

Cell-Free Fetal DNA Testing (for Kansas Only)

Policy Number: CS085KS.02

Effective Date: September 1, 2025

[Instructions for Use](#)

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Related Policies

- [Chromosome Microarray Testing \(Non-Oncology Conditions\) \(for Kansas Only\)](#)
- [Preimplantation Genetic Testing and Related Services \(for Kansas Only\)](#)

Application

This Medical Policy only applies to the state of Kansas.

Coverage Rationale

For medical necessity clinical coverage criteria for DNA-based noninvasive prenatal tests of fetal aneuploidy, refer to the [Kansas Medical Assistance Program Professional Fee-for-Service Provider Manual](#).

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
0060U	Twin zygosity, genomic targeted sequence analysis of chromosome 2, using circulating cell-free fetal DNA in maternal blood
0488U	Obstetrics (fetal antigen noninvasive prenatal test), cell-free DNA sequence analysis for detection of fetal presence or absence of 1 or more of the Rh, C, c, D, E, Duffy (Fya), or Kell (K) antigen in alloimmunized pregnancies, reported as selected antigen(s) detected or not detected
0489U	Obstetrics (single-gene noninvasive prenatal test), cell-free DNA sequence analysis of 1 or more targets (e.g., CFTR, SMN1, HBB, HBA1, HBA2) to identify paternally inherited pathogenic variants, and relative mutation-dosage analysis based on molecular counts to determine fetal inheritance of maternal mutation, algorithm reported as a fetal risk score for the condition (e.g., cystic fibrosis, spinal muscular atrophy, beta hemoglobinopathies [including sickle cell disease], alpha thalassemia)
0494U	Red blood cell antigen (fetal RhD gene analysis), next-generation sequencing of circulating cell-free DNA (cfDNA) of blood in pregnant individuals known to be RhD negative, reported as positive or negative
0536U	Red blood cell antigen (fetal RhD), PCR analysis of exon 4 of RHD gene and housekeeping control gene GAPDH from whole blood in pregnant individuals at 10+ weeks gestation known to be RhD negative, reported as fetal RhD status

CPT Code	Description
81422	Fetal chromosomal microdeletion(s) genomic sequence analysis (e.g., DiGeorge syndrome, Cri-du-chat syndrome), circulating cell-free fetal DNA in maternal blood
81479	Unlisted molecular pathology procedure

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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 DNA-based tests are regulated by the FDA under the Clinical Laboratory Improvement Amendments. Refer to the following website for more information:

<https://www.fda.gov/medical-devices/ivd-regulatory-assistance/clinical-laboratory-improvement-amendments-clia>.
(Accessed March 3, 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 March 4, 2025)

References

Kansas Medical Assistance Program Professional Fee-for-Service Provider Manual. Available at: <https://portal.kmap-state-ks.us/PublicPage/Public/ProviderManuals>. Accessed May 14, 2025.

Policy History/Revision Information

Date	Summary of Changes
09/01/2025	<p>Applicable Codes</p> <ul style="list-style-type: none"> Removed CPT codes 0327U, 81420, and 81507 <p>Supporting Information</p> <ul style="list-style-type: none"> Updated <i>FDA</i> section to reflect the most current information Archived previous policy version CS085KS.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 uses InterQual® for the primary medical/surgical criteria, and the American Society of Addiction Medicine (ASAM) criteria for substance use disorder (SUD) services, in administering health benefits. If InterQual® does not have applicable criteria, UnitedHealthcare may also use UnitedHealthcare Medical Policies that have been approved by the Kansas Department of Health and Environment. 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.