Policy Type	
ADMINISTRATIVE	

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health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

Administrative Policy Statements prepared by CareSource and its affiliates do not ensure an authorization or payment of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced in the Administrative Policy Statement. If there is a conflict between the Administrative Policy Statement and the plan contract (i.e., Evidence of Coverage), then the plan contract (i.e., Evidence of Coverage) will be the controlling document used to make the determination.

According to the rules of Mental Health Parity Addiction Equity Act (MHPAEA), coverage for the diagnosis and treatment of a behavioral health disorder will not be subject to any limitations that are less favorable than the limitations that apply to medical conditions as covered under this policy.

Table of Contents

The ADMINISTRATIVE Policy Statement detailed above has received due consideration as de

IV. The following are not considered medically necessary and will not be covered:
   A. repeat testing
   B. gene sequencing of anything other than the CFTR gene
   C. Fetal testing is generally not considered medically necessary. However, fetal testing is medically necessary with the presence of any of the following:
      1. Both parents have disease-causing mutations of the CFTR gene.
      2. Echogenic bowel is detected on ultrasound examination of fetus during pregnancy.
      3. The mother is a confirmed carrier, and father is unknown or unavailable for testing.

E. Conditions of Coverage

CareSource may request documentation for post-payment review of claims submitted for payment of CF testing. If documentation is not provided, CareSource may recoup previously paid claim(s).

F. Related Policies/Rules

Genetic Testing and Genetic Counseling

G. Review/Revision History

DATES		ACTION
Date Issued	09/02/2020	
Date Revised	07/20/2022 02/14/2024	Addition of Section D, IV and V. Annual review: changes to title, background, and definitions, expanded policy to include diagnostic testing, and updated references. Approved at Committee.
Date Effective	06/01/2024	
Date Archived		

H. References

1. Barben J, Castellani C, Munck A, et al. Updated guidance on the management of children with cystic fibrosis transmembrane conductance regulator-related metabolic syndrome/cystic fibrosis screen positive, inconclusive diagnosis (CRMS/CFSPID). *J Cyst Fibros*. 2021;20(5):810-819. doi:10.1016/j.jcf.2020.11.006
2. Bienvenu T, Lopez M, Girodon E. Molecular diagnosis and genetic counseling of cystic fibrosis and related disorders: new challenges. *Genes (Basel)*. 2020;11(6):619. doi:10.3390/genes11060619
3. Bombieri C, Claustres M, De Boeck K, et al. Recommendations for the classification of diseases as CFTR-related disorders. *J Cyst Fibros*. 2011;10(Suppl 2):S86-S102. doi:10.1016/S1569-1993(11)60014-3
4. Carrier. National Human Genome Research Institute. Updated October 15, 2023. Accessed December 28, 2023. www.genome.gov
5. Carrier testing for cystic fibrosis. Cystic Fibrosis Foundation. Accessed December 28, 2023. www.cff.org