

Genetic Testing for Hereditary Cancer (for Ohio Only)

Policy Number: CS049OH.E
Effective Date: May 1, 2026

[Instructions for Use](#)

Table of Contents	Page
Application	1
Coverage Rationale	1
Medical Records Documentation Used for Reviews	2
Applicable Codes	2
U.S. Food and Drug Administration	4
References	4
Policy History/Revision Information	4
Instructions for Use	5

Related Policies
None

Application

This Medical Policy only applies to the state of Ohio. Any requests for services that are stated as unproven or services for which there is a coverage or quantity limit will be evaluated for medical necessity using Ohio Administrative Code 5160-1-01.

Coverage Rationale

Pretest genetic counseling is strongly recommended to inform persons being tested about the advantages and limitations of the test, as applied to a unique person.

Single-gene testing and known mutation testing for familial cancer are proven and medically necessary.

For medical necessity clinical coverage criteria for **genetic testing for hereditary cancer**, refer to the InterQual® CP: Molecular Diagnostics:

- BRCA1 and BRCA2 in Hereditary Cancer
- Hereditary Prostate Cancer
- Hereditary Pheochromocytoma and Paraganglioma (PPGL)
- Lynch Syndrome (LS)
- Multi-Gene Panels for Hereditary Breast Cancer Syndromes
- Multi-Gene Panels for Hereditary Colorectal Cancer Syndromes
- Multi-Gene Panels for Hereditary Ovarian Cancer Syndromes
- Whole Genome Sequencing (WGS), Whole Exome Sequencing (WES), and Chromosomal Microarray (CMA) for Congenital or Hereditary Disorders

[Click here to view the InterQual® criteria.](#)

Genetic testing with a multi-gene hereditary cancer panel for individuals diagnosed with cancer at age 18 years or younger is proven and medically necessary.

Multigene hereditary cancer panels are unproven and not medically necessary for all other indications.

RNA panel testing for hereditary cancers is unproven and not medically necessary for all indications.

Genetic testing for the purpose of polygenic risk scoring for hereditary cancers is unproven and not medically necessary for all indications.

Medical Records Documentation Used for Reviews

Benefit coverage for health services is determined by the federal, state, or contractual requirements, and applicable laws that may require coverage for a specific service. Medical records documentation may be required to assess whether the member meets the clinical criteria for coverage but does not guarantee coverage of the services requested.

The patient's medical record must contain documentation that fully supports the medical necessity for the requested services. This documentation includes, but is not limited to, relevant medical history, physical examination, and results of pertinent diagnostic tests or procedures. Documentation supporting the medical necessity should be legible, maintained in the patient's medical record, and must be made available upon request.

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
BRCA1 and BRCA2	
0138U	BRCA1 (BRCA1, DNA repair associated), BRCA2 (BRCA2, DNA repair associated) (e.g., hereditary breast and ovarian cancer) mRNA sequence analysis (List separately in addition to code for primary procedure)
81162	BRCA1 (BRCA1, DNA repair associated), BRCA2 (BRCA2, DNA repair associated) (e.g., hereditary breast and ovarian cancer) gene analysis; full sequence analysis and full duplication/deletion analysis (i.e., detection of large gene rearrangements)
81163	BRCA1 (BRCA1, DNA repair associated), BRCA2 (BRCA2, DNA repair associated) (e.g., hereditary breast and ovarian cancer) gene analysis; full sequence analysis
81164	BRCA1 (BRCA1, DNA repair associated), BRCA2 (BRCA2, DNA repair associated) (e.g., hereditary breast and ovarian cancer) gene analysis; full duplication/deletion analysis (i.e., detection of large gene rearrangements)
Multi-Gene Panel	
0101U	Hereditary colon cancer disorders (e.g., Lynch syndrome, PTEN hamartoma syndrome, Cowden syndrome, familial adenomatosis polyposis), genomic sequence analysis panel utilizing a combination of NGS, Sanger, MLPA, and array CGH, with MRNA analytics to resolve variants of unknown significance when indicated (15 genes [sequencing and deletion/duplication], EPCAM and GREM1 [deletion/duplication only])
0102U	Hereditary breast cancer-related disorders (e.g., hereditary breast cancer, hereditary ovarian cancer, hereditary endometrial cancer), genomic sequence analysis panel utilizing a combination of NGS, Sanger, MLPA, and array CGH, with MRNA analytics to resolve variants of unknown significance when indicated (17 genes [sequencing and deletion/duplication])
0103U	Hereditary ovarian cancer (e.g., hereditary ovarian cancer, hereditary endometrial cancer), genomic sequence analysis panel utilizing a combination of NGS, Sanger, MLPA, and array CGH, with MRNA analytics to resolve variants of unknown significance when indicated (24 genes [sequencing and deletion/duplication], EPCAM [deletion/duplication only])
0129U	Hereditary breast cancer-related disorders (e.g., hereditary breast cancer, hereditary ovarian cancer, hereditary endometrial cancer), genomic sequence analysis and deletion/duplication analysis panel (ATM, BRCA1, BRCA2, CDH1, CHEK2, PALB2, PTEN, and TP53)
0130U	Hereditary colon cancer disorders (e.g., Lynch syndrome, PTEN hamartoma syndrome, Cowden syndrome, familial adenomatosis polyposis), targeted mRNA sequence analysis panel (APC, CDH1, CHEK2, MLH1, MSH2, MSH6, MUTYH, PMS2, PTEN, and TP53) (List separately in addition to code for primary procedure)
0133U	Hereditary prostate cancer-related disorders, targeted mRNA sequence analysis panel (11 genes) (List separately in addition to code for primary procedure)

CPT Code	Description
Multi-Gene Panel	
0134U	Hereditary pan cancer (e.g., hereditary breast and ovarian cancer, hereditary endometrial cancer, hereditary colorectal cancer), targeted mRNA sequence analysis panel (18 genes) (List separately in addition to code for primary procedure)
0162U	Hereditary colon cancer (Lynch syndrome), targeted mRNA sequence analysis panel (MLH1, MSH2, MSH6, PMS2) (List separately in addition to code for primary procedure)
0238U	Oncology (Lynch syndrome), genomic DNA sequence analysis of MLH1, MSH2, MSH6, PMS2, and EPCAM, including small sequence changes in exonic and intronic regions, deletions, duplications, mobile element insertions, and variants in non-uniquely mappable regions
0474U	Hereditary pan-cancer (e.g., hereditary sarcomas, hereditary endocrine tumors, hereditary neuroendocrine tumors, hereditary cutaneous melanoma), genomic sequence analysis panel of 88 genes with 20 duplications/deletions using next-generation sequencing (NGS), Sanger sequencing, blood or saliva, reported as positive or negative for germline variants, each gene
0475U	Hereditary prostate cancer-related disorders, genomic sequence analysis panel using next-generation sequencing (NGS), Sanger sequencing, multiplex ligation-dependent probe amplification (MLPA), and array comparative genomic hybridization (CGH), evaluation of 23 genes and duplications/deletions when indicated, pathologic mutations reported with a genetic risk score for prostate cancer
0495U	Oncology (prostate), analysis of circulating plasma proteins (tPSA, fPSA, KLK2, PSP94, and GDF15), germline polygenic risk score (60 variants), clinical information (age, family history of prostate cancer, prior negative prostate biopsy), algorithm reported as risk of likelihood of detecting clinically significant prostate cancer
81432	Hereditary breast cancer-related disorders (e.g., hereditary breast cancer, hereditary ovarian cancer, hereditary endometrial cancer, hereditary pancreatic cancer, hereditary prostate cancer); genomic sequence analysis panel, 5 or more genes, interrogation for sequence variants and copy number variants
81435	Hereditary colon cancer-related disorders (e.g., Lynch syndrome, PTEN hamartoma syndrome, Cowden syndrome, familial adenomatous polyposis), genomic sequence analysis panel, 5 or more genes, interrogation for sequence variants and copy number variants
81437	Hereditary neuroendocrine tumor-related disorders (e.g., medullary thyroid carcinoma, parathyroid carcinoma, malignant pheochromocytoma or paraganglioma), genomic sequence analysis panel, 5 or more genes, interrogation for sequence variants and copy number variants
81441	Inherited bone marrow failure syndromes (IBMFS) (e.g., Fanconi anemia, dyskeratosis congenita, Diamond-Blackfan anemia, Shwachman-Diamond syndrome, GATA2 deficiency syndrome, congenital amegakaryocytic thrombocytopenia) sequence analysis panel, must include sequencing of at least 30 genes, including BRCA2, BRIP1, DKC1, FANCA, FANCB, FANCC, FANCD2, FANCE, FANCF, FANCG, FANCI, FANCL, GATA1, GATA2, MPL, NHP2, NOP10, PALB2, RAD51C, RPL11, RPL35A, RPL5, RPS10, RPS19, RPS24, RPS26, RPS7, SBDS, TERT, and TINF2
81479	Unlisted molecular pathology procedure
Whole Exome and Whole Genome Sequencing	
0212U	Rare diseases (constitutional/heritable disorders), whole genome and mitochondrial DNA sequence analysis, including small sequence changes, deletions, duplications, short tandem repeat gene expansions, and variants in non-uniquely mappable regions, blood or saliva, identification and categorization of genetic variants, proband
0213U	Rare diseases (constitutional/heritable disorders), whole genome and mitochondrial DNA sequence analysis, including small sequence changes, deletions, duplications, short tandem repeat gene expansions, and variants in non-uniquely mappable regions, blood or saliva, identification and categorization of genetic variants, each comparator genome (e.g., parent, sibling)
0214U	Rare diseases (constitutional/heritable disorders), whole exome and mitochondrial DNA sequence analysis, including small sequence changes, deletions, duplications, short tandem repeat gene expansions, and variants in non-uniquely mappable regions, blood or saliva, identification and categorization of genetic variants, proband

CPT Code	Description
Whole Exome and Whole Genome Sequencing	
0215U	Rare diseases (constitutional/heritable disorders), whole exome and mitochondrial DNA sequence analysis, including small sequence changes, deletions, duplications, short tandem repeat gene expansions, and variants in non-uniquely mappable regions, blood or saliva, identification and categorization of genetic variants, each comparator exome (e.g., parent, sibling)
0265U	Rare constitutional and other heritable disorders, whole genome and mitochondrial DNA sequence analysis, blood, frozen and formalin-fixed paraffin-embedded (FFPE) tissue, saliva, buccal swabs or cell lines, identification of single nucleotide and copy number variants
0266U	Unexplained constitutional or other heritable disorders or syndromes, tissue-specific gene expression by whole-transcriptome and next-generation sequencing, blood, formalin-fixed paraffin-embedded (FFPE) tissue or fresh frozen tissue, reported as presence or absence of splicing or expression change
81415	Exome (e.g., unexplained constitutional or heritable disorder or syndrome); sequence analysis
81416	Exome (e.g., unexplained constitutional or heritable disorder or syndrome); sequence analysis, each comparator exome (e.g., parents, siblings) (List separately in addition to code for primary procedure)
81417	Exome (e.g., unexplained constitutional or heritable disorder or syndrome); re-evaluation of previously obtained exome sequence (e.g., updated knowledge or unrelated condition/syndrome)
81425	Genome (e.g., unexplained constitutional or heritable disorder or syndrome); sequence analysis
81426	Genome (e.g., unexplained constitutional or heritable disorder or syndrome); sequence analysis, each comparator genome (e.g., parents, siblings) (List separately in addition to code for primary procedure)
81427	Genome (e.g., unexplained constitutional or heritable disorder or syndrome); re-evaluation of previously obtained genome sequence (e.g., updated knowledge or unrelated condition/syndrome)

CPT® is a registered trademark of the American Medical Association

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 Act of 1988. More information is available at:

<https://www.fda.gov/medicaldevices/deviceregulationandguidance/ivdregulatoryassistance/ucm124105.htm>.

(Accessed September 19, 2025)

A list of nucleic acid based tests that have been cleared or approved by the FDA Center for Devices and Radiological Health is available at: <https://www.fda.gov/medical-devices/in-vitro-diagnostics/nucleic-acid-based-tests>.

(Accessed September 19, 2025)

References

Ohio Administrative Code/5160/Chapter 5160-1-01. Medicaid medical necessity: definitions and principles. Available at: <https://codes.ohio.gov/ohio-administrative-code/rule-5160-1-01>. Accessed December 17, 2025.

Policy History/Revision Information

Date	Summary of Changes
05/01/2026	<p>Coverage Rationale</p> <ul style="list-style-type: none"> Removed language indicating genetic testing for hereditary cancer is proven and medically necessary in certain circumstances Revised language pertaining to medical necessity clinical coverage criteria: <ul style="list-style-type: none"> Updated instruction to refer to the [listed] InterQual® criteria for medical necessity clinical coverage criteria <i>for genetic testing for hereditary cancer</i>

Date	Summary of Changes
	<ul style="list-style-type: none"> ○ Added reference to the InterQual® CP: Molecular Diagnostics, Whole Genome Sequencing (WGS), Whole Exome Sequencing (WES), and Chromosomal Microarray (CMA) for Congenital or Hereditary Disorders ● Added language to indicate genetic testing for the purpose of polygenic risk scoring for hereditary cancers is unproven and not medically necessary for all indications <p>Medical Records Documentation Used for Reviews</p> <ul style="list-style-type: none"> ● Added language to indicate: <ul style="list-style-type: none"> ○ Benefit coverage for health services is determined by the federal, state, or contractual requirements, and applicable laws that may require coverage for a specific service ○ Medical records documentation may be required to assess whether the member meets the clinical criteria for coverage but does not guarantee coverage of the service requested ○ The patient's medical record must contain documentation that fully supports the medical necessity for the requested services ○ This documentation includes but is not limited to relevant medical history, physical examination, and results of pertinent diagnostic tests or procedures ○ Documentation supporting the medical necessity should be legible, maintained in the patient's medical record, and must be made available upon request <p>Applicable Codes</p> <p>Multigene Panel</p> <ul style="list-style-type: none"> ● Removed CPT codes 0131U, 0132U, and 0135U <p>Whole Exome and Whole Genome Sequencing</p> <ul style="list-style-type: none"> ● Added CPT codes 0212U, 0213U, 0214U, 0215U, 0265U, 0266U, 81415, 81416, 81417, 81425, 81426, and 81427 <p>Supporting Information</p> <ul style="list-style-type: none"> ● Archived previous policy version CS049OH.D

Instructions for Use

This Medical Policy provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the federal, state (Ohio Administrative Code [OAC]) or contractual requirements for benefit plan coverage must be referenced as the terms of the federal, state (OAC) or contractual requirements for benefit plan coverage may differ from the standard benefit plan. In the event of a conflict, the federal, state (OAC) or contractual requirements for benefit plan coverage govern. Before using this policy, check the federal, state (OAC) 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 uses InterQual® for the primary medical/surgical criteria, and the American Society of Addiction Medicine (ASAM) for substance use, in administering health benefits. If InterQual® does not have applicable criteria, UnitedHealthcare may also use UnitedHealthcare Medical Policies, Coverage Determination Guidelines, and/or Utilization Review Guidelines that have been approved by the Ohio Department for Medicaid Services. The UnitedHealthcare Medical Policies, Coverage Determination Guidelines, and Utilization Review Guidelines 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.