## Procedures addressed

The inclusion of any procedure code in this table does not imply that the code is under management or requires prior authorization. Refer to the specific Health Plan's procedure code list for management requirements.

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**Note** * Generally defined as codes that include “DNA”, “RNA”, “nucleic acid”, “genotype”, “phenotype” or related language in the code description.
Description

eviCore manages claims payment for Molecular and Genomic diagnostic laboratory testing services for our subscribing Health Plans including Horizon BCBSNJ. Procedure codes (CPT, HCPCS) are adjudicated against claims review and payment rules generally described herein. Payment and coverage adjustments may be made in addition to those outlined herein.

The following claim reimbursement policies provide general guidance on what forms of review may be employed. They are intended to augment other clinical and administrative policies and do not represent all possible claim treatments.

- Medical Necessity Determinations
- Voluntary Pre-Service Medical Necessity Determination
- Substitutable Codes
- Post-Service Medical Necessity Review
- Gender Nondiscrimination
- Lifetime Maximums
- Frequency Rules
- Maximum Units per Date of Service

Criteria: Claims Reimbursement

Introduction

All procedure codes included in Horizon BCBSNJ’s Molecular and Genomic Testing Program (as outlined in the table at the top of this document) may be subject to claim review and payment policies. The following policies define many, but not all, of the most commonly applied claims edits performed under this program.

Medical Necessity Determinations

Procedure codes that require an approved medical necessity determination before payment are defined in the Plan Molecular and Genomic Testing Procedure Code Listing. All claims will be reviewed for the presence of any procedure code that has an approved medical necessity determination requirement and the following process will be employed:

- The procedure code(s) requiring an approved medical necessity determination will be checked against a case review database.
- If any of the following are true, the Plan’s requirements will be enforced. This may include denial for failure to comply with pre-service or post-service medical necessity determination requirements.
A case is not on file for all units of that CPT/HCPCS, or
- Any stipulated information is not provided on the claim (e.g., modifier, unique test identifier), or
- The approval time frame is not valid for the date of service.

**Voluntary Pre-Service Medical Necessity Determination**

Providers may choose to seek a pre-service medical necessity determination for one or more procedure codes that are in scope for the Molecular and Genomic Testing Program but do not routinely require it. This is referred to as seeking a voluntary pre-service medical necessity determination. A voluntary pre-service medical necessity determination will also be provided for all codes when they are being billed as part of a test panel with any codes that do require an approved medical necessity determination.

- If a case is on file for a procedure code that does not require an approved medical necessity determination, the approval or denial status will be applied during claims adjudication.
- If a case is not on file for all units of that procedure code, the stipulated information is not included on the claim, or the date of service is not valid, all or some of the units for that procedure may undergo any post-service medical necessity review processes in place for that procedure but will not be denied for failure to obtain a pre-service medical necessity determination approval.

**Substitutable Codes**

Note that a medical necessity determination for a procedure code may be used to approve coverage for a DIFFERENT billed procedure code that is substantially similar in clinical intent to the reviewed code (e.g., a case for CPT 81228 is substitutable if CPT 81229 is billed). Clinically reasonable substitution rules are automatically applied through eviCore's claims review process. When substitution rules are invoked, the billed procedure code is the paid procedure code. The companion *Procedure Code Substitution* table includes additional details.(See the Supporting Documents section at the end of this guideline.)

**Post-Service Medical Necessity Review**

Many lab tests that are in scope for the Molecular and Genomic Testing Program are not managed through a mandatory medical necessity determination requirement. Appropriate billing or medical necessity may be assessed upon claim submission (post-service) prior to payment as follows:

- All procedure codes managed under this program may be subject to post-service medical necessity review.
• Any and all available claims data (e.g., ICD code, age, gender, historical or co-existing procedures, etc.) may be used to determine medical necessity or identify cases requiring further review.
  
  o Claims data may be sufficient to determine medical necessity without additional clinical information. When medical necessity is determined based on claims data alone, the claims information that will either support or refute medical necessity is defined in the clinical policy (e.g., submitted ICD codes do not support medical necessity for a procedure).
  
  o When a case is identified for additional post-service medical necessity review, communication is sent to at least the rendering provider requesting additional clinical information with the following possible outcomes:
    
    ▪ If the requested clinical information is provided and fulfills criteria, the procedure is approved and the claim is released for further adjudication.
    
    ▪ If the requested clinical information is provided and does not fulfill criteria, the procedure is denied for lack of medical necessity.
    
    ▪ If the requested clinical information is not provided within the specified timeframe, the procedure is denied for failure to comply with the post-service review process.
  
• The factors that may prompt post-service medical necessity review include, but are not limited to:
  
  o ICD codes that support clinical criteria are not reported on the claim.
  
  o A billed amount threshold is exceeded.
  
  o A particular procedure code is billed with other procedure codes (bundled testing whether defined by the laboratory as a panel or not).
  
  o The claim is submitted by a provider (participating and non-participating) selected for focused review.
  
  o Billing history demonstrates billing patterns selected for focused review.
  
• There are multiple sources of the rules established by this policy including CMS documents, published code definitions, specialty guidelines, peer reviewed literature, expert opinion, and claims experience with codes or providers.

Gender Nondiscrimination

Gender reported on a claim is one element used to determine medical necessity. In situations where the reported gender may not be consistent with the medical needs based on biological sex (e.g., transgender, transsexual, intersex individuals), the KX modifier should be appended to each billed procedure code that may have gender-related policy. The KX modifier will allow automated gender-specific edits to be bypassed.
Lifetime Maximums

In general, the same or similar tests performed on heritable DNA should not need to be performed more than once on the same person in that person's lifetime (e.g., gene sequencing or a similar mutation panel on a gene should not need to be repeated). Rarely, a procedure code may be billed twice for the same female member when subsequent instances represent testing on the female member's fetus. It is the ordering physician's responsibility to determine if any contemplated genetic testing has already been performed for the member to avoid unnecessary repeat testing.

Lifetime maximum rules will be applied for procedure codes that involve genetic testing of heritable DNA in the following manner:

- The companion Lifetime Maximums table includes a list of procedure codes subject to the lifetime maximum policy. (See the Supporting Documents section at the end of this guideline.)
  - Only a single date of service will be reimbursed for any procedure code with a lifetime maximum for a single individual.
  - While most procedure codes have a lifetime maximum of one unit, some have a limit of 2 (e.g., known familial mutations for recessive conditions).
  - Procedure codes representing tests that may reasonably be performed on a fetus through prenatal diagnosis are covered services more than once per lifetime. When applicable, claims should include the following ICD code to indicate prenatal diagnosis: O35.2X.
- All claims submitted for procedure codes subject to lifetime maximums will be checked for previous payment in historical claims data.
- Testing more than once per lifetime is not medically necessary and such claims will be denied for reimbursement if:
  - The procedure code is known to have already been paid for that member, and
    - The member is a male, or
    - The member is a female, and
      - The code does not allow a prenatal diagnosis override, or
      - No ICD code suggesting prenatal diagnosis is submitted for a code that does allow a prenatal diagnosis override

Frequency Rules

Tests that do not involve unchanging, inherited DNA may be repeated for medically necessary reasons. Any limits to the frequency at which such tests should be repeated is defined in the applicable clinical policy. These frequency limits will be assessed at claim submission based on available historical claims data.
Maximum Units per Date of Service

Most procedure codes have a reasonable maximum number of expected units that should be billed on a single date of service. Maximum expected units are coded into claims systems to prevent billing, data entry, and payment errors.

The CMS National Correct Coding Initiative provides guidance on maximum units for many procedure codes through their Medically Unlikely Edits. When not provided by CMS, maximum units are established based on code definitions, specialty guidelines, peer reviewed literature, expert opinion and claims experience with those codes.

Maximum units per date of service rules are administered as follows:

- The Maximum Units table includes all procedure codes that have established maximum units. (See the Supporting Documents section at the end of this guideline.)
- The allowable daily maximum units for a procedure code are not reliant on medical necessity policy. They may only be addressed in this table and nowhere else in any other policy.
- Total billed units are calculated based on the combined number of times a procedure code is billed on a single date of service. This applies to codes billed with multiple units on a single claim line, units reported on separate claim lines on the same claim, or multiple units reported on separate claims for that date of service. All maximum unit rules are applied per date of services and do not allow additional units simply because they are billed on separate claim lines.
- When multiple units are billed, only the number of units up to the allowable daily maximum will be reimbursed.
- Some unusual circumstances justify exceeding the established maximum units per date of service.
  - When such exceptions are recognized in eviCore clinical policy, instructions for submitting claims with additional units are provided.
  - When exceptions are not specifically addressed in policy, reimbursement of additional units will be considered if supporting documentation is provided.

Supporting Documents

Supporting documents for this Laboratory Claim Reimbursement guideline are available here: https://www.evicore.com/healthplan/Horizon_Lab
References


