



DeanHealthPlan®

A member of SSM Health

Coverage of any medical intervention discussed in a Dean 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
Hereditary Hemorrhagic Telangiectasia (HHT)**

MP9524

Covered Service: Yes

**Prior Authorization
Required:** Yes

**Additional
Information:** Genetic testing is covered for a Dean Health Plan member if the test results provide a direct medical benefit or guides reproductive decision-making for the Dean 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 the hereditary cardiomyopathies and arrhythmias.

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

A third-degree relative is defined as first cousins, great-aunts, great-uncles, great-grandchildren, or great-grandparents.

Reproductive carrier screening (prenatal testing) does not require prior authorization and is addressed per [MP9477](#)

Medicare Policy: Prior authorization is dependent on the member's Medicare coverage. Prior authorization is not required for Medicare Cost (Dean Care Gold) and Medicare Supplement (Select) when this service is provided by participating providers. Prior authorization is required if a member has Medicare primary and Dean Health Plan secondary coverage. This policy is not applicable to our Medicare Replacement products.

**BadgerCare Plus
Policy:** Dean Health Plan covers when BadgerCare Plus also covers the benefit.
<https://www.forwardhealth.wi.gov/WIPortal/Default.aspx>



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Dean Health Plan Medical Policy:

1.0 **Hereditary Testing for Hemorrhagic Telangiectasia (HHT)** also referred to as Osler-Weber-Rendu syndrome) such as **ACVRL1, ENG, GDF2 and SMAD4** gene testing individually or as part of a panel **requires prior authorization** through the Health Services Division and is considered medically necessary when **ANY** of the following are met:

- 1.1 Confirmation of diagnosis in member with **2 or more** of the following:
 - 1.1.1 Cutaneous or multiple mucosal telangiectasias at characteristic sites;
 - 1.1.2 Epistaxis that is spontaneous and recurrent;
 - 1.1.3 First-degree relative diagnosed with hereditary hemorrhagic telangiectasia according to Curacao criteria;
 - 1.1.4 Presence of brain, spinal cord, or visceral (e.g. lung, liver, pancreas, gastrointestinal tract) arteriovenous malformation
- 1.2 Predictive testing for asymptomatic child or young adult with **ANY** of the following:
 - 1.2.1 Disease-causing mutation in ACVRL1, ENG, GDF2 and SMAD4 gene has been identified in a relative;
 - 1.2.2 Parent has been diagnosed with hereditary hemorrhagic telangiectasia

2.0 All other indications not listed above are considered experimental and investigational, and therefore are not medically necessary.

CPT/HCPCS Codes Related to MP9524

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 Dean 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
81405	Molecular pathology procedure level 6
81406	Molecular pathology procedure level 7
81479	Unlisted molecular pathology procedure



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	Committee/Source	Date(s)
Document Created:	Medical Policy Committee/Quality and Care Management Division	June 20, 2018
Revised:	Medical Policy Committee/Health Services Division	January 16, 2019
	Medical Policy Committee/Health Services Division	March 20, 2019
	Medical Policy Committee/Health Services Division	June 19, 2019
	Medical Policy Committee/Health Services Division	December 18, 2019
	Medical Policy Committee/Health Services Division	June 17, 2020
Reviewed:	Medical Policy Committee/Health Services Division	January 16, 2019
	Medical Policy Committee/Health Services Division	March 20, 2019
	Medical Policy Committee/Health Services Division	June 19, 2019
	Medical Policy Committee/Health Services Division	December 18, 2019
	Medical Policy Committee/Health Services Division	June 17, 2020
	Medical Policy Committee/Health Services Division	June 16, 2021
	Medical Policy Committee/Health Services Division	June 15, 2022

Published/Effective: 07/01/2022