Carrier Testing Panels for Genetic Diseases (for Idaho Only)

Policy Number: CS151ID.B
Effective Date: August 1, 2025

Instructions for Use

Table of Contents **Page**

Application 1
Coverage Rationale 1
Applicable Codes 1
U.S. Food and Drug Administration 2
References 2
Policy History/Revision Information 2
Instructions for Use 2

Related Policies

- Cell-Free Fetal DNA Testing (for Idaho Only)
- Preimplantation Genetic Testing and Related Services (for Idaho Only)
- Whole Exome and Whole Genome Sequencing (Non-Oncology Conditions) (for Idaho Only)

Application

This Medical Policy only applies the state of Idaho, including Idaho Medicaid Plus plans.

Coverage Rationale

For medical necessity clinical coverage criteria for genetic testing, refer to the Idaho Medicaid Provider Handbook, Laboratory Services, Chapter 4.8: Genetic Testing.

Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state, or contractual requirements and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

CPT Code	Description
0400U	Obstetrics (expanded carrier screening), 145 genes by next generation sequencing, fragment analysis and multiplex ligation dependent probe amplification, DNA, reported as carrier positive or negative
81412	Ashkenazi Jewish associated disorders (e.g., Bloom syndrome, Canavan disease, cystic fibrosis, familial dysautonomia, Fanconi anemia group C, Gaucher disease, Tay-Sachs disease), genomic sequence analysis panel, must include sequencing of at least 9 genes, including *ASPA, BLM, CFTR, FANCC, GBA, HEXA, IKBKAP, MCOLN1, and SMPD1*
81443	Genetic testing for severe inherited conditions (e.g., cystic fibrosis, Ashkenazi Jewish-associated disorders [e.g., Bloom syndrome, Canavan disease, Fanconi anemia type C, mucolipidosis type VI, Gaucher disease, Tay-Sachs disease], beta hemoglobinopathies, phenylketonuria, galactosemia), genomic sequence analysis panel, must include sequencing of at least 15 genes (e.g., *ACADM, ARSA, ASPA, ATP7B, BCKDHA, BCKDHB, BLM, CFTR, DHCR7, FANCC, G6PC, GAA, GALT, GBA, GBE1, HBB, HEXA, IKBKAP, MCOLN1, PAH*)
81479	Unlisted molecular pathology procedure

U.S. Food and Drug Administration (FDA)

This section is to be used for informational purposes only. FDA approval alone is not a basis for coverage.

Laboratories that perform genetic tests are regulated under the Clinical Laboratory Improvement Amendments (CLIA) Act of 1988. More information is available at: https://www.fda.gov/medicaldevices/deviceregulationandguidance/ivdregulatoryassistance/ucm124105.htm. (Accessed April 24, 2024)

References

Idaho Medicaid Provider Handbook. Laboratory Services. 4.8. Genetic Testing. Available at: https://www.idmedicaid.com/Provider%20Guidelines/Laboratory%20Services.pdf. Accessed March 21, 2025.

Policy History/Revision Information

Date	Summary of Changes

08/01/2025	**Coverage Rationale**
	• Replaced coverage guidelines with instruction to refer to the *Medical Provider Handbook, Laboratory Services, Chapter 4.8: Genetic Testing* for medical necessity clinical coverage criteria for genetic testing
	Definition
	• Removed definition of:
	  ○ Carrier Screening
	  ○ First-Degree Relative
	  ○ Panel
	  ○ Second-Degree Relative
	Supporting Information
	• Updated *References* section to reflect the most current information
	• Removed *Description of Services* and *Clinical Evidence* sections
	• Archived previous policy version CS151ID.A

Instructions for Use

This Medical Policy provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the federal, state or contractual requirements for benefit plan coverage must be referenced as the terms of the federal, state or contractual requirements for benefit plan coverage may differ from the standard benefit plan. In the event of a conflict, the federal, state or contractual requirements for benefit plan coverage govern. Before using this policy, please check the federal, state or contractual requirements for benefit plan coverage. UnitedHealthcare reserves the right to modify its Policies and Guidelines as necessary. This Medical Policy is provided for informational purposes. It does not constitute medical advice.

UnitedHealthcare may also use tools developed by third parties, such as the InterQual® criteria, to assist us in administering health benefits. The UnitedHealthcare Medical Policies are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.