



## Genetic Testing

<b>LOB(s):</b> <input checked="" type="checkbox"/> Commercial  <input checked="" type="checkbox"/> Medicare  <input checked="" type="checkbox"/> Medicaid	<b>State(s):</b> <input checked="" type="checkbox"/> Idaho <input checked="" type="checkbox"/> Montana <input checked="" type="checkbox"/> Oregon <input checked="" type="checkbox"/> Washington <input type="checkbox"/> Other:  <input checked="" type="checkbox"/> Oregon <input type="checkbox"/> Washington
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## Enterprise Policy

PacificSource is committed to assessing and applying current regulatory standards, widely-used treatment guidelines, and evidenced-based clinical literature when developing clinical criteria for coverage determination. Each policy contains a list of sources (references) that serves as the summary of evidence used in the development and adoption of the criteria. The evidence was considered to ensure the criteria provide clinical benefits that promote patient safety and/or access to appropriate care. Each clinical policy is reviewed, updated as needed, and readopted, at least annually, to reflect changes in regulation, new evidence, and advancements in healthcare.

Clinical Guidelines are written when necessary to provide guidance to providers and members in order to outline and clarify coverage criteria in accordance with the terms of the Member's policy. This Clinical Guideline only applies to PacificSource Health Plans, PacificSource Community Health Plans, and PacificSource Community Solutions in Idaho, Montana, Oregon, and Washington. Because of the changing nature of medicine, this list is subject to revision and update without notice. This document is designed for informational purposes only and is not an authorization or contract. Coverage determinations are made on a case-by-case basis and subject to the terms, conditions, limitations, and exclusions of the Member's policy. Member policies differ in benefits and to the extent a conflict exists between the Clinical Guideline and the Member's policy, the Member's policy language shall control. Clinical Guidelines do not constitute medical advice nor guarantee coverage.

## Background

Genetic testing, for purposes of this policy, are defined as tests performed to detect gene sequences or mutations which contribute to or cause certain diseases or conditions. This includes prenatal carrier screening and testing, chromosomal microarray analysis, pharmaocogenomic testing, liquid based panel testing (liquid biopsy), whole exome and genome sequencing, and polygenic risk score.

Carelon Medical Benefits Management, formerly AIM Specialty Health, reviews genetic testing codes (in scope) for PacificSource.

The codes considered out of scope by Carelon Medical Benefits Management will be reviewed by PacificSource. If Carelon Medical Benefits Management criteria is not available, PacificSource will use MCG, member specific benefit books or this policy to review genetic testing requests.

Note: In scope codes may require PacificSource review, rather than Carelon Medical Benefits Management due to a member's location, timeframes, or appeal process requirements.

## Criteria

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### Commercial

#### Prior authorization is required.

PacificSource may consider genetic testing medically necessary when **ONE** of the following criteria is met:

- A.** A requested genetic test meets the specific Carelon Medical Benefits Management criteria
- B.** A requested genetic test does not have specific Carelon Medical Benefits Management criteria available, but meets **ALL** of the following conditions:
  - Original requisition form is submitted and clearly identifies requested test
  - Confirming diagnosis by genetic testing would significantly influence medical or drug therapy, provide prognostic information, or provide prenatal/carrier information
  - All codes within a panel are considered medically necessary. If any of the codes within a requested panel are considered to be experimental, investigational, or unproven; the entire panel will be considered to be experimental, investigational, or unproven

### Medicaid

PacificSource Community Solutions follows the Oregon Health Plan (OHP) Prioritized List of Health Services and all Guideline Notes within, the OHP Diagnostic Procedure Codes/Procedure Group 1119.

PacificSource Community Solutions considers CPT codes 81535, 81536, 81538, 81417, 81479, 81599, 84999, S3854, 81541, 81545, and 83722 to be experimental, investigational, or unproven per the New and Emerging Technologies - Coverage Status policy.

### Medicare

PacificSource Medicare will use coverage determination set forth by Noridian MoIDx Covered-tests for clarification or tests out of the scope of AIM, in addition to diagnosis specific genetic testing outlined in LCDs and NCDs, respectively.

### Experimental/Investigational/Unproven

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PacificSource considers the following genetic tests to be Experimental/Investigational/ Unproven:

Genetic Test	CPT/HCPCS Codes
4K Score testing for prostate cancer	81539
Human epididymis protein 4 HE4 Assay	86305
Chemoresistance /chemosensitivity testing	81535, 81536, 88358
ST2 Assay	83006
Vectra™ DA (multi-biomarker blood test)	81490
VeriStrat Test (Biodesix)	81538

CPT® codes, descriptions and materials are copyrighted by the American Medical Association (AMA).

HCPCS® codes, descriptions and materials are copyrighted by Centers for Medicare and Medicaid Services (CMS).

## Related Policies

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New and Emerging Technologies - Coverage Status

## References

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Carelon Medical Benefits Management. Genetic Testing Guidelines.

<https://guidelines.carelonmedicalbenefitsmanagement.com/current-genetic-testing-guidelines/>

Noridian Healthcare Solutions. (April 2023). Medicare B News: Jurisdiction F.

<https://med.noridianmedicare.com/documents/10534/27634211/Medicare%20B%20News%20JF%20April%202023>

Oregon Health Authority. Oregon Health Plans Prioritized List Guideline Notes D1 and D17.

<https://www.oregon.gov/oha/HPA/DSI-HERC/Pages/Prioritized-List.aspx>

State of Oregon. Health and Human Services: Diagnostic Procedure Codes, Group 1119.

<https://data.oregon.gov/Health-Human-Services/Diagnostic-Procedure-Codes-Procedure-Group-1119-gmb4-77ea/data>

Washington State Health Care Authority. (July 13, 2018). Health Technology Clinical Committee (HTCC): Pharmacogenetic testing for patients being treated with oral anticoagulants.

<https://www.hca.wa.gov/assets/program/pharmaogenetic-testing-anticoagulants-final-findings-decision-20180713.pdf>

[Washington State Health Care Authority. \(March 17, 2017\). Health Technology Clinical Committee \(HTCC\): Pharmacogenetic testing for selected conditions.](https://www.hca.wa.gov/assets/program/PDX-final-findings-decision-20170317.pdf)

<https://www.hca.wa.gov/assets/program/PDX-final-findings-decision-20170317.pdf>

## Appendix

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**Policy Number:**

**Effective:** 6/1/2020

**Next review:** 2/1/2025

**Policy type:** Enterprise

**Author(s):**

**Depts:** Health Services

**Applicable regulation(s):**

**Commercial Ops:** 4/2024

**Government Ops:** 4/2024