Coverage of any medical intervention discussed in a Prevea360 Health Plan medical policy is subject to the limitations and exclusions outlined in the member's benefit certificate or policy and to applicable state and/or federal laws.

Genetic Testing for Stickler Syndrome MP9504

Covered Service: Yes

Prior Authorization Required: Yes

Additional Information: Genetic testing is covered for a Prevea360 Health Plan member if the test results provide a direct medical benefit or guides reproductive decision-making for the Prevea360 Health Plan member. See Genetic Testing MP9012 for additional information.

Pre and post-test genetic counseling is required for any individual undergoing genetic testing.

For ASO members pre and post-genetic counseling is not required. Please reference the ASO Summary Plan Document (SPD).

A first-degree relative is defined as an individual's parents, full siblings, and children.

A second-degree relative is defined as an individual's grandparents, grandchildren, aunts, uncles, nephews, nieces and half-siblings.

Prevea360 Health Plan Medical Policy:

1.0 Stickler Syndrome sequencing panel – including COL2A1, COL11A1, COL11A2, COL9A1, COL9A2 and COL9A3 genetic testing **requires** prior authorization through the Health Services Division and is considered medically necessary when **2 or more** of the following are met:

1.1 Ocular findings – vitreous changes or retinal abnormalities (lattice degeneration, retinal hole, retinal detachment, or retinal tear)

1.2 High-frequency sensorineural hearing loss and/or frequent ear infections

1.3 Characteristic facial features including midfacial underdevelopment, malar hypoplasia, broad or flat nasal bridge, and micro/retrognathia

1.4 Cleft palate (open cleft, submucous cleft, or bifid uvula)

1.5 Skeletal findings including:

1.5.1 Osteoarthritis before age 40

1.5.2 Slipped epiphysis or Legg-Perthes-like disease

1.5.3 Scoliosis, spondylolisthesis, or Scheuermann-like kyphotic deformity

1.5.4 First or second degree relative with a known pathogenic autosomal dominant or autosomal recessive sequence variant(s) in a related gene.

2.0 When criteria in 1.0 are met for testing of these genes we will cover deletion/duplication testing via array comparative genomic hybridization.

3.0 All other indications not listed above are considered experimental and investigational, and therefore are not covered.

CPT/HCPCS Codes Related to MP9504

The list of codes (and their descriptors, if any) is provided for informational purposes only and may not be all inclusive or current. Listing of a code in this medical policy does not imply that the service described by the code is a covered or non-covered service. Benefit coverage for any service is determined by the member's policy of health coverage with Prevea360 Health Plan. Inclusion of a code above does not imply any right to reimbursement or guarantee claim payment. Other medical policies may also apply.

CPT Code	Description
81479	Unlisted molecular pathology procedure

	Committee/Source	Date(s)
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