Medical Necessity Guidelines:

Human Leukocyte Antigen Genotyping for Tufts Health Direct, Tufts Health Together, Tufts Health One Care

Effective: July 1, 2026

Prior Authorization Required If REQUIRED, submit supporting clinical documentation pertinent to service request to the FAX numbers below.	Yes ☒ No ☐
Notification Required IF REQUIRED, concurrent review may apply	Yes ☐ No ☒

Applies to:

Commercial Products

☐ Harvard Pilgrim Health Care Commercial products; 800-232-0816
☐ Tufts Health Plan Commercial products; 617-972-9409

Public Plans Products

☒ Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product); 888-415-9055
☒ Tufts Health Together – MassHealth Accountable Care Partnership Plans; 888-415-9055
☒ Tufts Health RITogether – A Rhode Island Medicaid Plan; 857-304-6404
☒ Tufts Health One Care – A dual-eligible product; 857-304-6304

Senior Products

☐ Tufts Health Plan Senior Care Options (SCO), (a dual-eligible product); 617-972-9409
☐ Tufts Medicare Preferred HMO, (a Medicare Advantage product); 617-972-9409
☐ Tufts Medicare Preferred PPO, (a Medicare Advantage product); 617-972-9409

Note: While you may not be the provider responsible for obtaining prior authorization or notifying Point32Health, as a condition of payment you will need to ensure that any necessary prior authorization has been obtained and/or Point32Health has received proper notification. If notification is required, providers may additionally be required to provide updated clinical information to qualify for continued service.

For Tufts Health Plan Members:

To obtain InterQual® SmartSheets™"

- **Tufts Health Plan Commercial Plan products:** If you are a registered Tufts Health Plan provider click here to access the Provider Website. If you are not a Tufts Health Plan provider, please click on the Provider Log-in and follow instructions to register on the Provider website or call Provider Services at 888-884-2404
- **Tufts Health Public Plans products:** InterQual® SmartSheet(s) available as part of the prior authorization process

Tufts Health Plan requires the use of current InterQual® Smartsheet(s) to obtain prior authorization.

In order to obtain prior authorization for procedure(s), choose the appropriate InterQual® SmartSheet(s) listed below. The completed SmartSheet(s) must be sent to the applicable fax number indicated above, according to Plan

Clinical Guideline Coverage Criteria

The Plan considers human leukocyte antigen (HLA) testing medically necessary when used to assess histocompatibility of organ and tissue transplant recipients with compatible donors.

The Plan requires the use of the following InterQual® Subsets or SmartSheets to obtain prior authorization for HLA genotyping for the following indications:

1. HLA Genotyping for Celiac Disease

2. HLA Genotyping for Narcolepsy
3. HLA-B*1502 Genotyping for Drug Response
4. HLA-B*5701 Genotyping for Abacavir Response
5. HLA-B*5801 Genotyping for Allopurinol Response
6. HLA-B27 Genotyping for Ankylosing Spondylitis

Listed InterQual SmartSheets represent HLA genotyping for indications other than transplant. The appropriate InterQual SmartSheet must be completed and faxed to the appropriate fax number listed above according to Plan.

The following InterQual SmartSheets are to be used when requesting prior authorization for HLA Genotyping.

1. HLA Celiac Disease HLA DQ2 genotyping
2. HLA Celiac Disease HLA DQ8 genotyping
3. HLA-B*1502 genotyping
4. HLA-B*5701 genotyping
5. HLA-B*5801 genotyping
6. HLA in Ankylosing Spondylitis HLA-B27 genotyping

Codes

The following code(s) require prior authorization:

Table 1: CPT/HCPCS Codes

Code	Description
81370	HLA Class I and II typing, low resolution (e.g., antigen equivalents); HLA-A, -B, -C, -DRB1/3/4/5, and -DQB1
81371	HLA Class I and II typing, low resolution (e.g., antigen equivalents); HLA-A, -B, and -DRB1 (e.g., verification typing)
81372	HLA Class I typing, low resolution (e.g., antigen equivalents); complete (i.e., HLA-A, -B, and -C)
81373	HLA Class I typing, low resolution (e.g., antigen equivalents); one locus (e.g., HLA-A, -B, or -C), each
81374	HLA Class I typing, low resolution (e.g., antigen equivalents); one antigen equivalent (e.g., B*27), each
81375	HLA Class II typing, low resolution (e.g., antigen equivalents); HLA-DRB1/3/4/5 and -DQB1
81376	HLA Class II typing, low resolution (e.g., antigen equivalents); one locus (e.g., HLA-DRB1, -DRB3/4/5, -DQB1, -DQA1, -DPB1, or -DPA1), each
81377	HLA Class II typing, low resolution (e.g., antigen equivalents); one antigen equivalent, each
81378	HLA Class I and II typing, high resolution (i.e., alleles or allele groups), HLA-A, -B, -C, and -DRB1
81379	HLA Class I typing, high resolution (i.e., alleles or allele groups); complete (i.e., HLA-A, -B, and -C)
81380	HLA Class I typing, high resolution (i.e., alleles or allele groups); one locus (e.g., HLA-A, -B, or -C), each
81381	HLA Class I typing, high resolution (i.e., alleles or allele groups); one allele or allele group (e.g., B*57:01P), each
81382	HLA Class II typing, high resolution (i.e., alleles or allele groups); one locus (e.g., HLA-DRB1, -DRB3/4/5, -DQB1, -DQA1, -DPB1, or -DPA1), each
81383	HLA Class II typing, high resolution (i.e., alleles or allele groups); one allele or allele group (e.g., HLA-DQB1*06:02P), each

References:

1. Sullivan KM, Muraro P, Tyndall A. Hematopoietic cell transplantation for autoimmune disease: updates from Europe and the United States. Biol Blood Marrow Transplant. Jan 2010; 16(1 Suppl): S48-56.
2. Human leukocyte antigens (HLA): A roadmap. UpToDate.com/login [via subscription only]. Published May 8, 2025. Accessed September 1, 2025.
3. Kidney transplantation in adults: Overview of HLA sensitization and crossmatch testing. UpToDate.com/login [via subscription only]. Published May 8, 2025. Accessed September 1, 2025.
4. OPTN Organ Procurement and Transplantation Network. Accessed September 29, 2022 OPTN Member Evaluation Plan (hrsa.gov).

Approval And Revision History

July 20, 2022: Reviewed by Medical Policy Approval Committee (MPAC). Effective October 1, 2022, The Plan will continue to manage prior authorization requests for HLA testing Tufts Health Public Plans. AIM Specialty Health® (AIM) will oversee medical necessity review of all other genetic testing for Tufts Health Public Plans.

Subsequent endorsement date(s) and changes made:

- October 19, 2022: Reviewed at MPAC. For effective date December 1, 2022, Criteria applicable to HLA genotyping for transplant added. Continued used of InterQual for non-transplant related indications.
- September 20, 2023: Reviewed at MPAC, renewed without changes
- October 18, 2023: Reviewed at MPAC, renewed without changes
- November 2023: Unify rebranded to One Care effective January 1, 2024
- December 1, 2023: Reviewed and approved by UM Committee effective January 1, 2024
- June 13, 2024: Reviewed and approved by the UM Committee effective July 1, 2024
- June 20, 2024: Reviewed by MPAC for 2024 InterQual Upgrade, effective July 1, 2024
- May 21, 2025: Reviewed by MPAC for 2025 InterQual Update effective July 1, 2025
- September 17, 2025. Reviewed by MPAC, annual review no changes, effective November 1, 2025. References updated.
- October 2, 2025: Fax number for Senior Care Options, Tufts Medicare Preferred HMO and Tufts Medicare Preferred PPO updated; language for Carelink removed.
- May 20, 2026: Reviewed by MPAC for 2026 InterQual Update, effective July 1, 2026.

Background, Product and Disclaimer Information

Medical Necessity Guidelines are developed to determine coverage for benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. We make coverage decisions using these guidelines, along with the Member's benefit document, and in coordination with the Member's physician(s) on a case-by-case basis considering the individual Member's health care needs.

Medical Necessity Guidelines are developed for selected therapeutic or diagnostic services found to be safe and 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 our service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. We revise and update Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern. For Tufts Health Together (Medicaid), coverage may be available beyond these guidelines for pediatric members under age 21 under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits of the plan in accordance with 130 CMR 450.140 and 130 CMR 447.000, and with prior authorization.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this guideline is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to eligibility and benefits on the date of service, coordination of benefits, referral/authorization, utilization management guidelines when applicable, and adherence to plan policies, plan procedures, and claims editing logic.