Medical Necessity Guidelines:

Preimplantation Genetic Testing (PGT) for Harvard Pilgrim Commercial and Tufts Health Direct

Effective: September 1, 2024

Prior Authorization Required If REQUIRED, submit supporting clinical documentation pertinent to service request to the FAX numbers below	Yes ☒ No ☐
Notification Required IF REQUIRED, concurrent review may apply	Yes ☐ No ☒

Applies to:

Commercial Products

☒ Harvard Pilgrim Health Care Commercial products; 800-232-0816
☐ Tufts Health Plan Commercial products; 617-972-9409
CareLink℠ – Refer to CareLink Procedures, Services and Items Requiring Prior Authorization

Public Plans Products

☒ Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product); 888-415-9055
☐ Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans; 888-415-9055
☐ Tufts Health RITogether – A Rhode Island Medicaid Plan; 857-304-6404
☐ Tufts Health One Care—A dual-eligible product; 857-304-6304

Senior Products

☐ Harvard Pilgrim Health Care Stride Medicare Advantage; 866-874-0857
☐ Tufts Health Plan Senior Care Options (SCO), (a dual-eligible product); 617-673-0965
☐ Tufts Medicare Preferred HMO, (a Medicare Advantage product); 617-673-0965
☐ Tufts Medicare Preferred PPO, (a Medicare Advantage product); 617-673-0965

Note: While you may not be the provider responsible for obtaining prior authorization or notifying Point32Health, as a condition of payment you will need to ensure that any necessary prior authorization has been obtained and/or Point32Health has received proper notification. If notification is required, providers may additionally be required to provide updated clinical information to qualify for continued service.

Overview

Preimplantation genetic testing (PGT) is a technique used in conjunction with in vitro fertilization (IVF) to test embryos for specific genetic disorders prior to their transfer to the uterus. PGT makes it possible for couples or individuals who have or who carry a serious inherited disorder to decrease the risk of passing the disorder on to their child. PGT is performed in centers where expertise in genetic counseling, molecular genetics, and embryology coexist. The decision to perform PGT should be made in conjunction with genetic counseling to discuss the benefits and limitations of PGT, including potential diagnostic errors.

PGT can be performed to detect aneuploidy (PGT-A), monogenic (single-gene) disorders (PGT-M), or structural rearrangements (PGT-S).

Clinical Guideline Coverage Criteria

The Plan may authorize PGT-monogenic (PGT-M) and PGT-structural rearrangements (PGT-S) to test embryos for specific genetic disorders as part of in vitro fertilization when the coverage criteria for PGT-M and PGT-S outlined in the

Carelon Clinical Appropriateness Guidelines for Genetic Testing for Inherited Conditions.
Carelon Clinical Appropriateness Guidelines

Limitations

PGT-aneuploidy (PGT-A) is not a covered service for preimplantation genetic testing.

Codes

The following code(s) are managed by Carelon:

Table 1: CPT/HCPCS Codes

Code	Description
89290	Biopsy, oocyte polar body or embryo blastomere, microtechnique (for pre-implantation genetic diagnosis); less than or equal to 5 embryos
89291	Biopsy, oocyte polar body or embryo blastomere, microtechnique (for pre-implantation genetic diagnosis); greater than 5 embryos

Approval And Revision History

April 21, 2024: Reviewed by the Medical Policy Approval Committee (MPAC). Custom Criteria to be created for Carelon use for effective date of September 1, 2024.

Background, Product and Disclaimer Information

Medical Necessity Guidelines are developed to determine coverage for benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. We make coverage decisions using these guidelines, along with the Member's benefit document, and in coordination with the Member's physician(s) on a case-by-case basis considering the individual Member's health care needs.

Medical Necessity Guidelines are developed for selected therapeutic or diagnostic services found to be safe and proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in our service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. We revise and update Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern. For Tufts Health Together (Medicaid), coverage may be available beyond these guidelines for pediatric members under age 21 under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits of the plan in accordance with 130 CMR 450.140 and 130 CMR 447.000, and with prior authorization.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this guideline is not a guarantee of payment, or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to eligibility and benefits on the date of service, coordination of benefits, referral/authorization, utilization management guidelines when applicable, and adherence to plan policies, plan procedures, and claims editing logic.