Afirma Thyroid FNA Analysis

Policy Number: MM.02.025
Original Effective Date: 02/01/2015
Line(s) of Business: HMO; PPO; QUEST Integration
Current Effective Date: 05/01/2017
Section: Medicine
Place(s) of Service: Laboratory

I. Description

Approximately 15% to 30% of thyroid nodules are found to have indeterminate cytology on fine needle aspiration (FNA). The majority of patients with indeterminate cytology on fine needle aspiration undergo diagnostic thyroid surgery, and up to 75% of those nodules are ultimately confirmed as benign. The Afirma Thyroid FNA Analysis test uses an algorithm to compare gene expression from mRNA in thyroid FNA samples against gene expression of a panel of 142 genes to classify cytologically indeterminate nodules as either benign or suspicious. FNA of the thyroid is currently the most accurate procedure to distinguish benign thyroid lesions and malignant ones, reducing the rate of unnecessary thyroid surgery for patients with benign nodules and triaging patients with thyroid cancer to appropriate surgery.

II. Criteria/Guidelines

Afirma Thyroid FNA Analysis is covered (subject to Administrative Guidelines) when the thyroid FNA shows one of the following:

1. Atypical cells of undetermined significance; or
2. Follicular or Hürthle cell neoplasm, known or suspected; or
3. Follicular lesions of undetermined significance

III. Administrative Guidelines

Precertification is not required. Documentation must be kept in the patient’s medical record and made available to HMSA upon request. HMSA reserves the right to perform retrospective reviews using the above criteria to validate if services rendered met payment determination criteria.

There is no specific code for this laboratory test. These are the codes which would most likely be reported:

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<th>CPT Code</th>
<th>Description</th>
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### IV. Important Reminder

The purpose of this Medical Policy is to provide a guide to coverage. This Medical Policy is not intended to dictate to providers how to practice medicine. Nothing in this Medical Policy is intended to discourage or prohibit providing other medical advice or treatment deemed appropriate by the treating physician.

Benefit determinations are subject to applicable member contract language. To the extent there are any conflicts between these guidelines and the contract language, the contract language will control.

This Medical Policy has been developed through consideration of the medical necessity criteria under Hawaii’s Patients’ Bill of Rights and Responsibilities Act (Hawaii Revised Statutes §432E-1.4), generally accepted standards of medical practice and review of medical literature and government approval status. HMSA has determined that services not covered under this Medical Policy will not be medically necessary under Hawaii law in most cases. If a treating physician disagrees with HMSA’s determination as to medical necessity in a given case, the physician may request that HMSA reconsider the application of the medical necessity criteria to the case at issue in light of any supporting documentation.
V. References


