MEDICAL POLICY

POLICY TITLE	GENETIC TESTING FOR LI-FRAUMENI SYNDROME
POLICY NUMBER	MP 2.274

CLINICAL BENEFIT	☐ MINIMIZE SAFETY RISK OR CONCERN. ☐ MINIMIZE HARMFUL OR INEFFECTIVE INTERVENTIONS. ☐ ASSURE APPROPRIATE LEVEL OF CARE. ☐ ASSURE APPROPRIATE DURATION OF SERVICE FOR INTERVENTIONS. ☒ ASSURE THAT RECOMMENDED MEDICAL PREREQUISITES HAVE BEEN MET. ☐ ASSURE APPROPRIATE SITE OF TREATMENT OR SERVICE.
Effective Date:	**3/1/2024**

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I. POLICY

Genetic testing for *TP53* may be considered **medically necessary** to confirm a diagnosis of Li-Fraumeni syndrome under the following conditions:

- In an individual who meets either the classic or the Chompret clinical diagnostic criteria for Li- Fraumeni syndrome, **OR**
- In individuals with early-onset breast cancer (age of diagnosis <31 years), **OR**
- In pediatric hypodiploid acute lymphoblastic leukemia (see Policy Guidelines)

Targeted *TP53* familial variant testing may be considered **medically necessary** in an at-risk relative of a proband with a known *TP53* pathogenic variant.

Genetic testing for a germline *TP53* variant is considered **not medically necessary** for all other indications (see Policy Guidelines).

The National Comprehensive Cancer Network (NCCN) is a nonprofit alliance of cancer centers throughout the United States. NCCN develops the Clinical Practice Guidelines in Oncology which are recommendations aimed to help health care professionals diagnose, treat and manage patients with cancer. Guidelines evolve continuously as new treatments and diagnostics emerge and may be used by Capital Blue Cross when determining medical necessity according to this policy.

Policy Guidelines

The NCCN Pediatric Acute Lymphoblastic Leukemia panel considers “pediatric” to include any patient age ≤18 years, as well as adolescent and young adult (AYA) patients >18 years treated in a pediatric oncology setting; the latter could include patients up to age 30 years.

This reference medical policy addresses germline testing for TP53 and does not address somatic testing. Somatic TP53 variants found on tumor testing are common across many types of

cancers. The finding of somatic TP53 variant(s) on tumor testing would support genetic counseling for assessment of risk for germline alterations associated with Li-Fraumeni Syndrome.

GENETICS NOMENCLATURE UPDATE

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

Genetic counseling is primarily aimed at patients who are at risk for inherited disorders, and experts recommend formal genetic counseling in most cases when genetic testing for an inherited condition is considered. The interpretation of the results of genetic tests and the understanding of risk factors can be very difficult and complex. Therefore, genetic counseling will assist individuals in understanding the possible benefits and harms of genetic testing, including the possible impact

of the information on the individual's family. Genetic counseling may alter the utilization of genetic testing substantially and may reduce inappropriate testing. Genetic counseling should be performed by an individual with experience and expertise in genetic medicine and genetic testing methods.

II. PRODUCT VARIATIONS TOP

This policy is only applicable to certain programs and products administered by Capital Blue Cross and subject to benefit variations as discussed in Section VI. Please see additional information below.
FEP PPO - Refer to FEP Medical Policy Manual. The FEP Medical Policy manual can be found at: https://www.fepblue.org/benefit-plans/medical-policies-and-utilization-management-guidelines/medical-policies.

III. DESCRIPTION/BACKGROUND TOP

Li-Fraumeni syndrome (LFS) is a cancer predisposition syndrome associated with the development of several types of tumors. The syndrome is caused by germline pathogenic variants in the TP53 gene. Testing for LFS pathogenic variants may be useful in confirming the diagnosis of LFS and/or evaluating genetic status in asymptomatic relatives of an index case.

TP53 GENE

The *TP53* gene contains the genetic instructions for the production of tumor protein p53. The p53 protein is a tumor suppressor that functions as a cell cycle regulator to prevent cells from uncontrolled growth and division when there is DNA damage. Somatic (acquired) pathogenic variants are one of the most frequent alterations found in human cancers. Germline (inherited) pathogenic variants in *TP53* are associated with Li-Fraumeni syndrome (LFS).

LI-FRAUMENI SYNDROME

LFS is a cancer predisposition syndrome associated a high lifetime cumulative risk of cancer and a tendency for multiple cancers in affected individuals. The syndrome was originally described based on a retrospective analysis of families with aggressive soft tissue sarcomas in young siblings and their biologically related cousins.

The tumor types most closely associated with LFS include premenopausal breast cancer, bone and soft tissue sarcomas, central nervous system (CNS) tumor, adrenocortical carcinoma, hypodiploid acute lymphoblastic leukemia, unusually early onset of other adenocarcinomas, or other childhood cancers. Sarcoma, breast cancer, adrenocortical tumors, and certain brain tumors have been referred to as the “core” cancers of LFS since they account for the majority of cancers observed in individuals with germline TP53 pathogenic and likely pathogenic variants. Other malignancies associated with LFS include a wide variety of gastrointestinal tract, lung, skin, and thyroid cancers as well as leukemias and lymphomas.

Individuals with LFS are at increased risk of developing multiple primary tumors, with subsequent malignancies not all being clearly related to the treatment of the previous neoplasms. The risk of developing a second tumor has been estimated at 40% to 49%. In a study of 322 pathogenic

variant carriers from France, Bougeard et al (2015) reported that 43% of individuals had multiple malignancies.

Individuals with LFS are at increased risk of both bone and soft tissue sarcomas. Sarcomas of various histologies account for 25% of the cancers reported in people with LFS, with the most commonly reported sarcomas in an international database being rhabdomyosarcoma before age 5 years and osteosarcoma at any age. Women with LFS are at greatly increased risk of developing premenopausal breast cancer, with the median age of diagnosis being 33 years of age. Male breast cancer has rarely been reported in LFS families. Many types of brain tumors have been described in LFS, including astrocytomas, glioblastomas, medulloblastomas, and choroid plexus carcinomas. The median age of onset of LFS related brain tumors is 16 years of age. Individuals with LFS are at increased risk of developing adrenocortical carcinoma. For adults, Raymond et al (2013) estimated that 6% of individuals diagnosed with adrenocortical carcinoma after age 18 years have a germline TP53 pathogenic variant.

Data from M.D. Anderson Cancer Center's long-term clinical studies of LFS showed that the risk of developing soft tissue sarcomas is greatest before the age of 10 years, brain cancer appears to occur early in childhood with a smaller peak in risk in the fourth to fifth decade of life, risk for osteosarcoma is highest during adolescence, and breast cancer risk among females with LFS starts to increase significantly around age 20 and continues into older adulthood.

Clinical Diagnosis
The diagnosis of LFS is based on an evolving set of clinical classification criteria, established using salient aspects of family history and tumor-related characteristics. The first formal criteria, the classic LFS criteria, were developed in 1988, and are the most stringent used to make a clinical diagnosis of LFS.

Classic LFS
Classic LFS is defined by the presence of *all* of the following criteria:

- A proband with a sarcoma before 45 years of age
- A first-degree relative with any cancer before 45 years of age
- A first- or second-degree relative with any cancer before 45 years of age or a sarcoma at any age.

Chompret Criteria
Chompret et al (2001) developed criteria that have the highest positive predictive value, and that, when combined with the classic LFS criteria, provide the highest sensitivity for identifying individuals with LFS. The Chompret criteria were updated in 2009 to assist in identifying families with milder phenotypes. The Chompret criteria will also identify individuals with de novo TP53 pathogenic variants, whereas the classic LFS criteria require a family history.

The Chompret criteria, most recently updated in 2015, are defined as the following:

- Proband with tumor belonging to the LFS tumor spectrum (e.g., soft tissue sarcoma, osteosarcoma, brain tumor, premenopausal breast cancer, adrenocortical carcinoma)

before age 46 years AND at least 1, first- or second-degree relative with LFS tumor (except breast cancer if the proband has breast cancer) before age 56 years or with multiple tumors; or
- Proband with multiple tumors (except multiple breast tumors), 2 of which belong to the LFS tumor spectrum and the first of which occurred before age 46 years; or
- Patient with adrenocortical carcinoma, rhabdomyosarcoma of embryonal anaplastic subtype, or choroid plexus tumor, irrespective of family history; or
- Female proband with breast cancer before age 31 years.

The National Comprehensive Cancer Network guidelines recommend TP53 testing for individuals who meet classic LFS criteria and Chompret criteria.

Molecular Diagnosis
LFS is associated with germline pathogenic variants in the *TP53* gene (chromosome 17p13.1), which encodes for a ubiquitous transcription factor that is responsible for a complex set of regulatory functions that promote DNA repair and tumor suppression. *TP53* is the only gene in which pathogenic variants are known to cause LFS, and no other inherited phenotypes are associated specifically with germline pathogenic variants involving *TP53.* The presence of a *TP53* variant is considered diagnostic.

Li-Fraumeni syndrome is a highly penetrant cancer syndrome, with the risks of cancer being about 80% by age 70 years. It is inherited in an autosomal dominant manner. De novo germline *TP53* pathogenic variants (no pathogenic variant is identified in either biologic parent) are estimated to be 7% to 20%.

Approximately 95% of pathogenic variants detected in the *TP53* gene are sequence variants (small intragenic deletions and insertions and missense, nonsense, and splice site variants). Large deletions and duplications not readily detected by sequence analysis account for approximately 1% of the pathogenic variants detected.

Certain genotype-phenotype correlations have been reported in families with LFS and *TP53* pathogenic variants. Genotype-phenotype correlations in LFS are predictive of the age of onset of tumor, level of risk of developing tumor, and outcome in patients with *TP53* germline pathogenic variants.

Management

Treatment
The evaluation for cancer in an individual diagnosed with LFS should be based on personal medical history and, to some degree, the specific pattern of cancer in the family. Women with LFS who develop breast cancer are encouraged to consider bilateral mastectomies to reduce the risk of developing a second primary breast cancer and to avoid exposure to radiotherapy. Preventive measures may include risk-reducing (prophylactic) mastectomy in women, and in all patients with a *TP53* pathogenic variant, avoidance of radiotherapy, because the evidence suggests that *TP53*

pathogenic variants confer an increased sensitivity to ionizing radiation and the possibility of radiation-induced malignancies.

Surveillance
Li-Fraumeni syndrome confers a high risk of multiple different types of cancer, which poses challenges for establishing a comprehensive screening regimen, and many of the cancers associated with LFS do not lend themselves to early detection. There is no international consensus on the appropriate clinical surveillance strategy in individuals with LFS, but, in general, the strategy includes physical examination, colonoscopy, and breast imaging. Other protocols being evaluated include additional imaging techniques and biochemical assessment. The National Comprehensive Cancer Network has consensus-based screening guidelines.

Testing Strategy
Given the common germline TP53 variant types associated with LFS, a possible testing strategy to optimize yield would be:

1. Sequencing of the entire TP53 coding region (exons 2 through 11). Examples of types of pathogenic variants detected by sequence analysis include small insertions and deletions (frameshift), and missense, nonsense, and splice site variants; most are missense variants.
2. Deletion and duplication analysis, which detects large deletions and duplications involving the coding region (exon 1) or promoter; these types of deletions and duplications are not readily detectable by sequence analysis of the coding and flanking intronic regions of genomic DNA. These types of pathogenic variants account for less than 1% of those found in individuals with LFS.

REGULATORY STATUS
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 testsmust be licensed by the Clinical Laboratory Improvement Amendments or high complexity testing. To date, the U.S. Food and Drug Administration has chosen not to require any regulatory review of this test.

IV. RATIONALE TOP

SUMMARY OF EVIDENCE
For individuals with suspected LFS by clinical criteria who receive genetic testing for TP53, the evidence includes case series and cross-sectional studies. Relevant outcomes include overall survival, disease specific survival, test accuracy and validity, changes in reproductive decision making, and resource utilization. Evidence on the clinical validity of testing comes from the International Agency for Research on Cancer TP53 Database that has compiled records on 891 families with LFS. For patients with suspected LFS based on clinical criteria, the clinical sensitivity ranges from 50% to 80%. No evidence was identified on clinical specificity. A frequency of TP53 alterations upwards of 90% has been identified in individuals with low hypodiploid acute lymphoblastic leukemia (ALL), with nearly half suspected of germline pathogenic alterations; and,

nearly 30% of non-subtyped pediatric hypodiploid ALL having germline pathogenic TP53 alterations. No reports of germline TP53 pathogenic variants were identified among adult-onset hypodiploid ALL. In individuals with suspected LFS, a positive genetic test will establish a genetic diagnosis of LFS and facilitate the overall workup for cancer susceptibility syndrome when multiple conditions are considered. Also, the presence of a documented TP53 pathogenic variant may aid in decision making for risk-reducing (prophylactic) mastectomy. The evidence is sufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who are asymptomatic and have a close relative with a known TP53 pathogenic variant who receive targeted TP53 familial variant testing, the evidence includes case series and cross-sectional studies. Relevant outcomes include overall survival, disease-specific survival, test accuracy and validity, changes in reproductive decision making, and resource utilization. Evidence on the clinical validity of testing comes from the International Agency for Research on Cancer TP53 Database that has compiled records on 891 families with LFS. In asymptomatic individuals who have a close relative with a known TP53 pathogenic variant, targeted familial variant testing can confirm or exclude the presence of the familial variant with high certainty. A positive genetic test will lead to increased surveillance for LFS associated cancers, and a negative test will eliminate the need for enhanced surveillance. Knowledge of TP53 genetic status may also inform reproductive decision making in individuals considering offspring. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

V. DEFINITIONS TOP

NA

VI. BENEFIT VARIATIONS TOP

The existence of this medical policy does not mean that this service is a covered benefit under the member's health benefit plan. Benefit determinations should be based in all cases on the applicable health benefit plan language. Medical policies do not constitute a description of benefits. A member's health benefit plan governs which services are covered, which are excluded, which are subject to benefit limits, and which require preauthorization. There are different benefit plan designs in each product administered by Capital Blue Cross. Members and providers should consult the member's health benefit plan for information or contact Capital Blue Cross for benefit information.

VII. DISCLAIMER TOP

Capital Blue Cross's medical policies are developed to assist in administering a member's benefits, do not constitute medical advice and are subject to change. Treating providers are solely responsible for medical advice and treatment of members. Members should discuss any medical policy related to their coverage or condition with their provider and consult their benefit information to determine if the service is covered. If there is a discrepancy between this medical policy and a member's benefit information, the benefit information will govern. If a provider or a member has a question concerning the application of this medical policy to a specific member's plan of benefits, please contact Capital Blue Cross' Provider Services or Member Services. Capital Blue Cross

VIII. CODING INFORMATION

TOP

Note: This list of codes may not be all-inclusive, and codes are subject to change at any time. The identification of a code in this section does not denote coverage as coverage is determined by the terms of member benefit information. In addition, not all covered services are eligible for separate reimbursement.

Covered when medically necessary:

Procedure Codes								
81351	81352	81353	81479					

ICD-10-CM Diagnosis Code	Description
C50.011	Malignant neoplasm of nipple and areola, right female breast
C50.012	Malignant neoplasm of nipple and areola, left female breast
C50.111	Malignant neoplasm of central portion of right female breast
C50.112	Malignant neoplasm of central portion of left female breast
C50.211	Malignant neoplasm of upper-inner quadrant of right female breast
C50.212	Malignant neoplasm of upper-inner quadrant of left female breast
C50.311	Malignant neoplasm of lower-inner quadrant of right female breast
C50.312	Malignant neoplasm of lower-inner quadrant of left female breast
C50.411	Malignant neoplasm of upper-outer quadrant of right female breast
C50.412	Malignant neoplasm of upper-outer quadrant of left female breast
C50.511	Malignant neoplasm of lower-outer quadrant of right female breast
C50.512	Malignant neoplasm of lower-outer quadrant of left female breast
C50.611	Malignant neoplasm of axillary tail of right female breast
C50.612	Malignant neoplasm of axillary tail of left female breast
C50.811	Malignant neoplasm of overlapping sites of right female breast
C50.812	Malignant neoplasm of overlapping sites of left female breast
C50.911	Malignant neoplasm of unspecified site of right female breast
C50.912	Malignant neoplasm of unspecified site of left female breast
Z15.01	Genetic susceptibility to malignant neoplasm of breast

IX. REFERENCES

TOP

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X. POLICY HISTORY

TOP

MP 2.274	**CAC 7/22/14 New policy adopting BCBSA.** Previously Li-Fraumeni Syndrome genetic testing was not specifically addressed now listed as medically necessary with criteria.
	CAC 7/21/15 Consensus. No change to policy statements. References and rationale updated**.** No coding changes.
	11/2/15 Administrative update. LCD number changed from L34796 to L35396 due to Novitas update to ICD-10.
	CAC 7/26/16 Consensus. No change to policy statements. Background, rationale and references updated. Coding reviewed.
	1/1/17 Administrative update. Variation section reformatted.
	CAC 9/26/17 Minor review. Policy revised with updated genetics nomenclature. Policy statement updated for early-onset breast cancer to align with NCCN age cut-off of "<31 years". Coding updated with breast cancer diagnosis.
	7/9/18 Consensus review. No changes to the policy statements. References updated. Rationale revised**.**
	4/25/19 Consensus review. No change to policy statements. Background, summary of evidence and references reviewed.
	10/1/19 Coding updated. Coding reviewed; diagnosis codes updated.
	3/30/20 Consensus review. No change to policy statement. References reviewed, updated and one new code added (81404).
	9/30/20 Administrative update. Added new codes 81351, 81352 and 81353 effective 1/1/21. Removed 81405.
	10/5/2021 Consensus. References and background updated. Coding reviewed
	8/16/2022 Consensus review. No changes to policy statement. Background, FEP, references updated. Coding reviewed, no changes.
	08/22/2023 Minor review.
	1/19/2024 Administrative updated. Clinical benefit added.