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Moderator: Dr. Ola Awodele

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Coordinator: Welcome, everyone, and thank you for standing by. I would like to advise you that today's call is being recorded. If you have any objections, you may disconnect at this time.

All participants will be in listen-only mode until the question and answer sessions of today's call. I would now like to turn the conference over to Ola Awodele. Thank you so much. You may begin.

Ola Awodele: Thank you, Christina. I'd like to welcome everybody to the National Government Services J6-JK open meeting for today. I would like to also point out that everybody's line is on mute by default. And as we get to the various speakers, we would be opening up those lines.

Next slide, please. So this call is being recorded and transcribed. Thank you. And here are the list of our CMDs. And we'd like to welcome each and every one of you for taking the time out to be on this call.

And we're looking forward to hearing the comments that you have that would help us to be able to get these draft LCDs to final LCDs that would be helpful to you as our providers and also to us to help to better adjudicate your claims.

So it's myself, I'm Ola Awodele. It's Dr. Stephen Boren, Mark Duerden, Gina Mullen, Greg McKinney and Ella Noel.

Next slide, please. So we have three proposed LCDs that we'll be talking about today. One of them is new and that is DL39513, Allogeneic Hematopoietic Cell Transplantation for Primary Refractory or Relapsed Hodgkin and Non-Hodgkin lymphoma with B-cell or T-cell origin.

And we have two LCDs that we had before that we're bringing back as drafts for various adjustments or alterations. The first one is DL36037, which is Urine Drug Testing. And that would be commented and is being led by Dr. Boren.

And DL35000, Molecular Pathology Procedures, I happen to have two of three LCDs that we will be talking about today.

Next slide, please. Before we start with the first one, I just want to remind everybody that after we've discussed everything we've discussed today, we would appreciate getting the comments that are made today also in writing, both positive and negative comments. And at the end of the call, we will be giving information as to how to go about doing that.

So the first draft that we have on the docket is DL35913. Again that's Allogeneic Hematopoietic Cell Transplantation for Primary Refractory or Relapsed Hodgkin and Non-Hodgkin lymphoma with B-cell or T-cell origin. It came up as a result of a new LCD request by ASH.

And some background is currently Allo HSCT is covered for Medicare beneficiaries with the following indications, but it's only when they're participating in approved prospective clinical studies meeting specific criteria under the coverage with evidence development CED, otherwise known as CED paradigm.

And that would be for conditions such as myelodysplastic syndrome, multiple myeloma with Durie-Salmon stage two or three disease or international staging system, ISS, stage two or stage three disease, myelofibrosis with dynamic international prognostic scoring system, that is DIPSS Plus, intermediate two or

high primary or secondary disease or sickle cell disease that is severe and symptomatic.

And this information could be found in the CMS Internet Only Manual. It's in chapter - it's in 100-3, Medicare National Coverage Determinations Manual, Chapter 1, Part 2, otherwise known as NCD 110.23, titled Stem Cell Transplantation.

Next slide, please. So per the NCD, all other indications for stem cell transplantation not otherwise noted as covered or non-covered, remain at local Medicare administrative contractor discretion and hence why we're here.

This new policy describes additional locally covered indications for Allo HSCT for primary refractory or relapsed Hodgkin and Non-Hodgkin lymphomas with B-cell or T-cell origin that are medically necessary in patients for whom there are no other curative intent options.

Next slide, please. So we do have Dr. Steven Allen, who serves two purposes. He is a member of the American Society of Hematology and he also happens to be, in my opinion, a distinguished CAC member for NGS JK region.

So if Dr. Allen is on - I do believe he is on. If we can open up his mic, his line so that he can give his comments, I would appreciate that.

Coordinator: Absolutely. Dr. Allen, your line is open.

Dr. Allen: Thank you. Can you hear me?

Ola Awodele: Yes, we can, Dr. Allen.

Dr. Allen: Okay. Thank you. Good afternoon. I'm Dr. Steven Allen. I'm the hematology CAC representative for New York for many years. I'm also a Professor of Medicine at the Zucker School of Medicine at Hofstra/Northwell, Associate Chief of Hematology at Northwell Health.

I'm the secretary of the Empire State Hematology Oncology Society, and I'm the past chair of the Committee on Practice and a past member of the Executive Committee of the American Society of Hematology.

As a practicing hematologist and member of the American Society of Hematology, I would like to thank you for releasing this draft LCD for Allogeneic Hematopoietic Cell Transplantation for Primary Refractory or Relapsed Hodgkin and Non-Hodgkin lymphoma with B-cell or T-cell origin. We believe that this policy, as proposed, will fill an important coverage gap for Medicare beneficiaries.

NGS's draft LCD will expand coverage for allogeneic stem cell transplantation to Medicare patients with primary refractory or relapsed Hodgkin and non-Hodgkin lymphoma with B-cell or T-cell origin.

ASH supports the scientific evidence used to draft the LCD as it demonstrates the effectiveness and the comparable success rates of the procedure, regardless of age, providing the justification for this coverage decision.

Given that the Medicare national coverage determination for Allogeneic Stem Cell Transplantation does not include lymphoma as a covered indication, this LCD is critically important to the subset of lymphoma patients who require this treatment as Allo HSCT is their only option for curative intent therapy.

WPS, CGS and Palmetto already have such an LCD in place. This LCD mirrors the other MACs LCDs for the same treatment and therefore will provide continuity of coverage across the MACs and provide needed treatment to the beneficiaries covered under NGS.

In closing, on behalf of ASH and its members, thank you for the opportunity to comment. We encourage you to finalize this policy as proposed.

Ola Awodele: Thank you, Dr. Allen. And we would request that you please send that statement to us in writing. We would appreciate that. It's nice to have some positive feedback as well whenever we put out these draft LCDs.

So like I said, at the end of the meeting and also on our webpage, there will be the necessary information needed to know where to send those comments to. So I appreciate it. So now we'll go on.

Dr. Allen: Thank you.

Ola Awodele: Thank you. Thank you, sir. So now we'll go on to the line. Christina, could you please call for comments for people who have dialed in, please, anybody who has comments on this particular draft? Thank you.

Coordinator: Absolutely. If you would like to make a comment at this time, please press star 1 on your phone. Be sure your line is unmuted and record your name at the prompt. Again, to make a comment at this time, please press star 1.

It may take just a few moments for them to come through. Please stand by.

Ola Awodele: Thank you.

Coordinator: And I am showing no comments at this time. Speakers, you may proceed.

Ola Awodele: Thank you very much, Christina. So I'm going to hand over to Dr. Boren to facilitate the discussion on the next draft LCD. Dr. Boren?

Dr. Boren: Thank you. Can you hear me?

Ola Awodele: Yes, we can.

Dr. Boren: Thank you very much. This is a modification of our longstanding policy and it's really a clarification. The appropriate indications and allowed number of urine and drug testings built over time for safe medication, management of prescribed substances in risk stratified pain management patients and/or in identifying and treating substance use disorders (SUDS), designates documentation by the clinician caring for the beneficiary in the beneficiary's medical record of medical necessity for and testing ordered on individual patient basis. It provides an overall presumptive urine drug testing and definitive urine drug testing by various methodologies. Thank you.

Changes to this policy have been made to be consistent with other MAC and to help resolve issues noted in the recent OIG determination of potential overpayment of definitive testing and to clarify the use of urine drug testing.

The analysis of evidence supports the routine use of no more than 14 classes of drugs based on DEA and AACLM Clinical Guidelines.

We have several speakers to present. Adam Borden, Senior Vice President of Policy and Strategy, American Clinical Laboratory Association, speaking on behalf of ACLA and our member laboratories.

Adam Borden: Hi. This is Adam. Can you hear me?

Dr. Boren: Yes, I can hear you. And you stated you had no direct financial conflicts of interest to disclose, correct?

Adam Borden: Correct.

Dr. Boren: Okay. Thank you, sir.

Adam Borden: Great. Can we go to the next slide, please? All right. Great. So thank you for the opportunity to present today at the open meeting. We actually wanted to spend most of the time today talking about the urine drug testing policy or the proposed LCD.

And then we did have one comment. I know we're not there on the agenda yet, but on the molecular pathology procedures, LCD as well. And then we'll go through our recommendations.

Next slide, please. One more? Thank you. So first I'd say that, you know, we certainly appreciate the detail and the analysis that has gone into this policy.

We do know that there are several other MACs that worked collectively on this policy or on these proposed LCDs and certainly, again, appreciate the detail on the differences between presumptive and definitive drug testing in addition to the clinical sort of reasoning behind the testing itself.

However, we do have some significant concerns with these LCDs, mostly in the coverage indications, limitations and medical necessity section under the section of parent drugs and metabolite, essentially the chart that was just mentioned that limits testing to no more than 14 drug classes.

And what we believe is that the CMS has very clear instructions on how to count drug classes. And we do think that these proposed LCDs are not consistent with CMS's direct recommendations and guidance around how to count those drug classes.

And we don't necessarily believe that this is actually a coverage change. We think this is a coding and payment change, which is the LCD is not the appropriate venue to make coding and payment changes. And again, we think that does conflict with current policies from the CMS National Office on Payment and Coding Policies.

We do believe that these policies, if they are finalized as is, would cause significant disruptions to access for drug testing services and this is all during an ongoing public health emergency around the opioid epidemic.

It is not the right time to make these changes. Again, we think these changes are inappropriate to begin with, not necessarily based on clinical evidence. And we obviously would not want to see limitations on providers in terms of their only objective way to monitor certain patients that are in need of this type of testing.

In addition, this would significantly impact a laboratory's ability to keep up with the current drug market and testing for new drugs and metabolites that enter the streets and are being continuously changed and new drugs are sort of entering the streets essentially.

So we certainly do not want to see that happen or physicians to not have the ability to test patients for new and designer drugs. And again, just to reiterate that CMS has published very clear guidance on how to count drug classes and how to determine that based off of the AMA CPT manual.

On the right there, you see again, the statement from the NGS proposed LCD that limits this to only 14 tests. And we'll go through a little bit more detail on that in the next few minutes.

Next slide, please. So just very quickly, the value of definitive drug testing, and again, that's where we're focusing our concerns on really, three types of patients.

Those being treated for substance use disorder and in need of continuous care, those diagnosed with chronic pain who are currently prescribed controlled substances and also those who are being treated in an emergency setting, and you need to identify specific drugs to guide ongoing care for those patients.

The value of definitive drug testing is that it can very succinctly identify specific drugs, metabolites and most illicit substances whereas presumptive testing is limited in that sort of sense. And, of course, there is a need or a use for presumptive testing in certain scenarios.

However, definitive testing is able to identify those specific drugs where presumptive testing, usually through immunoassays, can often yield or sometimes yield false negative results, have low cross-reactivity or non-reactivity to specific drugs and ultimately cannot identify specific metabolites in certain drugs.

Next slide. So just going back through time a little bit. In 2015 essentially there were some new CPT codes created that identified, again, specific drugs. CMS did not ultimately accept those codes.

However, within the AMA CPT Code Book, they did list a table of specific drug classes. There were about 38 in the book with specific drugs that tied or were included in each of those classes.

Next slide. So CMS instead of, again, accepting those CPT codes had created a few HCPCS codes, some G codes for 2016, that were divided up into how many drug classes - not necessarily how many drugs were evaluated, but how many

drug classes are evaluated. And again that went through the rate setting process for 2016.

There was an adjustment in 2017. But these are the four codes, again, depending on how many drug classes, however many drugs are in a class, that's counted as one class and the codes were created and differentiated depending on how many drug classes, 1 through 7, 8 through 14, 15 to 21 and then 22 or more.

Next slide, please. So along with the - through the 2016 rate setting process, CMS did clearly define that definitive testing is the unit of - or the class is the unit that you should be counting for each of these definitive drug testing codes. And they listed specifically the drug classes that are included and referenced the CPT manual to map certain drugs into specific drug classes.

However, they say drug classes are listed below. And there were 37 drug classes listed here in their list. And this is within CMS guidance based on the 2016 final payment determinations for the clinical laboratory fee schedule.

Next slide, please. So we know that a catalyst for some of these particular LCDs was the OIG report from June 2021. We certainly recognize that report.

We do believe that that report had some significant flaws, the first of which was its OIG recommendation to CMS was that CMS should clearly indicate in LCDs, coverage articles or other instructions how laboratories should determine the number of drug classes.

CMS disagreed with that recommendation. They said LCDs are not the proper venue for billing or coding requirements, which are not directly related to reasonable and necessary standards. So CMS did not agree that the LCD is the right place to make coding and billing policy.

Again, there are other instructions and the OIG report failed to identify and recognize that there are instructions which were just reviewed that CMS has put forth on the number of drug classes and how to report those.

In addition, if you look towards the bottom of the slide, the OIG report language did note that six of the seven contractors stated that they considered the CPT guidance as the most appropriate source for determining the number of drug classes and that included NGS in that list of six.

So again, there was a recognition before and there was guidance from CMS that there are 37 drug classes and there are certain drugs that can map to those classes.

Next slide, please. So the proposed LCD essentially compresses these drug classes for counting purposes. Again, it does not change coverage. The only coverage change is around ethanol or alcohol testing, which is proposed to be only tested in blood and not in urine, which is not based on any evidence and there was no evidence that was cited to make that determination.

A lot of offices that send in samples do not have phlebotomists on staff. They are able to collect urine drug samples and there is no scientific evidence that says ethanol testing should only be tested in blood.

Again, however, on the drug class issue, the drug classes that were listed in the CPT Book, and that CMS has directly guided providers to utilize, are now being compressed artificially into 14, which also happens to be the cutoff for the G0481 and G0482 codes.

Again, that is essentially the cut-off which would eliminate payment for those two higher codes. Again, this is not based on evidence. Even in the AACC guidance, which is consensus-based, it is - there are 19 classes listed. The DEA Resource Guide is not all-inclusive of all types of drugs. So we do not believe that this LCD is based off of scientific evidence.

Next slide, please. Great. So just one more slide.

Ola Awodele: Excuse me. Sorry. This is Dr. Awodele. And may I request that we skip - we kind of keep the comments for the drug screen to - exactly. So if you could skip that slide as well. And then you can kind of finish up, yes, with your recommendations on

drug testing. And we will circle back to these when we are talking about the next LCD. Thank you.

Adam Borden: Sure, absolutely. Okay. So great. So our recommendations are that based again on these comments, which we will provide written comments during the comment period, that the LCD is not appropriate to effectuate what is essentially a coding and payment change.

We urge NGS to withdraw this proposed LCD and the accompanying article and also revert the current article back to open coverage for all four of these codes, not just the top two or the bottom two codes within the set.

We also have communicated with CMS on collaborations to address any current issues that have arisen or there are concerns from the agency around this issue. We are more than happy to engage on this topic, but certainly would recommend that these LCDs be withdrawn at this time. Next slide.

Dr. Boren: Dr. Boren here. Thank you very much.

Adam Borden: Thank you.

Dr. Boren: Can you hear me?

Adam Borden: Yes.

Ola Awodele: Yes, we can.

Dr. Boren: Okay. Thank you. Please send in writing what evidence you have to support your statements. Also one statement of yours, the third indication for the drug testing, I would like to have some literature to support the value of the drug testing across emergency departments.

Adam Borden: Yes. We will provide. Thank you.

Dr. Boren: Okay. I am a board certified, actually five times, emergency medicine physician who has had several academic appointments. And my experience has been that in general very few drug testing in urine give results immediately that make a

difference in the care and treatment of the patient, but I would be appreciative. Thank you very much, sir.

Adam Borden: Thank you. Next we have speakers from the Mayo Clinic, Dr. Paul Jannetto and Dr. Loralie Langman.

Dr. Jannetto : Hello. This is Paul. Can you hear me?

Dr. Boren: Yes, sir, I can.

Dr. Jannetto : Perfect. Will you guys be advancing the slides or will…

Dr. Boren: I think, is that (Alicia)? Are you going to be the one who is advancing it?

(Alicia): Yes. We'll advance them.

Dr. Jannetto : Perfect. Well, thank you very much for the opportunity to be here. If you could just advance to the next slide for me, thank you. Just as a quick disclosure, I am currently the Secretary on the Board of Directors for the American Association for Clinical Chemistry.

And Dr. Langman and I actually are the authors and co-chairs of the AACC Laboratory Medicine Practice Guideline actually cited in this LCD for using clinical laboratory tests to monitor drug therapy in pain management patients. And I also did some consulting for Roche and Thermo, but all that money goes to Mayo Clinic, not me. No other conflicts of interest.

Next slide. So just as a quick background, Dr. Langman and I each have over 20 years of directing a high complexity laboratories for both clinical and forensic toxicology testing using both definitive methods, things like gas chromatography, liquid chromatography and tandem mass chromatography for urine drug testing as well as immunoassays. And we're board certified.

Next slide. So there are three things that we wanted to bring up or raise of concerns with this proposed LCD. One is around the policy and article title. Two

is around the arbitrary classification of 14 drug classes in the parent-metabolite table. And then the third being the coverage of only two of the four G codes.

Next slide, please. So first of all, for the policy and article title, obviously this says it is specific to urine drug testing. But in the policy itself under specimen type it references both urine or oral fluids are the preferred biological specimen for testing and then in the billing and coding article, it says in the article text, blood, urine or oral fluid sample may be used.

And so the first thing is a clarification point. Is this policy and article only for urine drug testing? And if so, will there be a separate policy for blood and/or oral fluid testing as mentioned in these policies?

Next slide. The second one is really around the parent drugs and metabolite table. In this proposed LCD, they did arbitrarily classify the different drug classes to 14 categories. And they referenced AMA CPT 2021, DEA guide and the LMPG that actually Dr. Langman and I co-chaired and wrote on testing for urine drugs.

And really the main point we want to talk about here is this is really kind of an inappropriate grouping of drug classes. It's one thing to group them and talk about them as a larger class, a broader classification. But it's analytically and technically very different when it comes to testing these drugs. And that's something that's really important to note.

And so I want to go over a specific example of what I mean. So can we go to the next slide, please? So in the original AMA definitions that had more categories, up to 38, they defined opiates. It included codeine, dihydrocodeine, hydrocodone, hydromorphone and morphine in that category.

They did have separate categories for the fentanyls, which included fentanyl and the fentanyl analogs, a separate category for things like tramadol, oxycodone, methadone and its metabolite, EDDP, as well as others.

In the NGS proposal, they combined opiates, opioids and narcotics into one large drug class. And so this combines, from an analytical standpoint, things like

morphine, which is an opiate, with things that are synthetic opioids, like fentanyl and tramadol, as well as the semisynthetic opioids, like oxycodone, all into one category. And while talking about these things is one thing, analytically testing these is different.

So if you go to the next slide. So opiates and opioids are not the same, opiate, obviously, being the narrow drug. I'm going to give the example of morphine. Morphine is prescribed. The dosages are highly variable based on indication and tolerance.

Since this document's on urine drug testing, if you look at morphine in particular, morphine is excreted in the urine typically, over three days. That's what we say the window of detection is if you're going to do laboratory testing. So you can tell if somebody took morphine in the past three days. Eighty-seven percent of it gets excreted in the urine.

And if you look at parent drugs, so unchanged morphine, that could be up to 10% of the dose given. The rest of it's going to be the metabolites. And in chronic pain patients who are taking morphine, you'll see urine drug concentrations, on average, around 22,000 nanograms per mil, the range being 60,000 to 134,000 just in this one publication. I can tell you clinically we see values, again, much larger than that. And again, it's going to vary.

So at our institution, we have an LC-10/MS/BEC assay for urine opiates, which includes morphine. And our lower limit of quantitation, again, because this is being primarily used for compliance or adherence testing, is 25 nanograms per mil.

Contrast to fentanyl, which is a synthetic opioid, again 50 to 100 times more potent than morphine, again its dosages that are prescribed are highly variable on the indication and tolerance, but again for urine drug testing, you have a similar window of detection compared to morphine.

So up to three or four days in urine, 85% of fentanyl gets excreted. And you can see the parent or unchanged fentanyl account for up to 6% of that dose that you would find in the urine.

But if you compare the concentrations of fentanyl that you find in urine compared to morphine, you'll see again in chronic pain patients taking a transdermal patch, 25 micrograms per hour, the average fentanyl concentrations is 47 nanograms per mil, with the range being 0 to 983, again in this publication.

So the big difference here is much, much lower concentrations. Again, it's more potent. So it's 47 nanograms per mil compared to 22,000 nanograms per mil that you typically would find in morphine. And so analytically, we have a separate assay for fentanyl that uses LC-10/MS/BEC. And it has a lower limit of quantitation of 0.2 nanograms per mil, again because you have to be able to count those low doses and low concentrations that you can find.

Next slide, please. And so basically, you can't just arbitrarily group things as opiates and opioids into the same category because analytically, you have different considerations, including these very different ranges or concentrations that you're going to find for patients on clinical doses.

We can't just throw them all together because you have this large, dynamic range. In addition, we have to also account for things like spiked or adulterated samples, which represent about 3% of all samples that we test where people are either arbitrarily adding the drug directly to try to simulate compliance or trying to hide or mask other drug use.

In addition, these analytical ranges, because they're so large, we have to have separate assays to try to account for it and minimize repeat testing so we can get the assays and answers out as quickly and as efficiently as possible.

And every time we do have something that goes over the AMR, we still have to rule out things like carryover in the next samples that follow those high samples

to make sure they're not falsely positive due to carryover. Because even with advanced technologies of rinsing and methods, we still have carryover of things that we have to rule out.

And most importantly what people often forget what these drugs is when you arbitrarily group them together, they're very different chemistries. And some of these compounds are isobaric.

And what do I mean by that? Is that even when we use very definitive methods, like mass spectrometry, mass spectrometry alone cannot distinguish something like morphine and hydrocodone because they have the exact same molecular weight. So to a mass spec, without any chromatography upfront, those two would actually look the same.

And so we actually have to have varying methods that have varying protocols or chromatography up front with alternate gradients, chemistries and things to separate out these various compounds because it makes a big difference to a physician if they're prescribing hydromorphone if their patient is taking hydromorphone or morphine. And so we have to have analytical assays that can separate out and detect that.

And so one category really doesn't equal one assay, or one CPT code, or one reimbursement. And so you can't just arbitrarily lump them together. Well, we can talk about them as a group and say opioids is a large group, which also includes the opiates.

Analytically, even with definitive testing, mass spectrometry-based testing, it requires numerous assays because of the large concentration ranges, isobaric compounds and other challenges we face technically. And this doesn't hold true just for definitive testing, but also holds true for immunoassay or screening testing.

This is why the immunoassays have various assays for each of these individual drugs, which are all lumped together in this new category. So there's an opiate

immunoassay that picks up things like morphine and codeine very well. But those assays don't have any cross-reactivity to things like methadone, fentanyl, tramadol, tapentadol, buprenorphine, et cetera.

Again, same issues here with screening tests. We have to have multiple tests, multiple assays in order to accomplish and detect every one of those different compounds that you have combined into one group and therefore one CPT code of reimbursement.

Next slide, please. And again, one of the things referenced was that LMPG, of which Dr. Langman and I actually chaired and put together. And in that document, we combined - from the literature, it actually has 26 evidence-based recommendations and seven consensus-based recommendations.

In there, we list this table which shows the tiers of drug testing. And you can say, well, Paul, you just told me we shouldn't combine these all, but you have opiates and opioids all together in your table in tier one, which we consider, these are the drugs that you should routinely monitor on most patients.

What we didn't want to do is arbitrarily test hundreds of different drugs on everybody because that doesn't make sense financially. We want to be good stewards of testing, get the information you need, but not do over-testing. So again, it's about appropriate test utilization.

But when we combine opiates and opioids, we never said that's one assay so it's a tapentadol, tramadol, fentanyl. You'll see they're all listed under there as example drugs and that list is non-inclusive of every drug that needs to be in there and that's also stated in the text.

But it's basically to say that those are things that you should test on everybody. And then you can, for people who have a risk, say for alcohol abuse or misuse, then you can add that testing, again not testing everybody and the general population for everything but focusing on trying to have more narrow-based

panels. But nowhere does it say that by combining these it's one assay or one CPT code.

Next slide, please. And the last thing is just really around the G codes, which again, I think a previous presenter had talked about. It was only talking about the first two. Again, CMS created these G codes stating that they were based off the AMA Manual, which had the various 38 different classes.

And while that's not a perfect scenario or reflection or even accurate of what it takes from a clinical lab, meaning the number of different assays I have to measure to detect all these drugs because I can't group them all like you have into 14 nice little buckets, analytically it's actually multiple assays in order for me to accurately identify each one of those and quantitate them. And so really adding back all of those four classes would be important.

Next slide. And with that, I'll stop. And my colleague and I are both on to take any additional questions or any information. Thank you.

Dr. Boren: Thank you very much. I have no questions for you.

Dr. Jannetto: Thanks.

Dr. Boren: Just please make sure you send everything you have said in writing for us.

Dr. Jannetto: Yes. We will follow-up. Thank you.

Coordinator: And just a reminder for everyone else, if you would like to make a comment at this time, please press star 1. I am still showing no comments at this time. Speakers, you may proceed.

Ola Awodele: Awesome. Thank you very much, Christina. So thanks, Dr. Boren. We'll go to the - yes. So we're coming up on our last draft for today, and this is DL35000 and its molecular pathology procedures.

This is being brought back to open meeting as a result of a reconsideration request, which was concerning IgH and TP53 genes to facilitate decision-making

in the medical management of patients with CLL, or chronic lymphocytic leukemia.

After reviewing the literature provided and the NCCN biomarker compendium, we did determine that the NCCN Category 2A designation did support adding this coverage for these two STATA genes. Therefore, the changes are being made to the coverage guidance to allow for IgH and TP53 gene testing for CLL.

Next slide, please. Okay. I think that's - yes. So before that - sorry. So can we go back to slide - we do have two people that are going to comment. We have a comment from UCLA and then we have Dr. Loo. So, sir, you may proceed. Can you open the line for - yes, right.

Ola Awodele: And we have - Mr. Borden, can you make the comments you wanted to make on IgH and TP53?

Adam Borden: Yes. Can you hear me?

Ola Awodele: Yes, I can hear you now. Thank you.

Adam Borden: Okay. Excellent. Thank you. So I'll make this quick. So ACLA certainly supports adding IgH and TP53 testing for CLL patients.

We agree with the requester in terms of the rationale behind that. Again, this is all based off of NCCN Guidelines and biomarker compendium. So we certainly appreciate NGS proposing to add these two tests when appropriate for CLL patients.

Thank you so much.

Ola Awodele: Hello? Sorry. I was talking. I was on mute. I apologize. So I was saying thank you if you could send those comments in writing, I would appreciate that with the other comments that you had for the other LCD.

So I would now like us to open the line for Dr. Loo to make his comments. He also is one of our esteemed and appreciated CAC members. And so Dr. Loo, if you

could make the comments that you wanted to make concerning IgH and TP53 at this time.

Dr. Loo: Sure. Can you hear me okay?

Ola Awodele: I can hear you. Thank you.

Dr. Loo: Thank you so much. Yes. I'm Eric Loo. I'm one of the - I guess I am the pathology CAC representative from New Hampshire.

I just wanted to say thank you first off to allow us to provide commentary on these and thank you very much for including this IgH and TP53 in the LCD.

We've been testing these two genes for, you know, decades, and I had thought that this was standard of care and was surprised to actually see that it wasn't so that's really appreciated.

The concern that we had was that the wording for IgH was a little bit un-nuanced, and there are multiple tests that can be performed potentially on the IgH gene in the context of CLL. And we were just hoping that NGS might consider amending the wording to recognize the medical necessity of those evaluations.

The requester had, based on their wording, it seemed like that they were concerned about something called IgH somatic hypermutation analysis. And that is a study that has specific prognostic implications in patients with newly diagnosed CLL.

You know, it's a PCR-based study. You typically sequence the gene. And you typically have to evaluate an extremely long amplicon that's in excess of 600 nucleotides, which may necessitate some special PCR conditions for analysis. But in any event, the somatic hypermutation analysis has clear influence on the median survival of CLL and is predictive of a poor prognosis.

That is a test that you would typically do when you have a new diagnosis of CLL, and it's something that you don't tend to repeat. However, you can also, you know, do additional studies on IgH, specifically clonality studies, and those

would be needed, you know, for tracking the disease and something that you might order multiple times over time.

So the IgH clonality studies are kind of related to the somatic hypermutation analysis of the IgH gene. But they are really a quite different PCR-based study. You know, rather than focusing on the really long amplicon that goes from the leader region all the way to the joining region, you tend to do much smaller amplicons, you know, within different framework conserved regions in the variable portion of IgH.

And you would do that to get a baseline clonal sequence and then use that clonal sequence kind of as a barcode to identify the neoplastic cell population. And you would use that to identify, you know, residual disease that you aren't able to detect microscopically, usually after treatment because undetectable disease, like in an MRD study, after the end of treatment is really an important predictor of treatment efficacy.

And both of those are in the NCCN Guidelines that were stated. So I just wanted to draw the, you know, review committee's attention to that and see if maybe they were open to, you know, putting a little bit more nuance in the LCD.

The only reason I'm asking this is because I know that Medicare has that - what you call it, thing, the coding - the National Correct Coding Initiative. And they are like medically unlikely edits where if you have too many services ordered on the same thing or on the same day, you know, that, you know, something might get denied.

And all of those, you know, testings on IgH would be medically necessary and are separate things. But that's all I had to say, and I think I provided a letter already by email.

Ola Awodele: Yes, you did, Dr. Loo. And thank you. And you actually took the words out of my mouth because I was wanting to dialogue with you a little bit along the lines of how you ended this conversation, which is the clonality.

Would it also be heavy chain and if so, is there a different kind of way of distinguishing that it's not the heavy chain that is like the once in a lifetime, you know, in terms of the codes and stuff and how would that work out?

And so we would really love the opportunity to be able to work with you on that and what it would look like because like you rightfully said, there is NCCI. There are MUEs. And there are all of those things that go on, which is not necessarily in our court, right?

So no matter what our LCD says, there could be denial just on the basis of those. And so they don't really get into us just because those other things have kind of - they're the gatekeepers. So thank you.

Like you said, you have sent in your comments in writing already, and we are sorry that it couldn't make the slides and all of the...

Dr. Loo: I apologize for not making the deadline. I've just been too busy.

Ola Awodele: No, we appreciate it. So definitely, we would love the opportunity, you know, after we review this and everything that should we - and being a CAC member, I know we would have the opportunity to work with you as we go down on - as we continue along the line. So I really do appreciate that. Thank you very much, doctor.

Dr. Loo: No, thank you very much. Have a great day.

Ola Awodele: Thank you. You, too. So, Christina, could we please check online if there are any other comments from anybody online? Thank you.

Coordinator: Absolutely. And if you would like to make a comment at this time, please press star 1 on your phone, be sure your line is unmuted and record your name at the prompt. Again to make a comment, please press star 1.

And we do have a comment from Sameer with Mayo Clinic. Go ahead, please, your line is open. Thank you.

Dr. Parikh: Yes, hi. Thank you very much for giving me the opportunity to comment. My name is Dr. Sameer Parikh. I am a hematologist, and I care for patients with CLL here.

I just want to thank everyone on this committee and this call to actually discuss the role of IgH mutation testing as well as TP53 mutation testing. I think this is a huge thing for our patients who have CLL, and I think this will increase our ability to care for our patients and actually provide appropriate care. So I just wanted to say thank you very much.

Ola Awodele: Well thank you very much, sir, for your comments. And if you could please send those to us in writing, and I will be proceeding at the end of this call to be talking about how to do that because we really appreciate - we like to read and know that we are satisfying and catering to the needs of our providers and our beneficiaries as well. So thank you. We really appreciate that.

Dr. Parikh: Thank you.

Ola Awodele: Any other comments?

Coordinator: Yes. Our next comment comes from Steven Allen with Northwell Health Cancer Institute. Go ahead, please. Your line is open.

Dr. Allen: Hi. Thank you. I just had a question. The original submission letter from Mayo Clinic seemed to suggest there was a problem with the FISH CLL panel and that doesn't seem to have been addressed.

Ola Awodele: Yes. This one is more of the molecular, so the FISH, in terms of chemistry, right? So this is more of a molecular...

Dr. Allen: FISH is molecular.

Ola Awodele: Yes, I know. I'm trying to think my way through in terms of this. So when it comes to the IgH and the TP53 in terms of our accepting and our putting this into the policy, we - like Dr. Loo said, if you look at the actual policy, we tend to just put

like one or two lines in terms of the stuff and more of the information is found in the article in terms of the billing and when it would be covered.

So, Dr. Allen, have you been able to look at that and see whether it does satisfy what is needed?

Dr. Allen: I didn't see anything about FISH. That's why I was wondering. Unless does FISH come under genetic testing categories?

Ola Awodele: We don't have it listed under our molecular diagnostic categories. It would be - there is an NCD and the diagnosis will be added as discretionary to the NCD edit that we have. So there's an NCD for that and that's how we deal with the FISH testing.

Dr. Allen: I see. I understand. Thank you.

Ola Awodele: Okay. Thank you very much, sir. Any other questions, sir?

Coordinator: I'm showing no further comments at this time. You may proceed.

Ola Awodele: Okay. All right. Next slide, (Alicia). All right. So this officially marks the end of this open meeting. All the draft LCDs that were discussed today, the official comment period ends on March 18, 2023.

Next slide. And, as we have said, please send in your official comments to us. And these official comments should include a conflict of interest disclosure just so that we can know how to filter the comments that we get. And I'm sure people will agree with us that it does make sense.

So to comment on a proposed LCD during the official comment period, please send in your comments to partblcdcomments@anthem.com. That's via email. And that is our preferred method of receiving comments. But of course, if you only can mail comments in, we do have a mail-in address as well. It's National Government Services, Inc., LCD Comments, P.O. Box 7108, Indianapolis, Indiana, 46207-7108. This information is also available on our Draft LCD webpage as well.

I'd like to thank everybody for taking the time from their busy afternoon to join us and make this open meeting a success. It's only successful if we have participants. And we thoroughly enjoyed and we appreciate everybody who took the time off to participate today.

I believe that's the end of the slides, right, (Alicia)? Okay. Thank you very much, everybody. Christina, you can disconnect the call.

Coordinator: Thank you so much. That will conclude today's conference and we thank you for participating. You may disconnect at this time.

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