MASSACHUSETTS

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Medical Policy

Carelon (formerly AIM) Genetic Testing Management Program

Policy Number: **954**

BCBSA Reference Number: N/A
NCD/LCD: N/A
Effective Date: January 1, 2019

Related Policies

- Carelon Genetic Testing Management Program CPT and HCPCS Codes, #957
- Biomarkers for the Diagnosis and Cancer Risk Assessment of Prostate Cancer, #336
- Cardiovascular Risk Panels, #664
- Preimplantation Genetic Testing, #088

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Overview:

Effective January 1, 2019, BCBSMA has delegated utilization management of molecular genetic testing to Carelon Medical Benefits Management for Commercial products only. Medicare Advantage products do not require prior authorization from Carelon Medical Benefits Management.

The Genetic Testing Management Program requires prior authorization for molecular genetic tests per the medical necessity criteria reflected in the Carelon Medical Benefits Management Clinical Guidelines (for Commercial products only).

The Carelon Medical Benefits Management Clinical Guidelines are based on peer-reviewed literature and recommendations from evidence-based research centers such as (but not limited to): The American College of Medical Genetics (ACMG), The American College of Obstetrics and Gynecologists (ACOG), the American Society of Clinical Oncology (ASCO) and National Comprehensive Cancer Network (NCCN).

Policy and Coverage Criteria for Commercial Products:

The Carelon Medical Benefits Management Clinical Guidelines include medical necessity criteria for genetic tests in the following categories:

Genetic Testing for Hereditary Cancer Susceptibility
https://guidelines.carelonmedicalbenefitsmanagement.com/

Genetic Testing for Hereditary Cardiac Disease
https://guidelines.carelonmedicalbenefitsmanagement.com/

Genetic Testing for Pharmacogenetic and Thrombophilia
https://guidelines.carelonmedicalbenefitsmanagement.com/

Genetic Testing for Reproductive Carrier Screening and Prenatal Diagnosis
https://guidelines.carelonmedicalbenefitsmanagement.com/

Genetic Testing for Single-Gene and Multifactorial Conditions
https://guidelines.carelonmedicalbenefitsmanagement.com/

Genetic Testing for Whole Exome and Genome Sequencing
https://guidelines.carelonmedicalbenefitsmanagement.com/

Molecular Testing of Solid and Hematologic Tumors and Malignancies
https://guidelines.carelonmedicalbenefitsmanagement.com/

The following BCBSMA medical policy is used instead of the Carelon guideline on reproductive carrier screening and prenatal diagnosis:

- BCBSMA Medical Policy #088 Preimplantation Genetic Testing (including preimplantation genetic diagnosis). The policy is only available on the BCBSMA medical policy website.
- Prior authorization is required through BCBSMA. See instructions below.

The utilization management of molecular genetic testing through Carelon Medical Benefits Management does **not** include the following:

- Cytogenetics
- Human Leukocyte Antigen (HLA) testing
- Human Platelet Antigen (HPA) testing.

For a list of specific tests, CPT codes, and HCPCS codes that require prior authorization, see Carelon Genetic Testing Management Program CPT and HCPCS Codes, #957.

CPT codes and HCPCS that apply to BCBSMA Medical Policy #088 are found on the policy. Do not use BCBSMA Policy #957 to look up codes for Preimplantation Genetic Testing.

Molecular genetic/genomic testing that does not meet coverage criteria listed in these clinical guidelines may be considered experimental/investigational or not medically necessary, and therefore not covered.

Genetic testing is covered only when the patient meets coverage criteria outlined in the corresponding guideline or in the BCBSMA Medical Policy. Carelon guidelines are available at Guidelines.carelonmedicalbenefitsmanagement.com.

Requesting Prior Authorization Information through Carelon Medical Benefits Management:

To request prior authorization for the following products: Commercial Managed Care (HMO and POS) and Commercial PPO/EPO, please see instructions below.

1. Through the Blue Cross Blue Shield of Massachusetts website:
    - Log in to your Blue Cross Blue Shield of Massachusetts Provider Central account at www.bluecrossma.com/provider.
    - Click **eTools>** and then to Carelon Medical Benefits Management
    - Click **Go Now**

2. Going directly to Carelon's *ProviderPortal*[SM] (registration required)
    - Go to www.providerportal.com
    - Or calling 1-866-745-1783 (when applicable).

Requesting Prior Authorization Information through BCBSMA:

This only applies to Medical Policy #088 Preimplantation Genetic Testing.

To request prior authorization for the following products: Commercial Managed Care (HMO and POS) and Commercial PPO and Indemnity, please see instructions below.

Through the Blue Cross Blue Shield of Massachusetts website:

- Log in to your Blue Cross Blue Shield of Massachusetts Provider Central account at www.bluecrossma.com/provider.
- Prior authorization is required for the following biopsy codes only:
    - 89290 Biopsy, oocyte polar body or embryo blastomere, microtechnique (for pre-implantation genetic diagnosis); less than or equal to 5 embryos
    - 89291 Biopsy, oocyte polar body or embryo blastomere, microtechnique (for pre-implantation genetic diagnosis); greater than 5 embryos
- No additional authorization is required for genetic testing when the biopsy has been approved.

List of Retired BCBSMA Genetic Testing Medical Policies:

The following BCBSMA Genetic Testing Medical Policies will be retired effective January 1, 2019. For the list of impacted CPT and HCPCS codes, see Carelon Genetic Testing Management Program CPT and HCPCS Codes, #957. **Note:** These policies will no longer be available on the BCBSMA website as of this date. For medically necessary indications, see the Carelon Medical Benefits Management Clinical Guidelines for non-oncologic and oncologic conditions.

Medical Policy Title	Policy Number
Cardiology	
Gene Expression Testing in the Evaluation of Patients with Stable Ischemic Heart Disease	349
Genetic Testing for Congenital Long QT Syndrome	082
Genetic Testing for Dilated Cardiomyopathy	601
Genetic Testing for Marfan Syndrome, Thoracic Aortic Aneurysms and Dissections, and Related Disorders	729
Genetic Testing for Predisposition to Inherited Hypertrophic Cardiomyopathy	909
Genotyping for 9p21 Genetic Polymorphisms to Predict Cardiovascular Disease Risk	340
General Genetics	
DNA-Based Testing for Adolescent Idiopathic Scoliosis	545
General Approach to Evaluating the Utility of Genetic Panels	734
General Approach to Genetic Testing	735
Genetic Testing for Alpha Thalassemia	520
Genetic Testing for Alpha-1 Antitrypsin Deficiency	906
Genetic Testing for CHARGE Syndrome	540
Genetic Testing for Facioscapulohumeral Muscular Dystrophy	535
Genetic Testing for Familial Alzheimer's Disease	580
Genetic Testing for Helicobacter Pylori Treatment	288
Genetic Testing for Hereditary Hemochromatosis	908
Genetic Testing for Hereditary Pancreatitis	516
Genetic Testing for Heterozygous Familial Hypercholesterolemia	796
Genetic Testing for Inherited Thrombophilia	802
Genetic Testing for Lactase Insufficiency	565
Genetic Testing for Macular Degeneration	665
Genetic Testing for Muscular Dystrophies	828
Genetic Testing of CADASIL Syndrome	357
Human Leukocyte Antigen Testing for Celiac Disease	567
Miscellaneous Genetic and Molecular Diagnostic Tests	712

Whole Exome Sequencing	457
Hereditary Cancer	
Genetic Cancer Susceptibility Panels Using Next Generation Sequencing	574
Genetic Testing for Cutaneous Malignant Melanoma	300
Genetic Testing for Fanconi Anemia	714
Genetic Testing for Hereditary Breast and Ovarian Cancer	245
Genetic Testing for Inherited Susceptibility to Colon Cancer, Including Microsatellite Instability Testing	226
Genetic Testing for Li-Fraumeni Syndrome	684
Genetic Testing for PTEN Hamartoma Tumor Syndrome	615
Use of Common Genetic Variants (Single Nucleotide Variants) to Predict Risk of Nonfamilial Breast Cancer	252
Musculoskeletal	
Genetic Testing for Limb-Girdle Muscular Dystrophies	738
Genetic Testing for Mitochondrial Disorders	685
Neurology/Psychiatry	
Genetic Testing for Developmental Delay/Intellectual Disability, Autism Spectrum Disorder and Congenital Anomalies	228
Genetic Testing for Epilepsy	668
Genetic Testing for FMR1 mutations (including Fragile X Syndrome)	907
Genetic Testing for Mental Health Conditions	669
Genetic Testing for Neurofibromatosis	793
Genetic Testing for Nonsyndromic Hearing Loss	452
Genetic Testing for Rett Syndrome	803
Genetic Testing for the Diagnosis of Inherited Peripheral Neuropathies	569
Oncology	
Analysis of MGMT Promoter Methylation in Malignant Gliomas	587
Assays of Genetic Expression in Tumor Tissue as a Technique to Determine Prognosis in Patients with Breast Cancer	055
BCR-ABL1 Testing in Chronic Myelogenous Leukemia and Acute Lymphoblastic Leukemia	612
Circulating Tumor DNA and Circulating Tumor Cells for Cancer Management (Liquid Biopsy) – Retired effective 1.4.2021	797
BRAF Gene Mutation Testing to Select Melanoma Patients for BRAF Inhibitor Targeted Therapy	398
Detection of Circulating Tumor Cells in the Management of Patients with Cancer	265
Expanded Molecular Panel Testing of Cancers to Identify Targeted Therapies	790
Gene Expression Based Assays for Cancers of Unknown Primary	614
Gene Expression Profiling for Cutaneous Melanoma	056
Gene Expression Profiling for Uveal Melanoma	683
Genetic and Protein Biomarkers for the Diagnosis and Cancer Risk Assessment of Prostate Cancer: TMPRSS Fusion Genes in Prostate Cancer (using PCR); Mitochondrial DNA Mutation Testing (eg, Prostate Core Mitomics Test™); Candidate Gene Panels; Gene Hypermethylation Testing (eg, ConfirmMDx®)	333
Genetic Testing for CHEK2 Mutations for Breast Cancer	741
Genetic Testing for FLT3 and NPM1 Mutations in Acute Myeloid Leukemia	693
Genetic Testing for Germline Mutations of the RET Proto-Oncogene in Medullary Carcinoma of the Thyroid	564
KIT (c-KIT) Mutation Analysis	829
KRAS and BRAF Mutation Analysis in Metastatic Colorectal Cancer	104
Microarray-based Gene Expression Analysis for Prostate Cancer Management	670
Microarray-Based Gene Expression Profile Testing for Multiple Myeloma Risk Stratification	477
Moderate Penetrance Variants Associated with Breast Cancer in Individuals at High Breast Cancer Risk	722
Molecular Analysis for Targeted Therapy of Non-Small-Cell Lung Cancer	563
Molecular Markers in Fine Needle Aspirates of the Thyroid	913

Molecular Testing for the Management of Pancreatic Cysts or Barrett Esophagus	566
Multigene Expression Assay for Predicting Recurrence in Colon Cancer	239
Non-BRCA Breast Cancer Risk Assessment - e.g., OncoVue	188
Proteogenomic Testing for Patients with Cancer (GPS Cancer Test)	838
Tyrosine Kinase Mutations in Myeloproliferative Neoplasms	079
Pharmacogenetics	
Cytochrome p450 Genotyping	256
Genetic Testing for Lipoprotein(a) Variant(s) as a Decision Aid for Aspirin Treatment	339
Genetic Testing for Statin-Induced Myopathy	575
Genetic Testing for Tamoxifen Treatment	067
Genetic Testing for Warfarin Dose	214
KIF6 Genotyping for Predicting Cardiovascular Risk and or Effectiveness of Statin Therapy	129
Laboratory and Genetic for Use of 5-Fluorouracil in Patients with Cancer	318
Pharmacogenetic Testing for Pain Management	724
Pharmacogenomic and Metabolite Markers for Patients Treated with Thiopurines	096
Reproductive	
Carrier Screening for Genetic Diseases	666
Chromosomal Microarray Testing for the Evaluation of Pregnancy Loss	686
Invasive Prenatal (Fetal) Diagnostic Testing	708
Noninvasive Fetal RHD Genotyping Using Cell-Free Fetal DNA	667
Noninvasive Prenatal Screening for Fetal Aneuploidies and Microdeletions Using Cell-Free Fetal DNA	628

Genetic Testing for Medicare Advantage Products

Prior authorization through AIM Specialty Health is **not** required for Medicare Advantage products. Please see the appropriate National Coverage Determination (NCD) or Local Coverage Determination (LCD) through the CMS website for specific genetic testing guidelines.

Policy History

Date	Action
3/2023	AIM Specialty Health changed its name to Carelon Medical Benefits Management.
10/2022	Policy #790 Expanded Molecular Panel Testing of Cancers to Identify Targeted Therapies is retired. AIM Guidelines for Molecular Testing of Solid and Hematologic Tumors and Malignancies will be used to determine coverage. Effective 9/4/2022. For medical necessity criteria, see Carelon Medical Benefits Management Clinical Guidelines.
1/2021	Policy #797 Circulating Tumor DNA and Circulating Tumor Cells for Cancer Management (Liquid Biopsy) is retired. For medical necessity criteria, see Carelon Medical Benefits Management Clinical Guidelines. Effective 1/4/2021.
1/2019	Policy issued 1/1/2019.

Disclaimer

Coverage is subject to applicable benefit contract. Specific benefits may vary by product and/or employer group. Please reference appropriate member materials (e.g., Benefit Handbook, Certificate of Coverage) for member-specific benefit information.

Member's medical records must document that services are medically necessary for the care provided. BCBS MA maintains the right to audit the services provided to our members, regardless of the participation status of the provider. All documentation must be available upon request. Failure to produce the requested information may result in denial or retraction of payment.

References

Carelon Medical Benefits Management Clinical Guidelines