Medical Necessity Guidelines: Genetic Testing: Gene Expression for Cancer of Unknown Primary (CUP)

Effective: December 14, 2016


Applies to:
- ☑ Tufts Health Plan Commercial Plans products; Fax: 617.972.9409
- ☑ Tufts Health Public Plans products
  - ☑ Tufts Health Direct – Health Connector; Fax: 888.415.9055
  - ☑ Tufts Health Together – A MassHealth Plan; Fax: 888.415.9055
  - ☑ Tufts Health Unify – OneCare Plan; Fax: 781.393.2607
  - ☑ Tufts Health RITogether — A Rhode Island Medicaid Plan; Fax: 857.304.6404
- ☑ Tufts Health Freedom Plan products; Fax: 617.972.9409

Note: While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you will need to make sure that prior authorization has been obtained.

OVERVIEW
Gene expression testing for cancers of unknown primary (CUP) is used to aid in the diagnosis and treatment of metastatic cancers for which the site of primary remains uncertain or unknown after a complete medical work-up.

COVERAGE GUIDELINES
Tufts Health Plan may authorize the coverage of a gene expression testing assay for CUP when the test is ordered by an oncologist and ALL of the following are met:
- The Member has the diagnosis of metastatic cancer
- Clinical evaluation has failed to identify the primary site (tissue of origin) of the cancer
- The pathology report is submitted to Tufts Health Plan for review
- Pathology examination of the tumor is not able to conclusively identify the primary site or has identified two or more possible primary sites

LIMITATIONS
Tufts Health Plan will not cover this test when used to confirm a diagnosis.

CODES
The following CPT codes require prior authorization:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>81504</td>
<td>Oncology (tissue of origin), microarray gene expression profiling of &gt; 2000 genes, utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as tissue similarity scores</td>
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<tr>
<td>81540</td>
<td>Oncology (tumor of unknown origin), mRNA, gene expression profiling by real-time RT-PCR of 92 genes (87 content and 5 housekeeping) to classify tumor into main cancer type and subtype, utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as a probability of a predicted main cancer type and subtype</td>
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<tr>
<td>84999</td>
<td>Unlisted chemistry procedure (when used to describe a gene expression assay for cancer of unknown origin)</td>
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REFERENCES


APPROVAL HISTORY


Subsequent endorsement date(s) and changes made:
- January 9, 2013: Reviewed by Integrated Medical Policy Advisory Committee (IMPAC), renewed without changes.
- April 24, 2013: Reviewed at Medical Technology Assessment Committee (MTAC); Subject name changed. Prior laboratory no longer available.
- January 1, 2014: New CPT code 81504 added
- November 19, 2014: Reviewed by IMPAC, renewed without changes
- September 2015: Branding and template change to distinguish Tufts Health Plan products in "Applies to" section. Added Tufts Health Freedom Plan products, effective January 1, 2016.
- November 16, 2015: Reviewed by IMPAC, renewed without changes
- December 31, 2015: Coding updated. Per AMA CPT®, effective January 1, 2016 the following code(s) added: 81540
- November 9, 2016: Reviewed by IMPAC, renewed without changes
- December 14, 2016: Reviewed by IMPAC, renewed without changes
- April 2017: Added RITogether Plan product to template. For MNGs applicable to RITogether, effective date is August 1, 2017

BACKGROUND, PRODUCT AND DISCLAIMER INFORMATION

Medical Necessity Guidelines are developed to determine coverage for benefits, and are published to provide a better understanding of the basis upon which coverage decisions are made. We make coverage decisions using these guidelines, along with the Member’s benefit document, and in coordination with the Member’s physician(s) on a case-by-case basis considering the individual Member’s health care needs.

Medical Necessity Guidelines are developed for selected therapeutic or diagnostic services found to be safe and proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the our service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. We revise and update Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

Medical Necessity Guidelines apply to the fully insured Commercial and Medicaid products when Tufts Health Plan conducts utilization review unless otherwise noted in this guideline or in the Member’s benefit document, and may apply to Tufts Health Unify to the same extent as Tufts Health Together. This guideline does not apply to Tufts Medicare Preferred HMO, Tufts Health Plan Senior Care Options or to certain delegated service arrangements. For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Medical Necessity Guideline and a self-insured Member’s benefit document, the provisions of the benefit document will govern. Applicable state or federal mandates or other requirements will take precedence. For CareLink Members, Cigna conducts utilization review so Cigna’s medical necessity guidelines, rather than these guidelines, will apply.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of these guidelines is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to eligibility and benefits on the date of service, coordination of benefits, referral/authorization, utilization management guidelines when applicable, and adherence to plan policies, plan procedures, and claims editing logic.

Provider Services