MEDICAL POLICY	Genetic Testing: Hereditary Breast and Ovarian Cancer Genetic Testing (Medicare Only)
Effective Date: 1/01/2022  1/1/2022 Medical Officer Date	Medical Policy Number: 144 Medical Policy Committee Approved Date: 1/17; 5/17; 1/18; 2/19; 3/19; 9/19; 11/19; 4/2020; 12/2020; 5/2021; 10/2021

See Policy CPT CODE section below for any prior authorization requirements

SCOPE:

Providence Health Plan, Providence Health Assurance, Providence Plan Partners, and Ayin Health Solutions as applicable (referred to individually as "Company" and collectively as "Companies").

APPLIES TO:

Medicare only

MEDICARE POLICY CRITERIA

Notes:

- Testing of an unaffected Medicare eligible individual or family member is not a covered Medicare benefit. Please see the Limitations section in the LCD L36163 for more information.
- BRCA1 and BRCA2 testing consists of full sequence and duplication/deletion analysis. This includes BART testing for large rearrangements. Please see Policy Guidelines and Billing Guidelines sections below.
- Some BRCA-related testing may be addressed in other Medicare medical policies (e.g., BRACAnalysis CDx®). See Cross References below.

The following Centers for Medicare & Medicaid Service (CMS) guidelines should be utilized for medical necessity coverage determinations. Click the link provided in the table below to access applicable medical necessity criteria. All listed guidelines apply.

Service	Medicare Guidelines
BRCA1/BRCA2 Genetic Testing	***See "Policy Guidelines" for additional requirements for coverage and specific panel test information.*** General Coverage Criteria References:

	• For testing performed in the states of AK, ID, OR, WA, UT, AZ, MT, ND, SD, or WY: Local Coverage Determination (LCD): MolDX: BRCA1 and BRCA2 Genetic Testing (L36163) • For testing performed in CA or NV: LCD: MolDX: BRCA1 and BRCA2 Genetic Testing (L36161) • For testing performed in GA, TN, AL, NC, SC, VA, WV: LCD: MolDX: BRCA1 and BRCA2 Genetic Testing (L36082)

POLICY GUIDELINES

BART testing for large rearrangements (e.g., large deletions and/or duplications) may be included and is covered as a component of BRCA1 and/or 2 testing when medical necessity criteria above are met.

PLEASE READ: For any test within a service area which follows and uses MolDX Program policies and coverage guidance, all tests and assays require evaluation to determine if the test meets Medicare's reasonable and necessary requirement. Only tests which demonstrate analytical and clinical validity, and clinical utility at a level that meets the Medicare reasonable and necessary requirement are eligible for coverage under Medicare.

The outcome of MolDX TA reviews is maintained in the DEX™ Diagnostics Exchange registry catalog.

- Genetic tests noted as "covered" within this registry **may be medically reasonable and necessary** when all other Medicare coverage requirements are met, including criteria found in LCDs or LCAs.
- In contrast, if a test does **not** have a coverage determination noted within the registry, clinical validity or utility has not been established via the TA review process and the test **not considered medically reasonable and necessary** under *SSA §1862(a)(1)(A)* until a MolDX review is complete and coverage is indicated by MolDX or any other Medicare contractor (MAC) that uses MolDX policies or coverage guidance.

Related panel tests include:

Note: This list was accurate at the time of publication, but it is subject to change at any time by the Medicare MolDX Program contractor.

Proprietary Test Name *(When performed for HBOC-related conditions)*	**Laboratory**	**MolDX TA Review Outcome (as found in the DEX™ Diagnostics Exchange registry)**
BRCAplus	Ambry Genetics (California)	Covered
BRCAplus-Expanded	Ambry Genetics (California)	Covered
BreastNext *(No longer appears to be offered)*	Ambry Genetics (California)	Covered (while it was offered)

CancerNext	Ambry Genetics (California)	Covered
CancerNext +RNAinsight™	Ambry Genetics (California)	Not Covered
CancerNext-Expanded	Ambry Genetics (California)	Not Covered
CancerNext-Expanded +RNAinsight™	Ambry Genetics (California)	Not Covered
GYNPlus® *(No longer appears to be offered)*	Ambry Genetics (California)	Not Covered *(No TA review performed as of most recent policy review date)*
myRisk® Hereditary Cancer	Myriad (Utah)	Covered
myRisk® Hereditary Cancer *Update*	Myriad (Utah)	Not Covered
OvaNext	Ambry Genetics (California)	Not Covered *(No TA review performed as of most recent policy review date)*
VistaSeq Breast and Gyn Cancer Profile	LabCorp / Integrated Genetics / Integrated Oncology (Any state; LabCorp is headquartered in North Carolina, so LCD used would be selected based on this location)	Covered
VistaSeq Breast Cancer Profile	LabCorp / Integrated Genetics / Integrated Oncology (Any state; LabCorp is headquartered in North Carolina, so LCD used would be selected based on this location)	Covered
VistaSeq Hereditary Cancer Panel	LabCorp / Integrated Genetics / Integrated Oncology (Any state; LabCorp is headquartered in North Carolina, so LCD used would be selected based on this location)	Covered
VistaSeq Hereditary Cancer without BRCA	LabCorp / Integrated Genetics / Integrated Oncology (Any state; LabCorp is headquartered in North Carolina, so LCD used would be selected based on this location)	Covered
VistaSeq High/Moderate Risk Breast Cancer Profile	LabCorp / Integrated Genetics / Integrated Oncology (Any state; LabCorp is headquartered in North Carolina, so LCD used would be selected based on this location)	Covered

BILLING GUIDELINES

Please refer to the following local coverage articles (LCAs) for coding and billing assistance:

- LCA: Billing and Coding: MolDX: BRCA1 and BRCA2 Genetic Testing (A57355)[2]

BART testing for large rearrangements (e.g., large deletions and/or duplications), billed with 81164 **OR** 81166 and/or 81167, may be denied as not covered when the medical necessity for hereditary breast or ovarian cancer testing above is not met.

When no specific CPT or HCPCS code exists for the panel, the provider is required to bill using an unlisted code. It is not appropriate for the provider to bill any of the tests in a panel separately as if they were performed individually. This is a misrepresentation of services performed and is not appropriate based on either CPT or CMS guidelines. In a "Healthcare Fraud Prevention Partnership" white paper published in May, 2018, CMS identified unbundling of lab panels as an example of fraudulent billing.

CPT/HCPCS CODES

Genetic testing for hereditary breast and/or ovarian cancer may include but is not limited to any of the CPT codes listed below. Additional codes may apply.

Medicare Only	
Prior Authorization Required	
0102U	Hereditary breast cancer-related disorders (eg, hereditary breast cancer, hereditary ovarian cancer, hereditary endometrial cancer), genomic sequence analysis panel utilizing a combination of NGS, Sanger, MLPA, and array CGH, with MRNA analytics to resolve variants of unknown significance when indicated (17 genes [sequencing and deletion/duplication]) *(BreastNext®)*
0103U	Hereditary ovarian cancer (eg, hereditary ovarian cancer, hereditary endometrial cancer), genomic sequence analysis panel utilizing a combination of NGS, Sanger, MLPA, and array CGH, with MRNA analytics to resolve variants of unknown significance when indicated (24 genes [sequencing and deletion/duplication], EPCAM [deletion/duplication only]) *(OvaNext®)*
0129U	Hereditary breast cancer–related disorders (eg, hereditary breast cancer, hereditary ovarian cancer, hereditary endometrial cancer), genomic sequence analysis and deletion/duplication analysis panel (ATM, BRCA1, BRCA2, CDH1, CHEK2, PALB2, PTEN, and TP53) *(BRCAPlus)*
0137U	PALB2 (partner and localizer of BRCA2) (eg, breast and pancreatic cancer) mRNA sequence analysis (List separately in addition to code for primary procedure) *(RNAinsight™ for PALB2)*
0138U	BRCA1 (BRCA1, DNA repair associated), BRCA2 (BRCA2, DNA repair associated) (eg, hereditary breast and ovarian cancer) mRNA sequence analysis (List separately in addition to code for primary procedure) *(RNAinsight™ for BRCA1/2)*
0238U	Oncology (Lynch syndrome), genomic DNA sequence analysis of MLH1, MSH2, MSH6, PMS2, and EPCAM, including small sequence changes in exonic and intronic regions, deletions, duplications, mobile element insertions, and variants in non-uniquely mappable regions
81162	BRCA1, BRCA2 (Breast Cancer 1 AND 2) (EG, Hereditary breast and ovarian cancer) Gene analysis; full sequence analysis and full duplication/deletion analysis
81163	BRCA1 (BRCA1, DNA repair associated), BRCA2 (BRCA2, DNA repair associated) (eg, hereditary breast and ovarian cancer) gene analysis; full sequence analysis

81164	BRCA1 (BRCA1, DNA repair associated), BRCA2 (BRCA2, DNA repair associated) (eg, hereditary breast and ovarian cancer) gene analysis; full duplication/deletion analysis (ie, detection of large gene rearrangements)
81165	BRCA1 (BRCA1, DNA repair associated) (eg, hereditary breast and ovarian cancer) gene analysis; full sequence analysis
81166	BRCA1 (BRCA1, DNA repair associated) (eg, hereditary breast and ovarian cancer) gene analysis; full duplication/deletion analysis (ie, detection of large gene rearrangements)
81167	BRCA2 (BRCA2, DNA repair associated) (eg, hereditary breast and ovarian cancer) gene analysis; full duplication/deletion analysis (ie, detection of large gene rearrangements)
81212	BRCA1, BRCA2 (Breast Cancer 1 AND 2) (EG, Hereditary breast and ovarian cancer) Gene analysis; 185delAG, 5385de AG, 5385insC, 6174delT variants
81215	BRCA1 (Breast Cancer 1) (EG, Hereditary breast and ovarian cancer) Gene analysis; known familial variant
81216	BRCA1 (Breast Cancer 2) (EG, Hereditary breast and ovarian cancer) Gene analysis; full sequence analysis
81217	BRCA1 (Breast Cancer 2) (EG, Hereditary breast and ovarian cancer) Gene analysis; known familial variant
81307	PALB2 (partner and localizer of BRCA2) (eg, breast and pancreatic cancer) gene analysis; full gene sequence
81308	PALB2 (partner and localizer of BRCA2) (eg, breast and pancreatic cancer) gene analysis; known familial variant
81351	TP53 (tumor protein 53) (eg, Li-Fraumeni syndrome) gene analysis; full gene sequence
81352	TP53 (tumor protein 53) (eg, Li-Fraumeni syndrome) gene analysis; targeted sequence analysis (eg, 4 oncology)
81353	TP53 (tumor protein 53) (eg, Li-Fraumeni syndrome) gene analysis; known familial variant
81432	Hereditary breast cancer-related disorders (EG, hereditary breast cancer, hereditary ovarian cancer, hereditary endometrial cancer); Genomic sequence analysis panel, must include sequencing of at least 14 genes, including ATM, BRCA1, BRCA2, BRIP1, CDH1, MLH1, MSH2, MSH6, NBN, PALB2, PTEN, RAD51C, STK11, and TP53
81433	Hereditary breast cancer-related disorders (eg, hereditary breast cancer, hereditary ovarian cancer, hereditary endometrial cancer); duplication/deletion analysis panel, must include analyses for BRCA1, BRCA2, MLH1, MSH2, and STK11
81445	Targeted genomic sequence analysis panel, solid organ neoplasm, DNA analysis and RNA analysis when performed, 5-50 genes (EG, ALK, BRAF, CDKN2A, EGFR, ERBB2, KIT, KRAS, NRAS, MET, PDGFRA, PDGFRB, PGR, PIK3CA, PTEN, RET), interrogation for sequence variants and copy number variants or rearrangements, if performed
81455	Targeted genomic sequence analysis panel, solid organ or hematolymphoid neoplasm , DNA analysis and RNA analysis when performed, 51 or greater genes (EG, ALK, BRAF, CDKN2A, CEBPA, DNMT3A, EGFR, ERBB2, EZH2, FLT3, IDH1, IDH2, JAK2, KIT, KRAS, MLL, NPM1, NRAS, MET, NOTCH1, PDGFRA, PDGFRB, PGR, PIK3CA, PTEN, RET), interrogation for sequence variants and copy number variants or rearrangements, if performed
Non-Covered	

Based on an LCD or LCA, all codes in this section are **non-covered** by Medicare.	
0131U	Hereditary breast cancer–related disorders (eg, hereditary breast cancer, hereditary ovarian cancer, hereditary endometrial cancer), targeted mRNA sequence analysis panel (13 genes) (List separately in addition to code for primary procedure) *(RNAinsight™ for BreastNext®)*
0132U	Hereditary ovarian cancer-related disorders (eg, hereditary breast cancer, hereditary ovarian cancer, hereditary endometrial cancer), targeted mRNA sequence analysis panel (17 genes) (List separately in addition to code for primary procedure) *(RNAinsight™ for OvaNext®)*
0134U	Hereditary pan cancer (eg, hereditary breast and ovarian cancer, hereditary endometrial cancer, hereditary colorectal cancer), targeted mRNA sequence analysis panel (18 genes) (List separately in addition to code for primary procedure) *(RNAinsight™ for CancerNext®)*
0135U	Hereditary gynecological cancer (eg, hereditary breast and ovarian cancer, hereditary endometrial cancer, hereditary colorectal cancer), targeted mRNA sequence analysis panel (12 genes) (List separately in addition to code for primary procedure) *(RNAinsight™ for GynPlus®)*
Unlisted Codes All unlisted codes will be reviewed for medical necessity, correct coding, and pricing at the claim level. If an unlisted code is billed related to services addressed in this policy then **prior-authorization is required.**	
81479	Unlisted molecular pathology procedure

INSTRUCTIONS FOR USE

Company Medical Policies serve as guidance for the administration of plan benefits. Medical policies do not constitute medical advice nor a guarantee of coverage. Company Medical Policies are reviewed annually and are based upon published, peer-reviewed scientific evidence and evidence-based clinical practice guidelines that are available as of the last policy update. The Companies reserve the right to determine the application of Medical Policies and make revisions to Medical Policies at any time. Providers will be given at least 60-days' notice of policy changes that are restrictive in nature.

The scope and availability of all plan benefits are determined in accordance with the applicable coverage agreement. Any conflict or variance between the terms of the coverage agreement and Company Medical Policy will be resolved in favor of the coverage agreement.

REGULATORY STATUS

Mental Health Parity Statement

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.

MEDICAL POLICY CROSS REFERENCES

Genetic Testing: Pharmacogenetic Testing (Medicare Only), MP# 217