

# Medicare Medical Policy

## Gene Expression Profile Testing for Breast Cancer

MEDICARE MEDICAL POLICY NUMBER: 48

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**INSTRUCTIONS FOR USE:** Company Medicare Medical Policies serve as guidance for the administration of plan benefits and do not constitute medical advice nor a guarantee of coverage. Company Medicare Medical Policies are reviewed annually to guide the coverage or non-coverage decision-making process for services or procedures in accordance with member benefit contracts (otherwise known as Evidence of Coverage or EOCs) and Centers of Medicare and Medicaid Services (CMS) policies, manuals, and other CMS rules and regulations. In the absence of a CMS coverage determination or specific regulation for a requested service, item or procedure, Company policy criteria or applicable utilization management vendor criteria may be applied. These are based upon published, peer-reviewed scientific evidence and evidence-based clinical practice guidelines that are available as of the last policy update. Coverage decisions are made on the basis of individualized determinations of medical necessity and the experimental or investigational character of the treatment in the individual case. In cases where medical necessity is not established by policy for specific treatment modalities, evidence not previously considered regarding the efficacy of the modality that is presented shall be given consideration to determine if the policy represents current standards of care.

The Company reserves the right to determine the application of Medicare Medical Policies and make revisions to these policies at any time. Any conflict or variance between the EOC and Company Medical Policy will be resolved in favor of the EOC.

**SCOPE:** Providence Health Plan, Providence Health Assurance, and Providence Plan Partners as applicable (referred to individually as “Company” and collectively as “Companies”).

## PRODUCT AND BENEFIT APPLICATION

Medicare Only

### MEDICARE COVERAGE CRITERIA

**IMPORTANT NOTE:** More than one Centers for Medicare and Medicaid Services (CMS) reference may apply to the same health care service, such as when more than one coverage policy is available (e.g., both an NCD and LCD exist). All references listed should be considered for coverage decision-making. The Company uses the most current version of a Medicare reference available at the time of publication; however, these websites are not maintained by the Company, so Medicare references and their corresponding hyperlinks may change at any time. If there is a conflict between the Company Medicare Medical Policy and CMS guidance, the CMS guidance will govern.

Service	Medicare Guidelines
<i>BluePrint (Agendia®; California) (CPT 81479)</i>	Local Coverage Articles (LCA): MoIDX: BluePrint® Coding and Billing Guidelines ( <a href="#">A55115</a> )
<i>Breast Cancer Index (BCI) (bioTheranostics, Inc.; California) (CPT 81518)</i>	Local Coverage Determination (LCD): MoIDX: Breast Cancer Index <sup>SM</sup> Genetic Assay ( <a href="#">L37822</a> )
<i>EndoPredict (Myriad®; Utah) (CPT 81522)</i>	LCD: MoIDX: EndoPredict® Breast Cancer Gene Expression Test ( <a href="#">L37311</a> )
<i>MammaPrint or MammaPrint – NGS (Agendia®; California) (CPT 81521, 81523)</i>	LCA: MoIDX: MammaPrint Coding and Billing Guidelines ( <a href="#">A54445</a> )
<i>Oncotype DX Breast (Genomic Health Inc.; California) (CPT 81519)</i>	LCA: MoIDX: Oncotype DX® Breast Cancer Assay Billing and Coding Guidelines ( <a href="#">A54480</a> )
<i>Oncotype DCIS (Genomic Health Inc.; California) (CPT 0045U)</i>	LCD: MoIDX - Oncotype DX® Breast Cancer for DCIS (Genomic Health™) ( <a href="#">L36941</a> )
<i>Prosigna (PAM50) (NanoString Technologies Inc.; Washington) (CPT 81520)</i>	LCD: MoIDX: Breast Cancer Assay: Prosigna ( <a href="#">L36386</a> )
<i>DCISionRT® (Prelude Corp., California) (0295U)</i>	LCA: Billing and Coding: MoIDX: Proteomics Testing ( <a href="#">A59641</a> )  <b>NOTE:</b> This LCA states, “all proteomics tests in MoIDX jurisdictions must register with the DEX® Diagnostics Exchange Registry.” While DCISionRT® is listed in the registry, the registry does not indicate this test is “Covered” or that it has successfully completed the required MoIDX TA review. Therefore, this test is considered <b>not medically necessary</b> until indicated otherwise by

	the MoIDX MAC. See “Policy Guidelines” below for more information.
<ul style="list-style-type: none"> <li>• TargetPrint® (Agendia®; California)</li> <li>• BreastOncPx™ (LabCorp; headquartered in North Carolina)</li> <li>• BreastPRS™ (Signal Genetics; California)</li> <li>• Mammostrat® (Clariant Diagnostic Services; California)</li> <li>• Insight TNBCtype (Insight Molecular Labs; Tennessee) (0153U)</li> </ul>	<p>These tests are considered <b>not medically necessary</b>, based on Medicare guidelines.</p> <p>See “Policy Guidelines” below.</p>
<p><b>Medicare Coverage Criteria:</b> “MA organizations may create publicly accessible internal coverage criteria... when coverage criteria are not fully established in applicable Medicare statutes, regulations, NCDs or LCDs.” (§ 422.101(b)(6) – see <a href="#">Policy Guidelines</a> below)</p> <ul style="list-style-type: none"> <li>• <b>Medicare Coverage Manuals:</b> Medicare does not have criteria for the gene expression profile (GEP) breast cancer tests listed below in a coverage manual.</li> <li>• <b>National Coverage Determination (NCD):</b> Medicare does not have an NCD for the breast cancer GEP tests below.</li> <li>• <b>Noridian J-F Local Coverage Determination (LCD)/Local Coverage Article (LCA):</b> According to Medicare guidelines, “Jurisdiction of payment requests for laboratory services furnished by an independent laboratory... lies with the A/B MAC (B) serving the area in which the laboratory test is performed.”<sup>1</sup> As of the most recent policy review, the <b>Molecular Grade Index <u>or</u> Theralink® Reverse Phase Protein Array (RPPA)</b> tests do <b>not</b> have an available LCD or LCA for their respective service areas.</li> <li>• Therefore, in the absence of established Medicare coverage criteria in a manual, NCD, LCD, or other regulatory guidance for the health plan’s service area, Company criteria below are applied for medical necessity decision-making. In this case, Medicare coverage criteria are considered “not fully established” as defined under CFR § 422.101(6)(i)(C) as there is no Medicare coverage criteria available.</li> <li>• <b>NOTE:</b> The summary of evidence, as well as the list of citations/references used in the development of the Company’s internal coverage criteria, are publicly available and can be found using the Company medical policy link below [CFR § 422.101(6)(ii)(A) and (B)].</li> </ul>	
<ul style="list-style-type: none"> <li>• Molecular Grade Index (aka, Aviara MGI<sup>SM</sup>) (AviaraDx, Inc.)</li> <li>• Theralink® Reverse Phase Protein Array (RPPA) (Theralink® Technologies, Inc.; Colorado) (Code 0249U)</li> </ul>	<p>Company medical policy for <a href="#">Genetic Testing: Gene Expression Profile Testing for Breast Cancer</a></p> <p>I. These tests are considered <b>not medically necessary</b> for Medicare Plan members based on the Company medical policy. <u>See Policy Guidelines below.</u></p>

**IMPORTANT NOTICE:** While some services or items may appear medically indicated for an individual, they may also be a direct exclusion of Medicare or the member's benefit plan. Such excluded services or items by Medicare and member EOCs include, but are not limited to, services or procedures considered to be cosmetic, not medical in nature, or those considered not medically reasonable or necessary under *Title XVIII of the Social Security Act, §1862(a)(1)(A)*. If there is uncertainty regarding coverage of a service or item, please review the member EOC or submit a pre-service organization determination request. Note that the Medicare Advance Beneficiary Notice of Noncoverage (ABN) form **cannot** be used for Medicare Advantage members. (*Medicare Advance Written Notices of Non-coverage. MLN006266 May 2021*)

## POLICY CROSS REFERENCES

None

The full Company portfolio of Medicare Medical Policies is available online and can be [accessed here](#).

## POLICY GUIDELINES

### DIAGNOSTIC LABORATORY TEST JURISDICTION

In compliance with Medicare guidelines, some LCDs and LCAs used may be for test service areas **outside** of the Company service area. This is because Medicare's general rule regarding jurisdiction of claims furnished by an independent laboratory is that jurisdiction lies with the A/B MAC (B) (aka, Medicare Contractor) serving the **area in which the laboratory test is performed**.<sup>1</sup>

However, there are exceptions to this rule.

**Exception #1:** According to Medicare, while jurisdiction for laboratory services normally lies with the carrier serving the performing laboratory service area, there are situations where a regional or national lab chain jurisdiction (e.g., Quest Diagnostics, LabCorp, etc.) lies with a single carrier.<sup>2</sup> Therefore, tests performed by a national laboratory chain may have a single carrier established within the Company medical policies for all laboratory services they perform, regardless of the individual laboratory location. This allows for consistent outcomes for all members who receive the same test by the same lab chain.

**Exception #2:** Another exception to this rule involves "referring laboratory tests." This is when one laboratory sends the sample to another laboratory for processing. Under Medicare rules for referred tests, the location of the billing provider determines jurisdiction for claim payment and coverage criteria. Note that also under Medicare rules, only one laboratory is allowed to bill for the services rendered. If the performing laboratory and billing provider both submit a claim, then the performing laboratory's claim is the claim that would adjudicate according to member benefit.<sup>3-5</sup>

### MEDICARE AND MEDICAL NECESSITY

#### General

In order for a laboratory test to be considered for coverage, Medicare requires the test in question meet all of the following:

- Not be excluded from coverage by statute, regulation, National Coverage Determination, (NCD), or Local Coverage Determination (LCD);
- Be ordered by a physician or practitioner who is treating the beneficiary;
- Provide data that will be directly used in the management of a beneficiary’s specific medical problem;
- Be considered medically reasonable and necessary, as required per the Social Security Act, §1862(a)(1)(A).

In addition to the test being medically appropriate for the condition, this also includes performing the services at an appropriate frequency, in accordance with accepted standards of medical practice for the condition.

### Medicare Molecular Diagnostics (MoIDX) Program

Laboratories performing tests in service areas which have adopted guidelines or coverage determinations made by the Medicare Molecular Diagnostics (MoIDX) Program contractor are required to submit a technology assessment (TA) to establish analytical and clinical validity (AV/CV) and clinical utility (CU). Supporting LCDs regarding TA reviews include, but are not limited to, the following:

- Laboratories in CA & NV: LCD for MoIDX: Molecular Diagnostic Tests (MDT) ([L35160](#))
- Laboratories in NC, SC, GA, TN, AL, VA, & WV: LCD for MoIDX: Molecular Diagnostic Tests (MDT) ([L35025](#))
- Laboratories in AK, ID, OR, WA, UT, AZ, MT, ND, SD, & WY: LCD for MoIDX: Molecular Diagnostic Tests (MDT) ([L36256](#))

Coverage or non-coverage determinations made by MoIDX are maintained in the DEX™ Diagnostics Exchange registry catalog and are available for public viewing. If a test does not have a coverage determination by the MoIDX Program, then AV/CV and CU have **not** been established and the test is considered not medically reasonable and necessary under SSA §1862(a)(1)(A) until a MoIDX review is complete and coverage is indicated by MoIDX or Noridian. Therefore, tests identified in this policy as not meeting this requirement are not medically reasonable or necessary for Medicare under SSA §1862(a)(1)(A).

### Table 1: Tests relevant to this policy include the following

*This list only applies to tests which do **not** have an LCD or LCA specific to that individual test in the Medicare guideline table above. This list was accurate at the time of publication, but it is subject to change at any time by the Medicare MoIDX Program contractor. A “MoIDX TA Review Outcome” of “Covered” does not indicate the test is automatically covered. All relevant criteria from the above Medicare references as applicable to the individual test must still be met.*

Proprietary Test Name	Laboratory	MoIDX TA Review Outcome
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		(as found in the DEX™ Diagnostics Exchange registry)
<b>DCISionRT® (CPT 0295U)</b>	Prelude Corp. (California)	Not covered ( <i>No TA review noted in registry as of most recent policy review date</i> )
<b>TargetPrint®</b>	Agendia® (California)	Not covered ( <i>No TA review noted in registry as of most recent policy review date</i> )
<b>BreastOncPx™</b>	LabCorp (headquartered in North Carolina)	Not covered ( <i>No TA review noted in registry as of most recent policy review date</i> )
<b>BreastPRS™</b>	Signal Genetics (California)	Not covered ( <i>No TA review noted in registry as of most recent policy review date</i> )
<b>Mammostrat®</b>	Clariant Diagnostic Services (California)	Not covered ( <i>No TA review noted in registry as of most recent policy review date</i> )
<b>Insight TNBCtype (0153U)</b>	Insight Molecular Labs (Tennessee)	Not covered (As of 2/14/2019)

### Summary

Many Medicare contractors (MACs) have adopted guidelines developed and published by the Molecular Diagnostic Services (MoIDX) Program for their service area. As called out within relevant LCDs for these service areas (L36256, L35160, L35025, L36807, L36021), genetic and molecular tests performed within a MoIDX service area are required to undergo a technical assessment (TA) review by the MoIDX Medicare Contractor, Palmetto GBA. These TA reviews assess clinical utility and analytical validity (CU/AV) to ensure the tests meets requirements for Medicare coverage. The outcome of these TA reviews is maintained in the DEX™ Diagnostics Exchange registry catalog. When possible, the coverage outcome is included within this medical policy to assist with coverage decision-making.

- Tests listed as “not covered” in this registry have had the CU/AV reviewed and were determined to be not medically reasonable or necessary for Medicare under *Social Security Act, §1862(a)(1)(A)*.
- Tests not listed at all have not yet completed the required TA review are by default also considered to be not medically reasonable or necessary for Medicare under §1862(a)(1)(A), based on the requirements found in the LCDs noted above.
- Tests listed as “covered” in this registry have completed the required TA review and have been determined to be potentially medically reasonable or necessary for Medicare under *§1862(a)(1)(A)*; however, applicable NCD, LCD, and LCA criteria must still be met, and the member must have signs/symptoms of a relevant disease or condition.

### **Non-MoIDX Service Areas and Coverage in the Absence of a Specific Medicare Policy Guideline**

Services areas which have **not** adopted MoIDX guidelines include testing performed in the following states: FL, CO, NM, OK, TX, AR, LA, MS, DE, MD, NJ, PA, IL, MN, WI, CT, NY, ME, MA, NH, RI, and VT.

Only medically reasonable and necessary services or items which treat illness or injury are eligible for Medicare coverage, as outlined in *Title XVIII of the Social Security Act, §1862(a)(1)(A)*. LCDs and LCAs for each of the above service areas require clinical utility and analytical validity to be established, but most

tests are not called out by name specifically. Additionally, for multi-biomarker panel test, each requested biomarker needs to be individually contributory to the member's treatment.

MA organizations (MAOs) make medical necessity determinations based on coverage and benefit criteria, the member's unique personal medical history (e.g., diagnoses, conditions, functional status, comorbidities, etc.), physician recommendations, and clinical notes, as well as involvement of a plan medical director, where appropriate. (*§ 422.101(c)(1)*)

"MA organizations may create publicly accessible internal coverage criteria that are based on current evidence in widely used treatment guidelines or clinical literature when coverage criteria are not fully established in applicable Medicare statutes, regulations, NCDs or LCDs. Current, widely-used treatment guidelines are those developed by organizations representing clinical medical specialties, and refers to guidelines for the treatment of specific diseases or conditions. Acceptable clinical literature includes large, randomized controlled trials or prospective cohort studies with clear results, published in a peer-reviewed journal, and specifically designed to answer the relevant clinical question, or large systematic reviews or meta-analyses summarizing the literature of the specific clinical question." (*§ 422.101(b)(6) and Medicare Managed Care Manual, Ch. 4, §90.5*)

The Company policy for *PHA Medicare Medical Policy Development and Application* (MP50) provides details regarding Medicare's definition of medical necessity and the hierarchy of Medicare references and resources during the development of medical policies, as well as the Plan's use of evidence-based processes for policy development. In the absence of Medicare coverage policies (e.g., manual, national coverage determination [NCD], local coverage determination [LCD], article [LCA], etc.), Medicare regulatory guidelines do allow Medicare Advantage Organizations (MAOs) to make their own coverage determinations, as long as the MAO applies an objective, evidence-based process.

**When the biomarkers included in a test do not have proven clinical validity/utility, the test is not medically reasonable or necessary under Social Security Act, §1862(a)(1)(A) for Medicare members.** If there are not fully established coverage criteria for specific tests available in applicable Medicare statutes, regulations, NCDs or LCDs, then Company medical policy criteria will be applied. See the [Medicare Coverage Criteria](#) table above for more information regarding the use of internal coverage criteria when Medicare coverage criteria are not fully established

## REGULATORY STATUS

### U.S. FOOD & DRUG ADMINISTRATION (FDA)

While clearance by the Food and Drug Administration (FDA) is a prerequisite for Medicare coverage, the 510(k) premarket clearance process does not in itself establish medical necessity. Medicare payment policy is determined by the interaction of numerous requirements, including but not limited to, the availability of a Medicare benefit category and other statutory requirements, coding and pricing guidelines, as well as national and local coverage determinations and clinical evidence.

## BILLING GUIDELINES AND CODING



## GENERAL

See associated local coverage articles (LCAs) for additional coding and billing guidance:

- LCA for Coding Article for MolDX: Breast Cancer Index™ (BCI) Gene Expression Test ([A56335](#))
- LCA for Billing and Coding: MolDX: Oncotype DX® Breast Cancer for DCIS (Genomic Health™) ([A57620](#))
- LCA for Billing and Coding: MolDX: Breast Cancer Assay: Prosigna ([A57364](#))
- LCA for Billing and Coding: MolDX: EndoPredict® Breast Cancer Gene Expression Test ([A57608](#))

## FREQUENCY

Testing must be performed at an appropriate frequency, as determined by the above Medicare references, as well as established clinical edits (e.g., National Correct Coding Initiative [NCCI] edits) which may be in place. Laboratory tests that investigate the same germline genetic content, for the same genetic information, that has already been tested in a single member are not considered medically reasonable or necessary as it is considered duplicative.<sup>6</sup> “Germline DNA or RNA-based test is limited to one per lifetime. Examples of germline tests include (but are not limited to) single gene and gene panel tests for: hereditary cancer syndromes or cancer predisposition, inherited disorders, and pharmacogenomics/cytochrome P450 testing.”<sup>6</sup>

In the event retesting is performed, documentation in the medical record should clearly support the need for repeat testing. Examples include, but may not be limited to, recurrence of disease, change in behavior of disease, etc. In addition, there are some tumor specific scenarios where repeat testing may be appropriate for assessment of response to therapy or to identify basis of disease progression. In cases with metastatic or recurrent tumors, repeat testing may be useful in determining further clinical management. Still other biomarker tests may be useful in monitoring response to therapy and predict a response.<sup>7</sup>

Regardless of whether or not a specific Medicare coverage policy is available, **all** services performed must be considered medically reasonable and necessary, and supported by the medical record, including repeat testing.

## HCPCS CODE S3854

Like all S-codes, the *National Physician Fee Schedule Relative Value File (NPF SRVF)*, which is published by Medicare<sup>8</sup>, indicates HCPCS code S3854 has been assigned a Status Indicator of “I.” This is defined as “Not valid for Medicare purposes.” In addition, all S-codes codes, including S3854, are not recognized as valid codes for claim submission as indicated in the relevant Company Coding Policy (*HCPCS S-Codes and H-Codes*, 22.0). Providers need to use alternate available CPT or HCPCS codes to report for the service. If no specific CPT or HCPCS code is available, then an unlisted code may be used. Note that unlisted codes are reviewed for medical necessity, correct coding, and pricing at the claim level. Thus, if an unlisted code is billed related to a non-covered service addressed in this policy, it will be denied as not covered.

## CODES\*



<b>CPT</b>	0045U	Oncology (breast ductal carcinoma in situ), mRNA, gene expression profiling by real-time RT-PCR of 12 genes (7 content and 5 housekeeping), utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as recurrence score ( <i>Used to report the Oncotype DCIS test</i> )
	0153U	Oncology (breast), mRNA, gene expression profiling by next-generation sequencing of 101 genes, utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as a triple negative breast cancer clinical subtype(s) with information on immune cell involvement ( <i>Used to report the Insight TNBCtype, by Insight Molecular Labs; Tennessee</i> )
	0249U	Oncology (breast), semiquantitative analysis of 32 phosphoproteins and protein analytes, includes laser capture microdissection, with algorithmic analysis and interpretative report ( <i>Used to report the Theralink® Reverse Phase Protein Array (RPPA) test</i> )
	0295U	Oncology (breast ductal carcinoma in situ), protein expression profiling by immunohistochemistry of 7 proteins (COX2, FOXA1, HER2, Ki-67, p16, PR, SIAH2), with 4 clinicopathologic factors (size, age, margin status, palpability), utilizing formalin-fixed paraffin-embedded (FFPE) tissue, algorithm reported as a recurrence risk score ( <i>Used to report the DCISionRT® test</i> )
	81479	Unlisted molecular pathology procedure
	81518	Oncology (breast), mRNA, gene expression profiling by real-time RT-PCR of 11 genes (7 content and 4 housekeeping), utilizing formalin-fixed paraffin-embedded tissue, algorithms reported as percentage risk for metastatic recurrence and likelihood of benefit from extended endocrine therapy ( <i>Used to report the Breast Cancer Index (BCI) test</i> )
	81519	Oncology (breast), mRNA, gene expression profiling by real-time RT-PCR of 21 genes, utilizing formalin-fixed paraffin embedded tissue, algorithm reported as recurrence score ( <i>Used to report the Oncotype DX Breast test</i> )
	81520	Oncology (breast), mRNA gene expression profiling by hybrid capture of 58 genes (50 content and 8 housekeeping), utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as a recurrence risk score ( <i>Used to report the Prosigna (PAM50) test</i> )
	81521	Oncology (breast), mRNA, microarray gene expression profiling of 70 content genes and 465 housekeeping genes, utilizing fresh frozen or formalin-fixed paraffin-embedded tissue, algorithm reported as index related to risk of distant metastasis ( <i>Used to report the MammaPrint test</i> )
	81522	Oncology (breast), mRNA, gene expression profiling by RT-PCR of 12 genes (8 content and 4 housekeeping), utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as recurrence risk score ( <i>Used to report the EndoPredict test</i> )
	81523	Oncology (breast), mRNA, next-generation sequencing gene expression profiling of 70 content genes and 31 housekeeping genes, utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as index related to risk to distant metastasis ( <i>Used to report the MammaPrint test if performed by next generation sequencing [NGS]</i> )
	81599	Unlisted multi-analyte with algorithmic analysis
	84999	Unlisted chemistry procedure
<b>HCPCS</b>	S3854	Gene expression profiling panel for use in the management of breast cancer treatment ( <i>CMS-assigned Status "I" code – See above billing guidelines</i> )

\*Coding Notes:

- The code list above is provided as a courtesy and may not be all-inclusive. Inclusion or omission of a code from this policy neither implies nor guarantees reimbursement or coverage. Some codes may not require routine review for medical necessity, but they are subject to provider contracts, as well as member benefits, eligibility and potential utilization audit. According to Medicare, “presence of a payment amount in the MPFS and the Medicare physician fee schedule database (MPFSDB) does not imply that CMS has determined that the service may be covered by Medicare.” The issuance of a CPT or HCPCS code or the provision of a payment or fee amount by Medicare does **not** make a procedure medically reasonable or necessary or a covered benefit by Medicare. (*Medicare Claims Processing Manual, Chapter 23 - Fee Schedule Administration and Coding Requirements, §30 - Services Paid Under the Medicare Physician’s Fee Schedule, A. Physician’s Services*)
- All unlisted codes are reviewed for medical necessity, correct coding, and pricing at the claim level. If an unlisted code is submitted for non-covered services addressed in this policy then it will be **denied as not covered**. If an unlisted code is submitted for potentially covered services addressed in this policy, to avoid post-service denial, **prior authorization is recommended**.
- **See the non-covered and prior authorization lists on the Company [Medical Policy, Reimbursement Policy, Pharmacy Policy and Provider Information website](#) for additional information.**
- HCPCS/CPT code(s) may be subject to National Correct Coding Initiative (NCCI) procedure-to-procedure (PTP) bundling edits and daily maximum edits known as “medically unlikely edits” (MUEs) published by the Centers for Medicare and Medicaid Services (CMS). This policy does not take precedence over NCCI edits or MUEs. Please refer to the CMS website for coding guidelines and applicable code combinations.

## REFERENCES

1. Medicare Claims Processing Manual, Chapter 16 - Laboratory Services, §50.5 - Jurisdiction of Laboratory Claims; Available at: <https://www.cms.gov/Regulations-andGuidance/Guidance/Manuals/downloads/clm104C16.pdf>
2. Medicare Claims Processing Manual, Chapter 1 - General Billing Requirements, §10.1.5.4 - Independent Laboratories; Available at: <https://www.cms.gov/Regulations-andGuidance/Guidance/Manuals/Downloads/clm104c01.pdf>
3. Medicare Claims Processing Manual, Ch. 1 - General Billing Requirements, §10.1.5.4.1 – Cases Involving Referral Laboratory Services; Available at: <https://www.cms.gov/Regulations-andGuidance/Guidance/Manuals/Downloads/clm104c01.pdf>
4. Medicare Claims Processing Manual, Chapter 16 - Laboratory Services, §40.1 – Laboratories Billing for Referred Tests; Available at: <https://www.cms.gov/regulations-andguidance/guidance/manuals/downloads/clm104c16.pdf>
5. Medicare Claims Processing Manual, Chapter 16 - Laboratory Services, §50.5.1 - Jurisdiction Of Referral Laboratory Services; Available at: <https://www.cms.gov/regulations-andguidance/guidance/manuals/downloads/clm104c16.pdf>
6. Noridian Healthcare Solutions. Local Coverage Determination (LCD). MoIDX: Repeat Germline Testing (L38353). Accessed 3/5/2025.
7. Novitas Solutions. Local Coverage Determination (LCD). Biomarkers for Oncology (L35396). Accessed 3/5/2025.
8. Medicare Physician Fee Schedule (PFS) Relative Value Files; Available at: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files>

## POLICY REVISION HISTORY

DATE	REVISION SUMMARY
10/2022	Q4 2022 code updates (converted to new format 2/2023)
5/2023	Annual review; added 0153U
8/2023	Interim update; added S3854

5/2024  
5/2025

Annual review, no criteria change  
Annual review, no criteria change