Genomic and Molecular Biomarker Testing for Cancer

Humana.
Medicaid Medical Coverage Policy

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Scope

This policy applies to all physical and behavioral health prior authorization requests received by Humana Healthy Horizons in Ohio.

Policy

Humana Healthy Horizons in Ohio uses established criteria guidelines to make medical necessity decisions and follows the below procedure. Decisions are made on a case-by-case basis, utilizing the information provided about the member's health status and an assessment of the local delivery system. Emergent services do not require a referral or preauthorization.

The Plan covers all benefits and services required in Ohio Administrative Code (OAC) chapter 5160 in the amount, duration, and scope for the same services furnished to members under the fee-for-service (FFS) Medicaid.

When the plan receives a request for a primary code that requires prior authorization and the primary code is denied for lack of medical necessity, any related secondary codes submitted on the authorization request will be denied based on lack of medical necessity. When a primary code is approved, related secondary codes requiring prior authorization will be reviewed individually for medically necessity determinations.

Please see Ohio Medicaid Prior Authorization and Notification List for a list of CPT and HCPCS codes that require prior authorization.

Humana Healthy Horizons in Ohio will review requested non-MCO covered codes and services as required for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) for medical necessity to ensure children and adolescents receive appropriate and preventative, dental, mental health, developmental and specialty services.

Humana Healthy Horizons in Ohio does not cover services, items or devices that have not been approved by the Food and Drug Administration (FDA). Other factors affecting reimbursement supersede this policy. These factors include but are not limited to Federal and/or State statutes and regulations, the State Plan, the MCE Manual, physician or other provider contracts, the beneficiaries' benefit coverage documents, and/or other reimbursement, medical or drug policies.

Providers may submit authorization request(s) through the provider portal. A provider may request an urgent prior authorization in situations where the provider considers a delay in providing services, supplies or prescription drugs requiring prior authorization to be detrimental to the health of the member. The absence of authorization and/or notification prior to the date of a service could result in financial penalties for the practice and reduced benefits for the member, based on the healthcare provider's contract and the member's Certificate of Coverage. Services or medications provided without preauthorization may be subject to retrospective medical necessity review. We recommend individual practitioners making specific requests for services or medications verify benefits and preauthorization requirements with Humana prior to providing services.

Medical necessity documentation and rationale must be submitted with the prior authorization request. Providers may access physical and behavioral clinical coverage policies and medical necessity criteria at the below links.

Physical Health:
www.humana.com/provider/medical-resources/ohio-medicaid/physical-health-clinical-coverage-policies

Behavioral Health:
www.humana.com/provider/medical-resources/ohio-medicaid/behavioral-health-clinical-coverage-policies

Members may request a copy of the medical necessity criteria by calling member services at 877-856-5702 (TTY:711), Monday-Friday, 7AM to 8PM EST.

Providers may request a copy of the medical necessity criteria by calling provider services at 877-856-5707 (TTY:711), Monday-Friday, 7AM to 8PM EST or emailing the request to ODMCDUM@humana.com.

Procedures

1. The Plan uses the following hierarchy of guidelines to review for medical necessity:
   - 1.1 Federal or state regulation, including medical criteria published in the Ohio Administrative Code, Chapter 5160.
   - 1.2 Nationally accepted evidence based clinical guidelines: MCG (formerly Milliman Care Guidelines), American Society of Addiction Medicine (ASAM) Level of Care Adolescent Guidelines and American Society of Addiction Medicine (ASAM) Patient Placement Criteria (ASAM Admission Guidelines).
   - 1.3 Humana Healthy Horizons™ in Ohio clinical policies
   - 1.4 In the case of no guidance from above, additional information that the clinical reviewer will consider, when available, includes;
     - 1.4.1 Clinical practice guidelines and reports from peer reviewed medical literature, from which a higher level of evidence and study quality is more strongly considered in determinations;
     - 1.4.2 Professional standards for safety and effectiveness recognized in the US for diagnosis, care, or treatment;
     - 1.4.3 Medical association publications;
     - 1.4.4 Government-funded or independent entities that assess and report on clinical care; Decision and technology such as Agency for Healthcare Research and Quality (AHRQ), Hayes Technology Assessment, Up-To-Date, Cochrane Reviews, National Institute for Health and Care Excellence (NICE), etc.;
     - 1.4.5 Published expert opinions;
     - 1.4.6 Opinion of health professionals in the area of specialty involved;
     - 1.4.7 Opinion of attending provider;
   - 1.5 Dental: DentaQuest coverage guidelines and policies
     Dental Coverage - Humana Healthy Horizons in Ohio | Humana
   - 1.6 Vision: EyeMed coverage guidelines and policies
     Vision Care - Humana Healthy Horizons - Ohio Medicaid | Humana

HEMATOLOGIC MALIGNANCIES AND SUSPECTED MYELOID DISORDERS
Comprehensive Genomic Profiling/Multigene Panel Testing

Description

Comprehensive genomic profiling (CGP) (also referred to as comprehensive molecular profiling) is a type of test that involves a combination of laboratory methodologies to detect genetic alterations and biomarkers in blood or bone marrow to aid in the management of hematologic malignancies and suspected myeloid disorders. Testing is performed by removing a small sample of tissue for evaluation (eg, bone marrow biopsies, bone marrow aspirates, bone marrow clots), blood draw (peripheral blood samples), or sites located outside of the bone marrow (extramedullary) suspected of harboring a myeloid malignancy. Techniques can vary from test to test and may include but are not limited to, next-generation sequencing (NGS), fluorescence in situ hybridization (FISH) and immunohistochemistry (IHC). Examples of CGP tests include, but are not limited to, **FoundationOne Heme and Neogenomics myeloid and/or heme panels.**

Optical genome mapping (OGM) is a laboratory technique used to analyze long stretches of DNA allowing a broad view of the genome to detect large structural variations. This type of test may be able to detect changes that other assays may miss such as deletions, duplications, insertions, inversions and translocations. OGM has been proposed for use in hematologic malignancies and include tests such as **Augusta Hematology Optical Genome Mapping** and **DH Optical Genome Mapping/Digital Karyotyping Assay.**

Coverage Determination

Comprehensive Genomic Profiling or Multigene Panel Testing for Hematologic Malignancies and Suspected Myeloid Disorders

Humana members may be eligible under the Plan for **comprehensive genomic profiling or multigene panel testing (81450, 81455, 81456)** for any of the following indications**:**

- Cancer of the blood and bone marrow (eg, acute myelogenous leukemia [AML])[14]; **OR**
- Myelodysplastic syndrome (MDS)[15]; **OR**
- Myeloproliferative neoplasms (MPNs) which include polycythemia vera (PV), essential thrombocythemia (ET) or primary myelofibrosis (PMF)[16], **OR**
- Suspected myeloid malignancy (does not have a diagnosis of cancer) with undefined cytopenia***** for greater than four months without a known cause[13]; **OR**
- Systemic mastocytosis[18]

*****Clinical, laboratory and pathologic assessment are nondiagnostic (such as demonstration of persistent cytopenias [eg, four months] by complete blood count, microscopic examination of a bone marrow biopsy

and bone marrow cytogenetic studies. Other than the clinical feature of the number of cytopenias and specific cytogenetic changes found recurrently in myelodysplastic syndrome [MDS], all other diagnostic criteria in MDS rely upon light microscopy findings).[13]

Coverage Limitations

Humana members may **NOT** be eligible under the Plan for **optical genome mapping (81195)** including, but not limited to:

- Augusta Hematology Optical Genome Mapping (0331U)
- DH Optical Genome Mapping/Digital Karyotyping Assay (0413U)

A review of the current medical literature shows that there is **no evidence** to determine that these services are standard medical treatments. There is an absence of current, widely-used treatment guidelines or acceptable clinical literature examining benefit and long-term clinical outcomes establishing the value of these services in clinical management.

Coding Information

Any codes listed on this policy are for informational purposes only. Do not rely on the accuracy and inclusion of specific codes. Inclusion of a code does not guarantee coverage and/or reimbursement for a service or procedure.

CPT® Code(s)	Description	Comments
81450	Hematolymphoid neoplasm or disorder, genomic sequence analysis panel, 5-50 genes, interrogation for sequence variants, and copy number variants or rearrangements, or isoform expression or mRNA expression levels, if performed; DNA analysis or combined DNA and RNA analysis	
81455	Solid organ or hematolymphoid neoplasm or disorder, 51 or greater genes, genomic sequence analysis panel, interrogation for sequence variants and copy number variants or rearrangements, or isoform expression or mRNA expression levels, if performed; DNA analysis or combined DNA and RNA analysis	
81456	Solid organ or hematolymphoid neoplasm or disorder, 51 or greater genes, genomic sequence analysis panel, interrogation for sequence variants and copy number variants or rearrangements, or isoform expression or mRNA expression levels, if performed; RNA analysis	

CPT® Category III Code(s)	Description	Comments
No code(s) identified		
HCPCS Code(s)	**Description**	**Comments**
No code(s) identified		

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16. National Comprehensive Cancer Network (NCCN). NCCN Clinical Practice Guidelines in Oncology. Myeloproliferative neoplasms. https://nccn.org. Updated February 21, 2025.

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19. Ohio Administrative Code 5160-1-01 Medicaid medical necessity: definitions and principles. Rule 5160-1-01 - Ohio Administrative Code | Ohio Laws.

20. Ohio Administrative Code 5160-26-01 Managed care: definitions. Rule 5160-26-01 - Ohio Administrative Code | Ohio Laws.

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HEMATOLOGIC MALIGNANCIES AND SUSPECTED MYELOID DISORDERS
Single Gene Testing

Description

Single gene testing may also be performed for hematologic malignancies and suspected myeloid disorders and may be indicated for an individual who exhibits disease symptoms and may be necessary to diagnose or rule out suspected cancer or monitor known cancer. These include, but are not limited to, *ASXL1, BTK, CCND1, CEBPA, EZH2, IDH1, IDH2, MYD88, NPM1, PLCG2, RUNX1, SF3B1, SRSF2, U2AF1,* and *ZRSR2*.

Coverage Determination

***ASXL1* Gene Testing**
Humana members may be eligible under the Plan for ***ASXL1* gene testing (81175/81176)** for any of the following indications:

- AML (includes acute promyelocytic leukemia [APL]); **OR**
- Blastic plasmacytoid dendritic cell neoplasm (BPDCN); **OR**
- Chronic myeloid leukemia (CML) [14]; **OR**
- Myelodysplastic syndrome (MDS); **OR**
- Myeloproliferative neoplasms (MPN); **OR**
- Suspected myeloid malignancy with undefined cytopenia*****; **OR**
- Systemic mastocytosis

***EZH2* Gene Testing**
Humana members may be eligible under the Plan for ***EZH2* gene testing (81237)** for any of the following indications:

- AML (includes APL); **OR**
- Diffuse large b-cell lymphoma; **OR**
- Follicular lymphoma to determine benefit of treatment with tazemetostat (Tazverik) performed with an FDA-approved test; **OR**
- MDS; **OR**
- MPNs

Coverage Limitations

There are no limitations; refer to Coverage Determination Section.

Coding Information

Any codes listed on this policy are for informational purposes only. Do not rely on the accuracy and inclusion of specific codes. Inclusion of a code does not guarantee coverage and/or reimbursement for a service or procedure.

CPT® Code(s)	Description	Comments
81175	ASXL1 (additional sex combs like 1, transcriptional regulator) (eg, myelodysplastic syndrome, myeloproliferative neoplasms, chronic myelomonocytic leukemia), gene analysis; full gene sequence	
81176	ASXL1 (additional sex combs like 1, transcriptional regulator) (eg, myelodysplastic syndrome, myeloproliferative neoplasms, chronic myelomonocytic leukemia), gene analysis; targeted sequence analysis (eg, exon 12)	
81237	EZH2 (enhancer of zeste 2 polycomb repressive complex 2 subunit) (eg, diffuse large B-cell lymphoma) gene analysis, common variant(s) (eg, codon 646)	
CPT® Category III Code(s)	**Description**	**Comments**
No code(s) identified		
HCPCS Code(s)	**Description**	**Comments**
No code(s) identified		

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12. National Comprehensive Cancer Network (NCCN). NCCN Clinical Practice Guidelines in Oncology. Myeloproliferative neoplasms. https://nccn.org. Updated February 21, 2025.

13. National Comprehensive Cancer Network (NCCN). NCCN Clinical Practice Guidelines in Oncology. Systemic light chain amyloidosis. https://nccn.org. Updated June 11, 2025.

14. National Comprehensive Cancer Network (NCCN). NCCN Clinical Practice Guidelines in Oncology. Systemic mastocytosis. https://nccn.org. Updated February 21, 2025.

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17. Ohio Administrative Code 5160-1-01 Medicaid medical necessity: definitions and principles. Rule 5160-1-01 - Ohio Administrative Code | Ohio Laws.

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SOLID TUMORS
Comprehensive Genomic Profiling and Multigene Panel Testing

Description

Comprehensive genomic profiling (CGP) (also referred to as comprehensive molecular profiling or tumor profiling) is a laboratory diagnostic method used to analyze the genetic makeup of solid tumors. CGP examines a wide range of genetic variations including mutations, insertions, deletions, amplifications and rearrangements across hundreds of genes. CGP can help guide targeted treatment options. Some CGP tests analyze DNA to detect genetic alterations. These DNA-based tests focus on identifying somatic mutations which occur in tumor cells and are not inherited. Examples include, but are not limited to, **Guardant360 TissueNext, MSK-IMPACT, Oncotype MAP Pan-Cancer Tissue Test and PGDx elio tissue complete**.

Optical genome mapping, transcriptome, whole exome sequencing (WES) and **whole genome sequencing (WGS)** are other laboratory methods that have been proposed to profile tumors. These techniques purportedly identify genetic variants in an individual's cancer cells to potentially identify actionable genomic mutations to assist with selection of targeted therapies to treat cancer. Examples include, but are not limited to, **EXaCT-1 Whole Exome Sequencing, Praxis Somatic Combined Whole Genome Sequencing and Optimal Genome Mapping, Praxis Somatic Transcriptome** and **Praxis Somatic Whole Genome Sequencing**.

Coverage Determination

Comprehensive Genomic Profiling

Humana members may be eligible under the Plan for **comprehensive genomic profiling for solid tumors (81455, 81456)** for any of the following tests when the criteria below are met:

- ExaCT-1 Whole Exome Testing; **OR**
- Guardant360 Tissue Next; **OR**
- MSK-IMPACT; **OR**
- Oncotype MAP PanCancer Tissue Test; **OR**
- Oncomap ExTra; **OR**
- PGDx elio tissue complete;

AND both of the following:

- Individual to be tested has been diagnosed with recurrent, relapsed, refractory, metastatic, or advanced stage III or IV cancer; **AND**

- Individual has decided to seek further cancer treatment (eg, therapeutic chemotherapy)

Coverage Limitations

There are no limitations; refer to Coverage Determination Section.

Coding Information

Any codes listed on this policy are for informational purposes only. Do not rely on the accuracy and inclusion of specific codes. Inclusion of a code does not guarantee coverage and/or reimbursement for a service or procedure.

CPT® Code(s)	Description	Comments
81455	Solid organ or hematolymphoid neoplasm or disorder, 51 or greater genes, genomic sequence analysis panel, interrogation for sequence variants and copy number variants or rearrangements, or isoform expression or mRNA expression levels, if performed; DNA analysis or combined DNA and RNA analysis	
81456	Solid organ or hematolymphoid neoplasm or disorder, 51 or greater genes, genomic sequence analysis panel, interrogation for sequence variants and copy number variants or rearrangements, or isoform expression or mRNA expression levels, if performed; RNA analysis	
CPT® Category III Code(s)	**Description**	**Comments**
No code(s) identified		
HCPCS Code(s)	**Description**	**Comments**
No code(s) identified		

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51. Ohio Administrative Code 5160-26-01 Managed care: definitions. Rule 5160-26-01 - Ohio Administrative Code | Ohio Laws.

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Definitions

1. Adverse Benefit Determination – As defined in OAC rule 5160-26-01, is a managed care entity's (MCEs):
   1) Denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit;
   2) Reduction, suspension, or termination or services prior to the member receiving the services previously authorized by the MCE;
   3) Failure to provide services in a timely manner as specified in rule 5160-26-03.1 of the Administrative Code;
   4) Failure to act within the resolution timeframes specified in rule 5160-26-08.4 of the Administrative Code;
   5) Denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities, if applicable; or
   6) Denial, in whole or part, of payment for a service. A denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of a "clean claim" as defined in 42 C.F.R. 447.45(b) (October 1, 2021) is not an adverse benefit determination).
2. American Society of Addiction Medicine (ASAM) – a professional medical society representing over 7,000 physicians, clinicians, and associated professionals in the field of addiction medicine. ASAM produces a comprehensive set of standards for placement, continued stay, transfer or discharge of patients with addiction and co-occurring conditions used by clinical staff to determine whether to refer a service request for physician review based upon the clinical information submitted by the requestor.
3. MCG – are nationally recognized guidelines used by clinical staff to determine whether to refer a service request for physician review based upon the clinical information submitted by the requestor.
4. Medically Necessary or Medical Necessity – Has the same meaning as OAC rule 5160-1-01:
   A. Medical necessity for individuals covered by early and periodic screening, diagnosis, and treatment (EPSDT) is criteria of coverage for procedures, items, or services that prevent, diagnose, evaluate, correct, ameliorate, or treat as adverse health condition such as an illness, injury, disease or its symptoms, emotional or behavioral dysfunction, intellectual deficit, cognitive impairment, or developmental disability.
   B. Medical necessity for individuals not covered by EPSDT is criteria of coverage for procedures, items, or services that prevent, diagnose, evaluate or treat an adverse health condition such as an illness, injury, disease or its symptoms, emotional or behavioral dysfunction, intellectual deficit, cognitive impairment, or developmental disability and without which the person 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.
   C. Conditions of medical necessity for a procedure, item, or service are met all the following apply:
      1) It meets generally accepted standards of medical practice;
      2) It is clinically appropriate in its type, frequency, extent, duration, and delivery setting;

3) It is appropriate to the adverse health condition for which it is provided and is expected to produce the desired outcome;
4) It is the lowest cost alternative that effectively addresses and treats the medical problem;
5) It provides unique, essential, and appropriate information if it is used for diagnostic purposes; and
6) It is not provided primarily for the economic benefit of the provider nor for the sole convenience of the provider or anyone else other than the recipient.

D. The fact that a physician, dentist, or other licensed practitioner renders, prescribes, orders, certifies, recommends, approves, or submits a claim for a procedure, item, or service does not, in and of itself make the procedure, item, or service medically necessary and does not guarantee payment.
E. The definition and conditions of medical necessity articulated in this rule apply throughout the entire medicaid program. More specific criteria regarding the conditions of medical necessity for particular categories of service may be set forth within the Ohio Department of Medicaid (ODM) coverage policies or rules.

Change Summary

08/05/2025 New Policy.