Non-Invasive Fetal Testing (NIFT)

Origination: 07/11/13	**Revised:** 03/23/21	**Annual Review:** 12/19/23
Line of Business: Commercial Only ☐ QHP/Exchange Only ☐ Medicare Only ☐ Commercial & QHP/Exchange ☐ Commercial, QHP/Exchange, & Medicare ☒		

Purpose:

To provide non-invasive fetal testing (NIFT) guidelines for Population Health and Provider Alliances associates to reference when making benefit determinations.

Coverage Guidelines

- Measurement of cell-free fetal nucleic acids in maternal blood by a participating laboratory [Verifi Prenatal Test by Illumina, and Quest – QNatal are participating providers] is considered to be medically necessary for testing for fetal aneuploidy (trisomy 13, 18 and 21) in all pregnant women with single gestations.

Exclusion Criteria

- Measurement of cell free DNA for all other indications is considered experimental and investigational because its effectiveness has not been established.

- Measurement by non-participating laboratories is not a covered benefit.

References:

1. Palomaki GE, Deciu C, Kloza EM, et al. DNA sequencing of maternal plasma reliably identifies trisomy 18 and trisomy 13 as well as Down syndrome: An international collaborative study. Genet Med. 2012;14(3):296-305.

2. California Technology Assessment Forum (CTAF). Fetal aneuploidy detection by maternal plasma DNA sequencing. Topics for Review. San Francisco, CA: CTAF; June 20, 2012.

3. Swedish Council on Technology Assessment in Health Care (SBU). Analysis of Fetal DNA in Maternal Blood: Non-Invasive Fetal Diagnostic Tests for Blood Group and Sex Determination. SBU Alert Report No. 2011-07. Stockholm, Sweden: SBU; November 16, 2011.

4. Chitty LS, Crolla J. Noninvasive prenatal diagnosis using cell-free DNA in maternal blood. Scientific Advisory Committee Opinion Paper 15. London, UK: Royal College of Obstetricians and Gynaecologists (RCOG); June 2009.

5. American College of Obstetricians and Gynecologists (ACOG). Committee opinion no. 545: Noninvasive prenatal testing for fetal aneuploidy. Obstet Gynecol. 2012;120(6):1532-1534.

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Disclaimer Information:

Coverage Issues Guidelines and Medical Technology Assessment Recommendations are developed to determine coverage for AvMed's benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. AvMed makes coverage decisions using these guidelines, along with the Member's benefit document. The use of this guideline is neither a guarantee of payment nor a final prediction of how specific claim(s) will be adjudicated.

Coverage Issues Guidelines and Medical Technology Assessment Recommendations are developed for selected therapeutic or diagnostic services found to be safe, but proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the AvMed service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations.

Treating providers are solely responsible for the medical advice and treatment of Members. This guideline may be updated and therefore is subject to change.