

## Reimbursement Policy Statement Illinois Medicaid

<b>Effective Date</b>	<b>Next Annual Review</b>	<b>Policy Number</b>	
<b>06/01/2024</b>	<b>03/15/2027</b>	<b>ABHIL-RP-0024</b>	
<b>Policy Name</b>		<b>Department</b>	
<b>Genetic Testing</b>		<b>Claims Operations Medical Payment</b>	
<b>Policy Type</b>			
<b>Medical</b>	<b>Administrative</b>	<b>Pharmacy</b>	<b>Reimbursement</b>

Aetna Better Health® of Illinois (ABH IL) implements comprehensive and robust policies and procedures to ensure alignment with Illinois Department of Health Care and Family Services (HFS) and to warrant that regulatory standards are met.

ABH IL reimbursement policies are intended to provide a general reference for claims filing, coding, documentation guidelines and administrative functions. Providers are ultimately responsible for submission of accurate reporting of services provided.

Reimbursement of reported services is subject to member benefit, eligibility on date of service, medical necessity, related plan policies and procedures, correct coding and clinical editing logic, provider contracts and all applicable plan documentation and guidelines set forth by Illinois Department of Health Care and Family Services (HFS). Coding methodology, regulatory requirements, industry standard claims logic, guidance from specialty organizations and other factors are considered in the development of plan policies. ABH IL retains the right to change, amend or withdraw this policy as needed, at any time.

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## A. Policy

This policy is provided as a guide to medical coding and editing guidelines for the appropriate reporting of genetic testing. This policy aligns with guidance from the Centers for Medicare & Medicaid Services (CMS) as well as Illinois Department of Health Care and Family Services (HFS) guidance.

## B. Overview

This policy outlines the coding and editing guidelines for reporting genetic testing. Genetic tests are ordered by a provider to analyze a patient’s DNA. The results are helpful to identify inherited or acquired genetic variations that may be associated with disease risk, diagnosis, prognosis, or response to treatment. These tests are performed using blood, saliva, tissue, or other biological samples. This policy applies to all professional and facility claim types.

The most common categories of genetic testing include Germline or inherited DNA, somatic or acquired DNA and tumor or genomic DNA. There are some forms of DNA that can change in a person over time while others remain the same for life. Based on the differences in categories of genetic testing, the specific tests listed in this policy will only be considered as payable once per 1,095 days (3 years) or twice per 1,095 days (3 years). Specific codes are listed in *Section E* of this policy. Reporting of the codes listed that exceed the unit or timeframe allowance will be denied.

## C. Definitions

Term	Definition
Aetna Better Health of Illinois (ABHIL)	A subsidiary of CVS Health Corporation, Medicaid subsidiary that provides plan management and other administrative services for the Illinois Medicaid program.
American Medical Association (AMA)	A professional group that publishes research to advance public health and advocates for the interests of registered physician-members.
Centers for Medicare & Medicaid Services (CMS)	The federal agency that administers the Medicare program as well as works with the individual states to administer state Medicaid and Children’s Health Insurance Programs.
Current Procedural Terminology (CPT)	A medical code set maintained by the American Medical Association through the CPT Editorial Panel. The CPT code set (copyright protected by the AMA) describes medical, surgical, and diagnostic services and is designed to communicate uniform information about medical services and procedures among physicians, coders, patients, accreditation organizations, and payers for administrative, financial, and analytical purposes.



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Healthcare Common Procedure Coding System (HCPCS)	Level II of the HCPCS is a standardized coding system that is used primarily to identify products, supplies, and services not included in the CPT code set. Examples include ambulance services and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS). Level II HCPCS codes were established to allow these products, supplies and services to be reported for reimbursement.
Illinois Department of Health Care and Family Services (HFS)	The Department of Healthcare and Family Services administers health insurance programs for children, pregnant women, and adults who are residents of Illinois.
Medicaid	The state administered program that provides health coverage to millions of Americans, including eligible low-income adults, children, pregnant women, elderly adults, and people with disabilities, according to federal requirements. The program is funded jointly by states and the federal government.
Medicare	Medicare is a health insurance program for: people aged sixty-five (65) or older, people under age sixty-five (65) with certain disabilities, and people of all ages with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).

**D. Reimbursement Guidelines**

ABH IL will only reimburse for genetic testing when appropriately reported. Appropriate reporting includes

- Genetic testing units are reported within the allowed units and timeframes per this policy

Claims that are submitted will be denied when

- Genetic testing code units are reported with more units than this policy allows
- Genetic testing codes are reported more times in a 1,095-day timeframe than this policy allows

The medical record documentation is expected to support the specific CPT, HCPCS and ICD-10-CM codes reported.

**E. Codes/Condition of Coverage**

CPT & HCPCS Codes Allowed Once per Lifetime

81105	81283	81411	81471	0180U	0196U	0230U
81106	81301	81413	81520	0181U	0197U	0231U
81107	81303	81415	81525	0182U	0198U	0232U



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81108	81306	81419	81529	0183U	0199U	0233U
81109	81308	81425	81541	0184U	0200U	0234U
81110	81312	81430	0001U	0185U	0201U	0235U
81111	81314	81431	0019U	0186U	0203U	0236U
81112	81318	81432	0022U	0187U	0205U	0237U
81191	81326	81433	0026U	0188U	0209U	0238U
81192	81327	81436	0037U	0189U	0212U	0246U
81193	81328	81440	0045U	0190U	0214U	0260U
81194	81329	81445	0047U	0191U	0216U	0282U
81230	81333	81450	0069U	0192U	0217U	0286U
81231	81346	81455	0084U	0193U	0218U	0318U
81232	81353	81460	0105U	0194U	0221U	
81277	81410	81470	0175U	0195U	0222U	

**CPT & HCPCS Codes Allowed Twice per Lifetime**

81162	81203	81295	81317	81416	81552	0215U
81164	81212	81297	81319	81426	0005U	
81165	81216	81298	81321	81521	0008U	
81166	81288	81299	81323	81522	0113U	
81167	81292	81300	81351	81523	0153U	
81201	81294	81307	81352	81542	0213U	

**F. Frequently Asked Questions**

N/A

**G. Review/Revision Date**

Action	Date	Comments
Revision	03/03/2026	Policy template updated- No other content changes
Effective Date	06/01/2024	

**H. Resources**

1. American Medical Association. *CPT Professional Edition 2026, AMA; 2025.*
2. American Medical Association. *HCPCS Level II Professional 2026, AMA; 2025.*