

## Medical Coverage Policy | Immune Cell Function Assay



**EFFECTIVE DATE:** 10|01|2015

**POLICY LAST REVIEWED:** 01|17|2024

### OVERVIEW

Careful monitoring of lifelong immunosuppression is required to ensure the long-term viability of solid organ allografts without incurring an increased risk of infection. The monitoring of immunosuppression parameters attempts to balance the dual risks of rejection and infection. It is proposed that individual immune profiles, such as an immune cell function assay, will help assess the immune function of the transplant recipient and individualize immunosuppressive therapy.

The following test are addressed in this policy:

- ImmuKnow (ViraCor-IBT Laboratories) CPT code 86352
- Pleximmune (Plexision) CPT code 81560

### MEDICAL CRITERIA

Not applicable

### PRIOR AUTHORIZATION

Not applicable

### POLICY STATEMENT

#### Medicare Advantage Plans and Commercial Products

Use of the immune cell function assay to monitor and predict immune function after solid organ transplantation, hematopoietic stem-cell transplantation, and all other indications is not covered for Medicare Advantage Plans and not medically necessary for Commercial Products as the evidence is insufficient to determine the effects of the technology on health outcomes.

**Note:** Laboratories are not allowed to obtain clinical authorization or participate in the authorization process on behalf of the ordering physician. Only the ordering physician shall be involved in the authorization, appeal or other administrative processes related to prior authorization/medical necessity.

In no circumstance shall a laboratory or a physician/provider use a representative of a laboratory or anyone with a relationship to a laboratory and/or a third party to obtain authorization on behalf of the ordering physician, to facilitate any portion of the authorization process or any subsequent appeal of a claim where the authorization process was not followed and/or a denial for clinical appropriateness was issued, including any element of the preparation of necessary documentation of clinical appropriateness. If a laboratory or a third party is found to be supporting any portion of the authorization process, BCBSRI will deem the action a violation of this policy and severe action will be taken up to and including termination from the BCBSRI provider network. If a laboratory provides a laboratory service that has not been authorized, the service will be denied as the financial liability of the participating laboratory and may not be billed to the member.

#### Commercial Products

Some genetic testing services are not covered and a contract exclusion for any self-funded group that has excluded the expanded coverage of biomarker testing related to the state mandate, R.I.G.L. §27-19-81 described in the Biomarker Testing Mandate policy. For these groups, a list of which genetic testing services are covered with prior authorization, are not medically necessary or are not covered because they are a contract exclusion can be found in the Coding section of the Genetic Testing Services or Proprietary Laboratory Analyses policies.

Please refer to the appropriate Benefit Booklet to determine whether the member's plan has customized benefit coverage. Please refer to the list of Related Policies for more information.

## **COVERAGE**

Benefits may vary between groups and contracts. Please refer to the appropriate Benefit Booklet, Evidence of Coverage or Subscriber Agreement for applicable not medically necessary/not covered benefits/coverage.

## **BACKGROUND**

I In current clinical practice, levels of immunosuppression in patients being managed after a solid organ transplant or hematopoietic cell transplantation are determined by testing for clinical toxicity (eg, leukopenia, renal failure) and by therapeutic drug monitoring when available. However, drug levels are not a surrogate for overall drug distribution or efficacy because pharmacokinetics often differ among individuals due to clinical factors such as underlying diagnosis, age, sex, and race; circulating drug levels may not reflect the drug concentration in relevant tissues; and serum level of an individual immunosuppressant drug may not reflect the cumulative effect of other concomitant immunosuppressants. The main value of therapeutic drug monitoring is the avoidance of toxicity. Individual immune profiles, such as an immune cell function assay, could support clinical decision making and help to manage the risk of infection from excessive immunosuppression and the risk of rejection from inadequate immunosuppression.

Several commercially available tests of immune cell function have been developed to support clinical decision making.

ImmuKnow measures the concentration of adenosine triphosphate (ATP) in whole blood after a 15- to 18-hour incubation with phytohemagglutinin (a mitogenic stimulant). Cells that respond to stimulation show increased ATP synthesis during incubation. Concurrently, whole blood is incubated in the absence of stimulants for the purpose of assessing basal ATP activity. CD4-positive T lymphocytes are immunoselected from both samples using anti-CD4 monoclonal antibody-coated magnetic particles. After washing the selected CD4-positive cells on a magnet tray, a lysis reagent is added to release intracellular ATP. A luminescence reagent added to the released ATP produces light measured by a luminometer, which is proportional to the concentration of ATP. The characterization of the cellular immune response of a specimen is made by comparing the ATP concentration for that specimen with fixed ATP production ranges.

Pleximmune measures CD154 expression on T-cytotoxic memory cells in patient's peripheral blood lymphocytes. CD154 is a marker of inflammatory response. To characterize the risk of rejection, the patient's inflammatory response to transplant donor cells is expressed as a fraction of the patient's inflammatory response to third-party cells. This fraction or ratio is called the Immunoreactivity Index (IR). If the donor-induced response exceeds the response to third-party cells, the individual is at increased risk for rejection. Cells are cultured and then analyzed with fluorochrome-stained antibodies to identify the cells expressing CD154. For posttransplant blood samples, an IR greater than 1.1 indicates an increased risk of rejection, and an IR less than 1.1 indicates a decreased risk of rejection. For pretransplant samples, the threshold for IR is 1.23.

For individuals with a solid organ transplant or HCT who receive immune cell function assay testing with ImmuKnow, the evidence includes numerous studies on the association between assay test values and subsequent rejection or infection, and an RCT in liver transplant patients. Relevant outcomes are OS, other test performance measures, and morbid events. The ImmuKnow test has shown variable associations with infection and rejection, depending on the type of transplant and context of the study. Across all the studies among various types of patients, ImmuKnow levels are associated with the risk of rejection when levels are high and risk of infection when levels are low. However, the absolute risk and increments of risk are uncertain because of the heterogeneity of the studies. The predictive characteristics of the test are still uncertain and do not allow a strong chain of evidence for clinical utility. The trial of the ImmuKnow test in liver transplant patients showed improvement in OS; however, the trial had several limitations. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals with a solid organ transplant or HCT who receive immune cell function assay testing with Pleximmune, the evidence includes the U.S. FDA documentation and a report on the test's development and validation. Relevant outcomes are OS, other measures of test performance, and morbid events. Small studies have shown that Pleximmune values correlate with long-term survival. Pleximmune test results correlated with rejection, but conclusions are uncertain because of extremely limited evidence deriving from a small number of patients described briefly in the FDA approval documents and a second study, in which the CI bounds for sensitivity and specificity estimates were wide. No direct studies of clinical utility were identified. An argument for clinical utility using a chain of evidence would rely on both a demonstration of clinical validity and a rationale that specific clinical interventions based the results of the test decrease the risk of a poor health outcome. At present, the clinical interventions that would occur as a result of the test result are uncertain, and so the clinical validity is uncertain. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

## **CODING**

### **Medicare Advantage Plans and Commercial Products**

The following CPT code(s) are not covered for Medicare Advantage Plans and considered not medically necessary for Commercial Products:

This code can be used for Pleximmune

**81560** Transplantation medicine (allograft rejection, pediatric liver and small bowel), measurement of donor and third party-induced cd154+t-cytotoxic memory cells, utilizing whole peripheral blood, algorithm reported as a rejection risk score

This code can be used for ImmuKnow

**86352** Cellular function assay involving stimulation (eg, mitogen or antigen) and detection of biomarker (eg, ATP)

## **RELATED POLICIES**

Biomarker Testing Mandate

Genetic Testing Services

## **PUBLISHED**

Provider Update, March 2024

Provider Update, March/November 2023

Provider Update, April 2022

Provider Update, March 2021

Provider Update, March 2020

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2. Food and Drug Administration (FDA). Summary of Safety and Probable Benefit: Pleximmune. 2014; [http://www.accessdata.fda.gov/cdrh\\_docs/pdf13/H130004b.pdf](http://www.accessdata.fda.gov/cdrh_docs/pdf13/H130004b.pdf). Accessed November 16, 2023.
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