Connecticut Department of Social Services
Medical Assistance Program **Provider Bulletin 2015-34**
www.ctdssmap.com **April 2015**

To: Independent Laboratories, Outpatient Hospitals, Physicians and Physicians Groups
RE: Prior Authorization of Genetic Testing Services

The purpose of this bulletin is to provide clarification to providers submitting Prior Authorization (PA) requests for genetic testing services. Genetic testing services include Tier 1 Molecular Pathology Procedures, Tier 2 Molecular Pathology Procedures, Genomic Sequencing Procedures, and certain Multianalyte Assays.

When submitting requests for PA of genetic testing services, providers must ensure that the requested codes are valid and listed on the Department of Social Services' (DSS) Laboratory Fee Schedule.

Information Required for Review:
The following information is needed when submitting requests for genetic testing services:

- Fully completed State of Connecticut, DSS Outpatient Prior Authorization Request Form;
- Documentation supporting the medical necessity of the requested test;
- Documentation outlining how the test results will impact the client's plan of care; and
- Documentation clearly identifying the usual and customary charge for the requested test (for those tests listed on the fee schedule as "MP" or manually priced).

Providers may be asked to submit additional documentation supporting the usual and customary charge for a given test to include:

1. The type of test performed;
2. The number and source of specimen(s);
3. Resources required to perform the test; and
4. Amount of time and effort required to perform the test.

Providers are no longer required to submit "stacked codes".

Maximum Allowed Units:
The maximum number of allowed units reflects the Centers for Medicare and Medicaid Services' medically unlikely edits (MUEs). An MUE for a Healthcare Common Procedure Coding System (HCPCS) or Current Procedure Terminology (CPT) code is the maximum number of units that a provider would report in most cases for an individual client on a single date of service. Not all HCPCS/CPT codes have MUEs assigned. For a complete list of medically unlikely edits, providers may visit the following CMS website:
http://www.cms.gov/NationalCorrectCodInitEd/.

Prior Authorization Determinations:
PA determinations will be based upon a review of submitted clinical documentation and will conform to DSS' definition of medical necessity.

As part of the review process, Community Health Network of Connecticut, Inc.'s (CHNCT) medical reviewers will verify that there is significant evidence in peer reviewed literature of the clinical validity and clinical utility of the requested test.

Under Section 17b-262-645(b)(4) of the Regulations of Connecticut State Agencies, "payment shall not be made for any procedures or services of an **unproven**, educational, social, **research, experimental** or cosmetic nature; for services in excess of those deemed medically necessary and medically appropriate to treat the client's condition; or for services not directly related to the client's diagnosis, symptoms or medical history".

Prior Authorization Form:
Providers may access the Outpatient Prior Authorization Request Form on the HUSKY Health Web site: http://www.huskyhealth.com. To request authorization, providers may use one of the following methods:

- Phone: 1-800-440-5071 - follow the prompts to medical authorizations, or
- Fax: (203) 265-3994

For questions regarding the prior authorization process, please contact CHNCT at 1-800-440-5071, Monday through Friday between the hours of 8:00 am and 7:00 pm.

For Prior Authorization questions, please contact Community Health Network of Connecticut (CHNCT) at 1-800-440-5071 As a reminder, DSS will no longer distribute paper communications to providers as of June 30, 2015. Please see PB15-23 for details.