# Cell-Free Fetal DNA Testing (for Louisiana Only)

**Policy Number**: CS085LA1.I
**Effective Date**: April 1, 2025

➲ Instructions for Use
Content mandated by Louisiana Department of Health

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## Application

This Medical Policy only applies to the state of Louisiana. The coverage rationale contained in this policy represents Louisiana Medicaid coverage policy and is set forth below in accordance with State requirements.

## Coverage Rationale

### State-Specific Criteria

The coverage criteria for genetic counseling contained in this policy represents Louisiana Medicaid Managed Care Organization Manual (LA MCO) coverage policy and is set forth below in accordance with State requirements.

### *Genetic Counseling*

Genetic counseling before and after all genetic testing is required. Counseling must consist of at least all of the following and be documented in the medical record:

- Obtaining a structured family genetic history; and
- Genetic risk assessment; and
- Counseling of the enrollee and family about diagnosis, prognosis, and treatment

(LA MCO Genetic Counseling and Testing)

### Non-Invasive Prenatal Testing

Non-Invasive Prenatal Testing (NIPT) is a genetic test which uses maternal blood that contains cell-free fetal deoxyribonucleic acid (DNA) from the placenta. NIPT is completed during the prenatal period of pregnancy to screen for the presence of some common fetal chromosomal abnormalities. Common types of chromosomal abnormalities (aneuploidies and microdeletions) in fetuses include:

- Trisomy 21 (Down syndrome); and
- Trisomy 18 (Edwards syndrome); and
- Trisomy 13 (Patau syndrome)

**NIPT is considered medically necessary once per pregnancy for pregnant women over the age of 35, and for women of all ages who meet one or more of the following high-risk criteria:**

- Abnormal first trimester screen, quad screen, or integrated screen
- Abnormal fetal ultrasound scan indicating increased risk of aneuploidy
- Prior family history of aneuploidy in first (1st) degree relative for either parent
- Previous history of pregnancy with aneuploidy
- Known Robertsonian translocation in either parent involving chromosomes 13 or 21

**Note:** 1st degree relative is defined as a person's parent, children, or sibling. NIPT is not covered for women with multiple gestations.

## 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 |
| *0327U | Fetal aneuploidy (trisomy 13, 18, and 21), DNA sequence analysis of selected regions using maternal plasma, algorithm reported as a risk score for each trisomy, includes sex reporting, if performed |
| 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 (eg, 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 (eg, 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 |
| 81420 | Fetal chromosomal aneuploidy (e.g., trisomy 21, monosomy X) genomic sequence analysis panel, circulating cell-free fetal DNA in maternal blood, must include analysis of chromosomes 13, 18, and 21 |
| *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 |
| 81507 | Fetal aneuploidy (trisomy 21, 18, and 13) DNA sequence analysis of selected regions using maternal plasma, algorithm reported as a risk score for each trisomy |



Codes labeled with an asterisk (*) are not on the State of Louisiana Medicaid Fee Schedule and therefore may not be covered by the State of Louisiana Medicaid Program.

## References

Louisiana Department of Health: Professional Services Provider Manual, Section 5.1 – Non-Invasive Prenatal Testing Medicaid Services Manual: https://www.lamedicaid.com/provweb1/providermanuals/manuals/PS/PS.pdf. Accessed April 5, 2024.

Louisiana Medicaid Managed Care Organization (MCO) Manual, Genetic Counseling and Testing. https://ldh.la.gov/assets/medicaid/Manuals/MCO-Manual.pdf. Accessed April 5, 2024.

## Policy History/Revision Information

| Date | Summary of Changes |
|---|---|
| 04/01/2025 | **Applicable Codes**<br>• Updated list of applicable CPT codes to reflect quarterly edits; added 0536U<br>**Supporting Information**<br>• Archived previous policy version CS085LA1.H |

## 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.