

Resolution approving changes to the Medical Benefit Plan Master Plan Document regarding Genetic Services.

RESOLUTION

WHEREAS, the Director of Human Resources is responsible for the management of the City's self-insured Medical Benefit Plan, and

WHEREAS, at the direction of the Finance and Personnel Committee, the Director of Human Resources is to provide recommendations for possible changes in plan design and

WHEREAS, the City's Medical Benefit Plan Master Plan Document currently excludes all Genetic Testing, and

WHEREAS, the Director of Human Resources and the City's health plan consultant recommend changes to the 2017 medical benefit plan design to cover some genetic services, subject to pre-authorization.

NOW THEREFORE BE IT RESOLVED BY THE COMMON COUNCIL that the Exclusions Section of delete the exclusion language, and instead refer members to the attached Genetic Services provision within the Medical Benefit Plan Master Plan Document.

BE IT FURTHER RESOLVED that the Medical Benefit Plan Master Plan Document be amended to require pre-authorization for Genetic Services.

BE IT FURTHER RESOLVED that the Director of Human Resources shall provide the full amended Medical Benefit Plan Master Plan Document to the City Clerk's officer for record retention.

BE IT FURTHER RESOLVED that the Director of Human Resources is hereby directed to take all necessary steps to implement said document.

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*I, Teri Lehrke, certify that this resolution was duly and officially adopted by the Common Council of the City of La Crosse on January 12, 2017.*



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*Teri Lehrke, City Clerk  
City of La Crosse, Wisconsin*

## Genetic Services

A. Genetic Services (for claims to be considered for payment under this section, services must be prior-authorized)

1. Covered Genetic Services **MAY** include:

- (a) Genetic counseling provided to you by a physician, a licensed or Masters trained genetic counselor or a medical geneticist;
- (b) Amniocentesis during pregnancy;
- (c) Chorionic Villus sampling for genetic testing and non-genetic testing during pregnancy;
- (d) Identification of infectious agents such as influenza and hepatitis. Panel testing for multiple agents IS NOT covered unless your physician provides a justification for including each test in the panel;
- (e) Compatibility testing for a covered person who has been approved by us for a covered transplant;
- (f) Cystic Fibrosis testing as recommended by the American College of Medical Genetics;
- (g) Molecular Genetic Testing of pathological specimens. Such testing does not include any testing of blood, except testing for the diagnosis of Leukemia or Lymphoma. All other molecular testing of blood or body fluids require prior authorization unless the test is otherwise specified and pre-authorized by the Plan. Please note that many molecular tumor profiling tests or panel tests are not covered.
- (h) BRCA testing for a female covered person whose family history is associated with an increased risk for harmful BRCA1 and BRCA2 gene mutations and testing has been recommended after receiving genetic counseling;
- (i) All other genetic testing for which you receive prior authorization. Plan Supervisor **MAY** authorize genetic testing if the ordering health care provider shows that the results of such testing will directly impact your future treatment. Your physician must describe how and why, based on the results of the genetic testing requested, your individual treatment plan would be different than your current or expected treatment plan based on a clinical assessment without genetic testing. Upon request, the ordering health care provider must submit information regarding the genetic testing's clinical validity and clinical utility. Genetic testing that the Plan considers experimental/investigational/unproven will not be covered. Plan Supervisor will only accept prior authorization from the ordering health care provider (e.g. your physician); and will **NOT** accept prior authorization requests from the laboratory that will perform the genetic services.
- (j) Genetic testing for predisposition or carrier status for a genetic disorder when a certified genetic counselor has determined it is likely that you carry a gene mutation that substantially increases your risk of developing the disorder and the presence of a mutation will lead to modifications in future medical care.

B. Genetic Services Exclusions:

- (a) Genetic counseling, studies and testing other than coverage that is expressly described above;
- (b) Genetic testing for the purposes of confirming a suspected diagnosis of a disorder that can be diagnosed based on clinical evaluation alone;
- (c) Genetic testing for conditions that cannot be altered by treatment or prevented by specific interventions.

- (d) Genetic testing solely for the purpose of informing the care or management of your family members or for the purpose of identifying a mutation that is for the benefit of a non-covered family member;
- (e) Genetic counseling performed by the laboratory that performed the genetic testing;
- (f) Genetic testing that is done for reproductive planning; and
- (g) Genetic testing that is not prior authorized, or that the Plan Supervisor considers experimental/investigational/unproven will not be covered. (NOTE: PRIOR AUTHORIZATION does not guarantee benefits if the testing or counseling performed is otherwise excluded, experimental, etc.)