AmeriHealth Caritas Louisiana

Genetic Testing

Reimbursement Policy ID: RPC.0098.2100

Recent review date: 06/2026

Reimbursement policies and their resulting edits are based on guidelines from established industry sources, such as the Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA), state and federal regulatory agencies, and medical specialty professional societies. Reimbursement policies are intended as a general reference and do not constitute a contract or other guarantee of payment. The health plan may use reasonable discretion in interpreting and applying its policies to services provided in a particular case and may modify its policies at any time.

In making claim payment determinations, the health plan also uses coding terminology and methodologies based on accepted industry standards, including Current Procedural Terminology (CPT®); the Healthcare Common Procedure Coding System (HCPCS); and the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM), and other relevant sources. Other factors that may affect payment include medical record documentation, legislative or regulatory mandates, a provider's contract, a member's eligibility in receiving covered services, submission of clean claims, other health plan policies, and other relevant factors. These factors may supplement, modify, or in some cases supersede reimbursement policies.

This reimbursement policy applies to all health care services billed on a CMS-1500 form or its electronic equivalent, or when billed on a UB-04 form or its electronic equivalent.

To the extent that any procedure and/or diagnosis codes are specified in this policy, such inclusion is provided for reference purposes only, may not be all inclusive, and is not intended to serve as billing instructions. 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.

Policy Overview

This policy addresses reimbursement of prenatal cytogenetics, molecular pathology, breast cancer (BRCA) gene and ovarian cancer. Genetic testing modalities may be used in the prenatal or early post-natal period to assist in identification of the cause or confirm a diagnosis associated with developmental delay, intellectual disability, dysmorphic features, heart defects, multiple malformations, short stature, stillbirth, neonatal death, or fertility problems. Each of the genetic techniques or methods has its strengths and limitations. Different methods complement each other in trying to identify the genetic variation(s) responsible for a medical condition.

Exceptions

N/A

Reimbursement Guidelines

Claims for prenatal cytogenetic studies (88230-88239, 88245-88269, 88280-88289) may be denied when the only diagnosis on the claim is one of the following:

- full-term uncomplicated delivery (ICD-10-CM code O80),
- incidental pregnant state (ICD-10-CM code Z33.1), or
- supervision of normal pregnancy (ICD-10-CM codes Z34-Z34.93).

Claims for prenatal cytogenic testing require a diagnosis to support the need for ordered tests. Documentation in the medical record should support the need for testing.

Genetic testing for breast cancer, also known as BRCA1 and BRCA2, is covered and may require prior authorization. Testing codes include:

CPT code	Code Description
81162	BRCA1 and BRCA2 gene analysis
81215	BRCA1 known mutation analysis
81216	BRCA2 known mutation analysis
81217	BRCA1 and BRCA2 known mutation analysis
81432	Multi-gene panels for hereditary breast and ovarian cancer (including BRCA1, BRCA2, and other genes).

Covered tests are reimbursable when submitted with an approved diagnosis. Diagnosis codes include:

ICD-10-CM code	Code Description
C25.0-C25.9	Malignant neoplasm of the pancreas
C48.1	Malignant neoplasm of the peritoneum
C50.111- C50.229	Malignant neoplasm of the breast
C50.311-C50.629	Malignant neoplasm of the breast
C50.811-C50.829	Malignant neoplasm of the breast
C50.911-C50.919	Malignant neoplasm of the breast
C50.921-C50.929	Malignant neoplasm of the male breast
C50.A0- C50.A2	Malignant inflammatory neoplasm of the breast
C54.1	Malignant neoplasm of the endometrium
C56.1-C56.3	Malignant neoplasm of the ovary(s)
C56.9	Malignant neoplasm of unspecified ovary
C57.00-C57.02	Malignant neoplasm of the fallopian tube(s)
C61	Malignant neoplasm of the prostate
D05.10-D05.12	Intraductal neoplasm of the breast
Z15.01-Z15.03	Genetic susceptibility neoplasm of breast, ovary, prostate
Z15.04	Genetic susceptibility malignant neoplasm endometrium
Z15.05	Genetic susceptibility malignant neoplasm fallopian tube(s)
Z80.3	Family history of malignant neoplasm breast
Z80.41	Family history of malignant neoplasm ovary
Z80.42	Family history of malignant neoplasm prostate
Z80.44	Family history of malignant fallopian tube(s)
Z84.81	Family history of carriers of genetic disease
Z85.07	Personal history of malignant neoplasm pancreas
Z85.3	Personal history of malignant neoplasm breast
Z85.43	Personal history of malignant neoplasm ovary
Z85.44	Personal history of malignant neoplasm other female genital organs

Z85.46	Personal history of malignant neoplasm prostate
Z85.4A	Personal history of malignant neoplasm fallopian tube(s)
Z85.89	Personal history of malignant neoplasm other organs and systems
Z86.00	Personal history of in situ neoplasm

Definitions

Genetic Testing
A laboratory method that looks for changes in genes, gene expression, or chromosomes in cells or tissue of a person.

Cytogenetics
Testing samples of tissue, blood, amniotic fluid or bone marrow in a laboratory to look for changes in chromosomes, including broken, missing, rearranged, or extra chromosomes.

Edit Sources

I. Current Procedural Terminology (CPT) and associated publications and services.
II. International Classification of Diseases,10th Revision, Clinical Modification (ICD-10-CM).
III. Healthcare Common Procedure Coding System (HCPCS).
IV. Centers for Medicare and Medicaid Services (CMS).
V. National Correct Coding Initiative (NCCI)
VI. https://www.ncbi.nlm.nih.gov/gtr/all/labs/?term=cytogenetics%5Borgname%5D
VII. Applicable Medicaid Laboratory & Radiology Fee Schedule.

Attachments

N/A

Associated Policies

CCP.4012 Genetic testing for Breast and Ovarian Cancer

Policy History

10/2026	• Removed the next review date • Replaced the plan name with “the health plan”
06/2026	Reimbursement Policy Committee Approval
05/2026	Annual review • No major changes
02/2026	Reimbursement Policy Committee Approval
01/2026	CPT and ICD-10-Codes added per plan request
01/2026	Reimbursement Policy Committee Approval
12/2025	Annual review • Addition of BRACA testing
04/2025	Revised preamble
10/2024	Reimbursement Policy Committee Approval
	Precedes Act 319