

<b>Subject:</b>	Testing of Homocysteine Metabolism-Related Conditions		
<b>Policy Number:</b>	PO-RE-082v1		
<b>Effective Date:</b>	04/01/2024	<b>Last Approval Date:</b>	04/07/2024

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## I. Policy Description

Homocystinuria is a metabolic condition in which the body is unable to properly process certain amino acids, resulting in an abnormal accumulation of homocysteine and its metabolites in the blood and urine (NIH, 2023). Homocystinuria is primarily due to genetic causes; however, homocystinuria can also be due to non-genetic causes, including severe deficiency of vitamin B12, also known as cobalamin (Mudd et al., 2000).

Genetic counseling is strongly recommended for individuals pursuing genetic testing for homocystinuria.

### Indications and/or Limitations of Coverage

Application of coverage criteria is dependent upon an individual’s benefit coverage at the time of the request. Specifications pertaining to Medicare and Medicaid can be found in the “Applicable State and Federal Regulations” of this policy document.

1. Newborn screening for homocysteine-related conditions **MEETS COVERAGE CRITERIA** in any of the following situations:
  - a. Screening for classic homocystinuria due to CBS deficiency by performing quantitative plasma amino acids analysis and/or plasma or urine total homocysteine analysis.
  - b. Screening for homocystinuria in dried blood spots.
  - c. Screening for hypermethioninemia in dried blood spots.
2. When the initial screening test result exceeds the cut-off level of methionine, a repeat dried blood specimen submitted to the newborn screening program, or a quantitative plasma amino acid analysis and analysis of plasma total homocysteine **MEETS COVERAGE CRITERIA**.

3. For the diagnosis of phenotype variants of classic homocystinuria due to CBS deficiency, the pyridoxine (B6) challenge test **MEETS COVERAGE CRITERIA**.
4. For individuals over 18 years of age with homocystinuria suspected to be caused by CBS deficiency and for monitoring therapy in those with confirmed CBS deficiency, total homocysteine testing in plasma **MEETS COVERAGE CRITERIA**.
5. Plasma free homocysteine testing **DOES NOT MEET COVERAGE CRITERIA**.

### Scientific Background

Homocysteine (Hcy), a naturally occurring intermediary amino acid, is involved in multiple metabolic pathways, including the transsulfuration pathway as well as methionine (Met) metabolism. Classic homocystinuria, which results in an accumulation of Hcy and its metabolites in the blood and urine, is due to genetic mutations in *cystathionine-β-synthase (CBS)*. CBS is the enzyme responsible for the rate-limiting step of the transsulfuration pathway and is dependent on pyridoxine (vitamin B6) (Zhu et al., 2018). If this enzyme is blocked, the transsulfuration of Hcy and the accumulation of both Hcy and Met will be limited, as Met concentration is enhanced by remethylation. The disruption of the Met metabolic pathway, as shown in Figure 1 below (Zhu et al., 2018), prevents Hcy from being used properly; this creates in a buildup of Hcy and toxic by-products in the blood, with excess Hcy excreted in urine (Mazaheri et al., 2017).

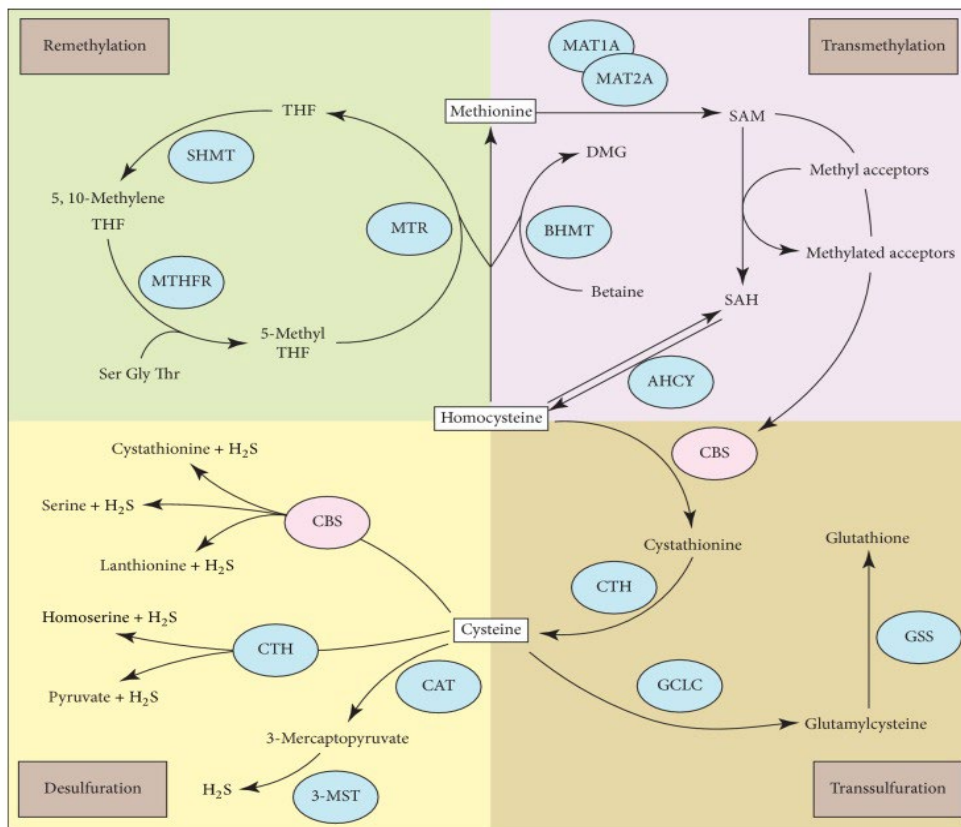


Figure 1: Homocysteine is a common metabolite linked to multiple metabolic pathways, including methionine/S-adenosyl methionine (SAM) metabolism, transsulfuration, and desulfuration. Figure taken from (Zhu et al., 2018).

Homocystinuria due to CBS deficiency can cause eye problems, skeletal abnormalities, an increased risk for blood clots, and developmental delay. Homocystinuria may also generate white matter abnormalities in the brain, potentially mimicking other disorders such as leukoencephalopathy when imaged with computed tomography (CT) and magnetic resonance imaging (MRI) scans (Ismayilova et al., 2019; Li et al., 2018).

The exact incidence of homocystinuria due to CBS deficiency is unknown. In 1985, the incidence was estimated to be around 1:344,000 worldwide (Mudd et al., 1985). However, the National Institutes of Health (NIH) is now estimating these rates to be much higher, around 1:150,000 worldwide, 1:200,000-300,000 in the United States, and 1:1,800 in Qatar (NIH, 2023). In European populations, incidence rates have been predicted by molecular epidemiological studies to be between 1:6,400 and 1:20,500 (Gaustadnes et al., 1999; Janosík et al., 2009). Higher prevalence in the MENA (Middle East and North Africa) region could be attributed to high consanguinity in those communities (Al-Sadeq & Nasrallah, 2020). Infants with homocystinuria due to CBS deficiency are asymptomatic at birth, with symptoms slowly developing if left untreated. However, these symptoms are highly variable. Some affected patients may exhibit mild symptoms of the disorder while others may develop potentially life-threatening complications. Depending on the population affected and type of CBS gene mutation, symptoms can be as severe as ectopia lentis, Marfanoid features, mental retardation, idiopathic infertility, osteoporosis, and severe premature atherosclerosis (Al-Sadeq & Nasrallah, 2020; Rosenson et al., 2023). The phenotype of these patients mainly relates to pyridoxine-responsiveness: pyridoxine treatment responders exhibit a milder phenotype and a later onset than pyridoxine treatment nonresponders (Abbott et al., 1987; Mudd et al., 1985). Early detection and treatment is important in preventing or reducing the severity of the disorder. Screening for homocystinuria is frequently incorporated into state newborn screening programs (Rose & Dolan, 2012). While a newborn blood spot specimen for hypermethioninemia will detect homocystinuria due to CBS deficiency in some, not all affected individuals will be detected by this test (Sacharow et al., 2004).

According to Sacharow et al. (2004), the biochemical features of homocystinuria include:

- Markedly increased concentrations of total homocysteine, plasma homocysteine, homocysteine-cysteine mixed disulfide, and methionine
- Increased concentration of homocysteine in urine
- Reduced CBS enzyme activity

Classical biochemical findings establishing the diagnosis are summarized in the following table titled: Cardinal Biochemical Findings that Establish the Diagnosis of Homocystinuria (Sacharow et al., 2004).

Analyte	Specimen	Expected Findings		
		Neonate with homocystinuria	Untreated older individual with homocystinuria	Control
Total homocysteine (tHcy)	Plasma	50 to >100 $\mu\text{mol/L}$	>100 $\mu\text{mol/L}$	<15 $\mu\text{mol/L}$
Methionine (on amino acid analysis)	Plasma	200-1500 $\mu\text{mol/L}$ (3-23 mg/dL)	>50 $\mu\text{mol/L}$ (>0.7 mg/dL)	10-40 $\mu\text{mol/L}$ (0.2-0.6 mg/dL)

Homocystinuria due to genetic causes is inherited in an autosomal recessive pattern. Many different forms of homocystinuria can occur and signs and symptoms vary depending on the gene mutation. *CBS* gene mutations cause the most common form of homocystinuria. This mutation is referred to as “classic” homocystinuria or CBS deficiency. Other gene mutations that can result in homocystinuria include *MTHFR*, *MTR*, *MTRR*, and *MMADHC*. The *MTHFR*, *MTR*, and *MTRR* genes all revolve around the remethylation pathway of Hcy, while the *MMADHC* gene plays a role in Vitamin B12 metabolism (Froese et al., 2015; Wang et al., 2016).

Homocystinuria may also be associated with a diagnosis of methylmalonic acidemia, when the body cannot efficiently break down specific fats or proteins, leading to a methylmalonic acid buildup in the blood. Methylmalonic aciduria and homocystinuria type C (cb1C) is characterized by a vitamin B12 disorder initiated by a mutation in the *MMACHC* gene; symptoms of this disorder fall into several categories, including thromboembolic and neurological issues such as cognitive and psychiatric episodes (Collison et al., 2015).

### Analytical Validity

This concentration of total homocysteine (tHcy) in blood plasma is the primary clinical analyte measured to diagnose homocystinuria. A study using liquid chromatography–mass spectrometry (LC-MS) calculated limits of detection (0.06  $\mu\text{mol/L}$ ) and quantification (0.6  $\mu\text{mol/Lu}$ ) of tHcy (Nelson et al., 2003). Another study using gas chromatography–mass spectrometry (GC-MS) found a detection limit of 0.4  $\mu\text{mol/L}$  as well as intra- and inter-run variations of five and eight percent, respectively. Furthermore, this method was found to compare well with the LC-MS-MS method; the GC-MS method had a mean difference of -0.4  $\mu\text{mol}$  compared to the LC-MS-MS method (Belkhiria et al., 2007). Fluorescence polarization immunoassay (FPIA) was found to compare favorably to the high performance liquid chromatography (HPLC) and MS approaches as well (five percent imprecision with

negative two percent to three percent bias) so it is a practical option if the more precise approaches are not available; unfortunately, this study only measured levels up to 45  $\mu\text{mol/L}$ , whereas severe homocystinuria can exceed 100  $\mu\text{mol/L}$  (Nexo et al., 2000).

More recently, Concepción-Alvarez et al. (2016) have validated a method to quantify Hcy in plasma samples via HPLC. Hcy levels were measured in a total of 46 patients and the authors found that HPLC was able to “identify and quantify Hcy without interferences” and that the identified detection limit was 3.12  $\mu\text{M}$  and quantification limit 6.25  $\mu\text{M}$  (Concepción-Alvarez et al., 2016). This research has provided further validation for Hcy plasma testing in ailments such as homocystinuria where this amino acid is increased.

For the detection of Hcy-related conditions, methylmalonic acid and tHcy are commonly measured in both plasma samples and dried blood spots. Using ultra performance liquid chromatography-tandem mass spectrometry (UPLC-MS/MS), de Sain-van der Velden et al. (2015) recently compared methylmalonic acid and tHcy levels collected either from a dried blood spot or from plasma concentration testing methods to determine which is the more efficient and accurate method. The authors note that the plasma assay performed better than the dried blood spot testing method in most areas, but that dried blood spot testing was superior for tHcy stability. Furthermore, a strong correlation of tHcy was found in both testing methods, ( $y=0.46\pm 1.12$  ( $r(2)=0.91$ )), leading to the authors suggestion that tHcy testing in plasma can be replaced by tHcy in dried blood spots (de Sain-van der Velden et al., 2015).

### ***Clinical Utility and Validity***

A diagnosis of classic homocystinuria (caused by CBS deficiency) is established by measurement of tHcy. The normal level is  $<15 \mu\text{Mol/L}$ , whereas a newborn with homocystinuria is expected to measure at  $>50 \mu\text{Mol/L}$  and an older, untreated individual will likely measure at  $>100 \mu\text{Mol/L}$  (Sacharow et al., 2004). A measurement of Met in plasma can corroborate a diagnosis, as the metabolic pathway involves a buildup of Met in addition to the buildup of Hcy (Sacharow et al., 2004). While free Hcy composes about 15-25% of tHcy levels, separate free Hcy testing is unnecessary: tHcy measurement already includes all forms of Hcy (Rosenson et al., 2023).

The detection of biallelic pathogenic variants in CBS can substantiate a diagnosis of classic homocystinuria (Sacharow et al., 2004). There are two phenotypic variants in homocystinuria, both caused by CBS: B6-responsive and B6-non-responsive homocystinuria. The pyridoxine (B6) challenge test is performed to determine the variant and if vitamin B6 therapy will be beneficial (Sacharow et al., 2004). Testing for homocystinuria usually involves biochemical testing in urine and/or genetic testing for known mutations. Genetic testing can be done using a single gene or multi-gene panel which may include sequence analysis, deletion/duplication analysis, and/or other non-sequencing-based tests. Homocystinuria typically involves CBS deficiency and while the activity of the CBS enzyme could be performed in cultured fibroblasts when genetic tests are inconclusive, enzymatic testing for CBS deficiency is no longer available in USA (Sacharow et al., 2004).

Methylene tetrahydrofolate reductase (*MTHFR*) mutations are of interest in homocystinuria. The *MTHFR* enzyme catalyzes the reduction of 5,10-methylenetetrahydrofolate to 5,10-

methyltetrahydrofolate, the methyl donor for the conversion of Hcy to Met. Failure of this enzyme (<20% of normal levels) leads to increased Hcy and Met, as well as the production of other symptoms associated with homocystinuria (Long & Goldblatt, 2016). The two most common mutations in the *MTHFR* gene are 677T (changed from a C nucleotide) and 1298C (changed from an A). Both mutations can be heterozygotic or homozygotic, and both can lead to loss of enzymatic function (Gonzales et al., 2017). The 677T mutation is more severe, as in the homozygous state (TT) it results in up to 70% loss of enzymatic function, compared to only a 35% loss of function in the heterozygous state (CT) (Frosst et al., 1995). The 1298C mutation results in a loss of enzymatic function; 30% and 15% for its homozygous and heterozygous forms, respectively (Weisberg et al., 1998).

However, it is possible that dietary factors (notably low levels of folate or Vitamin B12) influence tHcy levels more than genetic factors. A study covering 452 young adults found tHcy variance to have a nine percent total genetic contribution (i.e. genetic polymorphisms) compared to a 35% contribution from dietary factors. The only polymorphism found to have a significant effect on tHcy levels was the 677T mutation, which interacted with low folate levels to produce a high tHcy phenotype. Compared to the authors earlier studies of genetic influence on tHcy levels, the younger cohort's genetic contribution on tHcy levels was measured out to be higher than the older cohort's (nine percent compared to seven percent for the older cohort). Furthermore, the authors suggest that genetic influence on tHcy levels are more pronounced during early life and environmental factors are more influential as time passes (Gaughan et al., 2001; Harmon et al., 1999; Kluijtmans et al., 2003).

Another study conducted by Gales et al. (2018) found that focal epilepsy presentation in the context of adult or adolescent onset could result from a mutation leading to *MTHFR* deficiency. It is critical that this mutation found in homocystinuria be detected early for treatment, as the neuropsychiatric syndrome could be easily treated with a combination of vitamin B9, vitamin B12, and betaine (Gales et al., 2018).

A novel newborn screening method has been developed by researchers: a two-tier algorithm using a methionine (Met) to phenylalanine (Phe) ratio. Data from 125,047 neonates was utilized to determine this accuracy of this method (Okun et al., 2017). It was reported that "Met to Phe ratio was found to be more effective for first sieve than Met, sorting out nearly 90% of normal samples. Only 10% of the samples would have to be processed by second-tier measurement of Hcy in dried blood spots" (Okun et al., 2017). This novel testing method resulted in 100% sensitivity and specificity for classic homocystinuria newborn screening (Okun et al., 2017).

Guo et al. (2022) investigated the effects of maternal Hcy concentrations, *MTHFR*, and *MTRR* gene presence on the occurrence of fetal aneuploidy through a retrospective case-control study. From the differences in the maternal *MTHFR* 677C>T, *MTHFR* 1298A>C and *MTRR* 66A>G genetic polymorphisms and maternal Hcy concentrations between aneuploidy and control mothers, they found that the mutations were associated with multiple trisomies, including Down syndrome (Trisomy 21), trisomy 15, and Turner syndrome. The 677C>T polymorphism was associated with the most trisomies and transfer genes. Lastly, there was an increased concentration of Hcy among mothers of fetuses with trisomies 22, 21, 18, 16, and 15 and Turner syndrome in comparison to the control mothers. Due to the identified associations, it becomes even more crucial to study effects of combining maternal



genetic factors and body systemic factors like homocysteine concentration on spontaneous fetal aneuploidy formation that were not previously understood (Guo et al., 2022).

## **Guidelines and Recommendations**

### **The United States Department of Health and Human Services**

The Secretary of the U.S. Department of HHS has developed a recommended uniform screening panel for every universal newborn screening program; the amino acid disorder homocystinuria is recommended as a core condition for newborn screening, and the organic acid condition methylmalonic acidemia with homocystinuria is recommended as a secondary screening condition. Methylmalonic acidemia due to methylmalonyl-CoA mutase or cobalamin disorders is included as a core condition as well (HHS, 2023).

### **American College of Medical Genetics (ACMG)**

The American College of Medical Genetics recommends quantitative testing of plasma amino acids to determine increased levels of Hcy and Met; classic homocystinuria is characterized by increases in both Hcy and Met, while increased Met may be indicative of other disorders (ACMG, 2010). Also, plasma Hcy analysis will show increased Hcy in classic homocystinuria and normal or only slightly increased Hcy in the other disorders. Urine Hcy will be significantly increased in classic homocystinuria (ACMG, 2010).

In the Confirmatory Algorithms for Met, ACMG indicates that increased Met and increased tHcy are indicative of homocystinuria due to CBS deficiency (ACMG, 2021).

### **European Network and Registry for Homocystinuria and Methylation Defects (E-HOD)**

In 2015, a project by the E-HOD released the *Newborn Screening for Homocystinurias and Methylation Disorders: Systematic Review and Proposed Guidelines*. In this guideline, authors recommend newborn screening for CBS deficiency by detecting elevated Met, methionine-to-phenylalanine ratio, and/or tHcy in dried blood spots. Specificity is increased by analyzing tHcy as a second-tier marker and calculating Met/tHcy ratio is also suggested (Huemer et al., 2015)

Newborn screening for the cbID-Hcy, CblE, and cbIG defects, and for *MTHFR* deficiency could be possible by measuring Met and methionine-to-phenylalanine ratio in dried blood spots followed by analysis of tHcy as a second-tier marker. However, it is stated that the efficacy and feasibility of screening for these disorders is largely unknown (Huemer et al., 2015).

As a part of E-HOD, the *Guidelines for Diagnosis and Management of The Cobalamin-Related Remethylation Disorders cbIC, cbID, cbIE, cbIF, cbIG, cbIJ and MTHFR Deficiency* were released in 2017. Huemer et al. (2017) “strongly recommend measuring plasma total homocysteine in any patient presenting with the combination of neurological and/or visual and/or haematological symptoms,

subacute spinal cord degeneration, atypical haemolytic uraemic syndrome or unexplained vascular thrombosis.” For a “valid, timely laboratory diagnosis,” the authors also add:

- “We strongly recommend that investigations in patients with a suspected remethylation disorder should start with the measurement of total homocysteine in blood. We recommend the blood sample for tHcy to be centrifuged within an hour and kept at four degrees or frozen until analysis. Immunoassays or chromatographic methods are suitable for tHcy measurement. (Quality of the evidence: moderate)
- We strongly recommend against measuring free homocysteine instead of total homocysteine. (Quality of the evidence: moderate)
- We strongly recommend that in the case of high total homocysteine, plasma and urine samples for determination of MMA, methionine, folate and vitamin B12 are to be obtained before treatment is started. (Quality of the evidence: moderate)” (Huemer et al., 2017).

Another guideline written as a part of E-HOD provides practical guides to recognition, diagnosis and management of CBS deficiency. The guideline presented 41 separate recommendations based on a literature review by the Guideline Development Group and the authors admitted that the quality of the identified data was poor and many of their recommendations were grade D; however, the highest recommendation was given to measuring the plasma total homocysteine concentrations in any patient whose signs and symptoms strongly suggest the diagnosis (Morris et al., 2017).

For the biochemical diagnosis, a tHcy test is recommended as “the frontline test” for the diagnosis of CBS deficiency. Plasma free Hcy is only detectable at tHcy concentrations above 50-60  $\mu\text{mol/L}$ ; its measurement is not particularly sensitive or even reproducible and is, therefore, not recommended. Untreated patients with a CBS deficiency typically have tHcy concentrations above 100  $\mu\text{mol/L}$  and a diagnosis is likely if an elevated tHcy is found along with high or borderline high plasma Met concentrations. Further information such as low plasma cystathionine concentration or increased Met:Cystathionine ratio can support a diagnosis. Finally, tHcy measurement using dried blood spots can be done if plasma processing is not possible.

The European Network and Registry for Homocystinuria and Methylation Defects recommends confirming CBS deficiency by measuring cystathionine synthase activity in fibroblasts or plasma and/or by mutation analysis of CBS gene. The gold standard for confirming CBS deficiency is determination of cystathionine production of Hcy and serine in cultured fibroblasts. Either the enzyme or DNA can be analyzed and if one method does not confirm a diagnosis, the other method should be done. The grade of this recommendation is B-C.

Despite technical pitfalls of DNA testing, E-HOD recommends a molecular genetic analysis of the CBS gene for the confirmation of CBS deficiency and for carrier and prenatal testing (grade B). For the prenatal diagnosis, the molecular analysis is a preferred technique during the first trimester of pregnancy. If the mutations are known in the family, enzyme analysis can be performed in cultured amniocytes, but not in chorionic villi. Preimplantation analysis could also be done (grade C-D).



For newborn screening, it is recommended to increase specificity of Met testing by using tHcy as a second marker and calculating Met/tHcy ratio (grade C). Several other metabolic disorders can cause an increased Met concentration and the exact sensitivity of detecting Met in newborns with a CBS deficiency is unknown. Although the median Met concentration of CBS deficient patients is far greater than the median of a healthy neonate (103  $\mu\text{mol/L}$  compared to 20  $\mu\text{mol/L}$ ), individual Met values may still vary.

Screening for family members at risk is recommended by measuring tHcy but molecular genetic testing may also be utilized in exceptional cases (grade D).

Monitoring of tHcy, amino acids, folate and vitamin B12 is recommended in all patients during therapy. The frequency of the monitoring is variable on a case-by-case basis (due to severity, treatment plan, age, etc). The targeted concentration ranges for total plasma homocysteine are proposed to be  $<50 \mu\text{mol/L}$  in pyridoxine-responsive patients and at  $<11 \mu\text{mol/L}$  free homocysteine (about 120  $\mu\text{mol/L}$  total homocysteine) in pyridoxine-unresponsive patients (Morris et al., 2017).

## II. Applicable Codes

Code	Description	Comment
82136	Amino acids, 2 to 5 amino acids, quantitative, each specimen	
82139	Amino acids, 6 or more amino acids, quantitative, each specimen	
82615	Cystine and homocysteine, urine, qualitative	
83090	Homocysteine	
83921	Organic acid, single, quantitative	
84207	Pyridoxal phosphate (Vitamin B-6)	

## III. Definitions

Term	Meaning
N/A	N/A

## IV. Related Policies

Policy Number	Policy Description
N/A	N/A

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*Procedure codes appearing in Reimbursement Policy documents are included only as a general reference tool for each policy. They may not be all-inclusive.*

## V. Reference Materials

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## VI. Revision History

Revision Date	Summary of Changes
12/06/2023	Initial presentation of RTM only version.

### Disclaimer

Healthfirst’s claim edits follow national industry standards aligned with CMS standards that include, but are not limited to, the National Correct Coding Initiative (NCCI), the National and Local Coverage Determination (NCD/LCD) policies, appropriate modifier usage, global surgery and multiple procedure reduction rules, medically unlikely edits, duplicates, etc. In addition, Healthfirst’s coding edits incorporate industry-accepted AMA and CMS CPT, HCPCS and ICD-10 coding principles, National Uniform Billing Editor’s revenue coding guidelines, CPT Assistant guidelines, New York State-specific coding, billing, and payment policies, as well as national physician specialty academy guidelines (coding and clinical). Failure to follow proper coding, billing, and/or reimbursement policy guidelines could result in the denial and/or recoupment of the claim payment.

This policy is intended to serve as a resource for providers to use in understanding reimbursement guidelines for professional and institutional claims. This information is accurate and current as of the date of publication. It provides information from industry sources about proper coding practice. However, this document does not represent or guarantee that Healthfirst will cover and/or pay for services outlined. Reimbursement decisions are based on the terms of the applicable evidence of coverage, state and federal requirements or mandates, and the provider’s participation agreement. This includes the determination of any amounts that Healthfirst or the member owes the provider.