



Molecular Markers in Fine Needle Aspirates of the Thyroid

Policy # 00332

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Applies to all products administered or underwritten by Blue Cross and Blue Shield of Louisiana and its subsidiary, HMO Louisiana, Inc. (collectively referred to as the "Company"), unless otherwise provided in the applicable contract. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

When Services May Be Eligible for Coverage

Coverage for eligible medical treatments or procedures, drugs, devices or biological products may be provided only if:

- *Benefits are available in the member's contract/certificate, and*
- *Medical necessity criteria and guidelines are met.*

Based on review of available data, the Company may consider mutation analysis (e.g., BRAF V600, RAS, PIK3CA, RET, PAX8/PPARG), or the use of a gene expression classifier (GEC) or genomic sequencing classifier (GSC) in fine-needle aspirates of the thyroid to be **eligible for coverage****.

Patient selection criteria

Based on review of available data, the Company may consider mutation analysis (i.e., BRAF, RAS, PIK3CA, RET, PAX8/PPARG), or the use of a gene expression classifier (GEC) or genomic sequencing classifier (GSC) in fine-needle aspirates of the thyroid when **ALL** the following criteria are met:

- For an adult individual (18 years of age or older) with thyroid nodule being evaluated for thyroid carcinoma to assist in management decision; AND
- One or more thyroid nodules with a history or characteristics suggesting malignancy (any of the following):
 - Nodule growth over time
 - Family history of thyroid cancer
 - Hoarseness, difficulty swallowing or breathing
 - History of exposure to ionizing radiation
 - Hard nodule compared with rest of gland consistency
 - Presence of cervical adenopathy; AND
- Fine needle aspirates are cytologically characterized according to Bethesda criteria as Bethesda diagnostic category III [atypia of undetermined significance (AUS)] or follicular

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lesion of undetermined significance (FLUS)], or Bethesda diagnostic category IV [follicular neoplasm (FN) or suspicion for a follicular neoplasm (SFN)]; AND

- One of the following tests is used:
 - Afirma GSC (81546), and Afirma malignancy classifiers (i.e., Afirma BRAF or Afirma MTC classifier) only when Afirma GSC is suggestive that the individual should be considered for surgery (suspicious or malignant results)
 - ThyGeNEXT (0245U), and ThyraMIR (0018U) only when ThyGeNEXT is inconclusive
 - ThyroSeq genomic classifier (0026U), OR
- Requested testing was not done before (using the same or related test), unless there is clear documentation of second, unrelated thyroid nodule with indeterminate pathology.

Note: ThyroSeq[®] CRC (0287U) can be considered for patient with thyroid cancer, diagnosed as malignant FNA cytology (Bethesda diagnostic category VI) or thyroid cancer in formalin fixed paraffin, if testing was not previously done, to aid with medical management decisions.

In individuals with advanced thyroid carcinoma, molecular testing for actionable mutations can be considered if testing was not previously done (i.e., BRAF V600E, NTRK fusion, ALK fusion, RET, MSI by validated PCR, dMMR by validated IHC, and TMB by FDA approved companion diagnostic).

For 5 or more gene tests being run on the same platform, such as multi-gene panel next generation sequencing (NGS), single available procedure code for the multi-gene panel test is to be utilized.

When Services Are Considered Investigational

Coverage is not available for investigational medical treatments or procedures, drugs, devices or biological products.

Based on review of available data, the Company considers gene expression classifiers, genetic variant analysis, and molecular marker testing in fine needle aspirates of the thyroid not meeting criteria outlined above, including but not limited to repeat testing, simultaneous use of different tests, use of single-gene TERT testing and Afirma Xpression Atlas, to be **investigational**.*

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Policy Guidelines

In individuals who do not undergo surgical biopsy or thyroidectomy on the basis of gene expression classifier or molecular marker results, regular active surveillance is indicated.

Use of molecular marker testing based on fine needle aspirate of a thyroid nodule to rule in malignancy prior to surgical biopsy may guide surgical planning, particularly factors such as choice of surgical facility provider to ensure that the capability is available to conduct a frozen section pathologic reading during surgical biopsy so that surgical approach may be adjusted accordingly in a single surgery.

Genetic Counseling

Experts recommend formal genetic counseling for individuals who are at risk for inherited disorders and who wish to undergo genetic testing. Interpreting the results of genetic tests and understanding risk factors can be difficult for some individuals; genetic counseling helps individuals understand the impact of genetic testing, including the possible effects the test results could have on the individual or their family members. It should be noted that genetic counseling may alter the utilization of genetic testing substantially and may reduce inappropriate testing; further, genetic counseling should be performed by an individual with experience and expertise in genetic medicine and genetic testing methods.

Background/Overview

Thyroid Nodules

Thyroid nodules are common, present in 5% to 7% of the U.S. adult population; however, most are benign, and most cases of thyroid cancer are curable surgically when detected early.

Diagnosis

Sampling thyroid cells by fine needle aspirate (FNA) is currently the most accurate procedure to distinguish benign thyroid lesions from malignant ones, reducing the rate of unnecessary thyroid surgery for individuals with benign nodules and triaging individuals with thyroid cancer to appropriate surgery.

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About 60% to 70% of thyroid nodules are classified cytologically as benign, and 4% to 10% of nodules are cytologically deemed malignant. However, the remaining 20% to 30% have equivocal findings, usually due to overlapping cytologic features between benign and malignant nodules; these nodules usually require surgery for a final diagnosis. Thyroid FNA cytology is classified by Bethesda System criteria into the following groups: nondiagnostic; benign; follicular lesion of undetermined significance or atypia of undetermined significance; follicular neoplasm (or suspicious for follicular neoplasm); suspicious for malignancy; and malignant. Lesions with FNA cytology in the atypia of undetermined significance or follicular neoplasm of undetermined significance or follicular neoplasm categories are often considered indeterminate.

Management

There is some individualization of management for individuals with FNA-indeterminate nodules, but many individuals will require a surgical biopsy, typically thyroid lobectomy, with intraoperative pathology. Consultation would typically be the next step in the diagnosis. Approximately 80% of individuals with indeterminate cytology undergo surgical resection; postoperative evaluation has revealed a malignancy rate ranging from 6% to 30%, making this a clinical process with very low specificity. Thus, if an analysis of FNA samples could reliably identify the risk of malignancy as low, there is potential for individuals to avoid surgical biopsy.

Preoperative planning of optimal surgical management in individuals with equivocal cytologic results is challenging, because different thyroid malignancies require different surgical procedures (eg, unilateral lobectomy vs total or subtotal thyroidectomy with or without lymph node dissection) depending on several factors, including histologic subtype and risk-stratification strategies (tumor size, patient age). If a diagnosis cannot be made intraoperatively, a lobectomy is typically performed, and, if on postoperative histology the lesion is malignant, a second surgical intervention may be necessary for completion thyroidectomy.

Thyroid Cancer

Most thyroid cancers originate from thyroid follicular cells and include well-differentiated papillary thyroid carcinoma (PTC; 80% of all thyroid cancers) and follicular carcinoma (15%). Poorly differentiated and anaplastic thyroid carcinomas are uncommon and can arise de novo or from preexisting well-differentiated papillary or follicular carcinomas. Medullary thyroid carcinoma originates from parafollicular or C cells and accounts for about 3% of all thyroid cancers.

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The diagnosis of malignancy in the case of PTC is primarily based on cytologic features. If FNA in a case of PTC is indeterminate, surgical biopsy with intraoperative pathology consultation is most often diagnostic, although its efficacy and therefore its use will vary across institutions, surgeons, and pathologists. In 2016, reclassification of encapsulated follicular-variant PTC as a noninvasive follicular tumor with papillary-like nuclei was proposed and largely adopted; this classification removes the word *carcinoma* from the diagnosis to acknowledge the indolent behavior of these tumors.

For follicular carcinoma, the presence of invasion of the tumor capsule or blood vessels is diagnostic, and cannot be determined by cytology, because tissue sampling is necessary to observe these histologic characteristics. Intraoperative diagnosis of follicular carcinoma is challenging and often not feasible because extensive sampling of the tumor and capsule is usually necessary and performed on postoperative, permanent sections.

New approaches for improving the diagnostic accuracy of thyroid FNA include variant analysis for somatic genetic alterations, to more accurately classify which individuals need to proceed to surgery (and may include the extent of surgery necessary), and a gene expression classifier to identify individuals who do not need surgery and can be safely followed.

Genetic Variants Associated With Thyroid Cancer

A number of genetic variants have been discovered in thyroid cancer. The most common 4 gene variants are *BRAF* and *RAS* single nucleotide variants (SNVs) and *RET/PTC* and *PAX8/PPAR γ* rearrangements.

Papillary carcinomas carry SNVs of the *BRAF* and *RAS* genes, as well as *RET/PTC* and *TRK* rearrangements, all of which can activate the mitogen-activated protein kinase pathway. These mutually exclusive variants are found in more than 70% of papillary carcinomas. *BRAF* SNVs are highly specific for PTC. Follicular carcinomas harbor either *RAS* SNVs or *PAX8PPAR γ* rearrangements. These variants have been identified in 70% to 75% of follicular carcinomas. Genetic alterations involving the PI3K/AKT signaling pathway also occur in thyroid tumors, although they are rare in well-differentiated thyroid cancers and have a higher prevalence in less differentiated thyroid carcinomas. Additional variants known to occur in poorly differentiated and anaplastic

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carcinomas involve the *TP53* and *CTNNB1* genes. Medullary carcinomas, which can be familial or sporadic, frequently possess SNVs located in the *RET* gene.

Studies have evaluated the association between various genes and cancer phenotype in individuals with diagnosed thyroid cancer.

Telomerase reverse transcriptase (*TERT*) promoter variants occur with varying frequency in different thyroid cancer subtypes. Overall, *TERT* C228T or C250T variants have been reported in approximately 15% of thyroid cancers, with higher rates in the undifferentiated and anaplastic subtypes compared with the well-differentiated subtypes. *TERT* variants are associated with several demographic and histopathologic features such as older age and advanced TNM stage. *TERT* promoter variants have been reported to be independent predictors of disease recurrence and cancer-related mortality in well-differentiated thyroid cancer. Also, the co-occurrence of *BRAF* or *RAS* variants with *TERT* or *TP53* variants may identify a subset of thyroid cancers with unfavorable outcomes.

Molecular Diagnostic Testing

Variant Detection and Rearrangement Testing

SNVs in specific genes, including *BRAF*, *RAS*, and *RET*, and evaluation for rearrangements associated with thyroid cancers can be accomplished with Sanger sequencing or pyrosequencing or with real-time polymerase chain reaction (PCR) of single or multiple genes or by next-generation sequencing (NGS) panels. Panel tests for genes associated with thyroid cancer, with varying compositions, are also available. For example, Quest Diagnostics offers a Thyroid Cancer Mutation Panel, which includes *BRAF* and *RAS* variant analysis and testing for *RET/PTC* and *PAX8/PPAR γ* rearrangements.

The ThyroSeq v3 Next-Generation Sequencing panel (Sonic Healthcare) is an NGS panel of 112 genes. The test is indicated when FNA cytology suggests atypia of uncertain significance or follicular lesion of undetermined significance, follicular neoplasm or suspicious for follicular neoplasm, or suspicious for malignancy. In particular, it has been evaluated in individuals with follicular neoplasm and/or suspicious for follicular neoplasm on FNA as a test to increase both sensitivity and specificity for cancer diagnosis. ThyGenX is an NGS panel that sequences 8 genes

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and identifies specific gene variants and translocations associated with thyroid cancer. ThyGenX is intended to be used in conjunction with the ThyraMIR microRNA expression test when the initial ThyGenX test is negative.

Gene Expression Profiling

Genetic alterations associated with thyroid cancer can be assessed using gene expression profiling, which refers to the analysis of messenger RNA (mRNA) expression levels of many genes simultaneously. Several gene expression profiling tests are available and stratify tissue from thyroid nodules biologically.

The Afirma Gene Expression Classifier (Afirma GEC; Veracyte) analyzed the expression of 142 different genes to determine patterns associated with benign findings on surgical biopsy. It was designed to evaluate thyroid nodules that have an "indeterminate" classification on FNA as a method to select individuals ("rule out") who are at low-risk for cancer. In 2017, Veracyte migrated the Afirma GEC microarray analysis to a next-generation RNA sequencing platform and now markets the Afirma Gene Sequencing Classifier (Afirma GSC) which evaluates 10,196 genes with 1,115 core genes.

Other gene expression profiles have been reported in investigational settings, but have not been widely validated or used commercially (eg, Barros-Filho et al [2015], Zheng et al [2015]); they are not addressed in this review.

ThyraMIR is a microRNA expression-based classifier intended for use in thyroid nodules with indeterminate cytology on FNA following a negative result from the ThyGenX Thyroid Oncogene Panel.

Algorithmic Testing

Algorithmic testing involves the use of 2 or more tests in a prespecified sequence, with a subsequent test automatically obtained depending on results of an earlier test.

Algorithmic Testing Using Afirma GEC With Afirma MTC and Afirma BRAF

In addition to Afirma GSC, Veracyte also markets 2 "malignancy classifiers" that use mRNA expression-based classification to evaluate for *BRAF* variants (Afirma BRAF) or variants associated

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with medullary thyroid carcinoma (Afirma MTC). Table 1 outlines the testing algorithms for Afirma MTC and Afirma BRAF.

Table 1. Afirma MTC and Afirma BRAF Testing Algorithms

| Test 1 | Test 1 Result | Reflex to Test 2 |
|--|-----------------------------|------------------|
| Thyroid nodule on fine needle aspirate | "Indeterminate" | Afirma MTC |
| Afirma GSC | "Malignant" or "suspicious" | Afirma MTC |
| Afirma GSC | "Suspicious" | Afirma BRAF |

Afirma GSC: Afirma Gene Sequencing Classifier; Afirma MTC: Afirma medullary thyroid carcinoma

In a description of the Afirma BRAF test, the following have been proposed as benefits of the mRNA-based expression test for *BRAF* variants: (1) PCR-based methods may have low sensitivity, requiring that a large proportion of the nodule have a relevant variant; (2) testing for only 1 variant may not detect individuals with low-frequency variants that result in the same pattern of pathway activation; and (3) PCR-based approaches with high analytic sensitivity may require a large amount of DNA that is difficult to isolate from small FNA samples.

The testing strategy for both Afirma MTC and Afirma BRAF is to predict malignancy from an FNA sample with increased pretest probability for malignancy. A positive result with Afirma MTC or Afirma BRAF would inform preoperative planning such as planning for a hemi- vs a total thyroidectomy or performance of central neck dissection.

Algorithmic Testing Using ThyGenX and ThyraMIR

The ThyGenX Thyroid Oncogene Panel (Interpace Diagnostics; testing is done at Asuragen Clinical Laboratory) is an NGS panel designed to assess individuals with indeterminate thyroid FNA results. It includes sequencing of 8 genes associated with PTC and follicular carcinomas. ThyGenX has replaced the predicate *miRInform* Thyroid test that assesses for 17 validated gene alterations.

ThyraMIR (Interpace Diagnostics) is a microRNA expression-based classifier intended for use in

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thyroid nodules with indeterminate cytology on FNA following a negative result from the ThyGenX Thyroid Oncogene Panel.

The testing strategy for combined ThyGenX and ThyraMIR testing is first to predict malignancy. A positive result on ThyGenX would "rule in" individuals for surgical resection. The specific testing results from a ThyGenX positive test would be used to inform preoperative planning when positive. For a ThyGenX negative result, the reflex testing involves the ThyraMIR microRNA expression test to "rule out" for a surgical biopsy procedure given the high negative predictive value of the second test. Individuals with a negative result from the ThyraMIR test would be followed with active surveillance and avoid a surgical biopsy.

FDA or Other Governmental Regulatory Approval

U.S. Food and Drug Administration (FDA)

Clinical laboratories may develop and validate tests in-house and market them as a laboratory service; laboratory-developed tests must meet the general regulatory standards of the Clinical Laboratory Improvement Amendments. Thyroid variant testing and gene expression classifiers are available under the auspices of the Clinical Laboratory Improvement Amendments. Laboratories that offer laboratory-developed tests must be licensed by the Clinical Laboratory Improvement Amendments for high-complexity testing. To date, the U.S. FDA has chosen not to require any regulatory review of this test.

In 2013, the THxID™[†]-BRAF kit (bioMérieux), an in vitro diagnostic device, was approved by the U.S. FDA through the premarket approval process to assess specific *BRAF* variants in melanoma tissue via real-time PCR. However, there are currently no diagnostic tests for thyroid cancer mutation analysis with approval from the U.S. FDA. Table 2 provides a summary of commercially available molecular diagnostic tests for indeterminate thyroid pathology.

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Table 2. Summary of Molecular Tests for Indeterminate Thyroid Cytopathology FNA Specimens

| Test | Predicate | Methodology | Analyte(s) | Report |
|---------------------------|--|----------------------------|------------------------------|-------------------------------------|
| Afirma ^{®†} GSC | Afirma ^{®†} GEC | mRNA gene expression | 1,115 genes | Benign/suspicious |
| Afirma ^{®†} BRAF | | mRNA gene expression | 1 gene | Negative/positive |
| Afirma ^{®†} MTC | | mRNA gene expression | | Negative/positive |
| ThyroSeq v3 | ThyroSeq v2 | Next-generation sequencing | 112 genes | Specific gene variant/translocation |
| ThyGeNEXT ^{®†} | ThyGenX ^{®†a} , miRInform ^{®†a} | Next-generation sequencing | 10 genes and 32 gene fusions | Specific gene variant/translocation |
| ThyraMIR ^{™†} | | microRNA expression | 10 microRNAs | Negative/positive |

FNA: fine needle aspirate; mRNA: messenger RNA. PCR: polymerase chain reaction.

^a The miRInform^{®†} test is the predicate test to ThyGenX^{™†} and is not commercially available.

Rationale/Source

This medical policy was developed through consideration of peer-reviewed medical literature generally recognized by the relevant medical community, U.S. Food and Drug Administration approval status, nationally accepted standards of medical practice and accepted standards of medical practice in this community, technology evaluation centers, reference to federal regulations, other plan medical policies, and accredited national guidelines.

Description

To determine which individuals need thyroid resection, many physicians will perform a cytologic examination of fine needle aspirate (FNA) samples from a thyroid lesion; however, this method has

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diagnostic limitations. As a result, assays using molecular markers have been developed to improve the accuracy of thyroid FNA biopsies.

Summary of Evidence

For individuals with thyroid nodule(s) and indeterminate findings on FNA who receive FNA sample testing with molecular tests to rule out malignancy and to avoid surgical biopsy or resection, the evidence includes prospective clinical validity studies with the Afirma[®] Gene Sequencing Classifier (Afirma GSC), a systematic review of prospective and retrospective clinical validity studies, and a chain of evidence to support clinical utility. Relevant outcomes are disease-specific survival, test accuracy and validity, morbid events, and resource utilization. A systematic review of 1 prospective and 6 retrospective trials demonstrated a high negative predictive value (NPV) (96%; 95% confidence interval [CI], 94% to 98%). In a multicenter validation study, the Afirma GSC was also reported to have a high NPV (96%; 95% CI, 90% to 99%). These results are consistent with an earlier study on the Afirma Gene Expression Classifier (Afirma GEC) in the same study population and a randomized controlled trial of Afirma GSC in a similar population. In other multicenter and single-center studies, there is suggestive evidence that rates of malignancy are low in Afirma individuals who are classified as benign, but the exact NPV is unknown. The available evidence suggests that the decisions a physician makes regarding surgery are altered by Afirma GEC/GSC results; however, it should be noted that long-term follow-up of individuals with thyroid nodules who avoided surgery based on GEC results is limited. A chain of evidence can be constructed to establish the potential for clinical utility with GEC testing in cytologically indeterminate lesions, but there is only a single study of the marketed test reporting a true NPV. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals with thyroid nodule(s) and indeterminate findings on FNA who receive FNA sample testing with molecular tests to rule in malignancy and to guide surgical planning, the evidence includes prospective and retrospective studies of clinical validity. Relevant outcomes are disease-specific survival, test accuracy and validity, morbid events, and resource utilization. Variant analysis has the potential to improve the accuracy of an equivocal FNA of the thyroid and may play a role in preoperative risk stratification and surgical planning. Single-center studies have suggested that testing for a panel of genetic variants associated with thyroid cancer may allow for the appropriate selection of individuals for surgical management for the initial resection. Prospective studies in additional populations are needed to validate these results. Although the presence of certain variants

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may predict more aggressive malignancies, the management changes that would occur as a result of identifying higher risk tumors are not well-established. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals with thyroid nodule(s) and indeterminate findings on FNA who receive FNA sample testing with molecular tests to rule out malignancy and avoid surgical biopsy or to rule in malignancy for surgical planning, the evidence includes multiple retrospective and prospective clinical validation studies for the ThyroSeq[®] test, a systematic review of retrospective and prospective studies, and 2 retrospective clinical validation studies that used a predicate test 17-variant panel (miRInform) test to the current ThyGenX[®] and ThyraMIR[®]. Relevant outcomes are disease-specific survival, test accuracy and validity, morbid events, and resource utilization. In a retrospective validation study on FNA samples, the 17-variant panel (miRInform) test and ThyraMIR had a sensitivity of 89%, and an NPV of 94%. A prospective clinical validation study of ThyroSeq v3 reported an NPV of 97% and a positive predictive value (PPV) of 68%. Similarly, a systematic review including 3 prospective and 3 retrospective clinical validity studies reported an NPV of 92% and PPV of 70%. No studies were identified demonstrating the diagnostic characteristics of the marketed ThyGenX. No prospective studies were identified demonstrating evidence of direct outcome improvements. A chain of evidence for the ThyroSeq v3 test and combined ThyGenX and ThyraMIR testing would rely on establishing clinical validity. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

Supplemental Information

Clinical Input From Physician Specialty Societies and Academic Medical Centers

While the various physician specialty societies and academic medical centers may collaborate with and make recommendations during this process, through the provision of appropriate reviewers, input received does not represent an endorsement or position statement by the physician specialty societies or academic medical centers, unless otherwise noted.

2017 Input

Clinical input was sought to help determine whether testing for molecular markers in fine needle aspirates of the thyroid for management of individuals with thyroid nodule(s) with an indeterminate finding on the fine needle aspirates would provide a clinically meaningful improvement in net health

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outcome and whether the use is consistent with generally accepted medical practice. In response to requests, clinical input on 7 tests for molecular markers was received from 9 respondents, including 1 specialty society-level response, 1 physician from an academic center, and 7 physicians from 2 health systems.

Clinical input supports that the following uses provide a clinically meaningful improvement in net health outcome and indicates the uses are consistent with generally accepted medical practice:

For individuals who have FNA of thyroid nodules with indeterminate cytologic findings (ie, Bethesda diagnostic category III [atypia/follicular lesion of undetermined significance] or Bethesda diagnostic category IV [follicular neoplasm/suspicion for a follicular neoplasm]) who receive the following types of molecular marker testing to rule out malignancy and to avoid surgical biopsy:

- Afirma Gene Expression Classifier; or
- ThyroSeq v2

For individuals who have FNA of thyroid nodules with indeterminate cytologic findings or Bethesda diagnostic category V (suspicious for malignancy) who receive the following types of molecular marker testing to rule in the presence of malignancy to guide surgical planning for the initial resection rather than a 2 stage surgical biopsy followed by definitive surgery:

- ThyroSeq v2;
- ThyraMIR microRNA/ThyGenX;
- Afirma BRAF after Afirma Gene Expression Classifier; or
- Afirma MTC after Afirma Gene Expression Classifier.

Practice Guidelines and Position Statements

Guidelines or position statements will be considered for inclusion in 'Supplemental Information' if they were issued by, or jointly by, a US professional society, an international society with US representation, or National Institute for Health and Care Excellence (NICE). Priority will be given to guidelines that are informed by a systematic review, include strength of evidence ratings, and include a description of management of conflict of interest.

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American Association of Clinical Endocrinologists et al

The American Association of Clinical Endocrinologists, American College of Endocrinology, and Associazione Medici Endocrinologi (2016) updated their joint guidelines on molecular testing for cytologically indeterminate thyroid nodules, stating:

- "Cytopathology expertise, patient characteristics, and prevalence of malignancy within the population being tested impact the negative predictive values (NPVs) and positive predictive values (PPVs) for molecular testing."
- "Consider the detection of *BRAF* and *RET/PTC* and, possibly, *PAX8/PPARG* and *RAS* mutations if such detection is available."
- "*TERT* mutational analysis on FNA, when available, may improve the diagnostic sensitivity of molecular testing on cytologic samples."
- "Because of the insufficient evidence and the limited follow-up, we do not recommend either in favor of or against the use of gene expression classifiers (GECs) for cytologically indeterminate nodules."

For the role of molecular testing for deciding the extent of surgery the following recommendations were made:

- "Currently, with the exception of mutations such as BRAFV600E that have a PPV approaching 100% for papillary thyroid carcinoma (PTC), evidence is insufficient to recommend in favor of or against the use of mutation testing as a guide to determine the extent of surgery."

American Thyroid Association

The American Thyroid Association (2016) updated its guidelines on the management of thyroid nodules and differentiated thyroid cancer in adults. These guidelines made the following statements on molecular diagnostics in thyroid nodules that are atypia of undetermined significance or follicular lesion of undetermined significance on cytology and follicular neoplasm or suspicious for follicular neoplasm on cytology (see Table 3).

Table 3. Molecular Diagnostics in Thyroid Nodules on Cytology

| Recommendation | SOR | QOE |
|----------------|-----|-----|
| AUS or FLUS | | |

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| | | |
|--|--------|----------|
| "For nodules with AUS/FLUS cytology, after consideration of worrisome clinical and sonographic features, investigations such as repeat FNA or molecular testing may be used to supplement malignancy risk assessment in lieu of proceeding directly with a strategy of either surveillance or diagnostic surgery. Informed patient preference and feasibility should be considered in clinical decision-making." | Weak | Moderate |
| "If repeat FNA cytology, molecular testing, or both are not performed or inconclusive, either surveillance or diagnostic surgical excision may be performed for an AUS/FLUS thyroid nodule, depending on clinical risk factors, sonographic pattern, and patient preference." | Strong | Low |
| FN or SFN | | |
| "Diagnostic surgical excision is the long-established standard of care for the management of FN/SFN cytology nodules. However, after consideration of clinical and sonographic features, molecular testing may be used to supplement malignancy risk assessment data in lieu of proceeding directly with surgery. Informed patient preference and feasibility should be considered in clinical decision-making." | Weak | Moderate |

AUS: atypia of undetermined significance; FLUS: follicular lesion of undetermined significance; FN: follicular neoplasm; FNA: fine needle aspirate; QOE: quality of evidence; SFN: suspicious for follicular neoplasm; SOR: strength of recommendation.

The guidelines also stated: "there is currently no single optimal molecular test that can definitively rule in or rule out malignancy in all cases of indeterminate cytology, and long-term outcome data proving clinical utility are needed."

National Comprehensive Cancer Network

National Comprehensive Cancer Network (v.2.2022) guidelines on the treatment of thyroid cancer comment on the use of molecular diagnostics in thyroid cancer. For thyroid nodules evaluated with FNA, molecular diagnostics may be employed when lesions are suspicious for:

- Follicular or Hürthle cell neoplasms.
- Atypia of undetermined significance or follicular lesions of undetermined significance.

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The guidelines state that molecular diagnostics may not perform well for Hurthle cell neoplasms.

U.S. Preventive Services Task Force Recommendations

Not applicable.

Medicare National Coverage

There is no national coverage determination. In the absence of a national coverage determination, coverage decisions are left to the discretion of local Medicare carriers.

MolDX Program contractors Palmetto GBA, Wisconsin Physicians Service Insurance Corp., and CGS Administrators determined that the Afirma Gene Expression Classifier test meets criteria for analytic and clinical validity and clinical utility as a reasonable and necessary Medicare benefit. Effective 2015, the MolDX Program contractors will reimburse Afirma Gene Expression Classifier services for individuals with the following conditions:

- "Individuals with one or more thyroid nodules with a history or characteristics suggesting malignancy such as:
 - Nodule growth over time
 - Family history of thyroid cancer
 - Hoarseness, difficulty swallowing or breathing
 - History of exposure to ionizing radiation
 - Hard nodule compared with rest of gland consistency
 - Presence of cervical adenopathy
- Have an indeterminate follicular pathology on fine needle aspiration."

Ongoing and Unpublished Clinical Trials

Some currently ongoing and unpublished trials that might influence this review are listed in Table 4.

Table 4. Summary of Key Trials

| NCT No. | Trial Name | Planned Enrollment | Completion Date |
|----------------|------------|--------------------|-----------------|
| <i>Ongoing</i> | | | |

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- | | |
|------------|--|
| 02/01/2018 | Medical Policy Committee review |
| 02/21/2018 | Medical Policy Implementation Committee approval. Returned to active status. |
| 02/07/2019 | Medical Policy Committee review |
| 02/20/2019 | Medical Policy Implementation Committee approval. Policy statements revised to add investigational statement for TERT single-gene testing. |
| 02/06/2020 | Medical Policy Committee review |
| 02/12/2020 | Medical Policy Implementation Committee approval. "Afirma GEC" test replaced with new "Afirma GSC" test throughout the policy. |
| 02/04/2021 | Medical Policy Committee review |

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02/10/2021 Medical Policy Implementation Committee approval. Criteria rewritten. No change to coverage. FDA updated.

12/20/2021 Coding update

02/03/2022 Medical Policy Committee review

02/09/2022 Medical Policy Implementation Committee approval. No change to coverage.

03/25/2022 Coding update

09/01/2022 Medical Policy Committee review

09/14/2022 Medical Policy Implementation Committee approval. Updated per Senate bill requirements.

09/07/2023 Medical Policy Committee review

09/13/2023 Medical Policy Implementation Committee approval. Removed RosettaGX Reveal from policy.

Next Scheduled Review Date: 09/2024

Coding

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contains the complete and most current listing of CPT codes and descriptive terms. Applicable FARS/DFARS apply.

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Codes used to identify services associated with this policy may include (but may not be limited to) the following:

| Code Type | Code |
|------------------|--|
| CPT | 0018U, 0026U, 0204U, 0245U, 81345, 81445, 81546, 81479, 81599 Add codes effective 1/1/2023: 0287U, 81210, 81275, 81276, 81311 |
| HCPCS | No codes |
| ICD-10 Diagnosis | All related diagnoses |

*Investigational – A medical treatment, procedure, drug, device, or biological product is Investigational if the effectiveness has not been clearly tested and it has not been incorporated into standard medical practice. Any determination we make that a medical treatment, procedure, drug, device, or biological product is Investigational will be based on a consideration of the following:

- A. Whether the medical treatment, procedure, drug, device, or biological product can be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA) and whether such approval has been granted at the time the medical treatment, procedure, drug, device, or biological product is sought to be furnished; or
- B. Whether the medical treatment, procedure, drug, device, or biological product requires further studies or clinical trials to determine its maximum tolerated dose, toxicity, safety, effectiveness, or effectiveness as compared with the standard means of treatment or diagnosis, must improve health outcomes, according to the consensus of opinion among experts as shown by reliable evidence, including:
 1. Consultation with technology evaluation center(s);
 2. Credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community; or
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****Medically Necessary (or “Medical Necessity”)** - Health care services, treatment, procedures, equipment, drugs, devices, items or supplies that a Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

- A. In accordance with nationally accepted standards of medical practice;
- B. Clinically appropriate, in terms of type, frequency, extent, level of care, site and duration, and considered effective for the patient's illness, injury or disease; and
- C. Not primarily for the personal comfort or convenience of the patient, physician or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, “nationally accepted standards of medical practice” means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of Physicians practicing in relevant clinical areas and any other relevant factors.

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