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## CLINICAL APPROPRIATENESS GUIDELINES

# GENETIC TESTING

Appropriate Use Criteria: Genetic Testing for Inherited Conditions

### Proprietary

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## Description and Application of the Guidelines

The AIM Clinical Appropriateness Guidelines (hereinafter “the AIM Clinical Appropriateness Guidelines” or the “Guidelines”) are designed to assist providers in making the most appropriate treatment decision for a specific clinical condition for an individual. As used by AIM, the Guidelines establish objective and evidence-based criteria for medical necessity determinations where possible. In the process, multiple functions are accomplished:

- To establish criteria for when services are medically necessary
- To assist the practitioner as an educational tool
- To encourage standardization of medical practice patterns
- To curtail the performance of inappropriate and/or duplicate services
- To advocate for patient safety concerns
- To enhance the quality of health care
- To promote the most efficient and cost-effective use of services

The AIM guideline development process complies with applicable accreditation standards, including the requirement that the Guidelines be developed with involvement from appropriate providers with current clinical expertise relevant to the Guidelines under review and be based on the most up-to-date clinical principles and best practices. Relevant citations are included in the References section attached to each Guideline. AIM reviews all of its Guidelines at least annually.

AIM makes its Guidelines publicly available on its website twenty-four hours a day, seven days a week. Copies of the AIM Clinical Appropriateness Guidelines are also available upon oral or written request. Although the Guidelines are publicly-available, AIM considers the Guidelines to be important, proprietary information of AIM, which cannot be sold, assigned, leased, licensed, reproduced or distributed without the written consent of AIM.

AIM applies objective and evidence-based criteria, and takes individual circumstances and the local delivery system into account when determining the medical appropriateness of health care services. The AIM Guidelines are just guidelines for the provision of specialty health services. These criteria are designed to guide both providers and reviewers to the most appropriate services based on a patient’s unique circumstances. In all cases, clinical judgment consistent with the standards of good medical practice should be used when applying the Guidelines. Guideline determinations are made based on the information provided at the time of the request. It is expected that medical necessity decisions may change as new information is provided or based on unique aspects of the patient’s condition. The treating clinician has final authority and responsibility for treatment decisions regarding the care of the patient and for justifying and demonstrating the existence of medical necessity for the requested service. The Guidelines are not a substitute for the experience and judgment of a physician or other health care professionals. Any clinician seeking to apply or consult the Guidelines is expected to use independent medical judgment in the context of individual clinical circumstances to determine any patient’s care or treatment.

The Guidelines do not address coverage, benefit or other plan specific issues. Applicable federal and state coverage mandates take precedence over these clinical guidelines. If requested by a health plan, AIM will review requests based on health plan medical policy/guidelines in lieu of the AIM Guidelines.

The Guidelines may also be used by the health plan or by AIM for purposes of provider education, or to review the medical necessity of services by any provider who has been notified of the need for medical necessity review, due to billing practices or claims that are not consistent with other providers in terms of frequency or some other manner.

## General Clinical Guideline

### Clinical Appropriateness Framework

Critical to any finding of clinical appropriateness under the guidelines for a specific diagnostic or therapeutic intervention are the following elements:

- Prior to any intervention, it is essential that the clinician confirm the diagnosis or establish its pretest likelihood based on a complete evaluation of the patient. This includes a history and physical examination and, where applicable, a review of relevant laboratory studies, diagnostic testing, and response to prior therapeutic intervention.
- The anticipated benefit of the recommended intervention should outweigh any potential harms that may result (net benefit).
- Current literature and/or standards of medical practice should support that the recommended intervention offers the greatest net benefit among competing alternatives.
- Based on the clinical evaluation, current literature, and standards of medical practice, there exists a reasonable likelihood that the intervention will change management and/or lead to an improved outcome for the patient.

If these elements are not established with respect to a given request, the determination of appropriateness will most likely require a peer-to-peer conversation to understand the individual and unique facts that would supersede the requirements set forth above. During the peer-to-peer conversation, factors such as patient acuity and setting of service may also be taken into account.

### Simultaneous Ordering of Multiple Diagnostic or Therapeutic Interventions

Requests for multiple diagnostic or therapeutic interventions at the same time will often require a peer-to-peer conversation to understand the individual circumstances that support the medical necessity of performing all interventions simultaneously. This is based on the fact that appropriateness of additional intervention is often dependent on the outcome of the initial intervention.

Additionally, either of the following may apply:

- Current literature and/or standards of medical practice support that one of the requested diagnostic or therapeutic interventions is more appropriate in the clinical situation presented; or
- One of the diagnostic or therapeutic interventions requested is more likely to improve patient outcomes based on current literature and/or standards of medical practice.

### Repeat Diagnostic Intervention

In general, repeated testing of the same anatomic location for the same indication should be limited to evaluation following an intervention, or when there is a change in clinical status such that additional testing is required to determine next steps in management. At times, it may be necessary to repeat a test using different techniques or protocols to clarify a finding or result of the original study.

Repeated testing for the same indication using the same or similar technology may be subject to additional review or require peer-to-peer conversation in the following scenarios:

- Repeated diagnostic testing at the same facility due to technical issues
- Repeated diagnostic testing requested at a different facility due to provider preference or quality concerns
- Repeated diagnostic testing of the same anatomic area based on persistent symptoms with no clinical change, treatment, or intervention since the previous study
- Repeated diagnostic testing of the same anatomic area by different providers for the same member over a short period of time

## Repeat Therapeutic Intervention

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In general, repeated therapeutic intervention in the same anatomic area is considered appropriate when the prior intervention proved effective or beneficial and the expected duration of relief has lapsed. A repeat intervention requested prior to the expected duration of relief is not appropriate unless it can be confirmed that the prior intervention was never administered.

# Genetic Testing for Inherited Conditions

## Description and Scope

Genetic testing for inherited conditions including single gene testing, applies to individuals who are clinically symptomatic for a suspected condition and/or may be at increased risk for carrying a pathogenic variant associated with a condition(s) based on family history or ethnicity. The clinical utility of such testing may include making a definitive diagnosis or to offer important prognostic information that may meaningfully impact patient management and clinical outcomes for affected individuals and their family members. Specific testing realms discussed in this guideline are general indications for single gene or multi-gene testing, hereditary cardiac, neurogenetic, thrombophilia testing, and genetic biomarkers of rejection in solid organ transplantation.

*For specific test modalities, see separate guidelines including Chromosomal Microarray Analysis (CMA), Whole Exome Sequencing (WES) and Whole Genome Sequencing (WGS). For testing associated with reproduction, see Carrier Screening in the Prenatal Setting guideline.*

*For testing associated with hereditary cancer syndromes, see Hereditary Cancer Screening guideline.*

*For testing of tumor biomarkers, see Somatic Tumor Testing guideline for tumor testing criteria.*

## General Recommendations

### Genetic counseling

Genetic counseling is strongly recommended prior to genetic testing and should include **ALL** of the following components:

- Interpretation of family and medical histories to assess the probability of disease occurrence or recurrence
- Education about inheritance, genetic testing, disease management, prevention, risk reduction, and resources
- Counseling to promote informed choices and adaptation to the risk or presence of a genetic condition
- Counseling for the psychological aspects of genetic testing
- Post-test counseling for any positive screening test

### Rationale

Genetic testing is a procedure that involves risk that accompanies its potential benefits. The clinician and the patient should consider the balance of risks and potential benefits before testing is pursued through informed consent. As with any procedure, the clinical utility of the genetic test must be considered along with its psychological and sociologic implications.<sup>1</sup> Genetic counselors provide a patient-centered contribution to the care of individuals who are undergoing genetic testing. Genetic counseling is a communication process aimed at helping people understand and adapt to the medical, psychological, and familial implications of genetic contributions to disease.<sup>2</sup> Genetic counselors have advanced training in medical genetics and counseling which helps guide and support patients seeking more information about how inherited diseases and conditions might affect them or their families. This expertise is also applied to interpret genetic test results based on an individual's personal and family history. Genetic counselors are often specialized in prenatal, pediatric, oncology, neurology, ophthalmology, psychiatry, and many other areas.

The current literature demonstrates the clinical value of genetic counselor involvement in service delivery, including improvements in clinical management and positive psychological impact along with increased patient engagement. Physicians have varying levels of knowledge on how to interpret genetic and genomic information, and often express low confidence and high uncertainty in counseling about genetic testing findings.<sup>3</sup> Professional genetic counselors add unique value to the existing care team.

In the past decade, there has been explosive growth in the number of genetic tests available, the number and types of companies involved in providing these tests, diversity of the business models involved, and the diverse settings where genetic

tests are accessed by consumers. There is access to some kinds of testing through direct-to-consumer channels, but most of the healthcare-associated testing is from full-service commercial laboratories, for-profit specialized laboratories, or not-for-profit laboratories, such as those associated with academic medical centers.<sup>4</sup> While laboratory business models vary widely, there is increasing interest in use of de-identified data from genetic testing for use in research and discovery and other business purposes beyond the application to individual patient care. These other uses of genetic information have partly fueled a trend for broader indications for testing and testing of larger panels of genes. Furthermore, while genetic counselors have traditionally been trained to counsel patients in healthcare settings prior to germline testing for diseases with a Mendelian inheritance pattern, their education and skills can also be readily adapted to other settings. Genetic testing services are now delivered both in person and via telehealth, and counselors may be employed not only by healthcare institutions but also by laboratories working under various distinct business models.

Genomic technologies generate large amounts of data, and this increases the potential for uncertainty in managing and adapting to this information. Clinicians are tasked with accurately interpreting and communicating information about test validity and the reliability of test results, as well as the probability for individual patient benefit.<sup>5</sup> Uncovering incidental findings and being overwhelmed with information are important barriers to genetic testing, particularly among vulnerable patient subgroups.<sup>6</sup> Genetic counseling is an invaluable resource for patients undergoing genetic testing, but there are practical limitations because of the scarcity of genetic counselors relative to the current need. Clinicians are often required to stretch their skillsets and play a role in providing basic counseling about genetic testing and will need more training and skills to do so effectively. Further research is needed regarding the use of clinical practice tools to enhance patient care and uphold the clinical and ethical ideals of medical care in this complicated realm of care delivery.

The use of genetic counseling by professionals not employed by testing laboratories is strongly recommended for a wide variety of common clinical scenarios across all realms of medicine. Genetic counseling is considered mandatory for a subset of clinical scenarios related to germline or somatic testing where the stakes are predictably high in terms of the potential medical, and psychological consequences of testing process. The specific scenarios for which genetic counseling is mandatory and the minimum expected qualifications for genetic counseling providers may vary by health plan.

## Clinical Indications

### General Requirements

#### Genetic testing for inherited conditions

Genetic testing is considered **medically necessary** for an individual when **ALL** of the following criteria are met:

- The individual is either suspected to have a known genetic condition based on clinical presentation or the individual may be pre-symptomatic but at significant risk based on family history\*
- The genetic disorder being screened for has clearly defined gene(s) and pathogenic variants associated with it and the associated test has high sensitivity and specificity to guide clinical decision making
- The genetic testing has established analytical and clinical validity and is performed in an appropriately certified laboratory
- Alternate, biochemical, or other clinical tests are not available, provide an indeterminate result or are less effective than genetic testing
- The natural history of the disease is associated with significant morbidity and or mortality in affected individuals
- Knowledge of the pathogenic variant(s) is expected to directly impact clinical management (predictive, diagnostic, surveillance, or therapeutic) of the individual

Confirmatory genetic testing is considered **medically necessary** for an individual identified to have a pathological variant based on FDA-approved direct-to-consumer genetic testing.

**Testing may be performed only once per lifetime for a given condition.**

*\*Family history of the condition(s) being evaluated is present in first-, second- or third-degree relatives as applicable to the inheritance pattern of the condition (i.e., autosomal dominant, autosomal recessive, X-linked). This may also include family history of a known pathogenic variant with or without expression of the condition being evaluated.*

## Multi-gene panel testing for inherited conditions

Panel testing may be considered when all general and condition-specific criteria are met as well as all of the following:

- Any multi-gene panel should be as focused as reasonably possible taking into account the prevalence of each gene and the clinical utility of identifying the presence or absence of a pathogenic variant in each gene
- Each gene included must have evidence to show their association with the condition as well as important in management.
- A tiered approach to testing, with reflex to more detailed testing, should be undertaken where clinically appropriate

### Rationale

Mendelian disorders and monogenic traits result from combinations of variants in 1 or a few genes that have a large effect on the propensity for developing a certain condition or characteristic. While various common conditions are covered by specific guideline criteria, it is not feasible to establish criteria for every Mendelian disorder and monogenic trait. This general guideline describes criteria for testing for a single gene or a focused panel of genes in order to diagnose a specific condition or provide important information related to therapeutic choices or prognostication.

## Condition-Specific Requirements

### Cardiac conditions

Genetic testing for **hereditary cardiac conditions** is considered **medically necessary** when **ALL** of the general medical necessity criteria above are met in addition to the condition-specific criteria below.

#### Hereditary arrhythmia syndromes

Genetic testing for pathogenic variants associated with long QT syndrome, catecholamine polymorphic ventricular tachycardia (CPVT), or Brugada syndrome is considered **medically necessary** when **ANY** of the following are present:

- Individual to be tested is symptomatic with supporting clinical and ECG features for long QT syndrome, or catecholamine polymorphic ventricular tachycardia (CPVT), or Brugada syndrome
- Individual to be tested is pre-symptomatic with characteristic ECG features (at rest or with exercise) suggestive of an inherited cardiac arrhythmia syndrome **AND** the individual to be tested has a first-degree relative with **ANY** of the following:
  - Sudden cardiac death
  - Unexplained syncope
  - Unexplained cardiac arrest
- Known familial pathogenic variant associated with long QT syndrome, catecholamine polymorphic ventricular tachycardia (CPVT), or Brugada syndrome in a first or second degree relative
- The genetic testing is focused on pathogenic variants relevant to the individual's suspected clinical diagnosis and known familial genetics

#### Hereditary cardiomyopathy syndromes

Genetic testing for pathogenic variants associated with hereditary hypertrophic cardiomyopathy, arrhythmogenic right ventricular cardiomyopathy/dysplasia (ARVC/D), or inherited dilated cardiomyopathy is considered **medically necessary** when **ALL** of the following criteria are met:

- Individual to be tested has a first-degree relative with supporting clinical features of one of the inherited cardiomyopathy syndromes named above

- The individual to be tested has been clinically screened to exclude an alternate, acquired etiology of cardiomyopathy (e.g., ischemic cardiomyopathy, cardiac amyloidosis, etc.)
- The genetic testing is focused on pathogenic variants relevant to the individual's suspected clinical diagnosis and known familial genetics

## Post-mortem testing after sudden cardiac death

After sudden cardiac death, genetic testing for pathogenic variants associated with cardiac channelopathies are considered medically necessary when ALL of the following criteria are met:

- The decedent is < 50 years old
- The cause of sudden cardiac death remains unexplained despite the clinical history and autopsy, toxicology, and cardiac pathology findings

## Amyloidosis

Genetic testing with TTR gene sequencing in individuals for whom a diagnosis of transthyretin amyloidosis has been confirmed is considered **medically necessary** in order to differentiate the hereditary variant from wild-type transthyretin amyloidosis

### Rationale: Hereditary cardiac conditions

Genetic testing for certain inherited cardiomyopathy syndromes and inherited arrhythmia syndromes are recommended by cardiovascular societies. Finding a genetic cause for these inherited cardiac diseases makes an important impact by establishing a precise diagnosis, allowing predictive testing for family members, guiding choice of therapies, assisting in reproductive decisions (including preimplantation genetic diagnosis), and providing additional prognostic information.<sup>7</sup> In a study of broad screening of patients with cardiomyopathy and/or arrhythmias with testing of up to 150 genes, about 30% of patients had a pathogenic or likely pathogenic variant in one of these following 8 genes associated with adverse clinical outcomes associated with hypertrophic cardiomyopathy: ACTC1, MYL2, MYBPC3, MYH7, MYL3, TNN13, TNNT2, and TPM1.<sup>8</sup> Likewise, about 30% of patients undergoing broad genetic screening have pathogenic variants of one of 10 genes associated with heightened arrhythmia risk: ABCC9, DES, DSP, FLNC, LMNA, PLN, RBM20, SCN5A, or TTN. However, broad testing is associated with a high rate of variants of unknown significance (VUS), with 51% of patients screened having a VUS that is not clinically actionable and leads to potential harm to patients and their families. Overdiagnosis of certain cardiomyopathies (such as left ventricular noncompaction cardiomyopathy) can lead to lower yield of useful genetic test findings and higher rates of variants of unknown significance.<sup>8</sup> Overall, establishing a precise clinical diagnosis, and comprehensive pre-test and post-test genetic counseling that includes robust 3-generational assessment of the family history of the particular disease<sup>9</sup> will generate a higher pretest probability and positive genetic testing yield and will reduce the rate of uncertain findings. Family history may be informative in determining the likelihood of finding a pathogenic variant that fits the clinical picture of a pre-symptomatic individual. When a suspicious family history is present, the concern for an underlying genetic risk of an inherited cardiac syndrome would be higher. We recognize that there are inherent limitations to obtaining a family history such as adoption, estrangement, or limited health information. Additional considerations for family history in the setting of cardiac arrhythmias would include inter- and intra-familial variable expression, variable penetrance, and the possibility of the individual's condition being de novo. In these cases, further clinical review may be indicated.

Cardiomyopathies represent a group of disorders of the heart muscle associated with cardiac dysfunction, aggravated by arrhythmias, heart failure, and sudden cardiac death (SCD). The most common causes of cardiomyopathy and congestive heart failure include ischemic heart disease, myocardial infarction, hypertension, and valvular heart disease. Other causes of heart failure are classified according to their structural and functional phenotypes. Rare, heritable forms of cardiomyopathy include hypertrophic cardiomyopathy (HCM), dilated cardiomyopathy (DCM), restrictive cardiomyopathy (RCM), and arrhythmogenic right ventricular (ARVC)/arrhythmogenic cardiomyopathy (ACM). These cardiomyopathies range in prevalence from 1:250 to 1:5000, with variations in frequency across different populations. In adult-onset cardiomyopathies, genetic inheritance is typically autosomal dominant, whereas in pediatric-onset cardiomyopathies, X-linked, autosomal recessive, and de novo sporadic patterns are more often observed.<sup>10</sup> Identifying the specific cause of heart failure is important because there may be therapeutic and additional diagnostic implications.<sup>11</sup>

A rare cause of cardiomyopathy is transthyretin (ATTR) amyloidosis. This is a progressive fatal disease characterized by accumulation in tissues of amyloid fibrils composed of misfolded transthyretin (TTR) protein. The diagnosis is made by endomyocardial biopsy. The acquired (wild-type) ATTR amyloidosis is an increasingly recognized cause of cardiomyopathy. A hereditary form of ATTR amyloidosis is rare and thought to be present in approximately 50,000 persons worldwide.<sup>12</sup> Heart failure guidelines from the American Heart Association/American College of Cardiology/Heart Failure Society of America and also the Canadian Cardiovascular Society/Canadian Heart Failure Society guidelines recommend that in patients for whom a diagnosis of ATTR amyloidosis is made, genetic testing with TTR gene sequencing is recommended to differentiate the hereditary from the wild type forms of this disease.<sup>11, 13</sup>

Consensus guidelines published in 2022 from the European Heart Rhythm Association (EHRA)/HeartRhythm Society (HRS)/Asia Pacific Heart Rhythm Society (APHRS)/Latin American Heart Rhythm Society (LAHRS) distinguish syndromes for which there is significant diagnostic, prognostic, or therapeutic impact on the proband and genetic testing is recommended and considered useful from those where testing is sometimes considered by less useful.<sup>7</sup> For hereditary cardiomyopathic hypertrophic (HCM) and arrhythmogenic (ARVC) cardiomyopathies were recommended for testing based on diagnostic impact. Variants in genes encoding sarcomere proteins account for 30% to 60% of HCM, with MYH7 (encoding myosin heavy chain) and MYBPC3 (encoding cardiac myosin-binding protein C) the most commonly involved genes. ARVC is caused by variants in genes encoding desmosomal proteins. Dilated cardiomyopathy is genetically more heterogeneous than HCM, with > 50 genes contributing.<sup>10</sup> Dilated cardiomyopathy did not receive a consensus recommendation based on diagnostic or therapeutic impact but was considered useful for prognostication.<sup>7</sup>

In the realm of arrhythmia syndromes, the identification of pathogenic variants associated with increased risk of sudden death may trigger consideration of primary prevention implantable cardioverter-defibrillators (ICDs) even in patients who have LVEF > 0.35 or < 3 months of guideline recommended therapies.<sup>11</sup> Genetic testing was recommended by the 2022 consensus guidelines of the EHRA/HRS/APHRS/LAHRs for long QT syndrome based on diagnostic, prognostic, and therapeutic impact, and for catecholamine polymorphic ventricular tachycardia (CPVT) based on diagnostic impact.<sup>7</sup> While Brugada syndrome has a lower level of evidence regarding the impact of genetic testing for the proband in terms of diagnostic, prognostic, or therapeutic utility, it was nevertheless clearly recommended based on observational data and consensus recommendation that sequencing of SCN5A for performed for an index case of Brugada syndrome. Of note, Long-QT syndrome (LQTS) is the most common heritable arrhythmia at a prevalence of ≈1:2500. There are three forms of LQTS, with variants in KCNQ1 (encoding potassium voltage-gated channel subfamily Q member 1, type 1 LQTS), KCNH2 (potassium voltage-gated channel subfamily H member 2, type 2 LQTS), and SCN5A (type 3 LQTS).<sup>10</sup> More rare inherited arrhythmias include catecholaminergic polymorphic ventricular tachycardia (mostly RYR2-mediated), short-QT syndrome, early repolarization syndrome, familial atrial fibrillation, familial Wolff-Parkinson-White syndrome, and conduction system defects.

Most cases of sudden cardiac death (SCD) are caused by coronary artery disease and approximately 40% of cardiac arrests are unexplained. Inherited arrhythmias and cardiomyopathies are important contributors to SCD. Identifying an inherited condition after such an event has important ramifications for relatives who may be at risk for the familial condition.<sup>14</sup> The addition of genetic testing to autopsy investigation has been shown to substantially increase the identification of a possible cause of SCD among children and young adults.<sup>15</sup> In a case series of 109 consecutive families, a comprehensive strategy that involves cardiological evaluation of family members with genetic testing has a diagnostic yield of 18%, with the majority having LQTS and older age probands (above age 40) more likely to have Brugada syndrome.<sup>16</sup> There is sufficient yield in multi-gene panel genetic testing for channelopathies when young individuals experience otherwise unexplained sudden cardiac death to support this approach in recent cardiac guidelines.<sup>7</sup>

## Hereditary Neurologic Conditions

Genetic testing for screening or diagnosis of **ANY** of the following common categories of hereditary neurological conditions is considered **not medically necessary**:

- Alzheimer's dementia
- Frontotemporal dementias (i.e., Parkinson's disease, Pick disease, and others)
- Motor neuron diseases (such as amyotrophic lateral sclerosis)

### Rationale: Hereditary neurologic conditions

Nearly all major disorders treated by adult and pediatric neurologists on a daily basis are influenced by phenotypic variation, with heritability typically ranging widely from 20%-70%.<sup>17</sup> However, Mendelian (single-gene) forms of common neurological conditions are rare and most of these conditions are genetically complex. For example, although 25% of the general population age 55 or older have a family history of dementia in a first degree relative, only a few hundred families with Mendelian forms of Alzheimer's disease have been reported.<sup>18</sup> Genetic testing for any individual genetic variation has poor predictive power for dementia and is not recommended in clinical practice.<sup>18</sup> While there are specific genes that may be tested such as APOE, APP, PSEN1, PSEN2 and others, the diagnosis of Alzheimer's disease (AD) is clinical diagnosis of exclusion. However, the likelihood of a meaningful pathogenic variant rises if there are two or more affected first degree relatives with early-onset dementia (diagnosed at less than 65 years of age). However, only 2%-10% of those with AD have early-onset disease, and genetic mutations are found in only 30%-50% of those individuals. While genetic testing may be diagnostic in symptomatic individuals with familial forms of Alzheimer's dementia, and with dominantly inherited dementias (such as Huntington disease) frontotemporal dementia, such testing carries ethical risks and potential individual and family harms as well.<sup>19</sup> While early detection offers potential benefits including diagnostic closure, family planning, and opportunities for advance care planning the potential harms may include adverse psychological responses, confusion provoked by genetic variants of unknown significance and variable penetrance, and vulnerability to discrimination.

Amyotrophic lateral sclerosis (ALS) is a progressive disorder characterized by the selective degeneration of corticospinal and spinal motor neurons, resulting in progressive paralysis of the 4 limbs, the bulbar region, and the respiratory system, leading to death within an average of 3–5 years after disease onset. The incidence is estimated between 1.6 and 4/100,000 person-years, with the onset generally between age 45 and 65 years. Familial forms account for approximately 10% of ALS cases.<sup>20</sup>

ALS and fronto-temporal dementia (FTD) are conditions considered to belong to the same spectrum, and the hexanucleotide repeat expansion in C9ORF72 explains approximately 40% of familial ALS cases, 25% of familial FTD disease, and 5%–8% of apparently sporadic cases. The utility of pre-symptomatic genetic testing and counseling, however, is limited due to the unpredictability of the clinical phenotype.<sup>20</sup>

## Thrombophilia Testing

Thrombophilia testing for common pathogenic variants associated with Factor V Leiden or the prothrombin (Factor II) gene G20210A is considered **medically necessary** to inform anticoagulation decision-making when **ANY** of the following criteria are met:

- Individuals with VTE at age 50 or under in association with either weak provoking factors, recurrent VTE, or strong family history of VTE
- Individuals with VTE involving the cerebral or splanchnic veins
- An individual contemplating pregnancy who has a first-degree relative with VTE and a known hereditary thrombophilia
- An individual with an unprovoked VTE and low bleeding risk is planning to stop anticoagulation, test for thrombophilia if test results would change this decision
- An individual contemplating estrogen use with a first-degree relative with VTE and a known hereditary thrombophilia test for that thrombophilia

### Rationale: Thrombophilia testing

Venous thromboembolism (VTE) occurs in approximately 1 in 1000 persons and is associated with a small risk of death (less than 5%) but a higher risk of significant morbidity due to bleeding from use of anticoagulation, pulmonary and other complications of the event, and psychological distress.<sup>21</sup> For those with unprovoked VTE, the risk of recurrence after stopping anticoagulation is 5%-10% after 1 year and 11%-36% after 5 years, with recurrence risks higher in men.<sup>22</sup> Occult cancer is detected in approximately 5% of patients within one year of unprovoked VTE.<sup>23</sup>

Some individuals with VTE have an underlying genetic predisposition to the condition (inherited thrombophilia). The most common thrombophilias that involve genetic testing are Factor V Leiden (prevalence 2%-7%) and prothrombin gene G20210A mutation (1%-2%). The common MTHFR gene variants, 677C>T and 1298A>G, are prevalent in the general population. Recent meta-analyses have disproven an association between the presence of these variants and venous thromboembolism and the American College of Medical Genetics and Genomics (ACMG) included the [statement](#) “do not order MTHFR genetic testing for the risk assessment of hereditary thrombophilia” as part of their contribution to the *Choosing Wisely* campaign targeting five things patients and providers should question. Other thrombophilias that are approached through other laboratory testing include the antiphospholipid syndrome (prevalence 2%), and other more rare conditions including protein C or protein S deficiency (prevalence < 0.5%) or antithrombin deficiency (prevalence 0.02%).<sup>24</sup>

Factors associated with the presence of an inherited thrombophilia include VTE at age less than 50 years; a strong family history of VTE; VTE in conjunction with weak provoking factors at a young age; recurrent VTE events; and VTE in an unusual site such as the central nervous system or splanchnic veins. Although inherited and acquired thrombophilias are acknowledged to increase the risk of VTE, data showing the clinical usefulness and benefits of testing are limited or nonexistent, as are data supporting the benefit of primary or secondary VTE prophylaxis based on thrombophilia status alone.<sup>25</sup> Patients with inherited thrombophilia can and most often are identified and treated on the basis of the patient’s personal and family history of VTE, even without knowledge of test results. There are limited indications for testing in some specific circumstances, particularly when stopping anticoagulation is being planned.<sup>24, 26</sup>

The SARS-CoV-2 infection and COVID-19 illness is associated with arterial and venous thrombosis complications, but this does not have any known implications related to thrombophilia testing.<sup>27</sup>

## Biomarker Testing for Rejection in Solid Organ Transplantation

Use of Allomap gene-expression profiling for monitoring adolescent and adult patients post cardiac transplantation who are considered low risk for graft rejection is **medically necessary** when **ALL** of the following criteria are met:

- The individual is at least 15 years old and at least 6 months post cardiac transplantation
- The individual is clinically stable and does not have signs or symptoms of congestive heart failure

- The individual does not have signs or symptoms of graft rejection or require acute treatment for rejection
- Testing is not more frequent than the following:
  - Every 3 months between month 6 and month 24 after transplantation
  - Every 6 months between month 24 and month 60 after transplantation
  - Testing does not extend beyond 60 months after transplantation

### Not Medically Necessary:

Genetic testing (including donor-derived cell free DNA testing, gene expression profiling, or microRNA testing) for use as a biomarker for diagnosis and/or monitoring of kidney or other (non-cardiac) organ transplant rejection is considered **not medically necessary**.

### Rationale: Biomarker testing for rejection in solid organ transplantation

HLA incompatibility between donors and recipients who are not genetically identical is a key barrier to solid organ transplantation. This incompatibility causes a form of allograft rejection triggered by the production of antibodies directed toward donor HLA molecules—antibody-mediated rejection. The presence of donor-specific anti-HLA antibodies is a key component of diagnosis of antibody-mediated rejection.

The monitoring of transplanted kidney is based on physical examination, urine volume, the assessment of albuminuria or proteinuria, serum creatinine, and glomerular filtration rate estimation based on serum creatinine. However, the serum creatinine level is not a biomarker able to predict or evaluate the progression of chronic injury and as a consequence is not specific or predictive.<sup>28</sup> The histological examination through renal biopsy remains the gold standard for diagnosis to evaluate the rejection process of the transplanted kidney. Histologically, microvascular inflammation is a key diagnostic feature of antibody-mediated rejection in all types of organ allografts.<sup>29</sup> Following the example of the field of oncology, in which the measurement of multigene-expression profiles in tissue has been implemented with increasing frequency, recent development of high throughput cellular and molecular biotechnologies has allowed development of new biomarkers associated with chronic renal injury, which not only provide insight into pathogenesis of chronic rejection but are also being explored for early detection.<sup>29,30</sup> A wide array of biomarkers are being explored, including transcriptomic, epigenetic, proteomic, metabolomic, and cellular biomarkers<sup>30</sup> as well as imaging biomarkers. Urine and serum biomarkers such as NGAL, KIM-1, CXCL-10, CysC, OPN, and CLU play an essential role in detecting deteriorating renal function and are also being explored for the possibility of having an adjunctive role in the diagnosis of renal rejection alongside standard biochemical parameters and biopsy.<sup>28</sup>

In cardiac transplantation, endomyocardial biopsy is the current gold standard for cardiac allograft monitoring but is an expensive and invasive procedure. Although performing an endomyocardial biopsy is straightforward, the morbidity associated with this procedure motivated use of other means of diagnosing rejection. The Allomap gene expression profile (GEP) test, an 11-gene expression signature derived from peripheral blood mononuclear cells, is a noninvasive test with a high negative predictive value for acute cellular rejection and noninferiority to management based on endomyocardial biopsy results in the IMAGE randomized trial.<sup>31</sup> The Allomap GEP is commonly used to screen low-risk patients, defined as those who are clinically stable, have a cardiac ejection fraction of 45% or greater and no signs or symptoms of heart failure or antibody-mediated rejection. Suitable low risk patients are then screened at pre-determined intervals, using biopsies performed only if the GEP score is abnormal.

Proof of principle of a noninvasive diagnostic method based on high-throughput screening of circulating cell-free donor-derived DNA (cfDNA) has been demonstrated,<sup>32</sup> and similarly, early studies been conducted using specific sets of microRNAs to characterize antibody-mediated rejection<sup>33,34</sup> or gene-expression profiling test.<sup>35</sup> The clinical utility of such testing is not yet clear, and guidelines from the American Heart Association and Canadian Cardiovascular Society have no recommended such testing for routine use.<sup>36,37</sup>

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## Codes

The following code list is not meant to be all-inclusive. Authorization requirements will vary by health plan. Please consult the applicable health plan for guidance on specific procedure codes.

Specific CPT codes for services should be used when available. Nonspecific or not otherwise classified codes may be subject to additional documentation requirements and review.

### CPT/HCPCS

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- 81161 .....DMD (dystrophin) (eg, Duchenne/Becker muscular dystrophy) deletion analysis, and duplication analysis, if performed
- 81171 .....AFF2 (AF4/FMR2 family, member 2 [FMR2]) (eg, fragile X mental retardation 2 [FRAXE]) gene analysis; evaluation to detect abnormal (eg, expanded) alleles
- 81172 .....AFF2 (AF4/FMR2 family, member 2 [FMR2]) (eg, fragile X mental retardation 2 [FRAXE]) gene analysis; characterization of alleles (eg, expanded size and methylation status)
- 81173 .....AR (androgen receptor) (eg, spinal and bulbar muscular atrophy, Kennedy disease, X chromosome inactivation) gene analysis; full gene sequence
- 81174 .....AR (androgen receptor) (eg, spinal and bulbar muscular atrophy, Kennedy disease, X chromosome inactivation) gene analysis; known familial variant
- 81177 .....ATN1 (atrophin1) (eg, dentatorubral-pallidoluysian atrophy) gene analysis, evaluation to detect abnormal (eg, expanded) alleles
- 81178 .....ATXN1 (ataxin 1) (eg, spinocerebellar ataxia) gene analysis, evaluation to detect abnormal (eg, expanded) alleles
- 81179 .....ATXN2 (ataxin 2) (eg, spinocerebellar ataxia) gene analysis, evaluation to detect abnormal (eg, expanded) alleles
- 81180 .....ATXN3 (ataxin 3) (eg, spinocerebellar ataxia, Machado-Joseph disease) gene analysis, evaluation to detect abnormal (eg, expanded) alleles
- 81181 .....ATXN7 (ataxin 7) (eg, spinocerebellar ataxia) gene analysis, evaluation to detect abnormal (eg, expanded) alleles
- 81182 .....ATXN8OS (ataxin 8 opposite strand [non-protein coding]) (eg, spinocerebellar ataxia) gene analysis, evaluation to detect abnormal (eg, expanded) alleles
- 81183 .....ATXN10 (ataxin 10) (eg, spinocerebellar ataxia) gene analysis, evaluation to detect abnormal (eg, expanded) alleles
- 81184 .....CACNA1A (calcium voltage-gated channel subunit alpha1 A) (eg, spinocerebellar ataxia) gene analysis; evaluation to detect abnormal (eg, expanded) alleles
- 81185 .....CACNA1A (calcium voltage-gated channel subunit alpha1 A) (eg, spinocerebellar ataxia) gene analysis; full gene sequence

- 81186 .....CACNA1A (calcium voltage-gated channel subunit alpha1 A) (eg, spinocerebellar ataxia) gene analysis; known familial variant
- 81187 .....CNBP (CCHC-type zinc finger nucleic acid binding protein) (eg, myotonic dystrophy type 2) gene analysis, evaluation to detect abnormal (eg, expanded alleles)
- 81188 .....CSTB (cystatin B) (eg, Unverricht-Lundborg disease) gene analysis; evaluation to detect abnormal (eg, expanded) alleles
- 81189 .....CSTB (cystatin B) (eg, Unverricht-Lundborg disease) gene analysis; full gene sequence
- 81190 .....CSTB (cystatin B) (eg, Unverricht-Lundborg disease) gene analysis; known familial variant(s)
- 81200 .....ASPA (aspartoacylase) (eg, Canavan disease) gene analysis, common variants (eg, E285A, Y231X)
- 81204 .....AR (androgen receptor) (eg, spinal and bulbar muscular atrophy, Kennedy disease, X chromosome inactivation) gene analysis; characterization of alleles (eg, expanded size or methylation status)
- 81205 .....BCKDHB (branched-chain keto acid dehydrogenase E1, beta polypeptide) (eg, maple syrup urine disease) gene analysis, common variants (eg, R183P, G278S, E422X)
- 81209 .....BLM (Bloom syndrome, RecQ helicase-like) (eg, Bloom syndrome) gene analysis, 2281del6ins7 variant
- 81220 .....CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; common variants (eg, ACMG/ACOG guidelines)
- 81221 .....CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; known familial variants
- 81222 .....CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; duplication/deletion variants
- 81223 .....CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; full gene sequence
- 81224 .....CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; intron 8 poly-T analysis (eg, male infertility)
- 81234 .....DMPK (DM1 protein kinase) (eg, myotonic dystrophy type 1) gene analysis; evaluation to detect abnormal (expanded) alleles
- 81239 .....DMPK (DM1 protein kinase) (eg, myotonic dystrophy type 1) gene analysis; characterization of alleles (eg, expanded size)
- 81240 .....F2 (prothrombin, coagulation factor II) (eg, hereditary hypercoagulability) gene analysis, 20210G>A variant
- 81241 .....F5 (coagulation Factor V) (eg, hereditary hypercoagulability) gene analysis, Leiden variant
- 81242 .....FANCC (Fanconi anemia, complementation group C) (eg, Fanconi anemia, type C) gene analysis, common variant (eg, IVS4+4A>T)
- 81243 .....FMR1 (fragile X mental retardation 1) (eg, fragile X mental retardation) gene analysis; evaluation to detect abnormal (eg, expanded) alleles
- 81244 .....FMR1 (fragile X mental retardation 1) (eg, fragile X mental retardation) gene analysis; characterization of alleles (eg, expanded size and promoter methylation status)
- 81250 .....G6PC (glucose-6-phosphatase, catalytic subunit) (eg, Glycogen storage disease, Type 1a, von Gierke disease) gene analysis, common variants (eg, R83C, Q347X)
- 81251 .....GBA (glucosidase, beta, acid) (eg, Gaucher disease) gene analysis, common variants (eg, N370S, 84GG, L444P, IVS2+1G>A)
- 81252 .....GJB2 (gap junction protein, beta 2, 26kDa, connexin 26) (eg, nonsyndromic hearing loss) gene analysis; full gene sequence
- 81253 .....GJB2 (gap junction protein, beta 2, 26kDa, connexin 26) (eg, nonsyndromic hearing loss) gene analysis; known familial variants
- 81254 .....GJB2 (gap junction protein, beta 6, 30kDa, connexin 30) (eg, nonsyndromic hearing loss) gene analysis, common variants (eg, 309kb [del(GJB6-D13S1830)] and 232kb [del(GJB6-D13S1854)])
- 81255 .....HEXA (hexosaminidase A [alpha polypeptide]) (eg, Tay-Sachs disease) gene analysis, common variants (eg, 1278insTATC, 1421+1G>C, G269S)
- 81256 .....HFE (hemochromatosis) (eg, hereditary hemochromatosis) gene analysis, common variants (eg, C282Y, H63D)
- 81257 .....HBA1/HBA2 (alpha globin 1 and alpha globin 2) (eg, alpha thalassemia, Hb Bart hydrops fetalis syndrome, HbH disease), gene analysis; common deletions or variant (eg, Southeast Asian, Thai, Filipino, Mediterranean, alpha3.7, alpha4.2, alpha20.5, and Constant Spring)
- 81258 .....HBA1/HBA2 (alpha globin 1 and alpha globin 2) (eg, alpha thalassemia, Hb Bart hydrops fetalis syndrome, HbH disease), gene analysis; known familial variant
- 81259 .....HBA1/HBA2 (alpha globin 1 and alpha globin 2) (eg, alpha thalassemia, Hb Bart hydrops fetalis syndrome, HbH disease), gene analysis; full gene sequence

- 81260 .....IKBKAP (inhibitor of kappa light polypeptide gene enhancer in B-cells, kinase complex-associated protein) (eg, familial dysautonomia) gene analysis, common variants (eg, 2507+6T>C, R696P)
- 81269 .....HBA1/HBA2 (alpha globin 1 and alpha globin 2) (eg, alpha thalassemia, Hb Bart hydrops fetalis syndrome, HbH disease), gene analysis; duplication/deletion variants
- 81271 .....HTT (huntingtin) (eg, Huntington disease) gene analysis; evaluation to detect abnormal (eg, expanded) alleles
- 81274 .....HTT (huntingtin) (eg, Huntington disease) gene analysis; characterization of alleles (eg, expanded size)
- 81284 .....FXN (frataxin) (eg, Friedreich ataxia) gene analysis; evaluation to detect abnormal (expanded) alleles
- 81285 .....FXN (frataxin) (eg, Friedreich ataxia) gene analysis; characterization of alleles (eg, expanded size)
- 81286 .....FXN (frataxin) (eg, Friedreich ataxia) gene analysis; full gene sequence
- 81289 .....FXN (frataxin) (eg, Friedreich ataxia) gene analysis; known familial variant(s)
- 81290 .....MCOLN1 (mucolipin 1) (eg, Mucopolipidosis, type IV) gene analysis, common variants (eg, IVS3-2A>G, del6.4kb)
- 81291 .....MTHFR (5,10-methylenetetrahydrofolate reductase) (eg, hereditary hypercoagulability) gene analysis, common variants (eg, 677T, 1298C)
- 81302 .....MECP2 (methyl CpG binding protein 2) (eg, Rett syndrome) gene analysis; full sequence analysis
- 81303 .....MECP2 (methyl CpG binding protein 2) (eg, Rett syndrome) gene analysis; known familial variant
- 81304 .....MECP2 (methyl CpG binding protein 2) (eg, Rett syndrome) gene analysis; duplication/deletion variants
- 81312 .....PABPN1 (poly[A] binding protein nuclear 1) (eg, oculopharyngeal muscular dystrophy) gene analysis, evaluation to detect abnormal (eg, expanded) alleles
- 81329 .....SMN1 (survival of motor neuron 1, telomeric) (eg, spinal muscular atrophy) gene analysis; dosage/deletion analysis (eg, carrier testing), includes SMN2 (survival of motor neuron 2, centromeric) analysis, if performed
- 81330 .....SMPD1 (sphingomyelin phosphodiesterase 1, acid lysosomal) (eg, Niemann-Pick disease, Type A) gene analysis, common variants (eg, R496L, L302P, fsP330)
- 81331 .....SNRPN/UBE3A (small nuclear ribonucleoprotein polypeptide N and ubiquitin protein ligase E3A) (eg, Prader-Willi syndrome and/or Angelman syndrome), methylation analysis
- 81332 .....SERPINA1 (serpin peptidase inhibitor, clade A, alpha-1 antiproteinase, antitrypsin, member 1) (eg, alpha-1-antitrypsin deficiency), gene analysis, common variants (eg, \*S and \*Z)
- 81333 .....TGFB1 (transforming growth factor beta-induced) (eg, corneal dystrophy) gene analysis, common variants (eg, R124H, R124C, R124L, R555W, R555Q)
- 81336 .....SMN1 (survival of motor neuron 1, telomeric) (eg, spinal muscular atrophy) gene analysis; full gene sequence
- 81337 .....SMN1 (survival of motor neuron 1, telomeric) (eg, spinal muscular atrophy) gene analysis; known familial sequence variant(s)
- 81343 .....PPP2R2B (protein phosphatase 2 regulatory subunit Bbeta) (eg, spinocerebellar ataxia) gene analysis, evaluation to detect abnormal (eg, expanded) alleles
- 81344 .....TBP (TATA box binding protein) (eg, spinocerebellar ataxia) gene analysis, evaluation to detect abnormal (eg, expanded) alleles
- 81361 .....HBB (hemoglobin, subunit beta) (eg, sickle cell anemia, beta thalassemia, hemoglobinopathy); common variant(s) (eg, HbS, HbC, HbE)
- 81362 .....HBB (hemoglobin, subunit beta) (eg, sickle cell anemia, beta thalassemia, hemoglobinopathy); known familial variant(s)
- 81363 .....HBB (hemoglobin, subunit beta) (eg, sickle cell anemia, beta thalassemia, hemoglobinopathy); duplication/deletion variant(s)
- 81364 .....HBB (hemoglobin, subunit beta) (eg, sickle cell anemia, beta thalassemia, hemoglobinopathy); full gene sequence
- 81400 .....Molecular pathology procedure, Level 1 (eg, identification of single germline variant [eg, SNP] by techniques such as restriction enzyme digestion or melt curve analysis)
- 81401 .....Molecular pathology procedure, Level 2 (eg, 2-10 SNPs, 1 methylated variant, or 1 somatic variant [typically using nonsequencing target variant analysis], or detection of a dynamic mutation disorder/triplet repeat)
- 81402 .....Molecular pathology procedure, Level 3 (eg, > 10 SNP's 2-10 methylated variants, or 2-10 somatic variants [typically using non-sequencing target variant analysis], immunoglobulin and T-cell receptor gene rearrangements, duplication/deletion variants of 1 exon, loss of heterozygosity [LOH], uniparental disomy [UPD])
- 81403 .....Molecular pathology procedure, Level 4 (eg, analysis of single exon by DNA sequence analysis, analysis of >10 amplicons using multiplex PCR in 2 or more independent reactions, mutation scanning or duplication/deletion variants of 2-5 exons)
- 81404 .....Molecular pathology procedure, Level 5 (eg, analysis of 2-5 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 6-10 exons, or characterization of a dynamic mutation disorder/triplet repeat by Southern blot analysis)

- 81405 .....Molecular pathology procedure, Level 6 (eg, analysis of 6-10 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 11-25 exons, regionally targeted cytogenomic array analysis)
- 81406 .....Molecular pathology procedure, Level 7 (eg, analysis of 11-25 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 26-50 exons, cytogenomic array analysis for neoplasia)
- 81407 .....Molecular pathology procedure, Level 8 (eg, analysis of 26-50 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of >50 exons, sequence analysis of multiple genes on one platform)
- 81408 .....Molecular pathology procedure, Level 9 (eg, analysis of >50 exons in a single gene by DNA sequence analysis)
- 81410 .....Aortic dysfunction or dilation (eg, Marfan syndrome, Loeys Dietz syndrome, Ehler Danlos syndrome type IV, arterial tortuosity syndrome); genomic sequence analysis panel, must include sequencing of at least 9 genes, including FBN1, TGFB1, TGFB2, COL3A1, MYH11, ACTA2, SLC2A10, SMAD3, and MYLK
- 81411 .....Aortic dysfunction or dilation (eg, Marfan syndrome, Loeys Dietz syndrome, Ehler Danlos syndrome type IV, arterial tortuosity syndrome); duplication/deletion analysis panel, must include analyses for TGFB1, TGFB2, MYH11, and COL3A1
- 81413 .....Cardiac ion channelopathies (eg, Brugada syndrome, long QT syndrome, short QT syndrome, catecholaminergic polymorphic ventricular tachycardia); genomic sequence analysis panel, must include sequencing of at least 10 genes, including ANK2, CASQ2, CAV3, KCNE1, KCNE2, KCNH2, KCNJ2, KCNQ1, RYR2, and SCN5A
- 81419 .....Epilepsy genomic sequence analysis panel, must include analyses for ALDH7A1, CACNA1A, CDKL5, CHD2, GABRG2, GRIN2A, KCNQ2, MECP2, PCDH19, POLG, PRRT2, SCN1A, SCN1B, SCN2A, SCN8A, SLC2A1, SLC9A6, STXBP1, SYNGAP1, TCF4, TPP1, TSC1, TSC2, and ZEB2
- 81430 .....Hearing loss (eg, nonsyndromic hearing loss, Usher syndrome, Pendred syndrome); genomic sequence analysis panel, must include sequencing of at least 60 genes, including CDH23, CLRN1, GJB2, GPR98, MTRNR1, MYO7A, MYO15A, PCDH15, OTOF, SLC26A4, TMC1, TMPRSS3, USH1C, USH1G, USH2A, and WFS1
- 81431 .....Hearing loss (eg, nonsyndromic hearing loss, Usher syndrome, Pendred syndrome); duplication/deletion analysis panel, must include copy number analyses for STRC and DFNB1 deletions in GJB2 and GJB6 genes
- 81434 .....Hereditary retinal disorders (eg, retinitis pigmentosa, Leber congenital amaurosis, cone-rod dystrophy), genomic sequence analysis panel, must include sequencing of at least 15 genes, including ABCA4, CNGA1, CRB1, EYS, PDE6A, PDE6B, PRPF31, PRPH2, RDH12, RHO, RP1, RP2, RPE65, RPGR, and USH2A
- 81434 .....Hereditary retinal disorders (eg, retinitis pigmentosa, Leber congenital amaurosis, cone-rod dystrophy), genomic sequence analysis panel, must include sequencing of at least 15 genes, including ABCA4, CNGA1, CRB1, EYS, PDE6A, PDE6B, PRPF31, PRPH2, RDH12, RHO, RP1, RP2, RPE65, RPGR, and USH2A
- 81440 .....Nuclear encoded mitochondrial genes (eg, neurologic or myopathic phenotypes), genomic sequence panel, must include analysis of at least 100 genes, including BCS1L, C10orf2, COQ2, COX10, DGUOK, MPV17, OPA1, PDSS2, POLG, POLG2, RRM2B, SCO1, SCO2, SLC25A4, SUCLA2, SUCLG1, TAZ, TK2, and TYMP
- 81442 .....Noonan spectrum disorders (eg, Noonan syndrome, cardio-facio-cutaneous syndrome, Costello syndrome, LEOPARD syndrome, Noonan-like syndrome), genomic sequence analysis panel, must include sequencing of at least 12 genes, including BRAF, CBL, HRAS, KRAS, MAP2K1, MAP2K2, NRAS, PTPN11, RAF1, RIT1, SHOC2, and SOS1
- 81443 .....Genetic testing for severe inherited conditions (eg, cystic fibrosis, Ashkenazi Jewish-associated disorders [eg, Bloom syndrome, Canavan disease, Fanconi anemia type C, mucopolidosis type VI, Gaucher disease, Tay-Sachs disease], beta hemoglobinopathies, phenylketonuria, galactosemia), genomic sequence analysis panel, must include sequencing of at least 15 genes (eg, ACADM, ARSA, ASPA, ATP7B, BCKDHA, BCKDHB, BLM, CFTR, DHCR7, FANCC, G6PC, GAA, GALT, GBA, GBE1, HBB, HEXA, IKBKAP, MCOLN1, PAH)
- 81448 .....Hereditary peripheral neuropathies (eg, Charcot-Marie-Tooth, spastic paraplegia), genomic sequence analysis panel, must include sequencing of at least 5 peripheral neuropathy-related genes (eg, BSCL2, GJB1, MFN2, MPZ, REEP1, SPAST, SPG11, SPTLC1)
- 81470 .....X-linked intellectual disability (XLID) (eg, syndromic and non-syndromic XLID); genomic sequence analysis panel, must include sequencing of at least 60 genes, including ARX, ATRX, CDKL5, FGD1, FMR1, HUWE1, IL1RAPL, KDM5C, L1CAM, MECP2, MED12, MID1, OCRL, RPS6KA3, and SLC16A2
- 81471 .....X-linked intellectual disability (XLID) (eg, syndromic and non-syndromic XLID); duplication/deletion gene analysis, must include analysis of at least 60 genes, including ARX, ATRX, CDKL5, FGD1, FMR1, HUWE1, IL1RAPL, KDM5C, L1CAM, MECP2, MED12, MID1, OCRL, RPS6KA3, and SLC16A2
- 81479 .....Unlisted molecular pathology procedure
- 0170U.....Neurology (autism spectrum disorder [ASD]), RNA, next-generation sequencing, saliva, algorithmic analysis, and results reported as predictive probability of ASD diagnosis
- 0216U.....Neurology (inherited ataxias), genomic DNA sequence analysis of 12 common genes 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
- 0217U.....Neurology (inherited ataxias), genomic DNA sequence analysis of 51 genes 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

- 0218U.....Neurology (muscular dystrophy), DMD gene sequence analysis, including small sequence changes, deletions, duplications, and variants in non-uniquely mappable regions, blood or saliva, identification and characterization of genetic variants
- 0230U.....AR (androgen receptor) (eg, spinal and bulbar muscular atrophy, Kennedy disease, X chromosome inactivation), full sequence analysis, including small sequence changes in exonic and intronic regions, deletions, duplications, short tandem repeat (STR) expansions, mobile element insertions, and variants in non-uniquely mappable regions
- 0231U.....CACNA1A (calcium voltage-gated channel subunit alpha 1A) (eg, spinocerebellar ataxia), full gene analysis, including small sequence changes in exonic and intronic regions, deletions, duplications, short tandem repeat (STR) gene expansions, mobile element insertions, and variants in non-uniquely mappable regions
- 0232U.....CSTB (cystatin B) (eg, progressive myoclonic epilepsy type 1A, Unverricht-Lundborg disease), full gene analysis, including small sequence changes in exonic and intronic regions, deletions, duplications, short tandem repeat (STR) expansions, mobile element insertions, and variants in non-uniquely mappable regions
- 0233U.....FXN (frataxin) (eg, Friedreich ataxia), gene analysis, including small sequence changes in exonic and intronic regions, deletions, duplications, short tandem repeat (STR) expansions, mobile element insertions, and variants in non-uniquely mappable regions
- 0234U.....MECP2 (methyl CpG binding protein 2) (eg, Rett syndrome), full gene analysis, including small sequence changes in exonic and intronic regions, deletions, duplications, mobile element insertions, and variants in non-uniquely mappable regions
- 0236U.....SMN1 (survival of motor neuron 1, telomeric) and SMN2 (survival of motor neuron 2, centromeric) (eg, spinal muscular atrophy) full gene analysis, including small sequence changes in exonic and intronic regions, duplications and deletions, and mobile element insertions
- 0237U.....Cardiac ion channelopathies (eg, Brugada syndrome, long QT syndrome, short QT syndrome, catecholaminergic polymorphic ventricular tachycardia), genomic sequence analysis panel including ANK2, CASQ2, CAV3, KCNE1, KCNE2, KCNH2, KCNJ2, KCNQ1, RYR2, and SCN5A, including small sequence changes in exonic and intronic regions, deletions, duplications, mobile element insertions, and variants in non-uniquely mappable regions
- 0268U.....Hematology (atypical hemolytic uremic syndrome [aHUS]), genomic sequence analysis of 15 genes, blood, buccal swab, or amniotic fluid
- 0269U.....Hematology (autosomal dominant congenital thrombocytopenia), genomic sequence analysis of 14 genes, blood, buccal swab, or amniotic fluid
- 0270U.....Hematology (congenital coagulation disorders), genomic sequence analysis of 20 genes, blood, buccal swab, or amniotic fluid
- 0271U.....Hematology (congenital neutropenia), genomic sequence analysis of 23 genes, blood, buccal swab, or amniotic fluid
- 0272U.....Hematology (genetic bleeding disorders), genomic sequence analysis of 51 genes, blood, buccal swab, or amniotic fluid, comprehensive
- 0273U.....Hematology (genetic hyperfibrinolysis, delayed bleeding), genomic sequence analysis of 8 genes (F13A1, F13B, FGA, FGB, FGG, SERPINA1, SERPINE1, SERPINF2, PLAUI), blood, buccal swab, or amniotic fluid
- 0274U.....Hematology (genetic platelet disorders), genomic sequence analysis of 43 genes, blood, buccal swab, or amniotic fluid
- 0276U.....Hematology (inherited thrombocytopenia), genomic sequence analysis of 23 genes, blood, buccal swab, or amniotic fluid
- 0277U.....Hematology (genetic platelet function disorder), genomic sequence analysis of 31 genes, blood, buccal swab, or amniotic fluid
- 0278U.....Hematology (genetic thrombosis), genomic sequence analysis of 12 genes, blood, buccal swab, or amniotic fluid

## History

Status	Review Date	Effective Date	Action
Created	09/21/2022	02/12/2023	Independent Multispecialty Physician Panel (IMPP) review. Original effective date.