Clinical Policy: Homocysteine Testing

Reference Number: CP.MP.121 [Coding Implications](#Coding_Implications)

Last Review Date: 05/19

[Revision Log](#Revision_Log)

**See** [Important Reminder](#Important_Reminder) **at the end of this policy for important regulatory and legal information.**

## Description

Homocysteine is a nonproteinogenic amino acid that is generated during the conversion of methionine to cysteine. Mutations of the enzymes within the biochemical pathways that regulate homeostatic homocysteine levels are associated with risk factors for various diseases, including venous thromboembolism. Supplementation of folic acid, vitamin B6, and vitamin B12 are known to modulate homocysteine levels, given the interplay between the folate cycle and metabolism. This policy describes the medical necessity requirements for testing levels of homocysteine.

## Policy/Criteria

1. It is the policy of health plans affiliated with Centene Corporation® that homocysteine testing is **medically necessary** for the following indications:
   1. Borderline vitamin B12 deficiency;
   2. Homocystinuria caused by cystathionine beta-synthase deficiency;
   3. Idiopathic (unprovoked) venous thromboembolism, recurrent venous thromboembolism, thrombosis occurring at < 45 years of age, or thrombosis at an unusual site.
2. It is the policy of health plans affiliated with Centene Corporation® that homocysteine testing is considered **investigational** for the following indications:
   1. Cardiovascular risk testing;
   2. For the testing of all other conditions.

## Background

Homocysteine is a naturally occurring intermediary amino acid that is generated during the conversion of methionine to cysteine. While homoeostatic plasma levels of homocysteine typically range at low micro molar concentrations,epistatic mutations and other aberrant modifications of the metabolic pathways modulate homocysteine levels.1 The metabolic pathway of homocysteine consists of upstream remethylation pathways and a downstream transsulfuration pathway. Notably, mutations in cystathionine-β-synthase, a key enzyme of the transsulfuration pathway, are associated with excess levels of homocysteine and premature thrombotic events.1 Furthermore, a common mutation at a single nucleotide (677C🡪T) in the gene encoding 5,10-methenetetrahydrolate reductase, an enzyme in the folate cycle whose byproducts are necessary cofactors in the metabolism of homocysteine, affects homoeostatic levels of homocysteine. This mutation predisposes the individual to low folate plasma levels, and consequently a status of hyperhomocysteine.2

Changes in the plasma homocysteine levels can result from alterations in folate or vitamin B6 or vitamin B12.7  A meta-analysis of 25 randomized clinical trials demonstrated that daily supplementation of ≥ 0.8 mg folic acid is sufficient to achieve the maximal reduction in plasma homocysteine levels. 8  Moreover, basal levels of homocysteine range between 5-15 μmol/L, while moderate hyperhomocysteine concentrations are 15-30 μmol/L, intermediate levels are 30-100 μmol/L and severe hyperhomocysteine concentrations are >100 μmol/L.7

Hyperhomocysteine was identified as an independent risk factor for ischemic heart disease and vascular disease.3,4 Initial reports hypothesized that heterozygosity of cystathionine-β-synthase contributed to the accumulation of homocysteine, and these reports were corroborated by later meta-analyses.3,4 However, this rationale has not been corroborated, as two randomized controlled trials, the Heart Outcomes Prevention Evaluation 2 (Hope-2) and the Norwegian Vitamin (NORVIT) trials simultaneously demonstrated no effect from lowering homocysteine levels, by way of folic acid or vitamin B6 supplementation, on cardiovascular outcomes.5,6

A 2017 Cochrane review of homocysteine-lowering interventions for preventing cardiovascular events concluded that B-vitamin supplements lowered homocysteine but did not reduce risk of myocardial infarction or reduce death rates in patients at risk of, or living with cardiovascular disease.11 Compared with placebo, lowered homocysteine resulting from B-vitamin supplementation combined with antihypertensive medications produced uncertain benefit in preventing stroke- approximately 143 people would need to be treated for 5.4 years to prevent 1 stroke.11

Hyperhomocysteine is also a risk factor for venous thromboembolic disease. Ray et al. performed a meta-analysis of 9 case control studies measuring fasting plasma homocystine, as well as 5 studies measured after methionine loading. All 9 studies demonstrated a similar trend in the levels and the associated risk for venous thromboembolism; following methionine loading, the trend increased toward the risk of venous thromboembolism.9,10 Hyperhomocysteinemia has been associated with venous thromboembolic disease in some but not all studies. Additional research, however, has concluded that associations between “mild” hyperhomocysteinemia and the VTE may have been due to confounding. 17  The measurement of homocysteinemia may be indicated in unexplained idiopathic venous thrombosis, or recurrent episodes or venous thrombosis that occurred at an early age or at an uncommon site.19

High levels of serum homocysteine have been proposed as a risk factor for dementia, and several studies have evaluated the role of B-vitamin supplementation in lowering homocysteine and thus improving cognitive function, or preventing cognitive decline. A meta-analysis by Clarke et al. determined that B-vitamin supplementation significantly reduced homocysteine levels, but did not have a clinically significant effect on global cognitive function or on cognitive aging.12 In contrast, a 2018 International Consensus Statement argues for the presence of a causal relationship between homocysteine levels and cognitive decline, and for screening for hyperhomocysteine and treatment with B vitamins in patients presenting to memory clinics.13 However, the consensus body notes that 76% of the participants in the trials in the largest meta-analysis on the topic did not include baseline measures of cognitive function, and thus couldn’t adequately compare the intervention group to the placebo group. Furthermore, they point to the lack of an established homocysteine threshold for intervention, which reduces the clinical relevance of the measure.

**Coding Implications**

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| **CPT® Codes** | **Description** |
| --- | --- |
| 83090 | Homocysteine |

| **HCPCS Codes** | **Description** |
| --- | --- |
| N/A |  |

**ICD-10-CM Diagnosis Codes that Support Coverage Criteria**

| **ICD-10-CM Code** | **Description** |
| --- | --- |
| D51.0-D51.9 | Vitamin B12 deficiency anemia |
| E53.8 | Deficiency of other unspecified B group vitamins |
| E72.10 | Disorders of sulfur-bearing amino-acid metabolism, unspecified |
| E72.11 | Homocystinuria |
| E72.19 | Other disorders of sulphur-bearing amino-acid metabolism |
| I26.01-I26.99 | Pulmonary embolism |
| I81 | Portal vein thrombosis |
| I82.0-I82.91 | Other venous embolism and thrombosis |
| Z86.711 | Personal history of pulmonary embolism |
| Z86.718 | Personal history of other venous thrombosis or embolism |

| **Reviews, Revisions, and Approvals** | **Date** | **Approval Date** |
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| References reviewed and updated | 07/17 | 08/17 |
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**Important Reminder**

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

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**Note: For Medicare members,** to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at <http://www.cms.gov> for additional information.

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