Coverage Criteria, Preauthorization and Billing Instructions for Non-Invasive Prenatal Testing For Fetal Aneuploidy*

*Please note the Maryland Medicaid coverage for non-invasive prenatal testing for Fetal Aneuploidy (CPT code 81420) is not effective until July 1, 2017.

Effective July 1, 2017

PREAUTHORIZATION PROCEDURES FOR NON-INVASIVE PRENATAL TESTINGT FOR ANUEUPLOIDY (CPT 81420)

If the Maryland Medicaid recipient is enrolled in a MCO or have Medicare Part A & B do not proceed. Please consult the MCO or Medicare for payment.

The ordering provider must complete the Genetic Testing Preauthorization Form. The recipient must meet one or more of the following conditions:

- Maternal age of 35 years or older at delivery
- Fetal ultrasound findings indicating an increased risk of aneuploidy:
- History of a prior pregnancy with trisomy:
- Parental balanced Robertsonian translocation with an increased risk of fetal trisomy 13 or trisomy 21

The participant must have pre and post- test genetic counseling with a physician or certified genetic counselor.

Submit the preauthorization form by fax to Tenesha Lynch. (Fax# 410-333-5050). Use the fax cover sheet included with the preauthorization form. All sections of the pre-auth form must be completed. The ordering physician must sign and date the pre-auth form attesting that the Medicaid recipient meets at least one of the required conditions.

The Maryland Department of Health will send a written decision in response to all written requests for preauthorization via fax. **Do not perform the procedure without receiving an approval letter from the Maryland Department of Health. Claims submitted without receiving preauthorization will be denied.** If you want a copy of the preauthorization form faxed to the testing laboratory, include the contact person and fax number in the comment section of the fax cover sheet.

Preauthorization request will be denied (but not limited to) for the following reasons:

- The recipient is not enrolled with Maryland Medicaid
- The recipient is enrolled in and MCO or has Medicare Part A&B
- The ordering physician is not enrolled with Maryland Medicaid
- The testing laboratory is not enrolled with Maryland Medicaid
- The ordering physician has not attested that the recipient meets one or more of the required conditions.
- The test has already been performed for the recipient during the current pregnancy.

Once the approval letter is received the laboratory can perform the test. For payment the laboratory must mail the CMS 1500 directly to:

Maryland Department of Health
201 W. Preston Street, Room 212B
Atten: Tenesha Lynch
Baltimore, MD 21201

CMS 1500 will not be accepted by fax.

FAX COVER SHEET

(Genetic Testing Prior Authorization)

TO:	**Tenesha Lynch**
PHONE:	**410-767-3074**
FAX:	**410-333-5050**
FROM:	
PHONE:	
FAX:	
DATE:	

Comments:_____

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Genetic Testing Prior Authorization Form

Non-Invasive Prenatal Testing for Fetal Aneuploidy Using Cell – Free DNA

Participant Information

Name:	**Date of Birth:**
Medicaid Number:	**Sex**

Ordering Provider Information

Name:	**MA Provider Number:**
Street Address:	**Telephone**
City, State, Zip:	**Fax:**

Clinical Geneticist, Genetic Counselor information (if different than above)

Name:	
Street Address:	**Telephone**
City, State, Zip:	**Fax:**

Testing Laboratory Information (pay-to provider)

Name:	**MA Provider Number:**
Street Address:	**Telephone**
City, State, Zip:	**Fax:**

Prior Authorization Information

Requested Test Name: **FETAL CHRMOML ANEUPLOIDY**	**CPT/HCPCS code(s):** **81420**
Diagnoses	**ICD-10 code(s)**

Clinical Information

I, the ordering provider listed above, attest to the following: (please check boxes as applicable)

☐ The participant is a woman with a singleton pregnancy determined to be at increased risk of fetal aneuploidy (trisomy 12, 18, or 21) due to ONE or more of the following conditions:

- Maternal age of 35 years or older at delivery;
- Fetal ultrasound findings indicating an increased risk of aneuploidy;
- History of a prior pregnancy with a trisomy;
- Positive first- or second-trimester screening test results for aneuploidy; OR
- Parental balanced Robertsonian translocation with an increased risk of fetal trisomy 13 or trisomy 21

☐ The participant has or will have pre- and post-test genetic counseling with a physician or certified genetic counselor

☐ To my knowledge, the participant has not had this test performed previously during the current pregnancy

_____ _____

Signature of Ordering Provider Date

Submitting the request: Submission of this completed form certifies that the information is true and accurate. All fields are required for processing of this request.

Submit form by fax to:

- **Tenesha Lynch**
  410-767-3074 phone
  410-333-5050 fax

Preauthorization Line Item Information

Code	MOD1	MOD2	Request Units	Department Use Only
81420	_____	_____	1	