Genetic Testing for Heterozygous Familial Hypercholesterolemia

Policy # 00510
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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 genetic testing to confirm a diagnosis of familial hypercholesterolemia (FH) to be **eligible for coverage**** when a definitive diagnosis is required as an eligibility criterion for specialty medications.

Patient Selection Criteria
Coverage eligibility for genetic testing to confirm a diagnosis of familial hypercholesterolemia (FH) will be met when:

- Genetic testing is targeted to individuals who are in an uncertain category according to clinical criteria (personal and family history, physical exam, lipid levels), AND
- Alternative treatment considerations are in place for individuals who have an uncertain diagnosis of familial hypercholesterolemia (FH) and a negative genetic test.

Based on review of available data, the Company may consider genetic testing of children of individuals with familial hypercholesterolemia (FH) to determine future risk of disease to be **eligible for coverage**.**

Patient Selection Criteria
Coverage eligibility for testing of children of individuals with familial hypercholesterolemia (FH) will be met when:

- A pathogenic mutation is present in a parent; AND

- General lipid screening is not recommended based on age or other factors.

When Services Are Considered Investigational

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

The use of genetic testing to confirm a diagnosis of familial hypercholesterolemia (FH) when patient selection criteria are not met is considered to be **investigational.***

The use of Genetic testing to determine future risk of disease in children of individuals with familial hypercholesterolemia (FH) when patient selection criteria are not met is considered to be **investigational.***

Genetic testing in adults who are close relatives of individuals with familial hypercholesterolemia (FH) to determine future risk of disease is considered to be **investigational.***

Policy Guidelines

The definition of an "uncertain" diagnosis of familial hypercholesterolemia (FH) is not standardized. However, available diagnostic tools provide guidance on when a diagnosis is and is not definitive. When FH is suspected and evaluated against standardized diagnostic criteria, it can be interpreted that the individual is in an "uncertain" category when criteria for a definitive diagnosis are not met. Here are some examples of certain criteria not being met:

- Dutch Lipid Clinic Network Criteria. A score of 8 or greater on the Dutch Lipid Clinic Network criteria is considered definitive FH. Scores between 3 and 7 are considered "possible" or "probable" FH. The latter 2 categories can be considered to represent "uncertain" FH.
- Simon-Broome Register Criteria. A definitive diagnosis of FH is made based on a total cholesterol level greater than 290 mg/dL in adults (or low-density lipoprotein >190 mg/dL), together with either positive physical exam findings or a positive genetic test. Probable FH, which can be interpreted as "uncertain" FH, is diagnosed using the same cholesterol levels, plus family history of premature coronary artery disease or total cholesterol of at least 290 mg/dL in a first- or a second-degree relative.

- Make Early Diagnosis Prevent Early Death (MEDPED) Diagnostic Criteria. These criteria provide a yes/no answer for whether an individual has FH, based on family history, age, and cholesterol levels. An individual who meets criteria for FH can be considered to have definitive FH; however, there is no "possible" or "probable" category that allows assignment of an "uncertain" category.

When there is a clinical diagnosis of FH but no known pathogenic variant in the family, it is necessary to test an index case to determine variant status. Coverage of testing an index case to benefit family members depends on contract benefit language (see Benefit Application section).

It is unlikely that screening of adults who are close relatives of an index case of FH will improve outcomes because management decisions will be made according to lipid levels and will not differ based on a diagnosis of FH. However, there are conditions under which testing of relatives will lead to improved outcomes, particularly when testing is performed as part of a formal cascade screening program. Cascade testing refers to a coordinated program of population screening intended to identify additional patients with FH. Cascade screening may involve a combination of lipid levels and genetic testing; conversely, cascade screening may be performed with genetic testing alone. Beginning with an index case, close relatives are screened. For patients who screen positive, all close relatives are then identified and screened. This process is repeated until no further close relative eligible for screening can be identified. While such programs exist in Western Europe, there are barriers to implementation in the United States, such as a lack of an infrastructure to identify all individuals in the cascade; additionally there is a lack of coordination for patients with different types of medical insurance.

Eligibility for specialty medicines (eg, PCSK9 inhibitors) may require a definitive diagnosis of FH. The labeled indications for these agents state they are for individuals with FH, although criteria for diagnosis are not given. In the key trials that led to Food and Drug Administration approval of these inhibitors, having a diagnosis of FH served as an eligibility criterion. The diagnosis in these trials was based on clinical factors with or without genetic testing.

Genetics Nomenclature Update

The Human Genome Variation Society nomenclature is used to report information on variants found in DNA and serves as an international standard in DNA diagnostics. It is being implemented for

genetic testing medical evidence review updates starting in 2017 (see Table PG1). The Society's nomenclature is recommended by the Human Variome Project, the Human Genome Organization, and by the Human Genome Variation Society itself.

The American College of Medical Genetics and Genomics and the Association for Molecular Pathology standards and guidelines for interpretation of sequence variants represent expert opinion from both organizations, in addition to the College of American Pathologists. These recommendations primarily apply to genetic tests used in clinical laboratories, including genotyping, single genes, panels, exomes, and genomes. Table PG2 shows the recommended standard terminology-"pathogenic," "likely pathogenic," "uncertain significance," "likely benign," and "benign"-to describe variants identified that cause Mendelian disorders.

Table PG1. Nomenclature to Report on Variants Found in DNA

Previous	Updated	Definition
Mutation	Disease-associated variant	Disease-associated change in the DNA sequence
	Variant	Change in the DNA sequence
	Familial variant	Disease-associated variant identified in a proband for use in subsequent targeted genetic testing in first-degree relatives

Table PG2. ACMG-AMP Standards and Guidelines for Variant Classification

Variant Classification	Definition
Pathogenic	Disease-causing change in the DNA sequence
Likely pathogenic	Likely disease-causing change in the DNA sequence
Variant of uncertain significance	Change in DNA sequence with uncertain effects on disease
Likely benign	Likely benign change in the DNA sequence
Benign	Benign change in the DNA sequence

ACMG: American College of Medical Genetics and Genomics; AMP: Association for Molecular Pathology.

Genetic Counseling

Experts recommend formal genetic counseling for patients 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 patients; 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

Familial Hypercholesterolemia

Familial hypercholesterolemia (FH) is an inherited disorder characterized by markedly elevated low-density lipoprotein (LDL) levels, physical exam signs of cholesterol deposition, and premature cardiovascular disease. FH can be categorized as homozygous or heterozygous FH. Homozygous FH is an extremely rare disorder that arises from biallelic variants in a single gene, and the disorder has a prevalence of between 1:160,000 and 1:1,000,000. Individuals with homozygous FH have extreme elevations of LDL, develop coronary artery disease (CAD) in the second or third decade, and are generally diagnosed easily.

Heterozygous FH is more common, with an estimated prevalence between 1 in 200 to 1 in 500 individuals. Some populations, such as Ashkenazi Jews and South Africans, have a higher prevalence of up to 1 in 100. For affected individuals, the burden of illness is high. Patients with FH and increased LDL cholesterol (>190 mg/dL) have a 3 times higher risk of CAD than those with increased LDL cholesterol alone. The average age for presentation with CAD is in the fourth decade for men and the fifth decade for women, and there is a 30% to 50% increase in risk for men and women in the fifth and sixth decades, respectively. Increased risk of CAD is associated with a higher rate of death associated with cardiovascular causes in patients with homozygous and heterozygous FH.

Diagnosis

The diagnosis of FH relies on elevated LDL levels in conjunction with a family history of premature CAD and physical exam signs of cholesterol deposition. There is wide variability in cholesterol levels for patients with FH, and considerable overlap in levels between patients with FH and patients

with non-FH. Physical exam findings can include tendinous xanthomas, xanthelasma, and corneal arcus, but these are not often helpful in making a diagnosis. Xanthelasma and corneal arcus are common in the elderly population and therefore not specific. Tendinous xanthomas are relatively specific for FH but are not sensitive findings. They occur mostly in patients with higher LDL levels and treatment with statins likely delays or prevents the development of xanthomas.

Because of the variable cholesterol levels, and the low sensitivity of physical exam findings, there are a considerable number of patients in whom the diagnosis is uncertain. For these individuals, there are a number of formal diagnostic tools for determining the likelihood of FH.

- Make Early Diagnosis Prevent Early Deaths Diagnostic Criteria
    - This tool relies on a combination of total cholesterol levels, age, and family history. For example, a 20-year-old individual who has no family history is diagnosed with FH if total cholesterol is 270 mg/dL or higher. A 25-year-old individual with a first-degree relative who has FH is diagnosed with FH if total cholesterol is 240 mg/dL or higher.
    - Genetic testing is not considered as part of the diagnostic workup with this tool.
- Dutch Lipid Clinic Network Criteria
    - This tool assigns points for family history, CAD in the individual, physical exam signs of cholesterol deposition, LDL levels, and results of genetic testing. The diagnosis of definite FH is made when the score is 8 or higher and probable FH when the score is 6 to 8.
    - The diagnosis can be made with or without genetic testing. A positive genetic test is given 8 points, which is the highest for any criterion and indicates that a positive genetic test alone is sufficient to make a definitive diagnosis.
- Simon-Broome Register Criteria
    - Using these criteria, a definite diagnosis of FH is made based on total cholesterol that is greater than 290 mg/dL in adults (or LDL >190 mg/dL) together with tendinous xanthoma in the individual or a first-degree relative.
    - A definite diagnosis can also be made using cholesterol levels and a positive genetic test.

- Probable FH is diagnosed by cholesterol levels and either a family history of premature CHD or a family history of total cholesterol 290 mg/dL or higher in a first- or a second-degree relative.

Treatment

Treatment of FH is generally similar to that for non-FH and is based on LDL levels. Treatment may differ in that the approach to treating FH is more aggressive (ie, treatment may be initiated sooner, and a higher intensity medication regimen may be used). In adults, there are no specific treatment guidelines that indicate treatment for FH differs from standard treatment of hypercholesterolemia. There may be more differences in children, for whom the presence of a pathogenic variant may impact the timing of starting medications.

As with other forms of hypercholesterolemia, statins are the mainstay of treatment for FH. However, because of the degree of elevated LDL in many patients with FH, statins will not be sufficient to achieve target lipid levels. Additional medications can be used in these patients. Ezetimibe inhibits absorption of cholesterol from the gastrointestinal tract and is effective for reducing LDL levels by up to 25% in patients already on statins. The IMPROVE-IT trial randomized patients with acute coronary syndrome to a combination of ezetimibe plus statins vs statins alone, and reported that cardiovascular events were reduced for patients treated with combination therapy.

The PCSK9 inhibitors are the most recently approved drugs for hyperlipidemia. These medications have potent LDL-lowering properties and have been tested in patients with FH. When added to statins, these drugs can result in additional LDL reduction of 30% to 70% and have been reported to reduce the incidence of nonfatal myocardial infarction. Other antilipid medications (eg, bile acid sequestrants, niacin) are effective at reducing LDL levels but have not demonstrated efficacy in reducing cardiovascular events when added to statins. For patients who continue to have elevated LDL levels despite maximum medical treatment, lipid apheresis is an option.

Genetic Markers for FH

FH is generally inherited as an autosomal dominant condition. The primary physiologic defect in FH is the impaired ability to clear LDL from the circulation, resulting in elevated serum levels. Three genes have been identified as harboring variants associated with FH.

- The LDL receptor gene (*LDLR*) is the most common variant identified, accounting for between 60% and 80% of FH.
    - The LDL receptor binds LDL thus allowing removal of LDL from the circulation. A defect in the LDL receptor leads to reduced clearance of LDL.
    - Over 1500 different pathogenic variants have been identified in this gene. Characterization of the frequency and spectrum of variants is ongoing.
- The *APOB* gene accounts for approximately 1% to 5% of FH cases.
    - Apolipoprotein B is a cofactor in the binding of LDL to the LDL receptor, and variants in *APOB* lead to reduced clearance of LDL.
    - There are a limited number of variants of this gene, allowing targeted testing.
- The *PCSK9* gene accounts for approximately 0% to 3% of FH.
    - This variant results in increased PCSK9 levels, which impair the function of the LDL receptors leading to reduced clearance of LDL.
    - There are a limited number of known pathogenic variants, allowing targeted testing.

Penetrance for all FH genes is 90% or higher. Therefore, nearly all patients found to have a pathogenic variant will eventually develop clinical disease. There is some degree of variable clinical expressivity that might be mediated by both environmental factors such as diet and exercise, and unknown genetic factors that modify gene expression.

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. Laboratories that offer laboratory-developed tests must be licensed by the Clinical Laboratory Improvement Amendments for high-complexity testing. To date, the U.S. Food and Drug Administration has chosen not to require any regulatory review of this test.

Rationale/Source

Familial hypercholesterolemia (FH) is an inherited disorder characterized by markedly elevated low-density lipoprotein levels, physical exam signs of cholesterol deposition, and premature cardiovascular disease. FH can be either homozygous or heterozygous. Heterozygous FH, which is

more common and more difficult to diagnose, is the focus of this evidence review. Genetic testing for heterozygous FH can potentially improve the ability to make a diagnosis of FH and can identify asymptomatic relatives of affected individuals at risk for developing FH.

For individuals who have signs and/or symptoms of FH when a definitive diagnosis is required to establish eligibility for specialty medications or who have signs and/or symptoms of FH undergoing lipid-lowering therapy who receive genetic testing to confirm the diagnosis of FH, the evidence includes case series and cross-sectional studies. Relevant outcomes are test validity, other test performance measures, symptoms, change in disease status, and morbid events. For clinical validity, there are large samples of individuals with FH who have been systematically tested for FH variants. In these cohorts of patients, the clinical sensitivity ranges from 30% to 70% for those with definite FH. For suspected FH, the sensitivity is lower, ranging from 1% to 30%. Clinical specificity ranges from 99% to 100%. False-positives are expected to be low for known pathogenic variants, but the false-positive rate is unknown for novel variants or for variants of uncertain significance. Direct evidence for clinical utility is lacking. The clinical utility of genetic testing was evaluated using a chain of evidence in the following situations:

- *When a definitive diagnosis of FH is required to establish eligibility for specialty medications.* A chain of evidence demonstrates that clinical utility is present. For patients who are in an uncertain diagnostic category, a positive genetic test can confirm the diagnosis of FH and establish eligibility for specialty medications. Specialty medications (eg, PCSK9 inhibitors) have known efficacy in patients with FH and uncontrolled lipid levels despite treatment with statins and/or other medications. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.
- *All other situations.* Clinical utility of testing for diagnosis cannot be demonstrated through a chain of evidence. No changes in management occur as a result of establishing a definitive diagnosis with genetic testing compared with standard clinical evaluation. For adolescents and adults, measurement of lipid levels is indicated, and management decisions will be made primarily on lipid levels and will not differ in the presence of FH. Therefore, an improvement in health outcomes cannot be demonstrated. The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals who are adults or children and have a close relative with a diagnosis of FH who receive genetic testing to determine future risk of FH, the evidence includes case series and cross-sectional studies. Relevant outcomes include test validity, other test performance measures, symptoms, change in disease status, and morbid events. For clinical validity, there are large samples of individuals with FH who have been systematically tested for FH variants. In these cohorts, the clinical sensitivity ranges from 30% to 70% for those with definite FH. For suspected FH, the sensitivity is lower, ranging from 1% to 30%. Clinical specificity ranges from 99% to 100%. False-positives are expected to be low for known pathogenic variants, but the false-positive rate is unknown for novel variants or for variants of uncertain significance. Direct evidence for clinical utility is lacking. Clinical utility was evaluated using a chain of evidence in the following situations:

- *Adults*. Clinical utility cannot be demonstrated through a chain of evidence. While targeted genetic testing is superior to standard risk stratification for determining future risk of disease, it is unlikely that management changes will occur as a result of genetic testing. Adults who are close relatives of individuals with FH will have their lipid levels tested, and management decisions for adults are made primarily by low-density lipoprotein levels and will not differ for patients with a diagnosis of FH. The evidence is insufficient to determine the effects of the technology on health outcomes.
- *Children*. Clinical utility can be demonstrated through a chain of evidence. Targeted genetic testing is superior to standard risk stratification for determining future risk of disease. It is recommended that the children of individuals who have a pathogenic variant initiate screening at an early age; further, the affected children should begin treatment with statins as early as possible. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

Supplemental Information

Practice Guidelines and Position Statements

Migliara et al (2017) conducted a systematic review of guidelines on genetic testing and patient management of individuals with familial hypercholesterolemia (FH). The literature search, conducted through April 2017, identified 10 guidelines for inclusion. Three of the guidelines were developed within the United States: those by the National Lipid Association, International FH Foundation, and American Association of Clinical Endocrinologists and American College of Endocrinology. Guidance from the National Institute for Health and Care Excellence was also

included in the review. The quality of the guidelines was assessed using the Appraisal of Guidelines for Research and Evaluation II) instrument, with guideline quality ranging from average to good. Most guidelines agreed that genetic testing follows cholesterol testing, physical findings distinctive of FH, and highly suggestive family history of FH. Universal screening for FH was not recommended. This review highlighted the importance of genetic testing for FH in children, because aggressive treatment at an earlier age may prevent premature coronary heart disease.

National Heart, Lung, and Blood Institute
Recommendations from an expert panel on cardiovascular health and risk reduction in children and adolescents were published in 2011. The report contained the following recommendations (see Table 1).

Table 1. Recommendations on Cardiovascular Health and Risk Reduction in Children and Adolescents

Recommendation	GOE
"The evidence review supports the concept that early identification and control of dyslipidemia throughout youth and into adulthood will substantially reduce clinical CVD risk beginning in young adult life. Preliminary evidence in children with heterozygous FH with markedly elevated LDL-C indicates that earlier treatment is associated with reduced subclinical evidence of atherosclerosis."	B
"TC and LDL-C levels fall as much as 10-20% or more during puberty."	B
"Based on this normal pattern of change in lipid and lipoprotein levels with growth and maturation, age 10 years (range age 9-11 years) is a stable time for lipid assessment in children. For most children, this age range will precede onset of puberty."	D

CVD: cardiovascular disease; FH: familial hypercholesterolemia; GOE: grade of evidence; LDL-C: low-density lipoprotein cholesterol; TC: triglycerides.

U.S. Preventive Services Task Force Recommendations
The U.S. Preventive Services Task Force (2008) published recommendations on lipid disorders in adults which was archived in 2013. This publication did not make specific recommendations for genetic testing for FH.

A Task Force evidence report, conducted by Lozano et al (2016), evaluated lipid screening in children and adolescents to detect familial hypercholesterolemia. This report stated that genetic screening for FH was beyond the scope of the report. Further, the report stated that "because implementing this approach [cascade screening] in the United States would require new infrastructure, cascade screening is outside of the purview of U.S. primary care and beyond the scope of this review."

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.

Ongoing and Unpublished Clinical Trials
Some currently unpublished trials that might influence this review are listed in Table 2.

Table 2. Summary of Key Trials

NCT No.	Trial Name	Planned Enrollment	Completion Date
Ongoing			
NCT01524289[a]	Study to Assess the Tolerability and Efficacy of Anacetrapib Co-administered With Statin in Participants With Heterozygous Familial Hypercholesterolemia (MK-0859-020) (REALIZE)	306	Oct 2018
NCT03253432	IN-TANDEM Familial Hypercholesterolemia Pilot Study	400	Dec 2018
NCT01960244	Study of Awareness and Detection of Familial Hypercholesterolemia (CASCADE-FH)	5000	Oct 2020

NCT: national clinical trial.
[a:] Denotes industry-sponsored or cosponsored trial.

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Policy History

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06/30/2016	Medical Policy Committee review
07/20/2016	Medical Policy Implementation Committee approval. New Policy
01/01/2017	Coding update: Removing ICD-9 Diagnosis Codes
07/06/2017	Medical Policy Committee review
07/19/2017	Medical Policy Implementation Committee approval. No change to coverage
07/05/2018	Medical Policy Committee review
07/11/2018	Medical Policy Implementation Committee approval. No change to coverage
07/03/2019	Medical Policy Committee review
07/18/2019	Medical Policy Implementation Committee approval. No change to coverage
07/03/2019	Medical Policy Committee review
07/18/2019	Medical Policy Implementation Committee approval. No change to coverage
07/02/2020	Medical Policy Committee review
07/08/2020	Medical Policy Implementation Committee approval. No change to coverage

Next Scheduled Review Date: 07/2021

Coding

The five character codes included in the Blue Cross Blue Shield of Louisiana Medical Policy Coverage Guidelines are obtained from Current Procedural Terminology (CPT®)‡, copyright 2019

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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	81401, 81405, 81406
HCPCS	No codes
ICD-10 Diagnosis	E78.00, E78.01, Z13.6, Z13.79, Z84.81, Z83.42

*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 the Blue Cross and Blue Shield Association technology assessment program (TEC) or other nonaffiliated technology evaluation center(s);
    2. Credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community; or
    3. Reference to federal regulations.

**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.

‡ Indicated trademarks are the registered trademarks of their respective owners.

NOTICE: If the Patient's health insurance contract contains language that differs from the BCBSLA Medical Policy definition noted above, the definition in the health insurance contract will be relied upon for specific coverage determinations.

NOTICE: Medical Policies are scientific based opinions, provided solely for coverage and informational purposes. Medical Policies should not be construed to suggest that the Company recommends, advocates, requires, encourages, or discourages any particular treatment, procedure, or service, or any particular course of treatment, procedure, or service.