Priority Health	BILLING POLICY No. 011
GENETIC TESTING, COUNSELING AND SCREENING	
Date of origin: July 2024	**Review dates: 2/2025, 4/2025, 5/2025, 7/2025**

APPLIES TO

- Commercial
- Medicare follows CMS unless otherwise stated
- Medicaid follows MDHHS unless otherwise stated

MEDICAL POLICY

- Genetics: Counseling, Testing and Screening (#91540) – see the medical for guidelines and authorization requirements.

POLICY SPECIFIC INFORMATION

Unique test identifier requirement

All Molecular Diagnostic Tests require an identifier as additional claim documentation. This is due to code sets that describe the pathology and laboratory categories and tests aren't specific to the actual test results provided.

When an unlisted CPT code is reported, field 19 of the claim form must include:

- Specific name of the laboratory test and/or a short descriptor of the test(s). See additional information for field 19.

DEX Z-Codes may also be reported on the claim where applicable and outlined in the LCD.

Tier 1 molecular pathology procedures codes (81105-81383) typically refer to tests for a particular gene or Human Leukocyte Antigen (HLA) locus.

Tier 2 molecular pathology procedure codes (81400-81408) are utilized for reporting procedures not included in the Tier 1 molecular pathology codes. These codes cover rare diseases and molecular pathology procedures that are conducted less frequently than Tier 1 procedures.

In general, a Tier 1 or Tier 2 molecular pathology procedure CPT code should not be reported alongside a genomic sequencing procedure, molecular multianalyte assay, multianalyte assay with algorithmic analysis, or proprietary laboratory analysis CPT code if the CPT code descriptor includes testing for the analyte specified by the Tier 1 or Tier 2 molecular pathology code.

A provider should not report more than one unit of service for any Tier 1 molecular pathology CPT code when testing a specimen from a single source.

A provider or supplier should not report more than one unit of service for each listed Tier 2 molecular pathology procedure when testing a specimen from a single source.

Documentation requirements

The ordering practitioner's documentation must support the test(s) ordered. Each lab service ordered should be documented in the member's medical record and detailed on the lab order. The medical records should also detail the reasons each test is indicated and ordered to support management of the member's specific medical condition. Such documentation must indicate how the test results will impact clinical care

- Custom panel tests shouldn't be referenced on the written lab order; only panel tests defined by CMS or CPT are acceptable
- Orders must be signed and dated by the ordering practitioner
- Standing orders and/or routine screenings as part of a practitioner's protocol aren't payable without supporting documentation to support the member's specific medical assessment and treatment
- Our preventive health guidelines detail services that are considered preventive health services; provider defined protocols that may not align are subject to applicable benefit and supporting documentation requirements
- Priority Health Medical policy #91540 outlines certain conditions in Appendix A that require genetic counseling prior to and after testing. See below for additional information on genetic counseling.

Medical records may be requested to support accurate coding and support testing ordered. Although we don't expect billing labs to obtain medical records from ordering providers and submit them upon request, it's expected that at a minimum the lab order, requisition and results will be submitted. This requisition must contain the following:

- Signed, valid requisition from the ordering provider that specifically outlines the tests being ordered
- Specific lab being tested
- Member specific information
- Ordering provider (full name and credentials) and ordering provider NPI
- Legible signature (photocopy, stamp, or signature on file is not accepted)
- Facility/location where specimen was collected
- Sample type (urine, blood, etc.)
- Date sample collected
- Time sample collected
- Individual who collected sample
- Date/time received at the lab facility

Final reports for lab results must contain the following:

- Complete detail for entity performing the lab service (name, address, CLIA)
- Patient full name
- Patient date of birth
- Ordering full name and NPI
- Facility name if different from above
- Date sample was collected
- Date sample was received at facility
- Date results were reported
- Detail of complete test results for each test performed

Claims submitted with insufficient documentation to support lab services will be denied. The provider submitting the claim will receive a denial if there is insufficient documentation to support all services reported.

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.

Incorrect application of modifiers will result in denials. The modifier list below may not be an all-inclusive list. Learn more about modifier use in our Provider Manual.

- **GX**: Notice of liability issued, voluntary under payer policy
- **GY**: Item or service statutorily excluded, does not meet the definition of any Medicare benefit or, for non-Medicare insurers, is not a contract benefit
- **59**: Distinct Procedural Service
- **91**: Repeat Clinical Diagnostic Laboratory Test

COUNSELING

CPT 96041: Medical genetics and genetic counseling services, each 30 minutes of total time provided by the genetic counselor on the date of the encounter, will be reimbursed only when the service is provided by **trained genetic counselors**, as per CPT guidelines.

When genetic counseling and education are provided by a physician or another qualified healthcare professional who can report evaluation and management (E&M) services, the appropriate E&M service code must be used, according to CPT guidelines.

RELATED POLICIES

- Lab and Pathology billing policy
- All billing policies

REFERENCES

- Billing and Coding: Molecular Pathology and Genetic Testing (A58917) (CMS)
- PI Payment Policy 35: Breast Cancer Genetic Testing (Tier 1 vs Tier 2) (Molina Healthcare)
- Medicare NCCI Policy Manual Chapter X: Pathology/Laboratory Services (CMS)

DISCLAIMER

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 for 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 to 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
Feb. 4, 2025	Added "Disclaimer" section
Apr. 15, 2025	Added "Modifiers" and "Related policies" sections
May 13, 2025	• Added "Counseling" section to align with medical policy #91540 • Updated "Applies to" section to indicate Medicare follows CMS and Medicaid follows MDHHS, unless otherwise stated
July 11, 2025	• Added billing requirements for Tier 1 and Tier 2 molecular pathology testing to the "Unique test identifier requirement" section • Added reference to medical policy #91540, to Appendix A about the requirement for genetic counseling before and after testing