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Testing of Homocysteine Metabolism-Related Conditions

Policy Number: AHS – M2141 – Testing of Homocysteine Metabolism-Related Conditions	Original Effective Date: 05/15/2022 Current Effective Date: 05/01/2026

POLICY DESCRIPTION | RELATED POLICIES | INDICATIONS AND/OR LIMITATIONS OF COVERAGE | TABLE OF TERMINOLOGY | SCIENTIFIC BACKGROUND | GUIDELINES AND RECOMMENDATIONS | APPLICABLE STATE AND FEDERAL REGULATIONS | APPLICABLE CPT/HCPCS PROCEDURE CODES | EVIDENCE-BASED SCIENTIFIC REFERENCES | REVISION HISTORY

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.[1] 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.[2]

II. Related Policies

Policy Number	Policy Title
AHS-G2014	Vitamin B12 And Methylmalonic Acid Testing
AHS-G2035	Prenatal Screening (Nongenetic)
AHS-G2050	Cardiovascular Disease Risk Assessment
AHS-M2041	Venous and Arterial Thrombosis Risk Testing

III. 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 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**.

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4) Plasma free homocysteine testing **DOES NOT MEET COVERAGE CRITERIA.**

IV. Table of Terminology

Term	Definition
3-MST	3-mercaptopyruvate
ACMG	American College of Medical Genetics
cblC	Homocystinuria type C
cblD	Cobalamin D
cblD-Hcy	Cobalamin D homocysteine
CblE	Methylcobalamin type E
cblF	Cobalamin F
cblG	Methylcobalamin type G
cblJ	Methylcobalamin type J
CBS	*Cystathionine β-synthase*
CLIA '88	Clinical Laboratory Improvement Amendments of 1988
CMS	Centers for Medicare and Medicaid
CT	Computed tomography
HT	Heterozygous state
CTH	Cystathionine
DNA	Deoxyribonucleic acid
EDTA	Chelating agentin deoxyribose nucleic acid extraction
E-HOD	European Network and Registry for Homocystinuria and Methylation Defects
FDA	Food and Drug Administration
FPIA	Fluorescence polarization immunoassay
GCLC	Glutamylcysteine
GC-MS	Gas chromatography–mass spectrometry
Hcy	Homocysteine
HHS	The U.S. Department of Health and Human Services
HPLC	High performance liquid chromatography
LC-MS	Liquid chromatography–mass spectrometry
LC-MS-MS	Liquid chromatography tandem mass spectrometry
LDTs	Laboratory-developed tests
MENA	Middle East and North Africa
Met	Methionine
MMA	Methylmalonic acid
MMADHC	Methylmalonic aciduria and homocystinuria type D protein
MRI	Magnetic resonance imaging
MTHFR	Methylene tetrahydrofolate reductase
MTR	Methionine synthase
MTRR	Methionine synthase reductase
NIH	National Institutes of Health

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Phe	Phenylalanine
SAM	S-adenosyl methionine
tHcy	Total homocysteine
TT	Homozygous state
UPLC-MS/MS	Ultra performance liquid chromatography-tandem mass spectrometry

V. 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).[3] 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,[3] 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.[4]

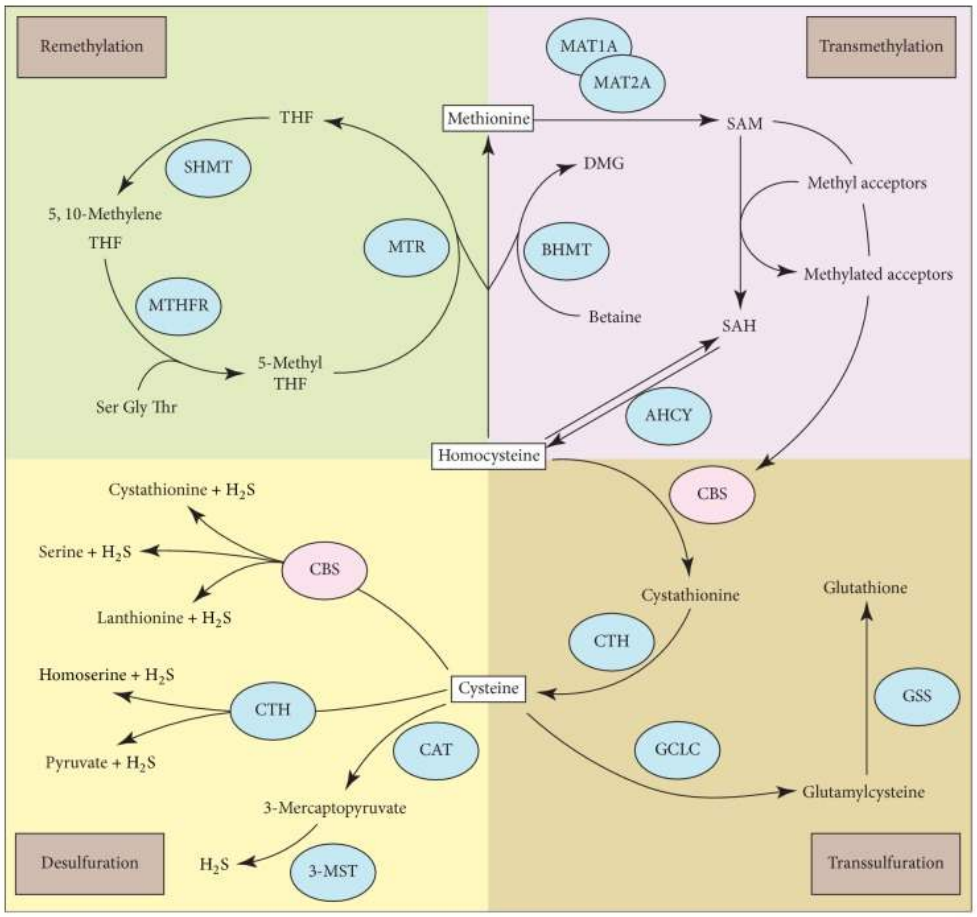

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Figure 1: Homocysteine is a common metabolite linked to multiple metabolic pathways, including methionine/S-adenosyl methionine (SAM) metabolism, transsulfuration, and desulfuration. Figure taken from.[3]

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.[5,6]

The exact incidence of homocystinuria due to CBS deficiency is unknown. In 1985, the incidence was estimated to be around 1:344,000 worldwide.[7] 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.[1] In European populations, incidence rates have been predicted by molecular epidemiological studies to be between 1:6,400 and 1:20,500.[8,9] Higher prevalence in the MENA (Middle East and North Africa) region could be attributed to high consanguinity in those communities.[10] 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.[10,11] 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.[7,12] 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.[13] 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.[14]

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.[14]

Analyte	**Specimen**	**Expected Findings**		
		Neonate with homocystinuria	**Untreated older individual with homocystinuria**	**Control**
Total homocysteine (tHcy)	Plasma	50 to >100 µmol/L	>100 µmol/L	<15 µmol/L

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Analyte	Specimen	Expected Findings		
		Neonate with homocystinuria	Untreated older individual with homocystinuria	Control
Methionine (on amino acid analysis)	Plasma	200-1500 µmol/L (3-23 mg/dL)	>50 µmol/L (>0.7 mg/dL)	10-40 µmol/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.[15,16]

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 (cblC) 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.[17]

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 µmol/L) and quantification (0.6 µmol/Lu) of tHcy.[18] Another study using gas chromatography–mass spectrometry (GC-MS) found a detection limit of 0.4 µmol/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 µmol compared to the LC-MS-MS method.[19] 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 µmol/L, whereas severe homocystinuria can exceed 100 µmol/L.[20]

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 µM and quantification limit 6.25 µM.[21] 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

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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±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.[22]

Clinical Utility and Validity

A diagnosis of classic homocystinuria (caused by CBS deficiency) is established by measurement of tHcy. The normal level is <15 µMol/L, whereas a newborn with homocystinuria is expected to measure at >50 µMol/L and an older, untreated individual will likely measure at >100 µMol/L.[14] 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.[14] While free Hcy composes about 15-25% of tHcy levels, separate free Hcy testing is unnecessary: tHcy measurement already includes all forms of Hcy.[11]

The detection of biallelic pathogenic variants in CBS can substantiate a diagnosis of classic homocystinuria.[14] 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.[14] 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.[14]

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.[23] 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.[24] 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).[25] The 1298C mutation results in a loss of enzymatic function; 30% and 15% for its homozygous and heterozygous forms, respectively.[26]

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.[27-29]

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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.[30]

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.[31] 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."[31] This novel testing method resulted in 100% sensitivity and specificity for classic homocystinuria newborn screening.[31]

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.[32]

VI. 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.[33]

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.[34] 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.[34]

In the Confirmatory Algorithms for Met, ACMG indicates that increased Met and increased tHcy are indicative of homocystinuria due to CBS deficiency.[35]

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

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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.[36]

Newborn screening for the cblD-Hcy, CblE, and cblG 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.[36]

As a part of E-HOD, the *Guidelines for Diagnosis and Management of The Cobalamin-Related Remethylation Disorders cblC, cblD, cblE, cblF, cblG, cblJ 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)."[37]

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.[38]

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 µmol/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 µmol/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

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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 µmol/L compared to 20 µmol/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 □mol/L in pyridoxine-responsive patients and at <11 □mol/L free homocysteine (about 120 □mol/L total homocysteine) in pyridoxine-unresponsive patients.[38]

VII. Applicable State and Federal Regulations

DISCLAIMER: If there is a conflict between this Policy and any relevant, applicable government policy for a particular member [e.g., Local Coverage Determinations (LCDs) or National Coverage Determinations (NCDs) for Medicare and/or state coverage for Medicaid], then the government policy will be used to make the determination. For the most up-to-date Medicare policies and coverage, please visit the Medicare search website: https://www.cms.gov/medicare-coverage-database/search.aspx. For the most up-to-date Medicaid policies and coverage, visit the applicable state Medicaid website.

Food and Drug Administration (FDA)

Many labs have developed specific tests that they must validate and perform in house. These laboratory-developed tests (LDTs) are regulated by the Centers for Medicare and Medicaid (CMS) as high-complexity tests under the Clinical Laboratory Improvement Amendments of 1988 (CLIA '88). LDTs are not approved or cleared by the U. S. Food and Drug Administration; however, FDA clearance or approval is not currently required for clinical use.

On May 13, 2011, the FDA approved the Invader *MTHFR* 677 created by Hologic, Inc. The Invader *MTHFR* 677 is an in-vitro diagnostic test intended for the detection and genotyping of a single point mutation (C to T at position 677) of the human 5,10-methylenetetrahydrofolate reductase (*MTHFR*) gene in isolated

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genomic DNA obtained from whole blood Potassium EDTA samples from patients with suspected thrombophilia.[39]

On April 25, 2011, the FDA approved the Invader *MTHFR* 1298 created by Hologic, Inc. The Invader *MTHFR* 1298 test is an in vitro diagnostic test intended for the detection and genotyping of a single point mutation (A to C at position 1298) of the human 5,10-methylenetetrahydrofo late reductase (*MTHFR*) gene in isolated genomic DNA obtained from whole blood potassium EDTA samples from patients with suspected thrombophilia.[40]

On April 22, 2010, the FDA approved the eSensor Thrombophilia Risk Test on XT-8 System created by Osmetech Molecular Diagnostics. The *MTHFR*-specific portion is as follows: The eSensor *MTHFR* Genotyping Test is an in-vitro diagnostic for the detection and genotyping of point mutations (C to T at position 677) and (A to C at position 1298) of the human 5,10-methylenetetrahydrofo late reductase (*MTHFR*) gene in isolated genomic DNA obtained from whole blood samples. The test is intended to be used on the eSensor XT-8 System.[41]

On October 11, 2007, the FDA approved the Verigene System created by Nanosphere Inc. The *MTHFR*-specific portion is as follows: The Verigene *MTHFR* Nucleic Acid Test is an in vitro diagnostic for the detection and genotyping of a single point mutation (C to T at position 677) of the human 5,10-methylenetetrahydrofolate reductase gene (*MTHFR*) in patients with suspected thrombophilia, from isolated genomic DNA obtained from whole blood samples. The test is intended to be used on the Verigene System.[42]

VIII. Applicable CPT/HCPCS Procedure Codes

CPT	Code Description
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

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IX. Evidence-based Scientific References

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X. Review/Revision History

Effective Date	Summary
05/01/2026	Clinical Advisory Board Meeting, policy review and approval: 12/03/2025 Reviewed and Updated: Updated the background, guidelines and recommendations, and evidence-based scientific references. Literature review did not necessitate any modifications to coverage criteria. The following edits were made for clarity and consistency: Removed CC3, as the pyridoxine (B6) challenge test is a medical procedure, not a laboratory test and as such, is outside the scope of Avalon management: "3) For the diagnosis of phenotype variants of classic homocystinuria due to CBS deficiency, the pyridoxine (B6) challenge test MEETS COVERAGE CRITERIA." Removed CPT code 84207
04/01/2025	Reviewed and Updated: Updated the background, guidelines and recommendations, and evidence-based scientific references. Literature review did not necessitate any modifications to coverage criteria.
05/01/2024	Initial presentation of RTM only version: Removed all genetic coverage criteria: CC1, CC2, CC3, CC9, and Note 1 (defined level of relations, which was specific to a genetic CC). Removed all genetic CPT codes: 81291, 81401, 81406, 81479
05/01/2023	Reviewed and Updated: Updated the background, guidelines and recommendations, and evidence-based scientific references. Literature review did not necessitate any modifications to coverage criteria. The following edits were made for clarity: All Coverage Criteria except CC5 edited for clarity and consistency.
05/15/2022	Initial Policy Implementation

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