Tennessee | Medicaid

# Reimbursement Policy
# Genetic Testing: Once per Lifetime

Policy Number: **G-23002**
Policy Section: **Laboratory**
Last Approval Date: **10/23/2025**
Effective Date: **02/01/2027**

Visit our provider website for the most current version of the reimbursement policies. If you are using a printed version of this policy, please verify the information by going to **https://provider.wellpoint.com/tn**.

## Policy

The health plan allows reimbursement for specific genetic tests once in a member's lifetime, unless provider, state, or federal contracts and/or requirements indicate otherwise.

During the member's lifetime, the germline genotype will not change. However, the interpretation of the gene sequence may change due to recategorization of variants or other factors. Repeat sequencing is not required for future interpretation of germline genotype or re-analysis of previously sequenced data.

The genetic procedures indicated in the Related Coding section below are limited to once per lifetime sequencing. Reinterpretation of the original results is not separately reimbursable.

This policy change impacts provider billing and/or reimbursement. It does not impact member care or services. Providers are not to balance bill members based on this policy change.

Medicaid coverage provided by Wellpoint Tennessee, Inc.
We comply with the applicable federal and state civil rights laws, rules, and regulations and do not discriminate against members or participants in the provision of services on the basis of race, color, national origin, religion, sex, age, or disability. If a member or a participant needs language, communication, or disability assistance or to report a discrimination complaint, call 833-731-2154. Information about the civil rights laws can be found at tn.gov/tenncare/members-applicants/civil-rights-compliance.html.
TN-WP-CD-RP-002637-25-GRP227 Matter ID: 2026-02195 | October 2026

## Related Coding

### Genetic Sequencing Once per Lifetime Procedures

## Definitions

- **Germline:** Cells arising from the germ cells containing genetic code that may be passed down to future generations. May also be referred to as hereditary or constitutional.
- **Genotype:** The genotype is the individual organism's unique set of all the genes.
- Sequencing: Determining the identity of each nucleotide (one of the four chemical building blocks - called "bases" - that make up the DNA molecule) to identify the kind of genetic information that is carried in a particular DNA segment.
- **Variant:** Nucleotide deviation from a reference sequence of DNA. For clinical testing, variants are classified into several categories (Pathogenic; Likely pathogenic; Variant of uncertain (or unknown) significance (VUS); Likely benign; Benign). As evidence on variants evolves, previous classifications may later require modification. Each laboratory decides what risk assessment to assign to each disease-causing variant within the gene; this is generally done according to an accepted classification scheme based on the likely clinical significance of each variant. Patient information (e.g., laboratory results, personal and family history of disease) may also inform how variants are classified.
- **General Reimbursement Policy Definitions**

## Related Policies and Materials

Code and Clinical Editing

## References and Research Materials

This policy has been developed through consideration of the following:

- CMS
- Optum EncoderPro 2025
- State contract
- State Medicaid

## Policy History

- 10/23/2025: Review approved 10/23/2025 and effective 02/01/2027: updated Related Coding section by adding codes
- 06/14/2023: Initial approval 06/14/2023 and effective 01/01/2024

## Disclaimer

These reimbursement policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement if the service is covered by a member’s benefit plan. The determination that a service, procedure, or item is covered

under a member's benefit plan is not a determination that you will be reimbursed. Services must also meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis, as well as to the member’s state of residence.

Ensure that you use proper billing and submission guidelines, including industry-standard, compliant codes on all claim submissions. Services should be billed with Current Procedural Terminology (CPT®) codes, Healthcare Common Procedure Coding System (HCPCS) codes, and/or revenue codes. These codes denote the services and/or procedures performed and, when billed, must be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our reimbursement policies apply to both participating and non-participating professional providers and facilities.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, we may:

- Reject or deny the claim.
- Recover and/or recoup claim payment.
- Adjust the reimbursement to reflect the appropriate services and/or procedures performed.

These reimbursement policies may be superseded by mandates in provider, state, federal, or Centers for Medicare & Medicaid Services (CMS) contracts and/or requirements. We strive to minimize delays in policy implementation. If there is a delay, we reserve the right to recoup and/or recover claims payment to the effective date, in accordance with the policy. We reserve the right to review and revise these policies when necessary. When there is an update, we will publish the most current policy to the website.

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