

MEDICAL POLICY

POLICY TITLE	GENETIC TESTING FOR DUCHENNE AND BECKER MUSCULAR DYSTROPHY
POLICY NUMBER	MP 2.257

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:	9/1/2024

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I. POLICY

Genetic testing for *DMD* gene variants may be considered **medically necessary** under the following conditions:

- In an individual assigned male at birth with signs and symptoms of a dystrophinopathy in order to confirm the diagnosis and direct treatment.
- For at-risk relatives assigned female at birth (see Policy Guidelines):
 - To confirm or exclude the need for cardiac surveillance.
 - For preconception testing to determine the likelihood of an affected offspring in an individual considering pregnancy.
- For at-risk offspring assigned male at birth (see Policy Guidelines):
 - To confirm or exclude the need for medical and cardiac surveillance.

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

POLICY GUIDELINES

Individuals assigned female at birth (AFB) who are heterozygous for a Duchenne muscular dystrophy (*DMD*) disease-associated variant are at increased risk for cardiomyopathy and need routine cardiac surveillance and treatment. At-risk individuals AFB are defined as first- and second-degree relatives and include the proband's mother, the proband's siblings who are AFB, the proband's offspring who are AFB, the proband's maternal grandmother, maternal aunts, and their offspring.

At-risk offspring assigned male at birth (AMB) is defined as an asymptomatic AMB offspring of an AFB carrier or an asymptomatic AMB sibling of an individual with a *DMD*-associated dystrophinopathy.

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Genetics Nomenclature Update

Human Genome Variation Society (HGVS) 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 policy review updates starting in 2017 (see Table PG1). HGVS nomenclature is recommended by HGVS, the Human Variome Project, and the Human Genome Organization (HUGO).

The American College of Medical Genetics and Genomics (ACMG) and Association for Molecular Pathology (AMP) standards and guidelines for interpretation of sequence variants represent expert opinion from ACMG, AMP, and 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.

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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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Variants in the *DMD* gene, which encodes the protein dystrophin, may result in a spectrum of X-linked muscle diseases, including the progressive diseases Duchenne (DMD) and Becker muscular dystrophy (BMD) and dilated cardiomyopathy. Genetic testing can confirm a diagnosis of a dystrophinopathy and distinguish the less from more severe forms, as well as identify female carriers at risk.

Dystrophinopathies

The dystrophinopathies include a spectrum of muscle diseases. The mild end of the spectrum includes asymptomatic increases in serum concentration of creatine phosphokinase and clinical symptoms such as muscle cramps with myoglobinuria and/or isolated quadriceps myopathy. The severe end of the spectrum includes progressive muscle diseases that lead to substantial morbidity and mortality. When skeletal muscle is primarily affected, the disease is classified as Duchenne (DMD) or Becker muscular dystrophy (BMD); when the heart is primarily affected, the disease is classified as *DMD*-associated dilated cardiomyopathy (left ventricular dilation and heart failure).

Duchenne Muscular Dystrophy

DMD, the most common muscular dystrophy, is a severe childhood X-linked recessive disorder that results in significant disability due to skeletal myopathy and cardiomyopathy. The disease is characterized by progressive, symmetric muscle weakness and gait disturbance resulting from a defective dystrophin gene. According to a 2022 systematic review and meta-analysis, the global prevalence of DMD is estimated at 4.8 cases (95% confidence interval [CI], 3.6 to 6.3) per 100,000 people. Approximately one-third of DMD cases arise from de novo variants and have no known family history. Infant males with DMD are often asymptomatic. Manifestations may be present as early as the first year of life in some patients, but clinical manifestations most often appear during preschool, from years 2 to 5. Affected children present with gait problems, calf hypertrophy, positive Gower sign, and difficulty climbing stairs. The affected child's motor status may plateau between 3 and 6 years of life with deterioration beginning at 6 to 8 years. Most patients will be wheelchair bound by ages 9 to 12 years but will retain preserved upper-limb function until a later period. Cardiomyopathy usually occurs after 18 years of age. Late complications are cardiorespiratory (e.g., decreased pulmonary function as a result of respiratory muscle weakness and cardiomyopathy). These severe complications commonly

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appear in the second decade of life and eventually lead to death. Few individuals with DMD survive beyond the third decade.

Becker Muscular Dystrophy

BMD is characterized by later onset skeletal muscle weakness. Individuals remain ambulatory into their twenties. Despite the milder skeletal muscle involvement, heart failure from cardiomyopathy is a common cause of morbidity and the most common cause of death in these patients, with a mean age of death in the mid-forties. According to a 2022 systematic review and meta-analysis, the global prevalence of BMD is estimated at 1.6 cases (95% CI, 1.1 to 2.4) per 100,000 people.

Female Carriers

Females heterozygous for a *DMD* disease-associated variant can manifest symptoms of the disease. An estimated 2.5% to 7.8% of female carriers are manifesting carriers who develop symptoms ranging from a mild muscle weakness to a rapidly progressive DMD-like muscular dystrophy. Female carriers are at increased risk for dilated cardiomyopathy. Most heterozygous women do not show severe myopathic features of DMD, possibly due to compensation by a normal X chromosome with inactivation of the mutated *DMD* gene in the affected X chromosome. In some cases, this compensation can be reversed by a nonrandom or skewed inactivation of X chromosome, resulting in greater expression of the affected X chromosome and some degree of myopathic features. Other mechanisms of manifesting female carriers include X chromosome rearrangement involving the *DMD* gene and complete or partial absence of the X chromosome (Turner syndrome).

Clinical Diagnosis

Duchenne Muscular Dystrophy

Suspicion of DMD should be considered irrespective of family history; it is most commonly triggered by an observation of abnormal muscle function in a male child, the detection of an increase in serum creatine kinase tested for unrelated indications, or detection of increased serum transaminases (aspartate aminotransferase and alanine aminotransferases). Clinical examination by a neuromuscular specialist for DMD includes visual inspection of mechanical function such as running, jumping, climbing stairs, and getting up from the floor. Common presenting symptoms include abnormal gait with frequent falls, difficulties rising from the floor or tip-toe walking, and pseudo hypertrophy of the calves. A clinical examination may reveal decreased or lost muscle reflexes and, commonly, a positive Gower sign. An elevation of serum creatine kinase, at least 10 to 20 times normal levels (between 5000 IU/L and 150,000 IU/L), is nonspecific to DMD but is always present in affected patients. Electromyography and nerve conduction studies were traditional parts of the assessment of neuromuscular disorders, but these tests may not be necessary for assessment of DMD. An open skeletal muscle biopsy is needed when a test for deletions or duplications of the *DMD* gene is negative. The biopsy will provide general signs of muscular dystrophy, including muscle fiber degeneration, muscle regeneration, and increased content of connective tissue and fat. Dystrophin analysis on a muscle biopsy will always be abnormal in affected patients but is not specific to DMD.

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Becker Muscular Dystrophy

BMD is clinically similar to DMD but is milder and has a later onset. BMD presents with progressive symmetric muscle weakness, often with calf hypertrophy, although weakness of quadriceps femoris may be the only sign. Activity-induced cramping may be present in some individuals, and flexion contractures of the elbows may be present late in the course. Neck flexor muscle strength is preserved, which differentiates BMD from DMD. Serum creatine kinase shows moderate-to-severe elevation (5-100 times the normal level).

Molecular Diagnosis

DMD is the only gene of which variants are known to cause DMD, BMD, and *DMD*-associated cardiomyopathy. Molecular genetic testing of *DMD* can establish the diagnosis of a dystrophinopathy without muscle biopsy in most patients with DMD and BMD.

The dystrophinopathies are X-linked recessive and penetrance is complete in males. The gene that codes for dystrophin is the largest known human gene. A molecular confirmation of DMD and BMD is achieved by confirming the presence of a pathogenic variant in this gene by a number of available assays. The large size of the dystrophin gene results in a complex variant spectrum with over 5000 reported disease-associated variants, as well as a high spontaneous de novo variant rate.

Treatment

There is no cure for DMD or BMD. Treatment is aimed at controlling symptoms to improve quality of life. However, the natural history of the disease can be changed by strategies such as corticosteroid therapy, proper nutrition, or rehabilitative interventions. Glucocorticoids were shown in a 1991 randomized controlled trial to prolong the period of independent ambulation by 3 years. The goal of this therapy is to preserve ambulation and minimize later respiratory, cardiac, and orthopedic complications. Glucocorticoids work by decreasing inflammation, preventing fibrosis, improving muscle regeneration, improving mitochondrial function, decreasing oxidative radicals, and stopping abnormal apoptosis pathways. Bone density measurement and immunization are prerequisites for corticosteroid therapy initiation, which typically begins at 2 to 5 years of age, although there has been no demonstrated benefit of therapy before 5 years of age.

New therapeutic trials require accurate diagnoses of these disorders, especially when the therapy is targeted at specific pathogenic variants. Exon-skipping is a molecular therapy aimed at skipping the transcription of a targeted exon to restore a correct reading frame using antisense oligonucleotides. Exon-skipping may result in a DMD protein without the mutated exon and a normal, nonshifted reading frame. Exon-skipping may also restore DMD protein function so that the treated patient's phenotypic expression more closely resembles BMD. Several therapies are currently in clinical trials. Exon-skipping therapies using antisense oligonucleotides approved by the U.S. Food and Drug Administration include: eteplirsen (Exondys 51) for treatment for patients who have a confirmed variant of the dystrophin gene amenable to exon 51 skipping, golodirsen (Vyondys 53), and viltolarsen (Viltepso) for patients who have a confirmed mutation of the DMD gene that is amenable to exon 53 skipping, and casimersen (Amondys 45) for patients who have a confirmed mutation of the DMD gene that is amenable to exon 45 skipping. These approvals were based on improvements in the surrogate

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outcome of increased dystrophin production in skeletal muscle and benefits in clinical outcomes have not yet been established.

A gene therapy, delandistrogene moxeparvovec-rokl (Elevidys), was also approved in 2023 to treat ambulatory children 4 to 5 years of age with DMD and a confirmed mutation in the DMD gene.

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 are male and have signs and symptoms of a dystrophinopathy who receive genetic testing for *DMD* gene variants to confirm diagnosis without biopsy, the evidence includes case series and database entries describing screening and results of types of variants found in patients with clinical signs of DMD or BMD. Relevant outcomes are test accuracy and validity, symptoms, change in disease status, morbid events, quality of life, medication use, and resource utilization. Virtually all males with DMD or BMD have identifiable *DMD* disease-associated variants, indicating a high clinical sensitivity for genetic testing. The clinical utility of *DMD* gene testing can be established for the index case to confirm the diagnosis without a muscle biopsy, to initiate effective treatment, and to distinguish between DMD and the less severe BMD. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

For individuals who are female and are a relative of a patient with a *DMD*-associated dystrophinopathy who receive targeted *DMD* testing for a known familial variant to determine carrier status, the evidence includes case series and database entries describing screening and results of types of variants found in patients with clinical signs of DMD or BMD. Relevant outcomes are test accuracy and validity, changes in reproductive decision making, symptoms, change in disease status, morbid events, quality of life, medication use, and resource utilization. Published data for the clinical validity for testing for a known familial variant are lacking but is expected to be high. Direct evidence on the clinical utility of *DMD* gene testing in at-risk female relatives is lacking. However, the chain of evidence is strong, because determination of carrier status in a female for a *DMD* familial variant necessitates or eliminates the need for routine cardiac surveillance and can indicate the likelihood of an affected offspring in women considering children. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

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For individuals who are asymptomatic male offspring of a female DMD familial variant carrier or an asymptomatic male sibling of a patient with a DMD-associated dystrophinopathy who receive targeted DMD testing for a known familial variant to determine DMD status, the evidence includes case series and database entries. Relevant outcomes are test accuracy and validity, symptoms, change in disease status, morbid events, quality of life, medication use, and resource utilization. Published data for clinical validity of testing for a known familial variant are lacking but is expected to be high. Direct evidence on the clinical utility of DMD gene testing in asymptomatic male offspring of a female DMD familial variant carrier or male sibling of a patient with a DMD-associated dystrophinopathy is lacking. However, the chain of evidence is strong, because detection of the DMD familial variant necessitates or eliminates the need for increased medical surveillance or cardiac surveillance in an asymptomatic male of a female carrier or the asymptomatic male sibling of a patient with a DMD-associated dystrophinopathy. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

V. DEFINITIONS

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N/A

VI. BENEFIT VARIATIONS

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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

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Capital Blue Cross' 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 considers the information contained in this medical policy to be proprietary and it may only be disseminated as permitted by law.

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VIII. CODING INFORMATION

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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							
81161	81403*	81408	0218U				

*Use when there is a known familial variant, not otherwise specified

ICD-10-CM Diagnosis Code	Description
G71.01	Duchenne or Becker muscular dystrophy
R62.59	Other lack of expected normal physiological development in childhood
Z31.430	Encounter of female for testing for genetic disease carrier status for procreative management
Z84.81	Family history of carrier of genetic disease
Z84.89	Family history of other specified conditions

IX. REFERENCES

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X. POLICY HISTORY

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MP 2.257	03/20/2020 Consensus Review. No change to policy statements. Background, rationale summary and references updated.
	03/13/2021 Consensus Review. No change to policy statement. Coding and references reviewed.
	07/25/2022 Consensus Review. No change to policy statement. Added code 0218U. Updated policy guidelines, FEP, references.
	06/06/2023 Consensus Review. Verbiage updates to policy statement and policy guidelines; no change to intent. Updated background, rationale, and references. Added CPT code 81403 and two ICD-10 codes.
	05/28/2024 Consensus Review. Updated background and references. No changes to coding.

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