Priority Health	BILLING POLICY No. 011
GENETIC TESTING	
Date of origin: July 2024	**Review dates: None yet recorded**

APPLIES TO
All plans

MEDICAL POLICY

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

POLICY SPECIFIC INFORMATION
Coding information
Priority Health follows Medicare billing guidance for genetic testing. For each test billed, consult the applicable LCD or NCD guidance for claim requirements.

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.

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

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.

CHANGE / REVIEW HISTORY

Date	Revisions made