

Genetic Testing for Hereditary Cancer (for Indiana Only)

Policy Number: CS049IN.02
Effective Date: May 1, 2022

[Instructions for Use](#)

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Related Policies
None

Application

This Medical Policy only applies to the state of Indiana.

Coverage Rationale

Genetic counseling is strongly recommended prior to these tests in order to inform persons being tested about the advantages and limitations of the test as applied to a unique person.

For medical necessity clinical coverage criteria, refer to the [Indiana Health Coverage Programs Provider Reference Module: 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
BRCA1 and BRCA2	
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)

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81167	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)
81216	BRCA2 (BRCA2, DNA repair associated) (e.g., hereditary breast and ovarian cancer) gene analysis; full sequence analysis

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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 December 10, 2021)

References

Indiana Health Coverage Programs, Provider Reference Module. Genetic testing. Version 4.0. Available at:

<https://www.in.gov/medicaid/providers/files/genetic-testing.pdf>. Accessed December 17, 2021.

Policy History/Revision Information

Date	Summary of Changes
05/01/2022	<p>Coverage Rationale</p> <ul style="list-style-type: none"> Replaced coverage guidelines with instruction to refer to the <i>Indiana Health Coverage Programs Provider Reference Module: Genetic Testing</i> for medical necessity clinical coverage criteria <p>Applicable Codes</p> <ul style="list-style-type: none"> Removed CPT codes 0101U, 0102U, 0103U, 0129U, 0130U, 0131U, 0132U, 0133U, 0134U, 0135U, 0138U, 0162U, 0238U, 81212, 81215, 81217, 81432, 81433, 81435, 81436, 81437, and 81438 <p>Supporting Information</p> <ul style="list-style-type: none"> Updated <i>References</i> section to reflect the most current information Removed <i>Definitions</i>, <i>Description of Services</i>, and <i>Clinical Evidence</i> sections Archived previous policy version CS049IN.01

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.