

MEDICAL POLICY

POLICY TITLE	GENETIC TESTING FOR FANCONI ANEMIA
POLICY NUMBER	MP 2.362

CLINICAL BENEFIT	<input type="checkbox"/> MINIMIZE SAFETY RISK OR CONCERN. <input type="checkbox"/> MINIMIZE HARMFUL OR INEFFECTIVE INTERVENTIONS. <input type="checkbox"/> ASSURE APPROPRIATE LEVEL OF CARE. <input type="checkbox"/> ASSURE APPROPRIATE DURATION OF SERVICE FOR INTERVENTIONS. <input checked="" type="checkbox"/> ASSURE THAT RECOMMENDED MEDICAL PREREQUISITES HAVE BEEN MET. <input type="checkbox"/> ASSURE APPROPRIATE SITE OF TREATMENT OR SERVICE.
Effective Date:	RETIRED 7/1/2026

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I. POLICY

Genetic testing for the diagnosis of Fanconi anemia may be considered **medically necessary** when the following criteria are met:

- Clinical signs and symptoms of Fanconi anemia are present; **and**
- A definitive diagnosis of Fanconi anemia cannot be made after standard workup, i.e., nondiagnostic results on chromosome breakage analysis.

Genetic testing for the diagnosis of Fanconi anemia is considered **investigational** when the above criteria are not met. There is insufficient evidence to support a conclusion concerning the health outcomes or benefits associated with this procedure.

Genetic testing of asymptomatic individuals to determine future risk of disease may be considered **medically necessary** when there is a first-degree relative with a documented diagnosis of Fanconi anemia (see Policy Guidelines).

Genetic testing for Fanconi anemia is considered **investigational** in all other situations. There is insufficient evidence to support a conclusion concerning the health outcomes or benefits associated with this procedure.

POLICY GUIDELINES

Genetic testing for Fanconi anemia is a complex process that involves multiple steps and a number of different potential approaches. Most testing procedures described in the literature involve a combination of polymerase chain reaction, direct sequencing, and next-generation sequencing to identify a full complement of variants associated with Fanconi anemia.

However, in clinical care, a more directed approach can be taken. In many cases, testing complementation groups will have been performed prior to genetic testing, and this will direct genetic testing to one of the 15 known genes associated with Fanconi anemia. Direct

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sequencing and/or deletion/duplication analysis of these few genes may be the most accurate and efficient approach in many cases.

In the absence of complementation testing, the greatest yield will be in testing for the FANCA gene, followed by the FANCC and FANCG genes. If a patient with Fanconi anemia is negative for variants in these genes, then testing for many low-frequency variants may be necessary. Next-generation sequencing offers considerable advantages in testing multiple genes simultaneously for patients in this situation.

First-degree relatives include parents, siblings, and off-spring. Fanconi anemia can be transmitted by autosomal recessive, autosomal dominant, or X-linked inheritance. Testing the father of an individual with X-linked Fanconi anemia would not be indicated.

Carrier, preimplantation, and in utero testing for Fanconi anemia are addressed in **MP 2.258**, **MP 2.278**, and **MP 7.009**.

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	Diseased-Assoc Variant	Disease-associated change in the DNA sequence.
	Variant	Change in 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

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Benign	Benign change in the DNA sequence
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ACMG: American College of Medical Genetics and Genomics; AMP: Association of 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.

Cross-References:

- MP 2.258 Carrier Screening for Genetic Diseases**
- MP 2.278 Invasive Prenatal (Fetal) Diagnostic Testing**
- MP 2.323 General Approach to Evaluating the Utility of Genetic Panels**
- MP 2.325 Genetic Cancer Susceptibility Panels Using Next Generation Sequencing**
- MP 7.009 Preimplantation Genetic Testing**

II. PRODUCT VARIATIONS

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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

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Fanconi Anemia

Fanconi Anemia (FA) is an inherited disorder that is characterized by congenital abnormalities, bone marrow failure, and predisposition to hematologic malignancies. It is rare, with an incidence of less than 10 per million live births. FA is usually transmitted by the autosomal recessive route (>99%) and by the X-linked route in a very small number of cases. The carrier frequency in the United States is approximately 1 in 300 for the general population, and as high as 1 in 100 for certain populations such as Ashkenazi Jews and South Africans of Afrikaner descent.

The clinical expression of FA is variable, but it is associated with early mortality and a high degree of morbidity. Approximately 60% to 70% have at least 1 congenital abnormality, most

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common being disorders of the thumb and radial bones, short stature, skin hyperpigmentation, hypogonadism, and cafe-au-lait spots. A variety of other abnormalities of internal organs such as the heart, lungs, kidneys, and gastrointestinal tract can occur in up to 20% to 25% of patients. The most serious clinical problems are bone marrow abnormalities and malignancies. Hematologic abnormalities and bone marrow failure present in the first decade of life, although they can present much later. There is an increased predisposition to malignancies, especially myelodysplastic syndrome, acute myeloid leukemia, and squamous cell cancers of the head and neck.

Diagnosis

For patients with suspected FA after clinical and hematologic examination, the diagnosis can be confirmed by chromosome breakage analysis. A positive chromosome breakage test after exposure to alkylating agents such as diepoxybutane or mitomycin C confirms the diagnosis of FA and a negative test rules out FA. However, results may sometimes be inconclusive, leaving uncertainty as to the diagnosis of FA. In these cases, the detection of a genetic variant that is known to be pathogenic for FA can confirm the diagnosis.

Other inherited bone marrow failure disorders can mimic FA. They include dyskeratosis congenita, Shwachman-Diamond syndrome, and congenital amegakaryocytic thrombocytopenia. These disorders will not typically have a positive chromosomal breakage test, but if the breakage test is not definitive, then it may be difficult to distinguish between the syndromes on clinical parameters. Genetic testing for these other disorders is also available, targeting variants that are distinct from those seen in FA.

Treatment

Treatment recommendations based on expert consensus were published in 2014, sponsored by the Fanconi Anemia Research Fund. For bone marrow failure, this document recommends monitoring for mild bone marrow failure and hematopoietic cell transplantation (HCT) for moderate-to-severe bone marrow failure. Androgen therapy and/or hematopoietic growth factors are treatment options if HCT is unavailable or if the patient declines transplantation. FA patients have increased sensitivity to the conditioning regimens used for HCT and, as a result, reduced intensity regimens are used. Because of this different treatment approach, it is crucial to confirm or exclude a diagnosis of FA before HCT.

Genetics of FA

Molecular genetic testing is complicated by the presence of at least twenty-three (23) genes. For all the known genes associated with FA sequence, the analysis is complicated by the number of genes to be analyzed, a large number of possible variants in each gene, the presence of large insertions or deletions in some genes, and the size of many of the FA-related genes. If the complementation group has been established, the responsible variant can be determined by sequencing of the corresponding gene (see Table 1).

Table 1. Genes Associated with Fanconi Anemia

Gene	Proportion of Individuals with Fanconi Anemia, %	Variant Type(s)
<i>BRCA1</i>	<1	Sequence variants
<i>BRCA2</i>	2	Sequence variants

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<i>BRIP1</i>	2	Sequence variants
<i>ERCC4</i>	<1	Sequence variants
<i>FAAP100</i>	1 individual	Sequence variants
<i>FANCA</i>	60-70	Sequence variants; deletions/duplications
<i>FANCB</i>	2	Sequence variants; deletions/duplications
<i>FANCC</i>	14	Sequence variants; deletions/duplications
<i>FANCD2</i>	3	Sequence variants; deletions/duplications
<i>FANCE</i>	3	Sequence variants
<i>FANCF</i>	2	Sequence variants; deletions/duplications
<i>FANCG (XRCC9)</i>	10	Sequence variants
<i>FANCI</i>	1	Sequence variants; deletion/duplications
<i>FANCL</i>	<1	Sequence variants; deletions/duplications
<i>FANCM</i>	<1	Sequence variants; deletions/duplications
<i>PALB2</i>	<1	Sequence variants; deletions/duplications
<i>RAD51</i>	2 reported	Sequence variants
<i>RAD51C</i>	<1	Sequence variants
<i>REV7 (MAD2L2)</i>	1 reported	Sequence variants
<i>RFWD3</i>	1 reported	Sequence variants
<i>SLX4</i>	<1	Sequence variants; deletions/duplications
<i>UBE2T</i>	<1	Sequence variants; deletions/duplications
<i>XRCC2</i>	1 reported	Sequence variants

Adapted from Mehta and Ebens (2021).

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 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.

IV. RATIONALE

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SUMMARY OF EVIDENCE

For individuals who have signs and/or symptoms of FA who receive genetic testing for FA, the evidence includes small cohort studies and case series. Relevant outcomes are test validity, other test performance measures, change in disease status, and morbid events. Due to the rarity of clinical FA, there is limited published evidence to determine whether genetic testing for FA improves outcomes. The available evidence demonstrates that most patients with a clinical diagnosis of FA have identified pathogenic variants. This supports the use of genetic testing for the diagnosis when standard testing, including chromosomal breakage analysis, is inconclusive. Therefore, when signs and/or symptoms of FA are present, but the diagnosis cannot be made by standard testing, genetic testing will improve the ability to make a definitive diagnosis and direct care. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

For individuals who have a close relative with the diagnosis of FA who receive genetic testing for FA to determine future risk of the disease, the evidence consists of small cohort studies and case series. Relevant outcomes are test validity, other test performance measures, and changes in reproductive decision making. Genetic testing has clinical utility if there is a close relative with FA primarily first-degree relatives. This will primarily apply to young siblings of an affected individual and may help to direct early monitoring and treatment of bone marrow failure that may prevent or delay progression. Treatment of bone marrow failure with hematopoietic cell transplantation is considered more likely to be successful if initiated earlier in the course of the disease. The evidence is sufficient to determine that the technology results in an improvement in the net health outcomes.

V. DEFINITIONS

NA

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VI. DISCLAIMER

Capital Blue Cross' medical policies are used to determine coverage for specific medical technologies, procedures, equipment, and services. These medical policies do not constitute medical advice and are subject to change as required by law or applicable clinical evidence from independent treatment guidelines. Treating providers are solely responsible for medical advice and treatment of members. These policies are not a guarantee of coverage or payment. Payment of claims is subject to a determination regarding the member's benefit program and eligibility on the date of service, and a determination that the services are medically necessary and appropriate. Final processing of a claim is based upon the terms of contract that applies to the members' benefit program, including benefit limitations and exclusions. If a provider or a member has a question concerning this medical policy, please contact Capital Blue Cross' Provider Services or Member Services.

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VII. CODING INFORMATION

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

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by the terms of member benefit information. In addition, not all covered services are eligible for separate reimbursement.

Covered when medically necessary:

Procedure Codes							
81163	81165	81167	81212	81215	81216	81217	81242
81307	81308	81403*	81441	81479**			

*Can be used if testing for known familial variant, not otherwise specified

**Can be used for single gene testing for genes associated with Fanconi anemia (see table 1) that do not have their own code or for Fanconi anemia gene panels that may not have their own code.

ICD-10-CM Diagnosis Code	Description
D61.03	Fanconi anemia
D61.09	Other constitutional aplastic anemia
D61.89	Other specified aplastic anemias and other bone marrow failure syndromes
D61.9	Aplastic anemia, unspecified

VIII. REFERENCES

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IX. POLICY HISTORY

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MP 2.362	05/08/2018 New Policy. New BCBSA adoption policy. Genetic testing for Fanconi anemia may be considered medically necessary when criteria is met. Coding added.
	03/25/2019 Consensus Review. No change to policy statements, references updated.
	04/03/2020 Consensus Review. No change to policy statements. References updated. Policy variations updated to include FEP policy.
	02/12/2021 Minor Review. Removed Carrier Testing, Preimplantation Genetic Testing, and Fetal Testing from Policy Statement as those are discussed in other policies. Related policies added to Cross Reference section. Rationale and References updated.
	02/18/2022 Consensus Review. No changes to policy statements. FEP and references updated.
	02/17/2023 Consensus Review. Updated cross references, rationale, and references. Added 81441 to coding table.
	03/21/2024 Minor Review. Added additional indication for genetic testing. Updated policy guidelines, background, rationale, and references. Updated coding table by adding several codes for genes associated with Fanconi Anemia.

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<p>08/15/2024 Administrative Update. Added D61.03 as part of New Code. Eff date 10/01/2024.</p>
<p>11/20/2025 Administrative Update. Removed NCCN statement.</p>
<p>02/18/2025 Minor Review. Updated criteria statement. Updated background, rationale, and references. Added 81167 to coding table.</p>
<p>06/11/2025 Administrative Update. Removing the Benefit Variations Section and updating the Disclaimer.</p>
<p>03/03/2026 Retirement Review. Indication to be managed by the vendor Evicore.</p>

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