



Clinical Medical Policy Genetic Testing

Benefit Coverage:

Covered benefit when conditional criteria are met.

No prior authorization or review is required for genetic testing related to a pregnancy.

Description:

Tests done for clinical genetic purposes including the diagnosis of genetic disease in children and adults; the identification of future disease risks; the prediction of drug responses; and the detection of risks of disease to future children.

Coverage Determination:

Neighborhood Health Plan of Rhode Island (Neighborhood) covers Genetic Testing, as a clinical option when determined medically necessary by the Medical Management Department. Prior authorization is required (exception pregnancy, see above).

Medical Necessity documentation sent to Neighborhood for review must be submitted by a participating practitioner and must include the following documentation:

- Previous testing performed, and/or other alternatives available to obtain the information.
- What the treating practitioners will do differently - diagnostically, therapeutically, or preventively, based on the results of this test.
- Genetic counseling received by the member and/or plans for this
- Where the testing will be done and who will interpret the results.

Criteria:

Genetic testing is considered a clinical option for patients when all of the following criteria are met:

1. Signs and symptoms are present that may be genetically linked to an inheritable disease, or documentation of a direct risk factor for a heritable disease
2. The testing is the only and/or most medically appropriate option available to obtain the necessary information to evaluate and treat the member.
3. Testing will impact the management of the member's treatment plan and result in a clinical difference for the member.
4. Pre and post genetic counseling must be provided by a qualified and appropriately trained practitioner.
5. The testing method is considered a proven method for the identification of a genetically-linked heritable disease; the sensitivity and specificity of the test are known, and there is evidence that the test is considered reproducible and accurate.



Clinical Medical Policy Genetic Testing

Covered Procedures:

Exclusions:

Genetic testing is NOT considered a clinical option for any of the following indications:

1. Testing will provide information for future generations of member's family
2. Testing is being conducted to benefit care and treatment of member of the patient's family who is not covered by Neighborhood.
3. Experimental testing

CMP Number: CMP-007.02

CMP Cross Reference:

References:

Medicine.Net (MedicineNet® is a network of [U.S. Board Certified Physicians and Allied Health Professionals](#))

CMS Website:

http://www.cms.hhs.gov/mcd/cpt_license.asp?page=overview.asp&type=lcd&from=basket&lmrp_id=23664&lmrp_version=4&viewAMA=N&basket=lcd%3A23664%3A4%3AGenetic+Testing%3ACarrier%3ANoridian+Administrative+Services%7C%7C+LLC+%2800820%29%3A

Copyright 2007:

Excerpts from LCD for Genetic Testing L23664

Genetic Testing and Diagnostic Tools in the Pharmacy Benefit, www.AISHealth.com

Erin Trompeter, Editor, Angela Maas, Managing Editor, Specialty Pharmacy News

Neal Learner, Managing Editor, Drug Benefit News, Susan Namovicz-Peat, Managing Editor

Atlantic Information Services, Inc.

National Guideline clearinghouse www.guideline.gov

Genetic risk assessment and BRCA mutation testing for breast and ovarian cancer susceptibility from US Preventive Services Task Force

Genetic Cancer risk assessment and counseling: recommendations of the National Society of Genetic Counselors

Clinical genetic evaluation of the child with mental retardation or developmental delays



Clinical Medical Policy Genetic Testing

Created: 11/03
Annual Review Month:
Review Dates: 4/08, 3/9/2010
Revision Dates:
Approval Dates: 11/03, 7/12/07, 5/13/08, 3/9/2010