Frequently Asked Questions

Who is Carelon Medical Benefits Management (Carelon MBM)?
Carelon Medical Benefits Management (Carelon MBM) is a leading specialty benefits management company with more than 30 years of experience. Our mission is to help ensure delivery of health care services are more clinically appropriate, safer, and more affordable. We promote the most appropriate use of specialty care services through the application of widely accepted clinical guidelines delivered via an innovative platform of technologies and services. One of the specialty areas that we manage is genetic testing. We review authorization requests for genetic testing services, although we are not responsible for reviewing or processing claims payments.

Who can submit a prior authorization through the Carelon MBM genetic testing program?
The ordering provider office should submit the request for an authorization prior to testing. Laboratories should verify that a preauthorization has been obtained prior to performing any service. Laboratories are not allowed to enter requests on a pre-service basis. For certain of our clients, laboratories are allowed to enter requests on a post-claim basis, which we refer to as our Post-Claims Clinical Appropriateness (PCCA) review program. Requests submitted on a post-claim basis are reviewed for clinical appropriateness by Carelon MBM, but review of the claim to verify payment eligibility for all other reasons is the responsibility of the health plan.

What happens if a prior authorization is not obtained prior to test initiation?
An ordering provider is permitted to submit a retrospective (pre-claim) review to Carelon MBM within a time period specified by the health plan, with 2 business days of the date of service (DOS) being the standard. A health plan may also delegate Carelon MBM to complete a PCCA review. Contact the health plan for details on their specific business rules.

If a sample has been obtained, can an authorization still be requested?
Most samples are stable for some time. For example, blood sample may be stable for weeks and DNA is stable for decades. For samples that are not stable long-term, such as those used for non-invasive prenatal testing (NIPT), a secondary sample may be required if authorization is not obtained prior to sample collection and the retro window has expired or the client does not allow PCCA reviews.

How are tests displayed within the Carelon MBM system?
Carelon MBM partners with laboratories to obtain their genetic testing test menus to facilitate the entering of authorization requests. Users will see each test tied to a single laboratory. Each test is tied to only one laboratory location provided to us by the health plan. If needed, the laboratory may be edited by the user. For further information on how to submit a case or edit the laboratory, please visit our provider website at https://providers.carelonmedicalbenefitsmanagement.com/genetictesting/.

There appear to be errors in the member and/or laboratory data. How can this be corrected?
Membership and provider files are controlled and provided by the health plan. Please reach out to the health plan directly with any related questions.

How do laboratories register their test menus to display in the Carelon MBM system?
Laboratories may contact DL-GeneticTestingSolution@carelon.com to inquire about test menu submissions.

Why might an individual test or an entire test menu not be displaying even though a test menu may have been submitted?
All tests are reviewed by a Carelon MBM board-certified genetic counselor prior to release to our production environment to ensure each test is tied to the correct coding and test category/subcategory combination. This ensures that each test is mapped to the appropriate clinical questions within the system. There are certain issues that may exist with a test menu that can only be corrected by the submitting laboratory. In this case, our test menu team contacts the laboratory to request that corrections be made and the test or test menu be resubmitted for review.

How does a laboratory request an update on the status of their test menu submission?
Laboratories may reach out to DL-GeneticTestingSolution@carelon.com to request an update on their test menu submission. Our test menu team documents all communications with laboratories regarding their test menu.

What do I do if the test is not found?
As always, users are able to manually add a test. A minimal amount of information is needed in order to manually add a test including test name, CPT codes and category/subcategory for that test. Once provided, the system will direct the user to clinical questions based on this information.

The clinical questions displayed do not seem appropriate for my request. What should I do?
Clinical questions are dependent on specific information related to the test requested or manually added. If they do not appear to be correct, the user will have an opportunity to provide additional clinical information prior to further review via free text and/or uploading additional clinical information. All requests that require additional review undergo a comprehensive review by a board-certified genetic counselor and/or Carelon physician reviewer. This review is not limited to responses to clinical questions but rather a thorough review of ALL clinical information provided.

Why do the clinical questions vary from one member request to the next even when the same test is requested?
The algorithm of questions is dependent on the answer to the previous question. Therefore, one cannot expect clinical questions to be uniform from one request to the next. In addition, our clinical team is continually working to update our clinical scenarios based on the most recent evidence based information available. Clinical questions and algorithms are updated accordingly.

If my request is covered under a Centers for Medicare & Medicaid Services (CMS) National Coverage Determination (NCD) or Local Coverage Determination (LCD), why is my request being denied?
NCDs and LCDs are the governing clinical criteria for Medicare requests but are not binding for requests involving other lines of business. If the request involves a Medicare member, a denial means that the applicable CMS criteria has not been met. This could include clinical criteria, network criteria or coding criteria. If the request does not involve a Medicare member, then the applicable clinical criteria that is the basis for the denial shall be listed in the determination letter.

Why is genetic counseling required for some tests when the clinical guidelines indicate that genetic counseling is recommended, not required?
While a clinical guideline may recommend genetic counseling in certain circumstances from a clinical appropriateness perspective, it is up to the health plan to determine the criteria for when benefits are payable. If a health plan requires genetic counseling in order for a genetic test to be covered, then Carelon MBM will include that requirement in its review.

Does Carelon MBM maintain documentation of the outcome of a review request?
Yes, Carelon MBM maintains documentation on all requests submitted and adjudicated. This information is also shared with the health plan.

Why didn't my claim get paid by the health plan?
Claim payment decisions are with the health plan. There are several reasons why a claim may not be paid, including failure to obtain a prior authorization, services not being medically necessary, improper billing of services, or member ineligibility. Each health plan will have a its own unique set of decision codes that will give you the reason for the denial on the explanation of payment (EOP).

Who do I contact if I have questions about claim payments?
Carelon MBM does not process or pay claims. Questions regarding claim payments should be directed to the health plan.
How is an appeal requested?
A health plan may delegate Carelon MBM to complete appeals of a utilization review request on their behalf. For those health plans that do not delegate this review to Carelon, the appeal is likely completed by the health plan themselves. Instructions on how to request an appeal are included with the determination letter. Carelon has no involvement in claims appeals.

What happens if a health plan issues a determination on a claim prior to the completion of review by Carelon MBM?
Carelon MBM adheres to applicable regulatory and/or contractual turnaround times (TAT) for all requests. If Carelon MBM is conducting a PCCA review for the health plan, then a claim determination should not occur until this process is completed. If this occurs, the laboratory should reach out to the health plan directly.

Does Carelon MBM provide regular training sessions?
Yes. Information and registration for our regular training session are available on our website at https://providers.carelonmedicalbenefitsmanagement.com/providerconnections/training/. For instructions on how to become a registered portal user and for more information regarding the Carelon MBM genetic testing program, please visit our provide site at https://providers.carelonmedicalbenefitsmanagement.com/genetictesting/.