ADMINISTRATIVE POLICY STATEMENT
INDIANA MEDICAID

Policy Name		Policy Number	Date Effective
Cystic Fibrosis Carrier Testing		AD-0841	01/01/2021-12/31/2022
Policy Type			
Medical	**ADMINISTRATIVE**	Pharmacy	Reimbursement

Administrative Policy Statements prepared by CareSource and its affiliates are derived from literature based on and supported by clinical guidelines, nationally recognized utilization and technology assessment guidelines, other medical management industry standards, and published MCO clinical policy guidelines. Medically necessary services include, but are not limited to, those 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.

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A. Subject

Cystic Fibrosis Carrier Testing

B. Background

Cystic Fibrosis is a genetic disorder that causes the body to make thick, sticky secretions that clog the lungs and other organs such as the digestive system. More than 10 million Americans are carriers of a defective cystic fibrosis gene and show no symptoms of the disease. Cystic fibrosis is a recessive disorder, therefore an abnormal gene must be inherited from both parents in order for the child to develop the disease. Carrier testing may provide an early indication as to whether a fetus might either be a carrier or might have cystic fibrosis.

C. Definitions

- **Carrier –** An individual that exhibits a genetic change that can result in a disease or disorder. The carrier usually has no signs of the disorder but can pass the genetic variation on to their children who may become a carrier, not inherit the gene, or develop the disease.
- **Autosomal Recessive-** Describes a trait or disorder requiring the presence of two copies of a gene mutation (one from each parent) at a particular locus in order to express observable phenotype of the disorder.
- **Prenatal Testing-**Testing that is done prior to birth, to identify changes in genes or chromosomes in embryos or fetuses to identify any potential genetic or chromosomal disorders
- **Prenatal Screening-** A non-invasive process of analysis using blood to identify the risk of a woman carrying a fetus with a chromosome abnormality or birth defect.

D. Policy

I. Prior authorization is not required for Cystic Fibrosis genetic testing.
   A. Cystic fibrosis testing should be performed once in a lifetime.

II. Genetic counseling is strongly suggested at the time of testing for the disorder.
   A. Counseling should be provided by a healthcare professional with knowledge, education and training in the genetic issue relevant to this disorder.

III. Carrier testing is for an individual who is female and who is pregnant or of reproductive age with intent and potential to procreate and has consented to the test.

E. Conditions of Coverage

F. Related Policies/Rules

Genetic Testing and Genetic Counseling MM-0737

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G. Review/Revision History

DATES		ACTION
Date Issued	**09/02/2020**	New Policy
Date Revised		
Date Effective	**01/01/2021**	
Date Archived	**12/31/2022**	This Policy is no longer active and has been archived. Please note that there could be other Policies that may have some of the same rules incorporated and CareSource reserves the right to follow CMS/State/NCCI guidelines without a formal documented Policy.

H. References

1. Cystic Fibrosis Foundation "Carrier Testing for CF" retrieved August 24,2020 from www.cff.org
2. Langfelder-Schwind, E., Karczeski, B., Strecker, M.N., Redman, J., Sugarman, E.A., Zaleski, C., Darrah, R (2014) *Molecular Testing for Cystic Fibrosis Carrier Status Practice Guidelines:* recommendations of the National Society for Genetic Counselors, retrieved June 20, 2019 from www.onlinelibrary.wiley.com
3. Grody WW, Cutting GR, Klinger KW, et al and the American College of Medical Genetics Accreditation of Genetic Services Committee, Subcommittee on Cystic Fibrosis Screening. Laboratory Standards and Guidelines for Population based Cystic Fibrosis Carrier Screening. American College of Medical Genetics Policy Statements. Genetic Med. 2001; 3(2):149-154.

The Administrative Policy Statement detailed above has received due consideration as defined in the Administrative Policy Statement Policy and is approved.

IN-MED-P-270977 Issue Date 09/02/2020 OMPP Approved 10/06/2020

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