2.04.130 ST2 Assay for Chronic Heart Failure and Heart Transplant Rejection

Policy Statement:
The use of the Presage® ST2 Assay to evaluate the prognosis of patients diagnosed with chronic heart failure is considered investigational.

The use of the Presage® ST2 Assay to guide management (e.g., pharmacological, device-based, exercise) of patients diagnosed with chronic heart failure is considered investigational.

The use of the Presage® ST2 Assay in the post cardiac transplantation period, including but not limited to predicting prognosis and predicting acute cellular rejection, is considered investigational.

Policy Guidelines

Coding
The following CPT code is specific for this test:
- 83006: Growth stimulation expressed gene 2 (ST2, Interleukin 1 receptor like-1)

Description
Clinical assessment and noninvasive imaging of chronic heart failure can be limited in accurately diagnosing patients with heart failure because symptoms and signs can poorly correlate with objective methods of assessing cardiac dysfunction. For management of heart failure, clinical signs and symptoms (e.g., shortness of breath) are relatively crude markers of decompensation and occur late in the course of an exacerbation. Thus, circulating biomarkers have potential benefit in heart failure diagnosis and management. A protein biomarker, soluble suppression of tumorigenicity-2 (ST2), has elicited interest as a potential aid to predict risk and manage therapy of heart failure as well as to manage in patients in the setting of heart transplant.

Related Policies
- Laboratory Tests for Heart Transplant Rejection

Benefit Application
Benefit determinations should be based in all cases on the applicable contract language. To the extent there are any conflicts between these guidelines and the contract language, the contract language will control. Please refer to the member’s contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

Some state or federal mandates [e.g., Federal Employee Program (FEP)] prohibits plans from denying Food and Drug Administration (FDA)-approved technologies as investigational. In these instances, plans may have to consider the coverage eligibility of FDA-approved technologies on the basis of medical necessity alone.
Regulatory Status

In December 2011, the Presage® ST2 Assay kit (Critical Diagnostics, San Diego, CA) was cleared for marketing by the U.S. Food and Drug Administration (FDA) through the 510(k) process for use with clinical evaluation as an aid in assessing the prognosis of patients diagnosed with chronic heart failure. The assay had already received Conformite Europeenne (CE) Mark in January 2011. The Presage® ST2 Assay kit is provided in a microplate configuration. The kit contains a ready-to-use 96-well microtiter plate coated with mouse monoclonal antihuman soluble suppression of tumorigenicity-2 (sST2) antibodies; a recombinant human sST2 standard calibrator (lyophilized); a standard diluent; an anti-ST2 biotinylated antibody reagent (mouse monoclonal antihuman sST2 antibodies) in phosphate-buffered saline; a sample diluent; a tracer concentrate and tracer diluent; a wash concentrate; a tetramethylbenzidine reagent; a stop solution; and 2 levels of controls provided in a sealed, lyophilized format (high and low control).

Rationale

Background
Heart Failure
Heart failure is a major cause of morbidity and mortality worldwide. The term heart failure refers to a complex clinical syndrome that impairs the heart’s ability to move blood through the circulatory system.¹ In the United States, an estimated 600,000 individuals live with chronic heart failure.² Heart failure is the leading cause of hospitalization among people older than age 65 years, with direct and indirect costs estimated at $37 billion annually in the United States.² Although survival has improved with treatment advances, absolute mortality rates of heart failure remain near 50% within 5 years of diagnosis.

Physiology
Heart failure can be caused by disorders of the pericardium, myocardium, endocardium, heart valves or great vessels, or metabolic abnormalities. Individuals with heart failure may present with a wide range of left ventricular (LV) anatomy and function. Some have normal LV size and preserved ejection fraction (EF); others have severe LV dilatation and depressed EF. However, most patients present with key signs and symptoms secondary to congestion in the lungs from impaired LV myocardial function.¹ They include dyspnea, orthopnea, and paroxysmal dyspnea. Other symptoms include weight gain due to fluid retention, fatigue, weakness, and exercise intolerance secondary to diminished cardiac output.

Diagnosis
Initial evaluation of a patient with suspected heart failure is typically based on clinical history, physical examination, and chest radiograph. Because people with heart failure may present with nonspecific signs and symptoms (e.g., dyspnea), accurate diagnosis can be challenging. Therefore, noninvasive imaging (e.g., echocardiography, radionuclide angiography) are used to quantify pump function of the heart, thus identifying or excluding heart failure in patients with characteristic signs and symptoms. These tests can also be used to assess prognosis by determining the severity of the underlying cardiac dysfunction.¹ However, clinical assessment and noninvasive imaging can be limited in accurately evaluating patients with heart failure because symptoms and signs can poorly correlate with objective methods of assessing cardiac dysfunction.³⁻⁵ Thus, invasive procedures (e.g., cardiac angiography, catheterization) are used in select patients with presumed heart failure symptoms to determine the etiology (i.e., ischemic vs nonischemic) and physiologic characteristics of the condition.

Treatment
Patients with heart failure may be treated using a number of interventions. Lifestyle factors such as the restriction of salt and fluid intake, monitoring for increased weight, and structured exercise programs are beneficial components of self-management. A variety of medications are available to treat heart failure. They include diuretics (e.g., Furosemide, Hydrochlorothiazide, Spironolactone), angiotensin-converting enzyme inhibitors (e.g., Captopril, Enalapril, Lisinopril),
angiotensin receptor blockers (e.g., Losartan, Valsartan, Candesartan), β-blockers (e.g., Carvedilol, Metoprolol succinate), and vasodilators (e.g., Hydralazine, Isosorbide dinitrate). Numerous device-based therapies also are available. Implantable cardioverter defibrillators reduce mortality in patients with an increased risk of sudden cardiac death. Cardiac resynchronization therapy improves symptoms and reduces mortality for patients who have disordered LV conduction evidenced by a wide QRS complex on electrocardiogram. Ventricular assist devices are indicated for patients with end-stage heart failure who have failed all other therapies and are also used as a bridge to cardiac transplantation in select patients.1

Heart Failure Biomarkers
Because of limitations inherent in standard clinical assessments of patients with heart failure, a number of objective disease biomarkers have been investigated to diagnose and assess heart failure patient prognosis, with the additional goal of using biomarkers to guide therapy.6 They include a number of proteins, peptides, or other small molecules whose production and release into circulation reflect the activation of remodeling and neurohormonal pathways that lead to LV impairment. Examples include B-type natriuretic peptide (BNP), its analog N-terminal pro B-type natriuretic peptide (NT-proBNP), troponin T and I, renin, angiotensin, arginine vasopressin, C-reactive protein, and norepinephrine.1,6

BNP and NT-proBNP are considered the reference standards for biomarkers in assessing heart failure patients. They have had substantial impact on the standard of care for diagnosis of heart failure and are included in the recommendations of all major medical societies, including the American College of Cardiology Foundation,1 European Society of Cardiology,7 and the Heart Failure Society of America.8 Although natriuretic peptide levels are not 100% specific for the clinical diagnosis of heart failure, elevated BNP or NT-proBNP levels in the presence of clinical signs and symptoms reliably identify the presence of structural heart disease due to remodeling and heightened risk for adverse events. Natriuretic peptides also can help in determining prognosis of heart failure patients, with elevated blood levels portending poorer prognosis.

In addition to diagnosing and assessing prognosis of heart failure patients, blood levels of BNP or NT-proBNP have been proposed as an aid for managing patients diagnosed with chronic heart failure.1,9,10 Levels of either biomarker rise in response to myocardial damage and LV remodeling, whereas they tend to fall as drug therapy ameliorates symptoms of heart failure. Evidence from a large number of randomized controlled trials (RCTs) that have compared BNP- or NT-proBNP-guided therapy to clinically guided adjustment of pharmacologic treatment of patients with chronic heart failure has been assessed in recent systematic reviews and meta-analyses. However, these analyses have not consistently reported a benefit for BNP-guided management. The largest meta-analysis to date is a 2013 patient-level meta-analysis of 2686 patients from 12 RCTs.9 This meta-analysis showed that NT-proBNP-guided management was associated with significant reductions in all-cause mortality and heart failure-related hospitalization compared with clinically guided treatment. Although BNP-guided management in this meta-analysis was not associated with significant reductions in these parameters, differences in patient numbers and characteristics may explain the discrepancy. A second patient-level meta-analysis (2014) included 11 RCTs with 2000 patients randomized to natriuretic peptide–guided pharmacologic therapy or usual care.10 The results showed that, among patients 75 years of age or younger with chronic heart failure, most of whom had impaired left ventricular ejection fraction (LVEF), natriuretic peptide–guided therapy was associated with significant reductions in all-cause mortality compared with clinically guided therapy. Natriuretic-guided therapy also was associated with significant reductions in hospitalization due to heart failure or cardiovascular disease.

Suppression of Tumorigenicity-2 Protein Biomarker
A protein biomarker, suppression of tumorigenicity-2 (ST2), has elicited interest as a potential aid to predict prognosis and manage therapy of heart failure.11-17 This protein is a member of the interleukin-1 (IL-1) receptor family. It is found as a transmembrane isoform (ST2L) and a soluble isoform (sST2), both of which have circulating IL-33 as their primary ligand. ST2 is a unique
biomarker that has pluripotent effects in vivo. Thus, binding between IL-33 and ST2L is believed to have an immunomodulatory function via T-helper type 2 lymphocytes and was initially described in the context of cell proliferation, inflammatory states, and autoimmune diseases. However, the IL-33/ST2L signaling cascade is also strongly induced through mechanical strain of cardiac fibroblasts or cardiomyocytes. The net result is mitigation of adverse cardiac remodeling and myocardial fibrosis, which are key processes in the development of heart failure. The soluble isoform of ST2 is produced by lung epithelial cells and cardiomyocytes, and is secreted into circulation in response to exogenous stimuli, mechanical stress, and cellular stretch. This form of ST2 binds to circulating IL-33, acting as a “decoy,” thus inhibiting the IL-33-associated antiremodeling effects of the IL-33/ST2L signaling pathway. Thus, on a biologic level, IL-33/ST2L signaling plays a role in modulating the balance of inflammation and neurohormonal activation, and is viewed as pivotal for protection from myocardial remodeling, whereas sST2 is viewed as attenuating this protection. In the clinic, blood concentrations of sST2 appear to correlate closely with adverse cardiac structure and functional changes consistent with remodeling in patients with heart failure, including abnormalities in filling pressures, chamber size, and systolic and diastolic function.

An enzyme-linked immunosorbent–based assay is commercially available for determining sST2 blood levels (Presage ST2 Assay). The manufacturer claims a limit of detection of 1.8 ng/mL for sST2, and a limit of quantification of 2.4 ng/mL, as determined according to Clinical and Laboratory Standards Institute guideline EP-17-A. In 1 published study (2013), a limit of detection of 2.0 ng/mL for sST2 was reported. In the same study, the assay had a within-run coefficient of variation (CV) of 2.5% and a total CV less than 4.0%, demonstrated linearity within the dynamic range of the assay calibration curve; and exhibited no relevant interference or cross-reactivity.

The ST2 biomarker is not intended to diagnose heart failure, because it is a relatively nonspecific marker that is increased in many other disparate conditions that may be associated with acute or chronic manifestations of heart failure. Although the natriuretic peptides (BNP, NT-proBNP) reflect different physiologic aspects of heart failure compared with sST2, they are considered the reference standard biomarkers when used with clinical findings to diagnose, prognosticate, and manage heart failure and as such are the comparator to sST2.

Literature Review

Use of Soluble Suppression of Tumorigenicity-2 Levels to Determine Prognosis and/or to Guide Management of Chronic Heart Failure

Clinical Context and Test Purpose

The purpose of biomarker testing in patients who have heart failure is to inform decisions about treatment goals and choice of treatment. This review evaluates whether the biomarker soluble suppression of tumorigenicity-2 (sST2) assay provides improved prognostic information compared with standardly used biomarkers.

The question addressed in this evidence review is: In individuals with chronic heart failure, does testing for sST2 levels change patient management decisions, especially choice of treatment, improve quality of life (QOL), and/or lead to improvements in health outcomes?

The following PICOTS were used to select literature to inform this review.

Patients

The relevant population of interest is patients with chronic heart failure.

Interventions

The intervention of interest is an sST2 assay cleared by the Food and Drug Administration (FDA).
Comparators
The comparators of interest are standard prognostic markers such as B-type natriuretic peptide (BNP) levels.

Outcomes
The primary outcome of interest is overall survival. Other relevant outcomes are cardiovascular mortality, QOL, and hospitalizations.

Time
The timing of survival outcomes are short-term (in-hospital and 30-day mortality) and longer term (e.g., 1- and 5-year) mortality. The timing for other outcomes is also short-term (30-days) and longer term.

Setting
The assay could be used in the inpatient or the outpatient setting.

Correlational Studies
A number of clinical studies in which sST2 blood levels were determined using the Presage ST2 Assay have reported that there is an association between ST2 levels and adverse outcomes in patients diagnosed with chronic heart failure. A substantial body of biomarker evidence has been reported retrospectively from subsets of patients enrolled in randomized controlled trials (RCTs) of heart failure interventions. These RCTs include Val-HeFT (Valsartan Heart Failure Trial)\textsuperscript{20}; HF-ACTION (Heart Failure: A Controlled Trial Investigating Outcomes of Exercise Training)\textsuperscript{21}; CORONA (Controlled Rosuvastatin Multinational Trial in Heart Failure)\textsuperscript{22}; and PROTECT (ProBNP Outpatient Tailored Chronic Heart Failure study)\textsuperscript{23}. Although patients in these RCTs were well-characterized and generally well-matched between study arms, the trials were neither intended nor designed specifically to evaluate biomarkers as risk predictors. At present, no prospectively gathered evidence is available from an RCT in which sST2 levels were compared with levels of a natriuretic peptide (BNP or N-terminal pro B-type natriuretic peptide [NT-proBNP]) to predict risk for adverse outcomes among well-defined cohorts of patients with diagnosed chronic heart failure. Key results of larger individual studies are summarized in Table 1.

Findings of studies on the prognostic value of sST2 for chronic heart failure were pooled in a 2017 meta-analysis by Aimo et al.\textsuperscript{24} The meta-analysis included 7 studies, including post hoc analyses of RCTs, and calculated the association between the Presage ST2 Assay and health outcomes. A pooled analysis of 7 studies found that sST2 was a statistically significant predictor of overall mortality (hazard ratio [HR], 1.75; 95% confidence interval [CI], 1.37 to 2.22). Moreover, a pooled analysis of 5 studies found that sST2 was a significant predictor of cardiovascular mortality (HR=1.79; 95% CI, 1.22 to 2.63).

No evidence is available from randomized or nonrandomized controlled studies in which outcomes from groups of well-matched groups of patients managed according to serial changes in sST2 blood levels were compared with those managed according the reference standard of BNP or NT-proBNP levels.

Section Summary: Use of Soluble Suppression of Tumorigenicity-2 to Determine Prognosis and/or to Guide Management of Chronic Heart Failure
Several analyses, mainly retrospective, have evaluated whether sST2 levels are associated with disease prognosis, especially mortality outcomes. Studies mainly found that elevated sST2 levels were statistically associated with elevated risk of mortality. A pooled analysis of study results found that sST2 levels significantly predicted overall mortality and cardiovascular mortality. Several studies, however, found that sST2 test results did not provide additional prognostic information compared with BNP or NT-proBNP levels. In general, it appears that elevated sST2 levels predict higher risk of poor outcomes better than lower levels. The available evidence is limited by interstudy inconsistency and differences in patient characteristics, particularly the severity of heart failure, its etiology, duration, and treatment. Furthermore, most of the evidence...
was obtained from retrospective analyses of sST2 levels in subsets of larger patient cohorts within RCTs, potentially biasing the findings. The evidence primarily shows associations between elevated sST2 levels and poor outcomes, but does not go beyond that in demonstrating a clinical connection among biomarker status, treatment received, and clinical outcomes.

**Use of Soluble ST2 in Post Heart Transplantation Patients**

**Clinical Context and Test Purpose**
The purpose of biomarker testing in patients who have had heart transplantation is to predict acute cellular rejection and provide information on prognosis to inform patient management decisions.

The question addressed in this evidence review is: In individuals who have had heart transplantation, does testing for sST2 levels reduce the need for endomyocardial biopsy, contribute to patient management decisions (e.g., dosing of antirejection medications), and/or lead to improvements in health outcomes?

The following PICOTS were used to select literature to inform this review.

**Patients**
The relevant population of interest is patients who have had heart transplantation.

**Interventions**
The intervention of interest is an FDA-cleared sST2 assay.

**Comparators**
The comparator of interest for predicting acute cellular rejection is endomyocardial biopsy.

**Outcomes**
The primary outcomes of interest are OS and morbid events (i.e., acute cellular rejection). Another outcome of interest is hospitalizations.

**Time**
The timing of survival outcomes are short-term (in-hospital and 30-day mortality) and longer term (e.g., 1- and 5-year) mortality. The timing of acute cellular rejection is primarily within the first year after transplantation.

**Setting**
The assay could be used in the inpatient or the outpatient setting.

**Observational Studies**
Serum ST2 levels have been proposed as a prognostic marker post heart transplantation and as a test to predict acute cellular rejection (graft-versus-host disease). There is very little evidence available for these indications. Januzzi et al (2013) retrospectively assessed sST2 levels in 241 patients post heart transplant.25 Over a follow-up of up to 7 years, sST2 levels were predictive of total mortality (HR=2.01; 95% CI, 1.15 to 3.51; p=0.01). Soluble ST2 levels were also associated with risk of acute cellular rejection, with a significant difference between the top and bottom quartiles of sST2 levels in the risk of rejection (p=0.003).

In study by Pascual-Figal et al (2011), 26 patients were identified with post cardiac transplantation and an acute rejection episode. Soluble ST2 levels were measured during the acute rejection episode and compared to levels measured when acute rejection was not present. Soluble ST2 levels were higher during the acute rejection episode (130 ng/mL) than during the nonrejection period (50 ng/mL; p=0.002). Elevated sST2 levels greater than 68 ng/mL had a positive predictive value of 53% and a negative predictive value of 83% for the presence of acute cellular rejection. The addition of sST2 levels to serum BNP resulted in incremental improvement in identifying rejection episodes.
Section Summary: Use of Soluble ST2 in Post Heart Transplantation Patients
Few studies are available and they are observational and retrospective. No prospective studies were identified that provide high-quality evidence on the ability of sST2 levels to predict transplant outcomes. One retrospective study (N=241) found that sST2 levels were associated with acute cellular rejection and mortality; another study (N=26) found that sST2 levels were higher during an acute rejection episode than before rejection.
### Table 1. Summary of Selected Clinical Studies of sST2 to Predict Outcomes in Chronic Heart Failure Patients

<table>
<thead>
<tr>
<th>Author (Year)</th>
<th>Population, N</th>
<th>Mean Age, y</th>
<th>Study Description and Biomarkers</th>
<th>Primary End Points</th>
<th>Mean FU</th>
<th>Synopsis of Findings</th>
</tr>
</thead>
</table>
| Ky et al (2011)²⁷      | Ambulatory CHF (N=1141, 75% of Penn HF Study population) | 56          | Retrospective analysis of sST2 and NT-proBNP levels and their incremental usefulness over clinical SHFM | Mortality or cardiac transplant | 2.8 y   | • Elevated sST2 levels associated with increased risk (adjusted p=0.002)  
  • sST2 in plus NT-proBNP levels showed moderate improvement over SHFM in predicting outcomes (p=0.017) |
| Bayes-Genis et al (2012)²⁸ | Ambulatory decompensated HF (N=891) | 70          | Retrospective analysis of sST2 and NT-proBNP levels from consecutive series of patients | Mortality                   | 2.8 y   | • Elevated sST2 and NT-proBNP levels provided independent and additive prognostic information for elevated risk of mortality (p<0.001) |
| Broch et al (2012)²⁹   | Ischemic CHF (N=1149, 30% of CORONA RCT) | 72          | Retrospective analysis of sST2 NT-proBNP, and CRP levels                                      | CV mortality, nonfatal myocardial infarction or stroke | 2.6 y   | • Elevated sST2 levels independently associated with increased risk for mortality, hospitalization due to HF, or any CV hospitalization (p<0.001)  
  • sST2 did not provide additive prognostic information vs NT-proBNP |
| Felker et al (2013)³⁰  | Ambulatory HF (N=910, 39% of HF-ACTION RCT) | 59          | Retrospective analysis of sST2 and NT-proBNP levels                                           | Mortality, hospitalization, functional capacity | 2.5 y   | • Elevated sST2 levels independently associated with increased risk for mortality, hospitalization due to HF, or any CV hospitalization (p<0.000)  
  • sST2 and NT-proBNP provided independent prognostic information  
  • sST2 did not provide additive prognostic information vs NT-proBNP |
| Gaggin et al (2013)³¹  | Recently decompensated CHF (N=151, 100% of PROTECT RCT) | 63          | Retrospective analysis of sST2 and NT-proBNP levels                                           | Composite outcome (worsening HF, hospitalization for HF, clinically significant CV events) | 0.8 y   | • Elevated sST2 levels associated with increased risk for adverse CV outcome (p<0.001)  
  • sST2 and NT-proBNP did not provide independent prognostic information |
| Anand et al (2014)³²   | CHF (N=1650, 33% of Val-HeFT RCT) | 63          | Retrospective analysis of sST2, NT-proBNP, and other biomarker levels                         | All-cause mortality and composite outcome (mortality, SCD with resuscitation, hospitalization for HF, or administration of IV inotropic or vasodilator drug for ≥4 h without hospitalization) | All-cause mortality | 1 y   | • Elevated sST2 levels independently associated with increased risk of poor outcomes (p<0.000)  
  • Baseline sST2 levels did not provide substantial prognostic information when added to a clinical model that included NT-proBNP levels |
<p>| Zhang et al (2015)³³   | De novo HF or decompensated CHF (N=1161) | 58          | Prospective analysis of sST2 in hospitalized patients                                 | All-cause mortality         | 1 y     | • Elevated sST2 levels independently associated with increased risk of all-cause mortality |</p>
<table>
<thead>
<tr>
<th>Author (Year)</th>
<th>Population, N</th>
<th>Mean Age, y</th>
<th>Study Description and Biomarkers</th>
<th>Primary End Points</th>
<th>Mean FU</th>
<th>Synopsis of Findings</th>
</tr>
</thead>
</table>
| Dupuy et al (2016) | HF for ≥6 mo (N=178) | 75 | Prospective analysis of sST2, NT-proBNP, and other biomarker levels in patient sample from 1 center in France | All-cause mortality and CV mortality | 42 mo<sup>a</sup> | • Elevated sST2 levels independently associated with increased risk for all-cause mortality and CV mortality (p<0.001)  
• In multivariate analysis, sST2 and CRP significantly associated with all-cause mortality and CV mortality |

CHF: chronic heart failure; CRP: C-reactive protein; CV: cardiovascular; FU: follow-up; HF: heart failure; IV: intravenous; NT-proBNP: N-terminal pro B-type natriuretic peptide; RCT: randomized controlled trial; SCD: sudden cardiac death; SHFM: Seattle Heart Failure Model; sST2: soluble suppression of tumorigenicity-2.  
<sup>a</sup> Median.
Summary of Evidence

For individuals who have chronic heart failure who receive the soluble suppression of
tumorigenicity-2 (sST2) assay to determine prognosis and/or to guide management, the
evidence includes correlational studies and a meta-analysis. Relevant outcomes are overall
survival, quality of life, and hospitalization. Most of the evidence is from reanalysis of existing
randomized controlled trials and not from studies specifically designed to evaluate the
predictive accuracy of sST2. Studies have mainly found that elevated sST2 levels are statistically
associated with elevated risk of mortality. A pooled analysis of study results found that sST2
significantly predicted overall mortality and cardiovascular mortality. Several studies, however,
found that sST2 test results did not provide additional prognostic information compared with N-
terminal pro B-type natriuretic peptide levels. Moreover, no comparative studies were identified
on the use of the sST2 assay to guide management of patients diagnosed with chronic heart
failure. The evidence is insufficient to determine the effects of the technology on health
outcomes.

For individuals who have heart transplantation who receive sST2 assay to determine prognosis
and/or to predict acute cellular rejection, the evidence includes a small number of
retrospective observational studies on the Presage ST2 Assay. Relevant outcomes are overall
survival, morbid events, and hospitalization. No prospective studies were identified that provide
high-quality evidence on the ability of sST2 to predict transplant outcomes. One retrospective
study (N=241) found that sST2 levels were associated with acute cellular rejection and mortality;
another study (N=26) found that sST2 levels were higher during an acute rejection episode than
before rejection. The evidence is insufficient to determine the effects of the technology on
health outcomes.

Supplemental Information

Practice Guidelines and Position Statements
In 2013, the American College of Cardiology Foundation (ACCF) and American Heart
Association (AHA) published joint evidence-based guidelines, informed by a systematic review
of the literature, on the management of heart failure. The review states that soluble suppression
of tumorigenicity-2 (sST2) is a biomarker for myocardial fibrosis that predicts hospitalization and
death in patients with heart failure and provides additive prognostic information to natriuretic
peptide levels. In the ambulatory heart failure setting, ACCF and AHA applied a class IIb
recommendation and assigned a level B of evidence for the use of sST2 as an option to provide
additive prognostic information to established clinical evaluation and biomarkers. The guidelines
do not address other uses of sST2.

U.S. Preventive Services Task Force Recommendations
Not applicable.

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.

Ongoing and Unpublished Clinical Trials
A search of ClinicalTrials.gov in April 2017 did not identify any ongoing or unpublished trials that
would likely influence this review.

References

1. Yancy CW, Jessup M, Bozkurt B, et al. 2013 ACCF/AHA guideline for the management of
heart failure: a report of the American College of Cardiology Foundation/American
2013;62(16):e147-239. PMID 23747642

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7. McMurray JJ, Adamopoulos S, Anker SD, et al. ESC guidelines for the diagnosis and treatment of acute and chronic heart failure 2012: The Task Force for the Diagnosis and Treatment of Acute and Chronic Heart Failure 2012 of the European Society of Cardiology. Developed in collaboration with the Heart Failure Association (HFA) of the ESC. Eur J Heart Fail. Aug 2012;14(8):803-869. PMID 22828712


Documentation for Clinical Review

- No records required

Coding

This Policy relates only to the services or supplies described herein. Benefits may vary according to benefit design; therefore, contract language should be reviewed before applying the terms of the Policy. Inclusion or exclusion of a procedure, diagnosis or device code(s) does not constitute or imply member coverage or provider reimbursement.

IE

The following services may be considered investigational.

<table>
<thead>
<tr>
<th>Type</th>
<th>Code</th>
<th>Description</th>
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<td>CPT</td>
<td>83006</td>
<td>Growth stimulation expressed gene 2 (ST2, Interleukin 1 receptor like-1)</td>
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<tr>
<td>HCPCS</td>
<td>None</td>
<td></td>
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<td>ICD-10 Procedure</td>
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### Policy History

This section provides a chronological history of the activities, updates and changes that have occurred with this Medical Policy.

<table>
<thead>
<tr>
<th>Effective Date</th>
<th>Action</th>
<th>Reason</th>
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<tbody>
<tr>
<td>04/30/2015</td>
<td>BCBSA Medical Policy adoption</td>
<td>Medical Policy Committee</td>
</tr>
<tr>
<td>07/01/2016</td>
<td>Policy title change from ST2 Assay for Chronic Heart Failure</td>
<td>Medical Policy Committee</td>
</tr>
<tr>
<td>07/01/2016</td>
<td>Policy revision without position change</td>
<td>Medical Policy Committee</td>
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<td>07/01/2017</td>
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<td>Medical Policy Committee</td>
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</table>

### Definitions of Decision Determinations

**Medically Necessary:** A treatment, procedure, or drug is medically necessary only when it has been established as safe and effective for the particular symptoms or diagnosis, is not investigational or experimental, is not being provided primarily for the convenience of the patient or the provider, and is provided at the most appropriate level to treat the condition.

**Investigational/Experimental:** A treatment, procedure, or drug is investigational when it has not been recognized as safe and effective for use in treating the particular condition in accordance with generally accepted professional medical standards. This includes services where approval by the federal or state governmental is required prior to use, but has not yet been granted.

**Split Evaluation:** Blue Shield of California/Blue Shield of California Life & Health Insurance Company (Blue Shield) policy review can result in a split evaluation, where a treatment, procedure, or drug will be considered to be investigational for certain indications or conditions, but will be deemed safe and effective for other indications or conditions, and therefore potentially medically necessary in those instances.

### Prior Authorization Requirements (as applicable to your plan)

Within five days before the actual date of service, the provider must confirm with Blue Shield that the member’s health plan coverage is still in effect. Blue Shield reserves the right to revoke an authorization prior to services being rendered based on cancellation of the member’s eligibility. Final determination of benefits will be made after review of the claim for limitations or exclusions.

Questions regarding the applicability of this policy should be directed to the Prior Authorization Department. Please call (800) 541-6652 or visit the provider portal at www.blueshieldca.com/provider.

 Disclaimer: This medical policy is a guide in evaluating the medical necessity of a particular service or treatment. Blue Shield of California may consider published peer-reviewed scientific literature, national guidelines, and local standards of practice in developing its medical policy. Federal and state law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over medical policy and must be considered first in determining covered services. Member contracts may differ in their benefits. Blue Shield reserves the right to review and update policies as appropriate.