WPS GHA May Draft LCD Open Meeting

Moderator: Dr. Ella Noel
May 14, 2019
1:00 pm CT
Confirmation # 5599315

OPERATOR: This is Conference # 5599315.

Operator: Good afternoon. My name is (Haydee), and I will be your conference operator today. At this time, I would like to welcome everyone to the May Draft LCD Open Meeting.

All lines have been placed on mute to prevent any background noise. After the speaker's remarks, there will be a question-and-answer session. If you would like to ask a question during this time, simply press "star" and the number "1" on your telephone keypad. And if you would like to withdraw your question, press the "pound" key. Thank you. And now I would like to turn the call over to Dr. Ella Noel.

Ella Noel: Hi.

Operator: You may begin your conference.

Ella Noel: Hi. I'd like to welcome everybody here to the J5 and J8 open meeting. This meeting will be held over the telephone and in person in Madison today. I want to thank you all for attending.

A reminder – this meeting is recorded and will be available at a later date on our website for review. Continuing on this call implies your consent to be recorded. If you do not consent, please leave the room or drop off the call. Anybody want to leave? OK. I didn't think so.

But, I will be presenting information of eight molecular diagnostic policies and one laboratory policy. I am the lead physician on all of these policies and work with senior policy coordinator (Beth Gamlin) to my left.

To the folks on the phone and here at the meeting, anybody can make comments. Comments will be limited to no longer than five minutes today because of the amount of policies that we need to get through.

Please state your name, position and any conflicts of interest that you may before you comment. And you are also invited to send your comments in writing on these drafts. And if you are going to send them in writing, send them to policycomments@wpsic.com.

The – all comments received, either oral or written, will be compiled and placed in the response to comments document for each policy. There is a 45-day comment period which started with the draft being posted on our website April 25, 2019.

So, we'll go ahead and get started. The first one is Laboratory Drug Interaction Testing, DL38162. Drug interaction testing is the use of a laboratory test for the intended purpose of determining whether a patient has pharmacologically interacting substances in his or her body.

Such testing combines a laboratory test to detect the presence of pharmacologically active substances in combination with interactions database to inform physicians of both what substances were detected and whether and how those substances interact with each other.

This is a non-coverage policy for drug interaction testing specifically. Definitive drug testing for an intended purpose other than a defined drug interaction such as to determine if a patient has unknown substances in his or her body is not addressed by this LCD.

At present, this contractor has found that for uses and defined benefit categories, there is insufficient evidence at present to cover the drug-to-drug

interaction testing. We found no evidence showing improved health outcomes in these patients following the use of drug interaction testing.

Additionally, we found no evidence comparing drug interaction testing to an assessment of interactions based on medication history, which would be the likely comparator. Any questions or comments about this draft in the room? (Haydee), do we have any comments or questions on the phone?

Operator: At this time, if you would like to ask a question or make a comment, please press “star” and the number “1” on your telephone keypad. Again, that’s “star” and the number “1” on your telephone keypad. We don’t have any questions or comment at the moment. Please continue.

Ella Noel: All right. We’ll move on to the second draft. The rest will be MolDX drafts. This is on the Decipher Biopsy Prostate Cancer Classifier Assay for Men with Favorable Intermediate Risk Disease.

There are two drafts this time around on Decipher. So, if you are going to submit a comment, make sure you clearly indicate which policy you are talking about so we don’t have any confusion. This has draft number DL38164.

This is a limited-coverage policy for the Decipher biopsy prostate cancer classifier assay. This test is considered reasonable and necessary to help identify men with localized favorable intermediate risk disease prostate cancer and a life expectancy of at least 10 years who are good candidates for active surveillance.

In 2017, over 160,000 men in the U.S. were diagnosed with prostate cancer, which accounts for 9.6 percent of all new cancer diagnoses. Clinically localized prostate cancer accounts for 80 percent of these newly diagnosed cases.

The NCCN classifies these men in to risk groups based on clinical and pathological features, which are intended to be used in conjunction with life expectancy estimates to select the optimal treatment approaches.

Intermediate risk disease is a heterogeneous disease state of localized prostate cancer with a significant range of possible treatment intensities. A clinical approach to better risk stratify this patient cohort was the creation of favorable and unfavorable intermediate risk disease groups developed by Zumsteg and Spratt at Memorial Sloan Kettering, now adopted by NCCN as guidelines.

In summary, research shows refinement of the current risk stratification techniques based on clinical and pathological variables could potentially allow for better assessment of the patient's risk of a poor outcome in the absence of treatment, thereby avoiding unnecessary treatment in men who are at lower risk of disease progression to an incurable state.

The availability of molecular diagnostic tests that provide a more accurate prediction on oncological endpoints like 10-year disease-specific mortality compared to standard clinical and pathological features provides an opportunity to refine risk stratification and may identity men who may safety pursue active surveillance and increase physician-patient confidence in that choice. The benefits associated with active surveillance and foregoing immediate intervention for appropriate men include a reduction in treatment-related complications and avoidance of adverse effects.

Criteria for coverage. We propose that with the Decipher biopsy that it is covered for men with favorable intermediate risk prostate cancer only when the following conditions are met – they have a needle biopsy with localized adenocarcinoma or the prostate and no evidence of mets or lymph node involvement and a formalin-fixed paraffin-embedded prostate biopsy specimen with at least 0.5 millimeters of cancer length and favorable intermediate risk disease defined as a Gleason grade group two and the patient has an estimated life expectancy of greater than 10 or equal to 10

years, the patient is a candidate for and is considered (doing) conservative management and yet would be eligible for definitive therapy.

The result will be used to determine treatment between definitive therapy and conservative management and the patient does not receive (inaudible) radiation or androgen deprivation prior to the biopsy and the patient will be monitored for disease progression according to an established standard of care. Any questions about the first draft on Decipher? (Haydee), do we have any questions on the phone?

Operator: Again, participants, if you would like to ask a question or make a comment, press “star” and the number “1” on your telephone keypad. We don’t have any questions or comment. Please continue.

Ella Noel: So, the third draft is also on Decipher. But, this one is for unfavorable intermediate risk disease. This is DL38166. This is also a limited-coverage policy.

This test is considered reasonable and necessary to help inform treatment decisions regarding the intensity of therapy for men with localized unfavorable intermediate risk disease prostate cancer who have a life expectancy of at least 10 years.

The recommendation to treat intermediate risk men, particularly those with unfavorable disease, is based on part on level-one evidence showing survival benefit from definitive therapy. However, the intensity of the treatment appropriateness risk stratum remains ambiguous despite further stratification of the intermediate risk disease category.

Prospective randomized clinical trials and retrospective (series) suggest that in addition to local control by surgery, radiation therapy in the form of external beam radiation with or without hormonal therapy with or without brachytherapy boost and with or without hypofractionation could all be employed to successfully treat these men.

The broad range of recommended interventions for intermediate risk men is reflective of the heterogenous metastatic potential of disease classified as intermediate risk and the increased morbidity of intensified therapy.

The clinical uncertainty and availability of multiple treatment options highlights the need for improved disease risk stratification beyond clinical and pathological features for men with this unfavorable intermediate risk disease. In all cases, treatment identification appears most appropriate in men that are at elevated risk of disease progression.

Since this test helps inform clinician at a decision point regarding treatment intensity and existing (inaudible) treatment guidelines, the clinical utility of this test hinges on both the framework's treatment recommendations and a certain level of decision uncertainty that accompanies treatment decisions with this framework.

As such, this contractor will continue to monitor evidence and consensus recommendations regarding optimal selection of treatment intensity and coverage may be re-evaluated following any new substantial evidentiary development or guidelines.

The Decipher biopsy is covered for men with prostate cancer only when they have the following clinical conditions met – they have a needle biopsy with localized adenocarcinoma of the prostate with no mets or lymph node disease, their prostate biopsy specimen is at least 0.5 millimeters of cancer length and an unfavorable risk disease defined as a Gleason score of a group two or group three (2TV) or (2TC) or a PSA of 10 to 20 with an estimated life expectancy greater than 10 years and the patient is a candidate for definite therapy.

The results will be used to determine treatment and the patient does not prior pelvic radiation or androgen deprivation therapy prior to the biopsy and the patient is monitored for disease progression according to the established standard or care. So, do we have any comments from the room? (Haydee), do we have any comments on the phone?

Operator: Again, participants, if you would like to have a comment, please press “star,” “1” on your telephone keypad. We don’t have any comment in the queue. Please continue.

Ella Noel: OK. So, the fourth draft is MolDX on Prospera. It is draft number 38174. This policy will get limited coverage to this Prospera. It’s a donor-derived cell-free DNA test to supplement the evaluation and management of kidney injury and active rejection in patients who have undergone renal transplantation. It can inform decision making along with standard clinical assessment.

The current tools for diagnosing active allograft rejection, the leading cause of graft failure, are inadequate. Early detection of allograft rejection has led to significant improvement in allograft survival in the first 12-month transplant patients – post-transplant patients.

However, the traditional tools used for this are either invasive because of a biopsy or inaccurate because of using serum biomarkers. This environment creates an unmet need for timely, sensitive, specific, non-invasive diagnostic tools to improve kidney transplant management.

The Prospera test detects donor-derived cell-free DNA in the recipient’s blood, which is elevated during acute rejection due to the increased cell death in the organ. This test is an effective non-invasive method of assessing kidney allograft status with better performance than current standard of care.

The Prospera assay is covered in only the following clinical conditions – if it is first-time renal allograft recipient and the physician assessed pretest need for further evaluation of the patient is showing probability of active renal allographic rejection, the evidence is sufficient to support that Prospera provides a non-invasive – try this again – non-invasive assessment tool to assess for the presence of active allograft rejection.

While the evidence does not indicate that the assay is a replacement for biopsy, the evidence does support that the assay performs sufficiently well to be covered if the patient’s treating clinical believe that the patient is in need of

an assessment for rejection that would – and he or she believes that the risk/benefit profile of this assay is superior to the risk/benefit profile of biopsy for that patient.

While the existing published (evidence) is sufficient to support coverage, the company has indicated that there are two post-marketing studies under way and that they will be submitted for peer-reviewed publication.

As such, we anticipate ongoing evolution of the evidence and potential changes in the accepted clinical practice. And we will continue to monitor the evidence for possible changes to the coverage policy. Any comments from the room? (Haydee), do we have any comments on the phone?

Operator: Please press “star,” “1” if you would like to make a comment or if you have a question. We don’t have any questions or comment at this time. Please continue.

Ella Noel: OK. On to the fifth policy. This one is Next-Generation Sequencing for Solid Tumors. It’s DL38176. This policy describes and clarifies coverage for lab-developed tests and FDA-approved clinical laboratory testing utilizing next-generation sequencing and cancer is allowable under the National Coverage Determination 90.2 under Section B describing managed care administrative contractor discretion for coverage.

This policy scope is specific for solid tumor testing only and is exclusive of all hematological malignancies, circulating tumor DNA testing and other cancer-related uses of NGS such as germline testing in and for patients with cancer.

NGS testing in solid tumors is becoming a routine component of the diagnostic process, and the results can uncover the genomic mechanisms of cancer that have predictive, diagnostic and prognostic utility to the patient and are used to better their management.

Understanding the mechanism of disease and targeting treatment based on those (aberrant) processes has improved patient outcomes in many tumor types and is the basis for precision medicine.

Capturing mutations and other relevant genetic and genomic information is standard of care for determining clinical care for many tumor types including the most common such as melanoma, lung, colorectal and breast cancer.

NGS has the ability to capture abundance genomic data both efficiently and relatively cheaply and is showing us to improve patient outcomes through studies, and they continue to have more studies.

NGS is not a specific test but a sequencing methodology utilized to capture genomic information. Unlike Sanger sequencing that typically provides sequencing information for a single DNA strand of molecule, NGS allows for massively parallel sequencing of (millions of) DNA molecules concurrently.

Two types of tests are considered for coverage – hotspot test and comprehensive genomic profile test. All of the following must be present for coverage eligibility.

As per NCD 90.2, this test is reasonable and necessary when the patient has either recurrent cancer, relapsed cancer, refractory cancer, metastatic cancer or advanced cancer in stages three or four and has not been previously tested by the same test with the same primary diagnosis and is seeking further treatment.

The test has to have satisfactorily completed a technical assessment by MolDX and the assay performed includes at least the minimum genes and genomic positions required for the identification of all FDA-approved therapies with a companying diagnostic biomarker for its intended use that can be reasonably detected by the test.

Because these genes and variants (will change the) literature and the drug indications involved, they are listed separately in an associated coverage article as well as in the MolDX technical assessment form.

The test in question is not covered if it does not fulfill the criteria set forth in NCD 90.2 as stated above, another test was performed on the same tumor specimen, and a technical assessment was not completed satisfactorily.

For tests that are currently covered but a TA submission has not been made, providers must submit a complete technical assessment material by October 1 of this year or coverage will then be denied. Any questions on this draft? All right. (Haydee), do we have any questions on the phone?

Operator: Again, if you would like to ask a question or make a comment, press “star,” “1” on your telephone keypad. We don’t have any questions or comment at the moment. Please continue.

Ella Noel: All right. On to the sixth draft, TruGraf Blood Gene Expression Test, DL38160. This Medicare contractor will provide limited coverage for the TruGraf blood gene expression test as an alternative to surveillance biopsies in kidney transplant recipients greater than 90 days post transplant in conjunction with clinical assessment.

The TruGraf test is a test that attempts to fill the role of a minimally invasive graft status monitoring. The TruGraf is a minimally invasive test that measures differently expressed genes in the blood of renal transplant recipients to identify patients who are likely to be adequately immunosuppressed.

TruGraf uses DNA microarray technology to determine whether the patient’s blood gene expression profile is more similar to that attained from a reference population classified by simultaneous histological analysis of a biopsy as transplant excellent and is likely adequately immunosuppressed or not.

The TruGraf is covered only with the following clinical conditions – one, the patient is 18 years of age, recipient of a primary or subsequent deceased donor or living donor kidney transplant, stable serum creatinine, kidney transplant patients who are more than 90 days post transplant, and the patient is being managed in a facility that utilizes surveillance biopsies.

It should not be used in patients who have had a combined organ transplantation, have had previous non-renal solid organ or islet cell transplantation, is suspected with HIV, has decay nephropathy or patients with nephrotic proteinuria. This test allows for surveillance without a biopsy, and it has a highly negative predictive value to assess for rejection.

In addition, the test has evidence suggesting that the practicing transplant physician find it to be clinically useful. As such, this contractor will cover the test to be used at the discretion of the treating physician in lieu of biopsies for transplant centers that do carry out surveillance biopsies. If the patient has evidence of renal graft problems, the test is not currently indicated.

MolDX will continue to monitor the science of transplant genomic space with the anticipation that what is reasonable and necessary for a test such as this may change (inaudible) new evidence about a test specifically or new evidence regarding standards of care on renal transplantation. Any questions in the room? (Haydee), any questions on the phone?

Operator: Participants, if you would like to make a comment or ask a question, press “star,” “1” on your telephone keypad. We don’t have any questions or comments. Please continue.

Ella Noel: OK. The seventh draft, Next-Generation Sequencing Lab-Developed Tests for Myeloid Malignancies and Suspected Myeloid Malignancies, DL38176. This policy describes and clarifies coverage for lab-developed tests and FDA-approved or -cleared clinical laboratory tests utilizing next-generation sequencing in cancers allowable under the National Coverage Determination 90.2 under Section D describing Medicare administrative contractor discretion for coverage.

For this – for the patient to be considered for coverage eligibility, tests are specifically indicated in patients who are known to have a myeloid malignancy at the time of testing. If the patient has a diagnosis of AML, MDS, MPN, they have to be classified as refractory or metastatic to fulfill the criteria.

The test has satisfactorily completed a technical assessment by MolDX. It is performed on at least the minimum genes and positions indicated for its intended use. The patients do not have a diagnosis of myeloid malignancy. Where one is suspected, the patient has to have an undefined cytopenia for greater than six months and other causes of cytopenia must have been ruled out.

Testing is performed on bone marrow biopsies or peripheral blood samples. It would not be covered or denied if the technical assessment has not been successfully completed, another NGS test is performed on the same specimen or blood draw for the same date of service and another NGS test was performed for the same indication within the past six months.

Given the abundant literature on genetic and genomic testing in cancer diagnosis and care, this contractor strongly feels that NGS methodology for testing is appropriate for use in Medicare beneficiaries.

However, given the variability for what information tests can provide, additional information must be submitted by providers to ensure the contractor understands what test is being performed, why it's being performed and if the test is both necessary and medically reasonable for cancer care for its intended use. Any comments from the room? Any comments, (Haydee), on the phone?

Operator: Participants, if you would like to make a comment, press "star," "1" on your telephone keypad. We don't have any comments. Please continue.

Ella Noel: On to the eighth draft, Guardant360 Plasma-Based Comprehensive Genomic Profiling in Solid Tumors. This is MolDX DL37671. Guardant360 is covered for patients with non-CNS originated solid tumor who meet the criteria of NCD 90.2 when the following conditions are met – tissue-based CGP is infeasible or specifically a non-small-cell lung cancer tissue-based CGP has shown no actionable mutation, the patient is a candidate for further treatment with the a drug that is either FDA-approved for the patient's cancer or has an (NCN 1) or NCCN 2A recommendation for that patient's cancer, and the FDA-approved indication or NCCN recommendation requires information about the presence or absence of a genetic marker tested for in the Guardant 360 assay.

Guardant360 is covered only when all of the following conditions have been met – the patient has been diagnosed with a recurrent relapsed refractory metastatic or advanced solid tumor that did not originate from the central nervous system, a patient who would need all of the indications on the FDA label for some drug I can't pronounce – I'm sorry – if they are found to have an NTRK mutation maybe considered to have advanced cancer and the patient has not previously been tested with the Guardant360 test for the same primary cancer.

For a patient who had been tested previously using the Guardant360 for cancer, that patient may not be tested again unless he has a new primary cancer diagnosis. In a patient with a previously tested primary cancer with evidence of a new malignant growth, that growth may be considered to be a different primary cancer if it does not originate from the cell line – same cell line or is physiologically different enough to be – respond differently to treatment than the previously tested cancer – the patient is untreated in the primary cancer test being tested and the patient is not responding to the treatment or – excuse me – or the patient is not responding to the treatment, the patient has decided to seek further cancer treatment with the following condition – the patient is a candidate for further drug – treatment with a drug that is FDA-approved for the cancer or has NCCN 1 or 2A recommendations for that cancer and the improved indication or NCCN recommendation is

based upon information about the presence or absence of a genetic biomarker tested for in Guardant360 and tissue-based CGP is infeasible because the quantity is not sufficient or an invasive biopsy is medically contraindicated or specially a non-small-cell lung cancer tissue-based CGP has shown no actional mutation. Any questions about that draft? (Haydee), any questions on the phone?

Operator: Again, participants, if you would like to ask a question or make a comment, press “star,” “1” on your telephone keypad. We don’t have any questions at the moment. Please continue.

Ella Noel: All right. Finally, the ninth one. This is a MolDX policy on the Pigmented Lesion Assay. This is DL38178. This Medicare contractor will provide limited coverage for the pigmented lesion assay. This is an RNA gene expression test conducted on skin samples obtained non-invasively by adhesive patches.

This test is intended to help rule out primary cutaneous melanoma and guide biopsy decisions of melanotic skin lesions with one or more clinical or (sterical) characteristics suggestive of melanoma. The evaluation with the PLA is limited to order by a physician or other qualified health care professional with expertise in melanoma.

It is indicated for use on primary melanotic skin lesions between 5 millimeters and 19 millimeters. The lesions where the skin is intact cannot be ulcerated or bleeding. Lesions that do not contain a scar or were previously biopsied – cannot be used lesions that are located in areas of psoriasis, eczema or similar skin conditions. It cannot be used on lesions that were clinically diagnosed as melanoma. And it cannot be used in other areas such as the palms of the hand, soles of the feet, nails, mucous membranes and hair-covered areas that cannot be trimmed.

It is not intended to be used as a screening test in patients without melanotic skin lesions. It is also not covered as an adjunct test in lesions that are considered to be already severe enough to warrant a biopsy. The PLA is a decision tool for atypical melanotic lesions prior to the decision to biopsy.

Coverage criteria. It is only for use by dermatologists on pigmented skin lesions which a diagnosis of melanoma is being considered. The specific characteristics that the lesion must have are as follows – the lesion must meet one or more of the A, B, D, E criteria; primarily melanotic lesion between 5 and 19 millimeters – we already talked about the skin being intact where there was no scar or previous biopsy and areas of psoriasis, eczema or similar skin lesion; an area that has already been clinically diagnosed as melanoma or used on the palms of the hands, soles of the feet, nails, mucous membranes.

Additional coverage requirements. The ordering dermatologist must also have a plan at the time of ordering the test to continue to monitor the skin lesion if the test is negative. The ordering physician must clearly the document the lesion site on the body of the patient. The test may not be ordered for the same lesion a second time. And only one test may be used per patient for clinical encounter.

Given the existing evidence for PLA and the alternative diagnostic approaches, the evidence is sufficient to indicate that the pigmented lesion assay provides adequate sensitivity and negative predicted value for malignant pigment lesions to be used as a clinical decision tool in select pigmented lesions where there is a question as to whether or not a biopsy is needed.

Additionally, while this coverage decision is presently based on only the published evidence discussed above, the test developer notes plans to publish longer-term outcome data. This data will be considered when available and may result in changes to the coverage policy. Any comments? Any comments from the phone, (Haydee)?

Operator: Again, participants, if you would like to have a comment or ask a question, press “star,” “1” on your telephone keypad. We don’t have any questions or comment. Please continue.

Ella Noel: All right. So, just as a reminder, if you have comments, please send them in writing to medicarepolicycomments@wpsic.com. The comment period is 45 days and it started on April 25. And just as a reminder to people in the room, please make sure that when you leave you have all of your personal items with you. Please don't leave behind any computers. Thank you. We're all done, (Haydee). Bye-bye.

Operator: This concludes today's – this concludes today's conference call. Thank you for your participation. You may now disconnect.