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Medicaid Alert

MA-2024-02 **November 2024**

TO: All Providers **– For Action**
Managed Care Organizations **– For Information Only**

SUBJECT: **Revision to the Genetic Supporting Information Form (FD-431)**

EFFECTIVE: Immediately

PURPOSE: To notify all providers of a revision to the Genetic Supporting Information Form (FD-431)

BACKGROUND: In the Medicaid Newsletter Volume 32, No. 22, dated August 2022, DMAHS provided important billing procedures and general guidelines for providers for gene assay testing claims. The Newsletter announced a requirement that providers of genetic assay testing complete and attach the **Genetic Supporting Information Form** (**FD-431**) when submitting claims for genetic assay testing.

In response to provider concerns, the Division is amending the FD-431 Form and offering providers the opportunity to submit gene assay test information with fee-for-service claims using other acceptable forms, as described below.

ACTION: **Effective Immediately**, the following amended billing procedures shall apply to claims for gene assay testing services.

- Providers who continue to use the FD-431 must report the "**Date Ordered**" and not the **"Date of Service"** on the attached (amended) version of the Genetic Supporting Information Form (FD-431).

- Any test requisition form currently in use for gene assay testing will be accepted when attached to gene assay testing claims in lieu of FD-431s, provided the following information is readily available on that form:

    - **Provider Information**: provider name, Medicaid/NJ FamilyCare (NJFC) provider ID, provider address, provider contact name and phone number

    - **Member information**: Medicaid/NJFC member name, Medicaid identification number, and date of birth

- **Gene assay testing information:** date ordered, ICD-10 diagnosis code(s), gene(s) tested, type of test (e.g., common variants, full sequence, del/dup)
- **Reason for testing**: clinical findings, family history, previous test results or other relevant supporting information
- **Description of future medical management:** a description of the impact of the genetic testing on future member care decisions
- **Authorized signature, title and date**

If you have any questions concerning this Alert, please contact Gainwell Technologies Provider Services at 1-800-776-6334.

RETAIN THIS ALERT FOR FUTURE REFERENCE

State of New Jersey
DEPARTMENT OF HUMAN SERVICES
Division of Medical Assistance and Health Services

GENETIC TESTING SUPPORTING INFORMATION FORM

This form must be completed by the ordering provider. Forms completed by the laboratory will not be accepted.

PROVIDER INFORMATION

Provider Name _____

Medicaid/NJ FamilyCare Provider ID _____

Provider Address _____

Provider Contact Name _____ **Provider Contact Phone No.** _____

BENEFICIARY INFORMATION

Beneficiary Name _____

Beneficiary Identification Number _____

Beneficiary Date of Birth _____

GENE ASSAY TESTING INFORMATION

Date Ordered _____ **CPT/HCPCS Code(s)** _____

ICD-10 Diagnosis Code(s) _____

Gene(s) Tested _____

Type of Test (e.g., Common Variants, Full Sequence, Del/Dup): _____

Reason for Testing (e.g., clinical findings, family history, previous test results)

How will the results of this genetic test change/impact future medical management of the patient?

To the best of my knowledge, the above information is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient

Authorized Signature	Title	Date