Texas Children's	Genetic Testing Guidelines	
Guideline # 6181	***Categories*** Clinical →Care Management CM, TCHP Guidelines, Utilization Management UM	***This Guideline Applies To:*** Texas Children's Health Plan ***Document Owner*** Andrea Canady

GUIDELINE STATEMENT:

Texas Children's Health Plan (TCHP) performs authorization of all genetic testing requests.

PRIOR AUTHORIZATION GUIDELINES

1. Genetic testing conducted by out-of-network providers will be treated as out-of-network requests and will comply with the out-of-network authorization Guidelines.

2. Requests for Noninvasive Prenatal Testing will comply with TCHP Noninvasive Prenatal Testing Guidelines.

3. All requests for prior authorization for genetic testing are received via online submission, fax, phone or mail by the Utilization Management Department and processed during normal business hours.

4. The Utilization Management professional receiving the request evaluates the submitted information to determine if the documentation supports the genetic testing as an eligible service.

   4.1. Testing requested on members 21 and older is subject to benefit limitations and will only be reviewed for medical necessity if the code requested is payable per the Texas Medicaid fee schedule.

5. To request prior authorization for genetic testing, documentation supporting the medical necessity of the test requested must be provided.

6. Utilization Management professionals will utilize the most recent available version of InterQual criteria for genetic testing to establish medical necessity when applicable.

7. TCHP will apply clinical criteria in the current Texas Medicaid Provider manual at the time of the request when applicable for the following:
   7.1. BRCA gene mutation analysis
   7.2. Genetic Testing for colorectal cancer
   7.3. Cytogenetic testing

7.4. Pharmacogenetic Testing

8. In cases where the clinical reason for the genetic testing is not clearly identified via Interqual criteria or the current Texas Medicaid Provider manual, TCHP considers the following as indications for medically necessary genetic testing:
   8.1. Preconception or prenatal carrier screening recommended by the American College of Obstetricians and Gynecologists (ACOG) OR
   8.2. When the following criteria are met:
      8.2.1. The individual for whom the test is requested is asymptomatic but is judged to be at significant risk, as determined by the likelihood of future disease and burden of suffering, for a genetic disease (for example, based on family history); OR Is currently symptomatic with suspicion of a known genetic disease;
      8.2.2. All of the following criteria apply:
         8.2.2.1. A specific mutation, or set of mutations, has been established in the scientific literature to be reliably associated with the disease; and
         8.2.2.2. A biochemical or other test is identified but the results are indeterminate, or the genetic disorder cannot be identified through biochemical or other testing; and
         8.2.2.3. The genetic disorder is associated with a potentially significant disability or has a lethal natural history; and
         8.2.2.4. Results of the genetic test, whether affirmative or negative, will impact the clinical management (predictive, diagnostic, prognostic or therapeutic) of the individual. Tests for conditions that are treated symptomatically are not appropriate since the treatment would not change. ; and
         8.2.2.5. The findings of the genetic test will likely result in an anticipated improvement in net health outcomes; that is, the expected health benefits of the interventions outweigh any harmful effects (medical or psychological) of the intervention; and
         8.2.2.6. Testing is accompanied by genetic counseling.
   8.3. OR Clinical risk verified by TCHP Medical Director/Physician Reviewer

9. In the absence of specific information regarding advances in the knowledge of mutation characteristics for a particular disorder, the current literature indicates that genetic tests for inherited disease need only be conducted once per lifetime of the member.

10. Genetic testing of Texas Children's Health Plan members is excluded from coverage under Texas Children's Health Plan's benefit plans if the testing is performed primarily for the medical management of other family members who are not covered under a Texas Children's Health Plan benefit plan. In these circumstances, the insurance carrier for the family members who are not covered by Texas Children's Health Plan should be contacted regarding coverage of genetic testing.

11. Texas Children's Health Plan does not cover genetic testing involving non- Texas Children's Health Plan members even when it will provide genetic information for a TCHP member.

12. Requests that do not meet the criteria established by this procedure will be referred to a TCHP Medical Director/Physician Reviewer for review and the Denial Policy will be followed.

13. Preauthorization is based on medical necessity and not a guarantee of benefits or eligibility. Even if preauthorization is approved for treatment or a particular service, that authorization applies only to

the medical necessity of treatment or service. All services are subject to benefit limitations and exclusions. Providers are subject to State and Federal Regulatory compliance and failure to comply may result in retrospective audit and potential financial recoupment.

REFERENCES:

Government Agency and Medical Society Publications:

- Texas Medicaid Provider Procedures Manual Volume 2: Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook http://www.tmhp.com/Manuals_PDF/TMPPM/TMPPM_Living_Manual_Current/2_Med_Specs_and_Phys_Srvs.pdf
- Carrier screening for genetic conditions. Committee Opinion No. 691. American College of Obstetricians and Gynecologists. Obstet Gynecol 2017;129:e41–55.

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