Medical Policy

Whole Exome and Whole Genome Sequencing for Diagnosis of Genetic Disorders

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Policy Number: 457
BCBSA Reference Number: 2.04.102
NCD/LCD: Local Coverage Determination (LCD): Molecular Pathology Procedures (L35000)

Related Policies
Genetic Testing for Developmental Delay/Intellectual Disability, Autism Spectrum Disorder, and Congenital Anomalies, #228
Genetic Testing for the Diagnosis of Inherited Peripheral Neuropathies, #569
Genetic Testing for Facioscapulohumeral Muscular Dystrophy, #535
Genetic Testing for Epilepsy, #668
Genetic Testing for Limb-Girdle Muscular Dystrophies, #738

Policy
Commercial Members: Managed Care (HMO and POS), PPO, and Indemnity

Whole exome sequencing (WES) may be considered MEDICALLY NECESSARY for the evaluation of unexplained congenital or neurodevelopmental disorders in children when ALL of the following criteria are met:

1. The patient has been evaluated by a clinician with expertise in clinical genetics and counseled about the potential risks of genetic testing, AND
2. There is potential for a change in management and clinical outcome for the individual being tested, AND
3. A genetic etiology is considered the most likely explanation for the phenotype despite previous genetic testing (eg, chromosomal microarray analysis and/or targeted single-gene testing), OR when previous genetic testing has failed to yield a diagnosis and the affected individual is faced with invasive procedures or testing as the next diagnostic/therapeutic step (eg, muscle biopsy, organ transplant).

WES is considered INVESTIGATIONAL for the diagnosis of genetic disorders in all other situations.

Whole genome sequencing (WGS) is considered INVESTIGATIONAL for the diagnosis of genetic disorders.
WES and WGS are considered **INVESTIGATIONAL** for screening for genetic disorders.

The policy statement is intended to address the use of whole exome and whole genome sequencing for diagnosis in patients with suspected genetic disorders and for population-based screening.

This policy does not address the use of whole exome and whole genome sequencing for preimplantation genetic diagnosis or screening, prenatal (fetal) testing, or testing of cancer cells.

**Medicare HMO Blue℠ and Medicare PPO Blue℠ Members**

This is not a covered service.

**Local Coverage Determination (LCD): Molecular Pathology Procedures (L35000)**

For medical necessity criteria and coding guidance for **Medicare Advantage members living outside of Massachusetts**, please see the Centers for Medicare and Medicaid Services website for information regarding your specific jurisdiction at [https://www.cms.gov](https://www.cms.gov).

**Prior Authorization Information**

Pre-service approval is required for all inpatient services for all products.

See below for situations where prior authorization may be required or may not be required for outpatient services.

Yes indicates that prior authorization is required.

No indicates that prior authorization is not required.

N/A indicates that this service is primarily performed in an inpatient setting.

<table>
<thead>
<tr>
<th>Outpatient</th>
<th>Commercial Managed Care (HMO and POS)</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Commercial PPO and Indemnity</td>
<td>No</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Medicare HMO Blue℠</td>
<td>No</td>
<td>This is not a covered service.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Medicare PPO Blue℠</td>
<td>No</td>
<td>This is not a covered service.</td>
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</tr>
</tbody>
</table>

**CPT Codes / HCPCS Codes / ICD Codes**

Inclusion or exclusion of a code does not constitute or imply member coverage or provider reimbursement. Please refer to the member’s contract benefits in effect at the time of service to determine coverage or non-coverage as it applies to an individual member.

Providers should report all services using the most up-to-date industry-standard procedure, revenue, and diagnosis codes, including modifiers where applicable.

The following codes are included below for informational purposes only; this is not an all-inclusive list.

The above medical necessity criteria MUST be met for the following codes to be covered for Commercial Members: Managed Care (HMO and POS), PPO, and Indemnity:

**CPT Codes**

<table>
<thead>
<tr>
<th>CPT codes:</th>
<th>Code Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>81415</td>
<td>Exome (eg, unexplained constitutional or heritable disorder or syndrome); sequence analysis</td>
</tr>
<tr>
<td>81416</td>
<td>Exome (eg, unexplained constitutional or heritable disorder or syndrome); sequence analysis, each comparator exome (eg, parents, siblings) (List separately in addition to code for primary procedure)</td>
</tr>
</tbody>
</table>
The following CPT codes are considered investigational for Commercial Members: Managed Care (HMO and POS), PPO, Indemnity, Medicare HMO Blue and Medicare PPO Blue:

<table>
<thead>
<tr>
<th>CPT codes:</th>
<th>Code Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>81425</td>
<td>Genome (eg, unexplained constitutional or heritable disorder or syndrome); sequence analysis</td>
</tr>
<tr>
<td>81426</td>
<td>Genome (eg, unexplained constitutional or heritable disorder or syndrome); sequence analysis, each comparator genome (eg, parents, siblings) (List separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td>81427</td>
<td>Genome (eg, unexplained constitutional or heritable disorder or syndrome); re-evaluation of previously obtained genome sequence (eg, updated knowledge or unrelated condition/syndrome)</td>
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</tbody>
</table>

**Description**

**CLINICAL CONTEXT AND TEST PURPOSE**

Whole exome sequencing (WES) is targeted sequencing of the subset of the human genome that contains functionally important sequences of protein-coding DNA, while whole genome sequencing (WGS) uses next-generation sequencing (NGS) techniques to sequence both coding and noncoding regions of the genome. WES and WGS have been proposed for use in patients presenting with disorders and anomalies not explained by standard clinical workup. Potential candidates for WES and WGS include patients who present with a broad spectrum of suspected genetic conditions. Given the variety of disorders and management approaches, there are a variety of potential health outcomes from a definitive diagnosis. In general, the outcomes of a molecular genetic diagnosis include (1) impacting the search for a diagnosis, (2) informing follow-up that can benefit a child by reducing morbidity, and (3) affecting reproductive planning for parents and potentially the affected patient.

The standard diagnostic workup for patients with suspected Mendelian disorders may include combinations of radiographic, electrophysiologic, biochemical, biopsy, and targeted genetic evaluations. The search for a diagnosis may thus become a time-consuming and expensive process. WES or WGS using NGS technology can facilitate obtaining a genetic diagnosis in patients efficiently. WES is limited to most of the protein-coding sequence of an individual (≈85%), is composed of about 20,000 genes and 180,000 exons (protein-coding segments of a gene), and constitutes approximately 1% of the genome. It is believed that the exome contains about 85% of heritable disease-causing mutations. WES has the advantage of speed and efficiency relative to Sanger sequencing of multiple genes. WES shares some limitations with Sanger sequencing. For example, it will not identify: intronic sequences or gene regulatory regions; chromosomal changes; large deletions; duplications; or rearrangements within genes, nucleotide repeats, or epigenetic changes. WGS uses techniques similar to WES, but includes noncoding regions. WGS has greater ability to detect large deletions or duplications in protein-coding regions compared to WES, but requires greater data analytics.

Technical aspects of WES and WGS are evolving, including databases such as the National Institutes of Health's ClinVar database (http://www.ncbi.nlm.nih.gov/clinvar/) to catalog variants, uneven sequencing coverage, gaps in exon capture before sequencing, and difficulties with narrowing the large initial number of variants to manageable numbers without losing likely candidate mutations. The variability contributed by the different platforms and procedures used by different clinical laboratories offering exome sequencing as a clinical service is unknown.

In 2013, the American College of Medical Genetics and Genomics, Association for Molecular Pathology, and College of American Pathologists convened a workgroup to develop standard terminology for
Guidelines developed by this workgroup, published in 2015, describe criteria for classifying pathogenic and benign sequence variants based on types of data into 5 categories: pathogenic, likely pathogenic, uncertain significance, likely benign, and benign.

### AVAILABLE WES AND WGS TESTING SERVICES

Several laboratories offer WES and WGS as a clinical service. Illumina offers 3 TruGenome tests: the TruGenome Undiagnosed Disease Test (indicated to find the underlying genetic cause of an undiagnosed rare genetic disease of single-gene etiology), Tru Genome Predisposition Screen (indicated for healthy patients interested in learning about their carrier status and genetic predisposition toward adult-onset conditions), and the TruGenome Technical Sequence Data (WGS for labs and physicians who will make their own clinical interpretations). Ambry Genetics offers 2 WGS tests, the ExomeNext and ExomeNext-Rapid, which sequence both the nuclear and the mitochondrial genomes. GeneDx offers WES with its XomeDx™ test. Medical centers may also offer WES and WGS as a clinical service.

Examples of laboratories offering WES as a clinical service and their indications for testing are summarized in Table 1.

<table>
<thead>
<tr>
<th>Laboratory</th>
<th>Laboratory Indications for Testing</th>
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<tbody>
<tr>
<td>Ambry Genetics (Aliso Viejo, CA)</td>
<td>“The patient's clinical presentation is unclear/atypical disease and there are multiple genetic conditions in the differential diagnosis.”</td>
</tr>
<tr>
<td>GeneDx (Gaithersburg, MD)</td>
<td>“a patient with a diagnosis that suggests the involvement of one or more of many different genes, which would, if even available and sequenced individually, be prohibitively expensive”</td>
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<tr>
<td>Baylor College of Medicine (Houston, TX)</td>
<td>“used when a patient’s medical history and physical exam findings strongly suggest that there is an underlying genetic etiology. In some cases, the patient may have had an extensive evaluation consisting of multiple genetic tests, without identifying an etiology.”</td>
</tr>
<tr>
<td>Illumina (San Diego, CA)</td>
<td>The TruGenome Undiagnosed Disease Test is indicated to find the underlying genetic cause of an undiagnosed rare genetic disease of single-gene etiology.</td>
</tr>
<tr>
<td>University of California Los Angeles Health System</td>
<td>“This test is intended for use in conjunction with the clinical presentation and other markers of disease progression for the management of patients with rare genetic disorders.”</td>
</tr>
<tr>
<td>EdgeBio (Gaithersburg, MD)</td>
<td>Recommended “In situations where there has been a diagnostic failure with no discernible path. In situations where there are currently no available tests to determine the status of a potential genetic disease. In situations with atypical findings indicative of multiple disease[s].”</td>
</tr>
<tr>
<td>Children’s Mercy Hospitals and Clinics (Kansas City, MO)</td>
<td>Provided as a service to families with children who have had an extensive negative workup for a genetic disease; also used to identify novel disease genes.</td>
</tr>
<tr>
<td>Emory Genetics Laboratory (Atlanta, GA)</td>
<td>“Indicated when there is a suspicion of a genetic etiology contributing to the proband’s manifestations.”</td>
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</table>

Note that this evidence review does not address the use of WES and WGS for preimplantation genetic diagnosis or screening, prenatal (fetal) testing, or for testing of cancer cells.
Summary
Whole exome sequencing (WES) sequences the portion of the genome that contains protein-coding DNA, while whole genome sequencing (WGS) sequences both coding and noncoding regions of the genome. WES and WGS have been proposed for use in patients presenting with disorders and anomalies that have not been explained by standard clinical workup. Potential candidates for WES and WGS include patients who present with a broad spectrum of suspected genetic conditions.

For individuals who have multiple unexplained congenital anomalies or a neurodevelopmental phenotype who receive WES, the evidence includes large case series and a within-subject comparison. Relevant outcomes are test accuracy and validity, functional outcomes, changes in reproductive decision making, and resource utilization. Patients who have multiple congenital anomalies or a developmental disorder with a suspected genetic etiology, but the specific genetic alteration is unclear or unidentified by standard clinical workup, may be left without a clinical diagnosis of their disorder, despite a lengthy diagnostic workup. For a substantial proportion of these patients, WES may return a likely pathogenic variant. Several large and smaller series have reported diagnostic yields of WES ranging from 25% to 60%, depending on the individual’s age, phenotype, and previous workup. One comparative study found a 44% increase in yield compared with standard testing strategies. Many of the studies have also reported changes in patient management, including medication changes, discontinuation of or additional testing, ending the diagnostic odyssey, and family planning. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

For individuals who have a suspected genetic disorder other than multiple congenital anomalies or a neurodevelopmental phenotype who receive WES, the evidence includes small case series. Relevant outcomes are test accuracy and validity, functional outcomes, changes in reproductive decision making, and resource utilization. There is 1 small series of patients with limb-girdle muscular dystrophy (LGMD), and larger series of patients with a broad spectrum of suspected genetic disorders. The diagnostic yield for unexplained LGMD is high, but a limited number of patients have been studied to date. The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals with a suspected genetic disorder who receive WGS, the evidence includes case series. Relevant outcomes are test accuracy and validity, functional outcomes, changes in reproductive decision making, and resource utilization. No studies were identified that directly compared WGS with alternative testing strategies in terms of the testing yield for pathogenic variants associated with the phenotype being evaluated. One small series evaluated the yield of WGS in patients with inherited retinal disorders and found a genetic cause in about half of patients. The estimated increase in diagnostic yield was 29% compared to standard workup. However, positive results were obtained in only 24 patients, and additional study is needed to evaluate WGS for other disorders. The evidence is insufficient to determine the effects of the technology on health outcomes.

Policy History

<table>
<thead>
<tr>
<th>Date</th>
<th>Action</th>
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<tr>
<td>1/2016</td>
<td>New references added from BCBSA National medical policy.</td>
</tr>
<tr>
<td>1/2015</td>
<td>Clarified coding information.</td>
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Information Pertaining to All Blue Cross Blue Shield Medical Policies
Click on any of the following terms to access the relevant information:
Medical Policy Terms of Use
Managed Care Guidelines
References


