Payment Policy: Genetic and Molecular Testing Services

Reference Number: CG.PP.551
Product Types: ALL
Date of Last Revision: 02/22/2024

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Policy Overview
Certain services, procedures or devices provided to members are covered in accordance with the member's coverage documents, when rendered by participating providers and, in certain circumstances, by non-participating provides, all in accordance with the treating provider's scope of practice and this policy. This policy expands the requirements for billing of molecular and genetic testing to advance the reliability of laboratory quality information and reduce variability in billing. Health plans affiliated with Centene Corporation© have contracted with Concert Genetics (Concert), a leader in data and digital infrastructure for the Genetic Health Information Network, to administer this policy. Concert Genetics has developed a novel method to translate a genetic test into a single code or code combination. This method, delivered as the Concert Coding Engine, standardizes the coding process for genetic testing, allowing a single way to code each test on the market. Concert provides tools that connect, unify, and simplify the world of genetic testing and ultimately lead to insights that accelerate healing and improve health.

Application
The policy applies to billing and payment for molecular pathology, Genomic Sequencing Procedures and Other Molecular Multianalyte Assays (GSP), Multianalyte Assays with Algorithmic Analyses (MAAA) and Proprietary Lab Analysis (PLA) testing services provided on an outpatient basis by laboratory providers.

Policy Description
To verify the accuracy of a test catalog and review coding engine standards for each molecular and genetic test, laboratories billing for genetic and molecular testing services should register using the Concert Genetics portal at https://www.concertgenetics.com/join-superior. The portal offers a quality metrics questionnaire for completion by laboratories that leverages industry-standard quality programs with customization to reflect the unique characteristics of genetic testing while being minimally burdensome on providers. Laboratories will also utilize the Concert Portal to obtain and access the Genetic Testing Unit (GTU), a unique identifier for every genetic test that will be utilized for billing and payment.

Reimbursement
Laboratories should adhere to the following requirements for billing and reimbursement for genetic and molecular testing services (see codes in Table 1 below), or payment for the services may be denied:

- Bill for the test performed as indicated on the test requisition form.
- Include ordering provider information on all claim transactions.

- Coding must be consistent with American Medical Association coding guidelines, as interpreted by the Concert Genetics coding engine (https://app.concertgenetics.com):
    - Codes are determined based on the attributes of the testing performed, not based on the clinical indication of the member.
    - If a test qualifies for panel code(s), the panel code(s) must be used. Per the NCCI Manual, Chapter 10, Section F-8, if one laboratory procedure evaluates multiple genes using a next generation sequencing procedure, the laboratory shall report only one unit of service of one genomic sequencing procedure.
    - If a panel code is not appropriate (or when medical policy exclusively covers components of panels), a limited number of individual components from multi- gene tests may be billed.
    - Only one unit of the non-specific procedure code, CPT code 81479, may be billed per test.
    - The Concert GTU is required in the procedure description of the claim (e.g. "GTU-6V98G" or "6V98G").
    - All providers requesting prior authorization for genetic and molecular testing services are required to add the appropriate Concert Genetics GTU descriptor to all prior authorization requests.

Coding and Modifier Information

This payment policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT® codes and descriptions are copyrighted 2023, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from current 2023 manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this payment policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

Table 1

Molecular/Genetic Testing Code	Description
81105-81383	Tier 1 codes
81400-81408	Tier 2 codes
81410-81471	Genomic Sequencing Procedures (GSP) and Other Molecular Multianalyte Assays
81490-81599	Multianalyte Assays with Algorithmic Analyses
0022U-0449U	Proprietary Laboratory Analyses (PLA) Codes

Table 2

Procedural Code(s)	Genetic Testing Unit (GTU) Requirements	Claim Type and Field or Segment	GTU Format
All molecular /genetic testing codes noted in Table 1 above	The Concert GTU is required as the claim procedure description.	• Electronic Professional– 837P Transaction: Loop 2400 Segment SV101-7 • Electronic Institutional– 837I Transaction: Loop 2400 Segment SV202-7 • Paper Professional – CMS-1500: Item/block 19 • Paper Institutional – CMS-1450: Item/block 80	Insert the exact GTU or the GTU preceded by "GTU-." For example, insert either: • 6V98G • GTU-6V98G

References

1. American Medical Association. *Current Procedural Terminology (CPT®)*. 2023
2. Centers for Medicare and Medicaid Services. Medicare National Correct Coding Initiative (NCCI) Policy Manual. Effective January 1, 2024. https://www.cms.gov/medicare/coding-billing/national-correct-coding-initiative-ncci-edits/medicare-ncci-policy-manual.

Revision History	
02/12/2024	Payment policy version A developed.
02/22/2024	Under "application," removed reference to "independent" providers and their contract status with health plans affiliated with Centene. Added Tier 1 and Tier 2 codes to Table 1 and removed molecular pathology codes as a separate requirement. Added Table 2, with claim and code types and description requirements.

Important Reminder

For the purposes of this payment policy, "Health Plan" means a health plan that has adopted this payment policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any other of such health plan's affiliates, as applicable.

The purpose of this payment policy is to provide a guide to payment, which is a component of the guidelines used to assist in making coverage and payment determinations and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage and payment determinations and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable plan-level administrative policies and procedures.

This payment policy is effective as of the date determined by Health Plan. The date of posting may not be the effective date of this payment policy. This payment policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this payment policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. Health Plan retains the right to change, amend or withdraw this payment policy, and additional payment policies may be developed and adopted as needed, at any time.

This payment policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This payment policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this policy are independent contractors who exercise independent judgment and over whom Health Plan has no control or right of control. Providers are not agents or employees of Health Plan.

This payment policy is the property of Centene Corporation. Unauthorized copying, use, and distribution of this payment policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this payment policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this payment policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs and LCDs should be reviewed prior to applying the criteria set forth in this payment policy. Refer to the CMS website at http://www.cms.gov for additional information.