FETAL ANEUPLOIDY

Policy Number: CP-IFP21-017A Effective Date: January 1, 2022

*The purpose of Maternal Plasma Tests for Detection of Cell-Free Fetal DNA for Analysis of Chromosomal Aneuploidies is to provide an assessment of the woman's **risk** of carrying a fetus with one of the more common fetal aneuploidies.*

DISCLAIMER

Coverage Policies are developed to assist in identifying coverage for UCare benefits under UCare's health plans. They are intended to serve only as a general reference regarding UCare's administration of health benefits and are not intended to address all issues related to coverage for health services provided to UCare members.

These services may or may not be covered by all UCare products (refer to product section of individual coverage policy for product-specific detail). Providers are encouraged to have their UCare patient refer to their UCare plan documents (Evidence of Coverage/Member Handbook/Member Contract) for specific coverage information. If there is a conflict between a coverage policy and the UCare plan documents, the Ucare plan documents prevail.

Coverage Policies do not constitute medical advice. Providers are responsible for submission of accurate and compliant claims.

PRODUCT SUMMARY

This coverage policy applies to the following UCare products:

UCARE PRODUCT	APPLIES TO
Individual and Family Plans (IFP), IFP with M Health Fairview	✓
UCare Medicare Plans, UCare Medicare with M Health Fairview and North Memorial, UCare Advocate (I-SNP), EssentiaCare	
Minnesota Senior Health Options (MSHO)	
UCare Prepaid Medical Assistance (PMAP), MNCare	
Connect	
Connect +Medicare	
MSC +	

Benefit Category: LABORATORY SERVICES

Definitions

Aneuploidy – a condition in which a cell has an incorrect number of chromosomes.

Fetal Aneuploidy - a condition where the fetus has one or more extra or missing chromosomes leading to either a nonviable pregnancy, offspring that may not survive after birth, or surviving newborn with congenital birth defects and functional abnormalities.

Fetal aneuploidy screening is designed to assess whether a patient is at increased risk of having a fetus affected by a genetic disorder. Cell-free DNA is the most sensitive and specific screening test for the common fetal aneuploidies.

Prenatal *diagnostic testing* for genetic disorders is:

- Not the same thing as aneuploidy *screening*
- Fetal chromosomes are evaluated for the presence or absence of abnormalities in chromosome number, deletions, and duplications, or
- fetal DNA is evaluated for *specific* genetic disorders.

Genetic counseling is the education of patients and families about prenatal diagnosis of illnesses caused by genetic disorders; diagnosis and management of children who may be born genetic conditions that cause birth defects or affect normal growth and development.

Coverage Policy

Covered

- Pregnant persons with a singleton pregnancy, regardless of maternal age or risk of chromosomal abnormality should be offered prenatal genetic screening for fetal aneuploidy (i.e., trisomy 13, 18 and/or 21)
    - Serum screening with or without nuchal translucency (NT) ultrasound
    - Cell-free DNA
- Testing is recommended with each pregnancy.
- Genetic counseling and Chorionic Villus Sampling (CVS) or second-trimester amniocentesis should be offered to women who are found to have an increased risk of aneuploidy to discuss the risks of fetal abnormalities but also the relative limitations of available tests.
    - *Chorionic Villus Sampling (CVS) and amniocentesis are not part of routine prenatal care and would be covered under the applicable benefit for diagnostic laboratory services.*

Non covered

- For all uses other than the detection of fetal trisomy of 13, 18, and 21 (including, but not limited to: unbalanced translocations, microdeletions and duplications).
- For determination of fetal sex.
- Repeat screening for women with negative screening results.
- Testing in the presence of multiple fetuses.
- Testing with multiple screening methodologies for fetal aneuploidy.

CPT/ HCPCS/ICD-10 Codes ***Note: The following codes will be considered for coverage when criteria is met. Codes listed below do not guarantee member coverage or provider reimbursement. Coverage is determined when the claim is processed. This list may not be all-inclusiv.***

CPT®, HCPCS or ICD-10 CODES	MODIFIER	NARRATIVE DESCRIPTION
81420		Fetal chromosomal aneuploidy (e.g., trisomy 21, monosomy X) genomic sequence analysis panel, circulating cell-free fetal DNA in maternal blood, must include analysis of chromosomes 13, 18, and 21
81507		Fetal aneuploidy (trisomy 21, 18, and 13) DNA sequence analysis of selected regions using maternal plasma, algorithm reported as a risk score for each trisomy.

*CPT is a registered trademark of the American Medical Association.

Prior Authorization

Not required

References and Source Documents

LINKS TO UCARE CONTRACT, CMS, MHCP, MINNESOTA STATUTE AND OTHER RELEVANT DOCUMENTS USED TO CREATE THIS POLICY.

ACOG Practice Bulletin 226, *Screening for Fetal Chromosomal Abnormalities October , 2020*
https://www.acog.org/clinical/clinical-guidance/practice-bulletin/articles/2020/10/screening-for-fetal-chromosomal-abnormalities

2022 Individual and Family Plan (IFP) member contract
https://home.ucare.org/en-us/health-plans/ifp/

Coverage Policy Development and Revision History

VERSION	DATE	NOTE
V1		New policy