁻¹⁰

With the advent of genetic testing in the late 1990s, *HFE*-related HH is now frequently identified in asymptomatic probands and in asymptomatic relatives of patients who are known to have the disease.² Therefore, a genetic diagnosis can be made in subjects who have not yet developed phenotypic expression; these subjects have a genetic susceptibility to developing iron overload but may never do so. A 2000 consensus conference of the European Association for the Study of Liver Diseases¹¹ led to recognition of different stages and progression of hemochromatosis. These stages were defined as:

1. Stage 1: Patients with “genetic susceptibility” who have the genetic disorder but no increase in iron stores.
2. Stage 2: Patients who have the genetic disorder and phenotypic evidence of iron overload but no tissue or end-organ damage.
3. Stage 3: Patients who have the genetic disorder with iron overload and iron deposition to the degree that tissue and end-organ damage occur.

Regulatory Status

Clinical laboratories may develop and validate tests in-house and market them as a laboratory service; laboratory-developed tests (LDTs) must meet the general regulatory standards of the Clinical Laboratory Improvement Act (CLIA). Laboratories that offer LDTs must be licensed by CLIA for high-complexity testing. To date, the U.S. Food and Drug Administration has chosen not to require any regulatory review of this test.

Services that are the subject of a clinical trial do not meet our Technology Assessment Protocol criteria and are considered investigational. *For explanation of experimental and investigational, please refer to the Technology Assessment Protocol.*

It is expected that only appropriate and medically necessary services will be rendered. We reserve the right to conduct prepayment and postpayment reviews to assess the medical appropriateness of the above-referenced procedures. **Some of this protocol may not pertain to the patients you provide care to, as it may relate to products that are not available in your geographic area.**

References

We are not responsible for the continuing viability of web site addresses that may be listed in any references below.

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