Priority Health	BILLING POLICY No. 207
EXPANDED CARRIER SCREENING GENETIC TESTS	
Date of origin: 08/2026	**Review dates: MM/YY**

POLICY OVERVIEW
This policy provides guidelines for billing, coding, and documentation, ensuring claims are processed according to contractual agreements and industry standards.

DEFINITIONS
Expanded carrier screening panels are laboratory tests designed to identify carrier status for multiple inherited genetic conditions through analysis of multiple genes in a single assay. Carrier screening may be targeted, pan-ethnic, universal, or expanded, and is commonly performed using multigene testing platforms. For purposes of this policy, a carrier screening panel is defined as a test that evaluates carrier status for more than five genes associated with inherited genetic disorders.

Examples of carrier screening panel codes addressed in this policy include, but are not limited to:

- CPT code 81412
- CPT code 81443
- CPT code 0400U
- CPT code 0449U

FOR MEDICARE
For indications that don't meet criteria of NCD, local LCD or specific medical policy a Pre-Service Organization Determination (PSOD) will need to be completed. Get more information on PSOD in our Provider Manual.

POLICY SPECIFIC INFORMATION
Priority Health will reimburse carrier screening panel services when billed in accordance with this policy, applicable coding guidelines, and member benefit provisions. Coverage determinations remain subject to the member's contract benefits and applicable medical policies. Any claim may require submission of medical records for post-service review.

Frequency Limitations
Carrier screening panels are reimbursable once per lifetime.

Repeat testing is not reimbursable unless documentation demonstrates one of the following:
- Correction of a prior test failure or inadequate specimen.
- Significant advancement in testing methodology is not available at the time of the prior testing.
- Other documented circumstances supporting the need for repeat testing.

If an Ashkenazi Jewish carrier screening panel was previously billed, an additional carrier screening panel will not be reimbursable.
If a non-Ashkenazi Jewish carrier screening panel was previously billed, subsequent carrier screening of any type will not be reimbursable (e.g. individual genes, Ashkenazi Jewish carrier screening panels).

Duplicate and Overlapping Panel Prevention

To prevent duplicate reimbursement and redundant testing:

- Carrier screening panels evaluating substantially overlapping genes or conditions are not separately reimbursable.
- Only one carrier screening panel may be reimbursed for the same member and testing purpose.
- Carrier screening panels are not reimbursable if the same genes or conditions have previously been tested and reimbursed.
- Multiple carrier screening panel codes submitted for the same member and date of service may be subject to claim denial, redirection, or post-payment review.

Coding specifics

Carrier screening panels must be billed using the single most appropriate procedure code representing the entire panel.

Proprietary Laboratory Analysis (PLA) Codes:
When a carrier screening panel has an assigned PLA code, the service must be billed using the applicable PLA code (e.g., 0400U, 0449U).

- Only one unit of service is reimbursable.

CPT 81443

- Carrier screening panels without a PLA code that evaluate at least 15 genes may be billed using CPT 81443.

CPT 81412

- Carrier screening panels without a PLA code may be billed using CPT 81412 when all CPT requirements are met, including inclusion of the required Ashkenazi Jewish-associated disorder genes.

CPT 81479

- Carrier screening panels that do not meet the requirements of CPT 81412 or CPT 81443 and do not have an assigned PLA code should be reported using CPT 81479.

Anti-Unbundling Requirements
To ensure correct coding and reimbursement:
• Carrier screening panels must be billed as a single panel service.
• Individual component gene codes may not be reported separately when performed as part of a carrier screening panel.
• Unbundling of genes contained within a carrier screening panel is not reimbursable.
• Individual gene testing submitted in lieu of an available panel code may be denied or reprocessed to the appropriate panel code.
• Non-specific molecular pathology codes reported in conjunction with a carrier screening panel for the same testing service are not separately reimbursable.
• Only one carrier screening panel code will be considered for reimbursement for the same testing event.

Laboratory Requirements:
The rendering laboratory must:
• Be a qualified provider of service in accordance with Priority Health policies and applicable regulatory requirements.
• Maintain all required federal, state, and CLIA certifications and licenses.
• Submit claims using appropriate procedure codes and billing practices.

Failure to meet credentialing or regulatory requirements may result in denial of reimbursement.

Modifiers

Priority Health follows standard billing and coding guidelines which include CMS NCCI. Modifiers should be applied when applicable based on this guidance and only when supported by documentation.

Place of service

Coverage will be considered for services furnished in the appropriate setting to the patient's medical needs and condition. Authorization may be required. Get more information in our Provider Manual.

Documentation requirements

Complete and thorough documentation to substantiate the procedure performed is the responsibility of the Provider. In addition, the Provider should consult any specific documentation requirements that are necessary for any applicable defined guidelines.

Documentation must be available upon request and include:

- Ordering provider information.
- Test name and billed procedure code
- Laboratory report identifying the genes, conditions, and/or the panel performed.
- Prior carrier screening history, when available.
- Documentation supporting repeat testing when applicable.

Incomplete documentation may result in denial of reimbursement or post-service review.

Reimbursement specifics

Submit references for fee schedules or specific reimbursement. Usually present in older versions of the policy.

Administrative Claim Edits:
Priority Health may apply automated claim edits including:

- Once-per-lifetime frequency edits.
- Duplicate testing edits.
- Mutually exclusive carrier panel edits.
- Same-date-of-service panel edits.
- Diagnosis edits consistent with pregnancy or reproductive planning indications.
- Post-payment review for billing patterns suggestive of duplicate, overlapping, or unbundled testing.

The procedure codes listed in this policy may not be all-inclusive. To be reimbursable, the billed service must be a covered benefit under the member's health plan. Claims submitted without information necessary for automated processing or claim adjudication may not be reimbursable as billed. Priority Health reserves the right to request additional records to support claim review and reimbursement determination.

DISCLAIMER

CMS and/or MDHHS guidelines apply unless otherwise specified in this policy or provider manual. Where such guidance is absent, this policy applies. Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS) and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standard, compliant codes defined by CPT, HCPCS, and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made
08/2026	New policy created