Genetic Testing Payment Policy

Applies to the following Tufts Health Public Plans products:

☒Tufts Health Direct – Health Connector

☒Tufts Health RITogether – A RI Medicaid Plan

☒Tufts Health Together – Includes MassHealth Plan and Accountable Care Partnership Plans

☒Tufts Health Unify – OneCare Plan

The following payment policy applies to Tufts Health Plan contracting providers who render laboratory services for Tufts Health Public Plans products.

In addition to the specific information contained in this policy, providers must adhere to the information outlined in the Professional Services and Facilities Payment Policy.

Note: Audit and disclaimer information is located at the end of this document.

POLICY

Tufts Health Plan covers medically necessary genetic testing as described below.

DEFINITION

Genetic testing is testing rendered by a provider to identify a member's genetic predisposition to certain inherited conditions.

AUTHORIZATION REQUIREMENTS

Prior authorization is not required for certain prenatal and newborn genetic tests, in accordance with state regulations. Refer to the following Medical Necessity Guidelines for a listing of genetic tests/codes covered without prior authorization.

- Genetic and Molecular Diagnostic Testing
- Maternal Test for Fetal Trisomy
- Prenatal, Preconception

Prior authorization is required for all other genetic testing services rendered by preferred in-network, non-preferred in-network and out-of-network providers, except for tests noted as not covered in the Noncovered Investigational Services Medical Necessity Guidelines.

BILLING AND REIMBURSEMENT

Tufts Health Plan compensates for genetic testing in accordance with appropriate state regulations or contracted compensation rates. An invoice may be required for payment.

Tufts Health Direct, Tufts Health Together and Tufts Health Unify

An invoice must be submitted for all codes that MassHealth designates as Individual Consideration. Refer to the Individual Consideration Services Payment Policy for more information.

Diagnosis Limitations

Tufts Health Plan does not routinely compensate 81235 (EGFR gene analysis, common variants) when billed without a diagnosis of malignant neoplasm of the trachea, bronchus or lung, malignant neoplasm of the pleura, or malignant neoplasm of the brain.

Genetic Testing Frequency

Tufts Health Plan does not routinely compensate specific genetic testing procedures when billed more than once in a patient's lifetime.

Tier 1 Molecular Pathology and HCPCS Genetic Analysis/Testing Procedures

- Tufts Health Plan does not routinely compensate genetic testing procedures when billed with a Tier 1 molecular pathology procedure based on CPT and HCPCS procedure code definitions.
- Tufts Health Plan does not routinely compensate procedures billed out of sequence. If 81211 (BRCA1, BRCA2 (breast cancer 1 and 2) gene analysis), 81214 (BRCA1 (breast cancer 1) gene analysis), or 81216 (BRCA2 (breast cancer 2) gene analysis) is billed and any of these codes (different CPT than the code being processed) has been previously paid for the same date of

service, then all subsequently billed codes will be denied with reason Procedure Inappropriately Coded.

ADDITIONAL RESOURCES

Medical Necessity Guidelines: Genetic and Molecular Diagnostic Testing
Medical Necessity Guidelines: Genetic Testing BRCA-Related Breast and/or Ovarian Cancer Syndrome
Medical Necessity Guidelines: Genetic Testing – Gene Expression for Cancer of Unknown Primary (CUP)
Medical Necessity Guidelines: Genetic Testing – Maternal Tests for Fetal Trisomy
Medical Necessity Guidelines: Genetic Testing – Prenatal, Preconception
Medical Necessity Guidelines: Noncovered Investigational Services

DOCUMENT HISTORY

- March 2018: Template updates
- December 2017: Updated to include RITogether; added previously communicated edits for diagnosis limitations, tier 1 molecular pathology and HCPCS genetic analysis/testing procedures and genetic testing frequency
- February 2017: Template updates

AUDIT AND DISCLAIMER INFORMATION

Tufts Health Plan reserves the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in this payment policy. If such an audit determines that your office/facility did not comply with this payment policy, Tufts Health Plan will expect your office/facility to refund all payments related to non-compliance. For more information about Tufts Health Plan's audit policies, refer to our website.

This policy provides information on Tufts Health Plan claims adjudication processes. As every claim is unique, this policy is neither a guarantee of payment, nor a final indication of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management requirements (when applicable), adherence to plan policies and procedures, and claims editing logic. An authorization is not a guarantee of payment. Claims for services subject to authorization may be reviewed for accuracy and compliance with payment policies.

This policy applies to the Tufts Health Plan products, as identified in the checkboxes on the first page, and to CareLink℠ for providers in Massachusetts and Rhode Island service areas. Providers in the New Hampshire service area are subject to Cigna's provider agreements with respect to CareLink members. This policy does not apply to the Private Health Care Systems (PHCS) network (also known as Multiplan). Tufts Health Plan reserves the right to amend a payment policy at its discretion.