The Catalyst Center
BU School of Social Work
Center for Innovation in Social Work & Health

Medical Necessity Webinar Series

NCC National Coordinating Center for the Regional Genetics Networks

Medical Necessity Webinar Series Part 2 - Medicaid and Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)- The Title V and Medicaid Relationship

Questions and Answers on the Live Webinar

Where can one find the specific coverage policies?

Answer shared on webinar: Google is your friend! Google [Health Plan] "Medical Policies". National payers have them published and many regional plans (like state blues) do too. Medicaid is trickier, because most states don't have specific policies, so you might look to the fee schedule by googling State Fee Schedule and looking for the laboratory fee schedule for relevant CPT codes. While not 100%- if a code is not on the fee schedule, it is rarely covered. Also we did try to upload relevant policies for microarray and exome for many health plans on the Heartland site.

My tip is to spend an afternoon gathering this information for the 5 health plans you see in your clinic and look at policies for the top 3 most common tests you order. And a brief description of their PA process if applicable. Kind of a cheat sheet.

What is the role of laboratory benefit managers here? Are they setting genetic testing policies for many commercial payers? And should we be looking at those policies as well?

Answer shared on webinar: Yes, we touched on this a bit last webinar but so glad you asked so we can bring this up again. Evicore, AIM specialty health, Avalon, MCG, and Evidence street write policies for many plans. BUT that should be obvious and accessible from the health plan medical policy site. They will either publish the policy or send you to the appropriate page.

There is absolutely an opportunity to provide feedback on policies either directly to health plans or LBMs, but I feel pretty strongly that this is not effective on a case-by-case basis (and leads to burnout). Instead, I think it's great if your clinic can gather case examples of how policy is off-base (even better if a group of facilities can work together) and request an audience with a health plan medical director. If they use an LBM, you can still ask for the health plan Medical Director and ask for an LBM representative, too. No harm in trying

If they meet medical necessity, are premium priced tests (WGS) typically fully covered? Are there scenarios where there is a co-insurance or co-pay? And if so, will those be reflected in policies?

Answer shared on webinar: Wonderful question! Even when a test is covered and then found to meet policy (i.e. authorized), there is still a risk of financial liability. This is entirely PLAN specific, so even if the provider has a policy, this person's PLAN may have a high deductible or

high co-insurance. Much like auto insurance, choice of plan by a person or their employer should come with a full explanation of coverage structure. I personally think it is outside the realm of possibility to expect providers to know and provide this information to all patients, but perhaps the no surprises act will change these expectations. Laboratories that provide a benefit investigation can be really helpful here, but I think those are rarer these days aren't they?