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.

Genetic Testing for Hereditary Hemorrhagic Telangiectasia (HHT) MP9524

Covered Service: Yes–when meets criteria below

Prior Authorization Required: Yes–as shown below

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.

Prevea360 Health Plan Medical Policy:

1.0 **Hereditary Testing for Hemorrhagic Telangiectasia (HHT** also referred to as Osler-Weber-Rendu syndrome**)** ACVRL1, ENG, and SMAD4 genes **require** prior authorization through the Quality and Care Management Division and is considered medically necessary when **ALL** 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 Visceral involvement such as lung, liver, gastrointestinal or cerebral arteriovenous malformations

1.2 Predictive testing for asymptomatic child or young adult with **1 or more** of the following:

1.2.1 Disease-causing mutation in ACVRL1, ENG, and SMAD4 gene has been identified in a relative; **or**

1.2.2 Parent has been diagnosed with hereditary hemorrhagic telangiectasia.

1.3 Prenatal diagnosis when disease-causing mutation in gene ACVRL1, ENG, and SMAD4 has been identified in a parent.

2.0 All other indications not listed above are considered investigational and experimental, 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 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
81405	Molecular pathology procedure level 6
81406	Molecular pathology procedure level 7
81479	Unlisted molecular pathology procedure

	Committee/Source	Date(s)
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Revised:		
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