MEDICAL POLICY – 12.04.117
Genetic Testing for Mitochondrial Disorders

BCBSA Ref. Policy: 2.04.117
Effective Date: Aug. 1, 2017
Last Revised: July 18, 2017
Replaces: 2.04.117

RELATED MEDICAL POLICIES:
None

Select a hyperlink below to be directed to that section.

POLICY CRITERIA | CODING | RELATED INFORMATION
EVIDENCE REVIEW | REFERENCES | HISTORY

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Introduction

Mitochondria are found in all cells of the body except red blood cells. The mitochondria have many functions within a cell, including creating most of the energy the cells need. When mitochondria are damaged, the cell has less energy. And less energy leads to problems within the cell and even cell death. Because mitochondria come from only the mother, a child can inherit mitochondrial DNA problems only from the mother. Mitochondrial disease is a chronic illness that may be present when a child is born or may develop later. It usually causes severe physical problems and developmental issues. Physical examination is usually enough to diagnose mitochondrial disease. Other specialized tests may also be needed for an accurate diagnosis. Genetic testing can be used when the other usual tests for mitochondrial disease are not able to make a clear diagnosis. This policy describes when genetic testing for mitochondrial disease is considered medically necessary.

Note: The Introduction section is for your general knowledge and is not to be taken as policy coverage criteria. The rest of the policy uses specific words and concepts familiar to medical professionals. It is intended for providers. A provider can be a person, such as a doctor, nurse, psychologist, or dentist. A provider also can be a place where medical care is given, like a hospital, clinic, or lab. This policy informs them about when a service may be covered.

Policy Coverage Criteria
<table>
<thead>
<tr>
<th>Testing</th>
<th>Medical Necessity</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>To establish a genetic diagnosis of a mitochondrial disorder</strong></td>
<td>Genetic testing to establish a genetic diagnosis of a mitochondrial disorder may be considered medically necessary when signs and symptoms of a mitochondrial disorder are present and genetic testing may eliminate the need for muscle biopsy. Patients usually have complex multisystem clinical findings (see Table 1 below).</td>
</tr>
<tr>
<td></td>
<td>Genetic testing for mitochondrial disorders is considered investigational in all other situations when the criteria for medical necessity are not met.</td>
</tr>
<tr>
<td><strong>At-risk relatives</strong></td>
<td>Targeted genetic testing for a known familial variant of at-risk relatives may be considered medically necessary as preconceptional carrier testing under the following conditions:</td>
</tr>
<tr>
<td></td>
<td>• There is a defined mitochondrial disorder in the family of sufficient severity to cause impairment of quality of life or functional status <strong>AND</strong></td>
</tr>
<tr>
<td></td>
<td>• A variant that is known to be pathogenic for that specific mitochondrial disorder has been identified in the index case.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Panel Testing</th>
<th>Investigational</th>
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</thead>
<tbody>
<tr>
<td><strong>Expanded Panel Genetic testing</strong></td>
<td>Genetic testing for mitochondrial disorders using expanded panel testing is considered investigational</td>
</tr>
<tr>
<td><strong>Note:</strong> This includes but is not limited to the following tests:</td>
<td></td>
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<tr>
<td>• Comprehensive Mitochondrial Nuclear Gene Panel (Gene Dx® Gaithersburg, MD)</td>
<td></td>
</tr>
<tr>
<td>• Complete Mitochondrial Evaluation (Transgenomic® New Haven, CT)</td>
<td></td>
</tr>
<tr>
<td>• nucSEEK® Comprehensive (Courtagen® Woburn, MA)</td>
<td></td>
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<tr>
<td>• nucSEEK® Focus (Courtagen® Woburn, MA)</td>
<td></td>
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<tr>
<td>• mtSEEK® (Courtagen® Woburn, MA)</td>
<td></td>
</tr>
<tr>
<td>• Mitochondrial Disorders Panel, Mitochondrial Disorders (mtDNA) Sequencing (ARUP® Salt Lake City, UT)</td>
<td></td>
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<tr>
<td>• BCM-MitomeNGSSM (Baylor Genetics Laboratory Houston, TX)</td>
<td></td>
</tr>
<tr>
<td>• MitoMED1204™ (MEDomics® Azusa, CA)</td>
<td></td>
</tr>
<tr>
<td>• Mitochondrial Diseases: Sequencing Panel (Emory Genetics Laboratory Tucker, GA)</td>
<td></td>
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</tbody>
</table>
Mitochondrial disorders can be caused by variants in mitochondrial DNA (mtDNA) or nuclear DNA (nDNA). A 3-generation family history may suggest a mode of inheritance. A family history in which affected women transmit the disease to male and female children and affected men do not transmit the disease to their children suggests the familial variant(s) is in the mtDNA. A family history consistent with Mendelian autosomal dominant or autosomal recessive inheritance or with X-linked inheritance suggests the familial variant(s) is in the nDNA. De novo pathogenic variants are also possible.

**Testing Strategy**

*Individuals with a Suspected Mitochondrial Disorder*

If the phenotype is highly suggestive of a specific disorder that is supported by the inheritance pattern noted in the family history, it would be reasonable to begin genetic testing with single genes or targeted multigene panels that test for pathogenic variants specific for that disorder.

If a mitochondrial disorder is suspected, but the phenotype is nonspecific, broader genetic testing is appropriate under the guidance of a clinical geneticist and genetics counselor. For patients in whom the family history is suggestive of a disorder due to pathogenic variant(s) in mtDNA, multigene panels or sequencing of the mitochondrial genome may be appropriate. If multiple mtDNA deletions are noted, or the family history is suggestive of a disorder due to variants in nDNA, then multigene panels covering known nuclear genes associated with mitochondrial disease may be appropriate.

*Individuals With a Family Member With a Mitochondrial Disorder and Known Familial Variant*

Targeted testing for a known familial variant in at-risk relatives as part of preconceptual carrier testing is appropriate. At-risk relatives include only female relatives if the familial pathogenic variant is in the mtDNA but includes both male and female relatives if the familial pathogenic variant is in the nDNA.
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>81401</td>
<td>Molecular pathology procedure, Level 2 (eg, 2-10 SNPs, 1 methylated variant, or 1 somatic variant [typically using nonsequencing target variant analysis], or detection of a dynamic mutation disorder/triplet repeat)</td>
</tr>
<tr>
<td>81403</td>
<td>Molecular pathology procedure, Level 4 (eg, analysis of single exon by DNA sequence analysis, analysis of &gt;10 amplicons using multiplex PCR in 2 or more independent reactions, mutation scanning or duplication/deletion variants of 2-5 exons)</td>
</tr>
<tr>
<td>81440</td>
<td>Nuclear encoded mitochondrial genes (eg, neurologic or myopathic phenotypes), genomic sequence panel, must include analysis of at least 100 genes, including BCS1L, C10orf2, COQ2, COX10, DGUOK, MPV17, OPA1, PDSS2, POLG, POLG2, RRM2B, SCO1, SCO2, SLC25A4, SUCLA2, SUCLG1, TAZ, TK2, and TYMP</td>
</tr>
<tr>
<td>81460</td>
<td>Whole mitochondrial genome (eg, Leigh syndrome, mitochondrial encephalomyopathy, lactic acidosis, and stroke-like episodes [MELAS], myoclonic epilepsy with ragged-red fibers [MERFF], neuropathy, ataxia, and retinitis pigmentosa [NARP], Leber hereditary optic neuropathy [LHON]), genomic sequence, must include sequence analysis of entire mitochondrial genome with heteroplasmy detection</td>
</tr>
<tr>
<td>81465</td>
<td>Whole mitochondrial genome large deletion analysis panel (eg, Kearns-Sayre syndrome, chronic progressive external ophthalmoplegia), including heteroplasmy detection, if performed</td>
</tr>
<tr>
<td>81479</td>
<td>Unlisted molecular pathology procedure</td>
</tr>
</tbody>
</table>

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Code 81401 includes:

- MT-ATP6 (mitochondrially encoded ATP synthase 6) (eg, neuropathy with ataxia and retinitis pigmentosa [NARP], Leigh syndrome), common variants (eg, m.8993T>G, m.8993T>C)
- MT-ND4, MT-ND6 (mitochondrially encoded NADH dehydrogenase 4, mitochondrially encoded NADH dehydrogenase 6) (eg, Leber hereditary optic neuropathy [LHON]), common variants (eg, m.11778G>A, m.3460G>A, m.14484T>C)
- MT-TK (mitochondrially encoded tRNA lysine) (eg, myoclonic epilepsy with ragged-red fibers [MERRF]), common variants (eg, m.8344A>G, m.8356T>C)
- MT-ND5 (mitochondrially encoded tRNA leucine 1 [UUA/G], mitochondrially encoded NADH dehydrogenase 5) (eg, mitochondrial encephalopathy with lactic acidosis and stroke-like episodes [MELAS]), common variants (eg, m.3243A>G, m.3271T>C, m.3252A>G, m.13513G>A)
- MT-TL1 (mitochondrially encoded tRNA leucine 1 [UUA/G]) (eg, diabetes and hearing loss), common variants (eg, m.3243A>G, m.14709 T>C)
- MT-TS1, MT-RNR1 (mitochondrially encoded tRNA serine 1 [UCN], mitochondrially encoded 12S RNA) (eg, nonsyndromic sensorineural deafness [including aminoglycoside-induced nonsyndromic deafness]), common variants (eg, m.7445A>G, m.1555A>G)

Code 81403 includes:
- MT-RNR1 (mitochondrially encoded 12S RNA) (eg, nonsyndromic hearing loss), full gene sequence
- MT-TS1 (mitochondrially encoded tRNA serine 1) (eg, nonsyndromic hearing loss), full gene sequence

If there is no specific listing in the CPT molecular pathology code list for the mitochondrial DNA test that is performed, the unlisted molecular pathology code 81479 may be reported. If multiple unlisted mitochondrial DNA tests are performed, the unlisted code is only reported once for all of the unlisted tests.

### Related Information

#### 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.

Evidence Review

Description

Mitochondrial disorders are multisystem diseases that arise from dysfunction in the mitochondrial protein complexes involved in oxidative metabolism. There are many related but distinct syndromes, and some patients have overlapping syndromes. As a result, these disorders can be difficult to diagnose. Genetic testing has the potential to improve the accuracy of the diagnosis of mitochondrial disorders. Genetic testing also has the potential to determine future risk of disease in individuals who have a close relative with a pathogenic mutation.

Background

Mitochondrial DNA

Mitochondria are organelles within each cell that contain their own set of DNA, distinct from the nuclear DNA that makes up most of the human genome. Human mitochondrial DNA (mtDNA) consists of 37 genes. Thirteen genes code for protein subunits of the mitochondrial oxidative phosphorylation complex, and the remaining 24 genes are responsible for proteins involved in the translation and/or assembly of the mitochondrial complex.¹ In addition, there are over 1000 nuclear genes that code for proteins that support mitochondrial function.² The protein products from these genes are produced in the nucleus and later migrate to the mitochondria.

Mitochondrial DNA differs from nuclear DNA (nDNA) in several important ways. Inheritance of mtDNA does not follow traditional Mendelian patterns. Rather, mtDNA is inherited only from maternal DNA so that disorders that result from mutations in mtDNA can only be passed on by the mother. Also, there are thousands of copies of each mtDNA gene in each cell, as opposed to nuclear DNA, which contains only 1 copy per cell. Because there are many copies of each gene, mutations may be present in some copies of the gene but not others. This phenomenon is called heteroplasmy. Heteroplasmy can be expressed as a percentage of genes that have the mutation, ranging from 0% to 100%. Clinical expression of the mutation will generally depend...
on a threshold effect (ie, clinical symptoms will begin to appear when the percentage of mutated genes exceeds a threshold amount).³

**Mitochondrial Disorders**

Primary mitochondrial disorders arise from dysfunction of the mitochondrial respiratory chain. The mitochondrial respiratory chain is responsible for aerobic metabolism, and dysfunction therefore affects a wide variety of physiologic pathways dependent on aerobic metabolism. Organs with a high energy requirement, such as the central nervous system, cardiovascular system, and skeletal muscle, are preferentially affected by mitochondrial dysfunction.

The prevalence of these disorders has risen over the last 2 decades as the pathophysiology and clinical manifestations have been better characterized. It is currently estimated that the minimum prevalence of primary mitochondrial disorders is at least 1 in 5000.¹⁴

Some of the specific mitochondrial disorders are:

- Mitochondrial encephalopathy with lactic acidosis and stroke-like episodes (MELAS) syndrome
- Myoclonic epilepsy with ragged-red fibers (MERRF) syndrome
- Kearns-Sayre syndrome (KSS)
- Leigh syndrome (LS)
- Chronic progressive external ophthalmoplegia (CPEO)
- Leber hereditary optic neuropathy (LHON)
- Neurogenic weakness with ataxia and retinitis pigmentosa (NARP)

Most of these disorders are characterized by multisystem dysfunction, which generally includes myopathies and neurologic dysfunction and may involve multiple other organs. Each of the defined mitochondrial disorders has a characteristic set of signs or symptoms. The severity of illness is heterogeneous and can vary markedly. Some patients will have only mild symptoms for which they never require medical care, while other patients have severe symptoms, a large burden of morbidity, and a shortened life expectancy.
**Diagnosis**

The diagnosis of mitochondrial disorders can be difficult. The individual symptoms are nonspecific and symptom patterns can overlap considerably. As a result, a patient often cannot be easily classified into one particular syndrome. Biochemical testing is indicated for patients who do not have a clear clinical picture of one specific disorder. Measurement of serum lactic acid is often used as a screening test, but the test is neither sensitive nor specific for mitochondrial disorders.

A muscle biopsy can be performed if the diagnosis is uncertain after biochemical workup. However, this is an invasive test and is not definitive in all cases. The presence of “ragged red fibers” on histologic analysis is consistent with a mitochondrial disorder. Ragged red fibers represent a proliferation of defective mitochondrial. This characteristic finding may not be present in all types of mitochondrial disorders, and also may be absent early in the course of disease.

**Treatment**

Treatment of mitochondrial disease is largely supportive, because there are no specific therapies than impact the natural history of the disorder. Identification of complications such as diabetes and cardiac dysfunction is important for early treatment of these conditions. A number of vitamins and cofactors (eg, coenzyme Q, riboflavin) have been used, but empirical evidence of benefit is lacking. Exercise therapy for myopathy is often prescribed, but the effect on clinical outcomes is uncertain. The possibility of gene transfer therapy is under consideration, but is at an early stage of development and has not yet been tested in clinical trials.

**Genetic Testing for Mitochondrial Disorders**

Mitochondrial disorders can be caused by pathogenic variants in the maternally inherited mtDNA or one of many nDNA genes. Genetic testing for mitochondrial disorders may involve testing for point mutations, deletion/duplication analysis, and/or whole mitochondrial exome sequencing of nDNA or mtDNA. The type of testing done depends on the specific disorder being considered. For some primary mitochondrial disorders such as MELAS and MERRF, most variants are point mutations, and there are a finite number of variants associated with the disorder. When testing for one of these disorders, known pathogenic variants can be looked for by using polymerase chain reaction, or sequence analysis can be performed on the particular gene. For other mitochondrial disorders such as CPEO and KSS, the most common variants are
deletions, and therefore duplication/deletion analysis would be the first test when these disorders are suspected.

Table 1 provides examples of clinical symptoms and particular genetic variants in mtDNA or nDNA associated with particular mitochondrial syndromes.\textsuperscript{5,7} A repository of published and unpublished data on variants in human mtDNA is available in the MITOMAP database.\textsuperscript{8} Lists of mtDNA and nDNA genes that may lead to mitochondrial disorders and testing laboratories in the United States are provided at the GeneTests website (funded by BioReference Laboratories) and Genetic Testing Registry of the National Center for Biotechnology Information website.\textsuperscript{9,10}

**Table 1. Examples of Mitochondrial Disorders, Clinical Manifestations, and Associated Pathogenic Genes**

<table>
<thead>
<tr>
<th>Syndrome</th>
<th>Main Clinical Manifestations</th>
<th>Major Genes Involved</th>
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</thead>
<tbody>
<tr>
<td>MELAS</td>
<td>Stroke-like episodes at age &lt;40 y, Seizures and/or dementia, Pigmentary retinopathy, Lactic acidosis</td>
<td>MT-TL1, MT-ND5 (&gt;95%) MT-TF, MT-TH, MT-TK, MT-TQ, MT-TS, MT-TS, MT-ND1, MT-ND6 (rare)</td>
</tr>
<tr>
<td>MERFF</td>
<td>Myoclonus, Seizures, Cerebellar ataxia, Myopathy</td>
<td>MT-TK (&gt;80%) MT-TF, MT-TP (rare)</td>
</tr>
<tr>
<td>CPEO</td>
<td>External ophthalmoplegia, Bilateral ptosis</td>
<td>Various deletions of mtDNA</td>
</tr>
<tr>
<td>Kearns-Sayre syndrome</td>
<td>External ophthalmoplegia at age &lt;20 y, Pigmentary retinopathy, Cerebellar ataxia, Heart block</td>
<td>Various deletions of mtDNA</td>
</tr>
<tr>
<td>Leigh syndrome</td>
<td>Subacute relapsing encephalopathy, Infantile-onset, Cerebellar/brain stem dysfunction</td>
<td>MT-ATP6, MT-TL1, MT-TK, MT-TW, MT-TV, MT-ND1, MT-ND2, MT-ND3, MT-ND4, MT-ND5, MT-ND6, MT-CO3 mtDNA deletions (rare) SUCLA2, NDUSFx, NDFVx, SDHA, BCS1L, SURF1, SCO2, COX15</td>
</tr>
<tr>
<td>Syndrome</td>
<td>Main Clinical Manifestations</td>
<td>Major Genes Involved</td>
</tr>
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<td>-----------------</td>
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</tr>
</tbody>
</table>
| LHON            | Painless bilateral visual failure  
                 Male predominance  
                 Dystonia  
                 Cardiac pre-excitation syndromes                                                             | MT-ND1, MT-ND4, MT-ND6        |
| NARP            | Peripheral neuropathy  
                 Ataxia  
                 Pigmentary retinopathy                                                                   | MT-ATP6                       |
| MNGIE           | Intestinal malabsorption  
                 Cachexia  
                 External ophthalmoplegia  
                 Neuropathy                                                                   | TP                            |
| IOSCA           | Ataxia  
                 Hypotonia  
                 Athetosis  
                 Ophthalmoplegia  
                 Seizures                                                                   | TWINKLE                       |
| SANDO           | Ataxic neuropathy  
                 Dysarthria  
                 Ophthalmoparesis                                                               | POLG                          |
| Alpers syndrome | Intractable epilepsy  
                 Psychomotor regression  
                 Liver disease                                                        | POLG, DGUOK, MPV17            |
| GRACILE         | Growth retardation  
                 Aminoaciduria  
                 Cholestasis  
                 Iron overload  
                 Lactic acidosis                                                      | NDUSFx                        |
| Coenzyme Q10 deficiency | Encephalopathy  
                 Steroid-resistant nephrotic syndrome  
                 Hypertrophic cardiomyopathy                                             | COQ2, COQ9, CABC1             |
<table>
<thead>
<tr>
<th>Syndrome</th>
<th>Main Clinical Manifestations</th>
<th>Major Genes Involved</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Retinopathy</td>
<td>ETFDH</td>
</tr>
<tr>
<td></td>
<td>Hearing loss</td>
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</tbody>
</table>


CPEO: chronic progressive external ophthalmoplegia; GRACILE: growth retardation, aminoaciduria, cholestasis, iron overload, early death; IOSCA: infantile onset spinal cerebellar atrophy; LHON: Leber hereditary optic neuropathy; MELAS: mitochondrial encephalomyopathy, lactic acidosis, and stroke-like episodes; MERFF: myoclonic epilepsy with ragged-red fibers; MNGIE: mitochondrial neurogastrointestinal encephalopathy; NARP: neuropathy, ataxia, and retinitis pigmentosa; Sando: sensory ataxia, neuropathy, dysarthria and ophthalmoplegia.

Summary of Evidence

For individuals who have signs and/or symptoms of a mitochondrial disorder who receive genetic testing, the evidence includes case series and cohort studies. Relevant outcomes are test accuracy and validity, other test performance measures, symptoms, functional outcomes, health status measures, and quality of life. There is a lack of published data on analytic validity. Commercial testing sites claim analytic validity approaches 100% and describe testing methods expected to have high analytic validity. There is some evidence on clinical validity that varies by the patient population and testing strategy. Studies reporting diagnostic yield for known pathogenic variants using next-generation sequencing panels tend to report rates ranging from 15% to 25%. Clinical specificity is unknown, but population-based studies have reported that the prevalence of certain variants exceeds the prevalence of clinical disease, suggesting that the variant will be found in some people without clinical disease (false positives). Clinical utility is relatively high for confirming the diagnosis of mitochondrial disorders in people who have signs and symptoms of disease. In these patients, a positive result on genetic testing can avoid a muscle biopsy and eliminate the need for further clinical workup. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

Targeted familial variant testing may be appropriate for individuals who are symptomatic and have a close relative with a mitochondrial disorder and are known to carry a pathogenic variant. The evidence for such testing includes case series and cohort studies. Relevant outcomes are test accuracy and validity, other test performance measures, changes in reproductive decision making, symptoms, functional outcomes, health status measures, and quality of life. There is a lack of published data on analytic validity. Commercial testing sites claim analytic validity approaching 100% and describe testing methods expected to have high analytic validity. Clinical validity is expected to be high for targeted testing of a known familial variant, assuming
sufficient analytic validity. Clinical utility can be demonstrated for testing of at-risk family members who have a close relative with a pathogenic variant. When a specific mitochondrial disease is present in the family that is severe enough to cause impairment and/or disability, genetic testing may impact reproductive decision making. The evidence is sufficient to determine qualitatively that the technology results in a meaningful improvement in the net health outcome.

Ongoing and Unpublished Clinical Trials

A search of ClinicalTrials.gov in May 2017 did not identify any ongoing or unpublished trials that would likely influence this review.

Practice Guidelines and Position Statements

Foundation for Mitochondrial Medicine

The Foundation for Mitochondrial Medicine published an overview of mitochondrial disease in 2013; genetic testing was specifically addressed. The overview included the following statements:

- Mitochondrial disease can look like a number of different diseases such as autism, Parkinson disease, Alzheimer disease, Lou Gehrig disease, muscular dystrophy, and chronic fatigue. No one approach is sufficient for an accurate diagnosis.
- There are 3 categories of diagnostic criteria:
  - Clinical
  - Biochemical
  - Genetic
- A diagnosis of mitochondrial disease requires an integrated approach; there is “no single test to diagnose mitochondrial disease in most patients.”
- Genetic testing, alone, is “rarely ... sufficient to diagnose mitochondrial disease.”
Mitochondrial Medicine Society

The Mitochondrial Medicine Society published a consensus statement on the diagnosis and management of mitochondrial disease in 2015.\textsuperscript{30} Most evidence was grade III or less (case-control, low-quality cohort studies, or expert opinion without explicit critical appraisal) using the Oxford Centre for Evidence-Based Medicine criteria. Consensus recommendations were reported using the Delphi method. A subset of the consensus recommendations for DNA testing are as follows:

1. Massively parallel sequencing/NGS [next-generation sequencing] of the mtDNA genome is the preferred methodology when testing mtDNA and should be performed in cases of suspected mitochondrial disease instead of testing for a limited number of pathogenic point mutations.

2. mtDNA deletion and duplication testing should be performed in cases of suspected mitochondrial disease via NGS of the mtDNA genome, especially in all patients undergoing a diagnostic tissue biopsy.
   a. If a single small deletion is identified using polymerase chain reaction–based analysis, then one should be cautious in associating these findings with a primary mitochondrial disorder.
   b. When multiple mtDNA deletions are noted, sequencing of nuclear genes involved in mtDNA biosynthesis is recommended.

3. When considering nuclear gene testing in patients with likely primary mitochondrial disease, NGS methodologies providing complete coverage of known mitochondrial disease genes is preferred. Single-gene testing should usually be avoided because mutations in different genes can produce the same phenotype. If no known mutation is identified via known NGS gene panels, then whole exome sequencing should be considered.

Medicare National Coverage

There is no national coverage determination (NCD). In the absence of an NCD, coverage decisions are left to the discretion of local Medicare carriers.
Regulatory Status

Clinical laboratories may develop and validate tests in-house and market them as a laboratory service; laboratory-developed tests (LDTs) must meet the general regulatory standards of the Clinical Laboratory Improvement Amendments (CLIA). Genetic testing for mitochondrial disorders is under the auspices of CLIA. Laboratories that offer LDTs must be licensed by CLIA for high-complexity testing. To date, the U.S. Food and Drug Administration has chosen not to require any regulatory review of this test.

References


### History

<table>
<thead>
<tr>
<th>Date</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>08/11/14</td>
<td>New Policy. Policy developed with literature review through April 20, 2014. Genetic testing for specific mitochondrial mutations may be considered medically necessary for patients with signs and symptoms of mitochondrial disorders, and for at-risk family</td>
</tr>
<tr>
<td>Date</td>
<td>Comments</td>
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</tr>
<tr>
<td>01/14/15</td>
<td>Coding update. New CPT code 81440, effective 1/1/15, added to the policy.</td>
</tr>
<tr>
<td>07/14/15</td>
<td>Annual Review. Policy updated with literature review through 05/01/15, references 8 and 22-24 added. Wording of policy statements revised to be consistent with standardized genetic language. ICD-9 and ICD-10 diagnosis codes removed; these were listed for informational purposes only.</td>
</tr>
<tr>
<td>01/01/17</td>
<td>Update Related Policies. Removed 12.04.520 as it was archived.</td>
</tr>
<tr>
<td>08/01/17</td>
<td>Annual Review, approved July 18, 2017. Policy moved into the new format. Policy updated with literature review through April 25, 2017; references 7-10, 13-14, 16-18, 20-22, and 30 added. Policy revised with updated genetics nomenclature. Policy statements revised so that genetic testing is no longer restricted to a set of specific mutations documented for a particular mitochondrial disorder.</td>
</tr>
</tbody>
</table>

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This Notice has Important Information. This notice may have important information about your application or coverage through Premera Blue Cross. There may be key dates in this notice. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost. Call 800-722-1471 (TTY: 800-842-5357).

Arabic (Amharic):
لا يمكن الحصول على معلومات تعويضية من خلال تقديم طلب للحصول على معلومات عن أي حالات السرطان أو الأمراض التورم الاسمية في حالات السرطان. قد تكون هناك حالات السرطان التي تتطلب علاجات معينة تظهر في هذه الرسالة.

Arabic (Arabic):
لا يمكن الحصول على معلومات تعويضية من خلال تقديم طلب للحصول على معلومات عن أي حالات السرطان أو الأمراض التورم الاسمية في حالات السرطان. قد تكون هناك حالات السرطان التي تتطلب علاجات معينة تظهر في هذه الرسالة.

中文 (Chinese):
本通知有重要的訊息。本通知可能有關於您透過 Premera Blue Cross 提交的申請或保單的重要訊息。本通知可能有重要的日期。您可以可能需要在截止日期之前採取行動，以保留您的健康保險或費用補貼。您可以權利免費以您的母語得到本訊息和幫助。請撥電話 800-722-1471 (TTY: 800-842-5357).

Français (French):

Italiano (Italian):

Oromo (Cushite):

Deutsche (German):

Hmoob (Hmong):

Ilokano (Illocano):
Daytoy a Pakdaak ket naglaon iti Napategic na Impormasion. Daytoy a pakdaak mabalin nga adda ket naglaon iti napategic nga impormasion maipanggep iti aplikasyon no yowo coverage baben a Premera Blue Cross. Daytoy ket mabalin dagiti importante a petsa iti daytoy a pakdaak. Mabalin nga adda rumbeng nga aramideng nga addang sakbay dagiti partikular a naituding nga adda aldaw tapno mapattaglaidneyo to coverage ti salan-ayto woyu tulong kadagiti gastos. Adda karbenganyo a mangala iti daytoy nga impormasion ken tulong iti bukodyo a pagasasao nga awan ti bayadayo. Tumawagi no numero nga 800-722-1471 (TTY: 800-842-5357).

Kreyòl ayisyen (Creole):
Ayi siila a gen Enfòmasyon Enpòtan lidadann. Ayi siila a kapab geny enfòmasyon enpòtan konsènan aplikasyon w lan oswa konèsan kouvèti asirans lan atravè Premera Blue Cross. Kapab geny en dat ki enpòtan nan ayi siila a. Ou ka gen pou pou anoti ak aksyon avèn senten dat limit pou ko ya kent kev kouvèti asirans sante w lan oswa pou yo ko ede w avèk depans yo. Se dwa w pou resevwa enfòmasyon sa a ak assistans nan lang ou pale a, san ou pa gen pou peye pou sa. Rate nan 800-722-1471 (TTY: 800-842-5357).

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Premera Blue Cross complying with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Premera does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Premera:

• Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  • Qualified sign language interpreters
  • Written information in other formats (large print, audio, accessible electronic formats, other formats)
• Provides free language services to people whose primary language is not English, such as:
  • Qualified interpreters
  • Information written in other languages

If you need these services, contact the Civil Rights Coordinator.

If you believe that Premera has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Civil Rights Coordinator - Complaints and Appeals
PO Box 91102, Seattle, WA 98111
Toll free 855-332-4535, Fax 425-918-5592. TTY 800-842-5357
Email AppealsDepartmentInquiries@Premera.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at:
https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:
U.S. Department of Health and Human Services
200 Independence Avenue SW, Room S09F, HHH Building
Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at