


MEDICAL POLICY		Genetic Testing: Diagnostic Evaluation of Interstitial Lung Disease (Medicare Only)	
Effective Date: 1/1/2021		Section: GT	Policy No: 444
 <div style="text-align: right;">1/1/2021</div>		Medical Policy Committee Approved Date: 5/2020; 12/2020	
		Medical Officer	Date

See Policy CPT/HCPCS CODE section below for any prior authorization requirements

SCOPE:

Providence Health Plan, Providence Health Assurance, Providence Plan Partners, and Ayin Health Solutions as applicable (referred to individually as “Company” and collectively as “Companies”).

APPLIES TO:

Medicare Only

MEDICARE POLICY CRITERIA

The following Centers for Medicare & Medicaid Service (CMS) guidelines should be utilized for medical necessity coverage determinations. Click the link provided in the table below to access applicable medical necessity criteria. All listed guidelines apply.

Service	Medicare Guidelines
<i>Envisia® Genomic Classifier for diagnostic evaluation of interstitial lung disease</i>	Local Coverage Determination (LCD): MoIDX: Envisia, Veracyte, Idiopathic Pulmonary Fibrosis Diagnostic Test (L37891) ¹

BILLING GUIDELINES

Please see Local Coverage Article (LCA): Billing and Coding: MoIDX: Envisia, Veracyte, Idiopathic Pulmonary Fibrosis Diagnostic Test ([A57420](#))²

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CPT/HCPCS CODES

Medicare Only	
Prior Authorization Required	
81554	Pulmonary disease (idiopathic pulmonary fibrosis [IPF]), mRNA, gene expression analysis of 190 genes, utilizing transbronchial biopsies, diagnostic algorithm reported as categorical result (eg, positive or negative for high probability of usual interstitial pneumonia [UIP])
Unlisted Codes	
All unlisted codes will be reviewed for medical necessity, correct coding, and pricing at the claim level. If an unlisted code is billed related to services addressed in this policy then it will be denied as not covered .	
81479	Unlisted molecular pathology procedure

INSTRUCTIONS FOR USE

Company Medical Policies serve as guidance for the administration of plan benefits. Medical policies do not constitute medical advice nor a guarantee of coverage. Company Medical Policies are reviewed annually and are based upon published, peer-reviewed scientific evidence and evidence-based clinical practice guidelines that are available as of the last policy update. The Companies reserve the right to determine the application of Medical Policies and make revisions to Medical Policies at any time. Providers will be given at least 60-days notice of policy changes that are restrictive in nature.

The scope and availability of all plan benefits are determined in accordance with the applicable coverage agreement. Any conflict or variance between the terms of the coverage agreement and Company Medical Policy will be resolved in favor of the coverage agreement.

REGULATORY STATUS

Mental Health Parity Statement

Coverage decisions are made on the basis of individualized determinations of medical necessity and the experimental or investigational character of the treatment in the individual case. In cases where medical necessity is not established by policy for specific treatment modalities, evidence not previously considered regarding the efficacy of the modality that is presented shall be given consideration to determine if the policy represents current standards of care.

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REFERENCES

1. Local Coverage Determination (LCD): MoIDX: Envisia, Veracyte, Idiopathic Pulmonary Fibrosis Diagnostic Test (L37891). 2019; <https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=37891>. Accessed 4/2/2020.
2. Local Coverage Article (LCA): Billing and Coding: MoIDX: Envisia, Veracyte, Idiopathic Pulmonary Fibrosis Diagnostic Test (A57420) 2019; <https://www.cms.gov/medicare-coverage-database/details/article-details.aspx?articleId=57420>. Accessed 4/2/2020.