

PROJECT FOR REDUCING INEFFECTIVE MEDICAID EXPENDITURES

High-Complexity Genetic Testing

Genetic testing has increased rapidly in the United States, accompanied by increased spending and concerns over fraud, waste, and abuse. In an analysis of Medicaid data from 2024, we found substantial use of genetic tests, including the highest complexity single-gene testing code (81408). Estimated expenditures totaled \$147.8 million nationally (state and federal share) with significant state-by-state variation. A majority of expenditures appeared to be related to prenatal carrier screening. Our research found multiple insurers working to address reimbursement of these genetic tests through differing strategies. State Medicaid program administrators can use this brief to identify whether reimbursement of high-complexity genetic testing is an issue in their state and potential policy solutions.

BACKGROUND

The availability of genetic testing has increased rapidly in recent years.¹ A core purpose of genetic testing is to screen, diagnose, and aid in treatment and prognosis for illnesses with a genetic cause or component.² In combination with information about an individual's environment and lifestyle, genetic testing can facilitate individualized prevention, diagnosis, and treatment (i.e., precision medicine).³

With increasing use, expenditures on genetic testing have also increased rapidly. For example, Medicare spending on human genetic tests increased from approximately \$1.0 billion in 2018 to \$2.2 billion in 2024.⁴ In addition, there are concerns about pervasive fraud, waste, and abuse within the genetic testing landscape.^{5,6}

Coding and reimbursement for genetic testing is complex and evolving. Historically, genetic testing (a subset of laboratory tests called molecular pathology) was coded by “stacking” procedure codes representing the technical steps undertaken in performing the test.⁷ In 2013, these codes were replaced by a mixture of gene-specific and more general codes, organized into groups⁷:

- **Genomic Sequencing Procedures:** typically panel-based testing of many genes for a given condition or set of conditions
- **Multi-Analyte With Algorithmic Analyses:** combinations of tests arriving at a computationally derived result, such as a score or probability
- **Proprietary Lab Analyses:** codes that uniquely identify specific tests
- **Tier 1 codes:** includes commonly performed tests on well-described genes
- **Tier 2 codes:** includes tests for rarer disease genes with increasing levels of technical complexity

Coding of panel tests, in which a single test produces results for multiple genes, remains an area of significant concern due to complex and sometimes unclear guidance.¹⁰ For laboratory services, the Medicaid National Correct Coding Initiative (NCCI) generally specifies that, “[i]f a laboratory procedure produces multiple reportable test results, only a single [Healthcare Common Procedure Coding System (HCPCS) or Common Procedural Terminology (CPT)] code shall be reported for the procedure.”^{11(p4)} However, the manual goes on to say, “[i]f multiple genes are evaluated by one procedure, the laboratory shall report only one unit of service for that CPT code”; and, “[i]f no CPT code accurately describes the procedure performed, the laboratory may report CPT code 81479 (Unlisted molecular pathology procedure) with one unit of service or may report multiple individual CPT codes describing the component test results when medically reasonable and necessary.”^{11(p8)} In other words, according to NCCI, panel tests can sometimes be coded using a single specific procedure code, sometimes using a procedure code indicating an unlisted test (81479), and sometimes by listing all the component procedure codes describing the test results.¹¹

The highest complexity single-gene testing code (81408) has been identified as a specific area of concern (Box 1).⁵ For example, in Medicare, an audit by the Office of Inspector General identified a risk of up to \$888 million in improper payments for 81408.⁵ Specifically, the audit identified a potential lack of oversight in ensuring that ordering providers had established

Box 1. CPT Code 81408

- Represents the highest level of technical resources for a single-gene test⁸
- Typically tests very large genes with greater than 50 exons (portions of the gene that are expressed)⁸
- Does not distinguish the method of testing⁸; some methods can be more costly than others
- Medicare reimbursement of \$2,000 per test, which is the highest for any single-gene test, and higher than many multi-gene panel tests⁹

relationships with patients, that the genes tested were most appropriately coded by 81408, and that the relative frequency of the testing was appropriate.⁵

Because of its known coding and reimbursement issues in Medicare,⁵ we selected this service for review in the Project for Reducing Ineffective Medicaid Expenditures (PRIME). The purpose of PRIME is to identify Medicaid-covered services that may warrant coverage limitation due to limited or no demonstrated benefit relative to harms. For the highest complexity single-gene testing code (81408), we first analyzed Medicaid data to attempt to determine the type of testing performed, followed by a review of relevant guidelines and payer policies.

MEDICAID DATA ANALYSIS

To understand how high-complexity genetic testing is used, we analyzed data from Transformed Medicaid Statistical Information System Analytical Files for 50 states and the District of Columbia for 2024, the most recent year available from the Centers for Medicare & Medicaid Services (CMS). First, for each state, we identified fully adjudicated paid fee-for-service (FFS) claims and managed care encounters for the highest complexity single-gene testing code (81408). Second, because a single genetic test can be billed using multiple procedure codes at the same time, including 81408, we extracted data on any other genetic testing procedures performed on the same day, for the same patient, and by the same provider. We assumed that each of these genetic testing procedures were part of the same overall clinical genetic test. Third, we quantified the most common individual genetic testing procedures and genetic testing procedure combinations. Finally, we estimated expenditures on 81408 alone and 81408 plus all other genetic testing procedures reimbursed as part of the same genetic test. Because CMS suppresses paid amounts for managed care encounters, we estimated payments based on FFS claims. The full data table for all results is available in Appendix Table A2.

Findings

Nationally, we identified 50,470 genetic tests involving 72,056 units of 81408 (mean: 1.4 units per test) among 48,340 Medicaid members. The number of units of 81408 reimbursed per 100,000 member months varied significantly by state (Figure 1). Overall, 93.9% of claims for 81408 also included other genetic testing procedures, with some state-by-state variation.

TABLE 1

Top 5 Genetic Testing Procedure Combinations Including High-Complexity Genetic Testing (81408), 2024

Tests, % ^a	Procedure Codes ^b	Clinical Purpose	Average Estimated Expenditures per Test, \$
42.5%	81161, 81200, 81220, 81243, 81251, 81255, 81257, 81260, 81329, 81361, 81400, 81401, 81405, 81408	Prenatal carrier screening	\$3,104
11.2%	81161, 81220, 81243, 81329, 81408	Prenatal carrier screening	\$2,447
4.3%	81161, 81200, 81220, 81243, 81251, 81255, 81257, 81260, 81361, 81400, 81401, 81405, 81408	Prenatal carrier screening	\$1,289 ^c
3.4%	81161, 81220, 81243, 81257, 81260, 81329, 81361, 81400, 81401, 81405, 81408	Prenatal carrier screening	\$3,163
2.9%	81161, 81220, 81257, 81260, 81329, 81361, 81400, 81401, 81405, 81408	Prenatal carrier screening	\$3,087

Notes. ^a Tests are defined as all genetic testing procedures performed for the same patient, on the same day of service, by the same provider, as 1 or more unit of 81408. This column represents the percentage of tests that are the given combination of procedure codes. Only the top 5 combinations are shown in this table. ^b Test combinations can include more than one unit of 81408 or other procedure codes listed. ^c 90.1% of tests involving this procedure combination were from 1 state that generally had lower expenditures per test; therefore, the mean may not be nationally representative.

Source. Center analysis of Transformed Medicaid Statistical Information System analytical files for 50 states and the District of Columbia, 2024.

GUIDELINE AND PAYER POLICY LANDSCAPE

Our Medicaid data analysis suggested that most of the high-complexity genetic testing identified was intended for prenatal carrier screening. Therefore, we focused on this service for our guideline and payer policy review.

Guidelines for Prenatal Carrier Screening

We identified 3 relevant guidelines on prenatal carrier screening:

- American College of Obstetricians and Gynecologists (ACOG, 2017, reaffirmed 2025)^{12,13}
- American College of Medical Genetics and Genomics (ACMG, 2021)¹⁴

Generally, there are 3 types of screening strategies¹⁵:

- **Ethnic-specific:** for specific populations at elevated risk of certain disorders

- **Pan-ethnic:** screening “all individuals regardless of reported ancestry for a select panel of genetic conditions”
- **Expanded carrier screening:** screening for “up to hundreds of [conditions] simultaneously” typically defined by frequency in the population in addition to having a well-defined clinical presentation, negative effects on quality of life, early onset of disease, available interventions, and being identifiable before birth

While guidelines endorse prenatal carrier screening, they differ on the specific strategies recommended.¹²⁻¹⁴ ACOG guidelines state that any of the 3 screening strategies are acceptable but recommend that “all patients who are considering pregnancy or are already pregnant” should be offered screening for cystic fibrosis, spinal muscular atrophy, and certain blood disorders.¹² Further, Fragile X syndrome screening is recommended in the presence of certain risk factors.¹² The guideline also notes that, “[a]dditional screening also may be indicated based on family history or specific ethnicity.”¹³ For expanded carrier screening, the guideline recommends inclusion of variants that have a carrier frequency of 1 in 100 or greater.¹²

ACMG guidelines describe a tiered approach to prenatal carrier screening¹⁴:

- Tier 1: cystic fibrosis, spinal muscular atrophy, and risk-based screening
- Tier 2: carrier frequency $\geq 1/100$
- Tier 3: carrier frequency $\geq 1/200$, including X-linked disorders
- Tier 4: carrier frequency $< 1/200$, genes and conditions will vary by lab

ACMG recommends that screening be “ethnic and population neutral and more inclusive of diverse populations to promote equity and inclusion.”^{14(p1796)} ACMG recommends Tier 3 for all pregnant patients and those planning pregnancy, with Tier 4 recommended in certain circumstances.¹⁴

In summary, while the guidelines agree on several general principles, there are differences in screening strategy recommendations (i.e., ACMG recommends broader screening) as well as some technical differences (e.g., for cystic fibrosis screening).¹⁵

Payer Policies for Prenatal Carrier Screening

We reviewed medical policies for 4 commercial insurers¹⁶⁻¹⁹; Medicare excludes prenatal carrier screening because it is considered out of scope.¹⁰ Aetna and Cigna cover expanded prenatal carrier screening.^{20,21} Carelon (owned by Elevance Health) covers screening for cystic fibrosis and certain blood disorders for all pregnant individuals and individuals considering pregnancy, with expanded prenatal carrier screening only covered with certain risk factors.²² UnitedHealthcare does not cover expanded prenatal carrier screening.²³ Medical policies are described in more detail in Appendix Table A1.

Of the 4 commercial insurers, 2 had additional relevant coding and reimbursement policies.^{24,25} For Cigna, when a panel has a specific CPT code or Proprietary Lab Analyses code, that code must be used.²⁴ For panels of more than 5 genes without a specific CPT code or Proprietary Lab Analyses code, a single unit of 81479 must be used.²⁴ For panels of 5 genes or less the test can be reimbursed using a single unit of 81479 or a maximum of 5 procedure codes representing the components of the test.²⁴ For UnitedHealthcare, panel tests involving multiple genes that produce a single result require submission of only one procedure code along with a DEX Z-code, a classification system for tests.²⁵

STATE POLICY ACTIONS

Several states have implemented coverage policies around prenatal carrier screening, including:

- **California** does not cover expanded prenatal carrier screening panels with at least 15 genes (i.e., 81443) but may allow exceptions based on medical necessity²⁶
- **North Carolina** does not cover expanded carrier screening²⁷
- **Oregon** covers expanded carrier screening under requirements consistent with ACOG and ACMG guidelines²⁸
- **Texas** covers expanded prenatal carrier screening, effective September 1, 2024.²⁹ The policy specifies an age limit, requires pre-screening genetic counseling, and links panel content to ACMG's guideline framework.²⁹

We did not identify specific coding and reimbursement policies for prenatal carrier screening panels for these states.

STATE CONSIDERATIONS

While high-complexity genetic testing is a broad issue, our data analysis found that prenatal carrier screening accounted for the majority of tests within that category. State Medicaid program administrators can consider reviewing coverage and reimbursement of prenatal carrier screening, including:

- Establishing or updating coverage policy for prenatal carrier screening
 - » Implementing criteria for coverage of expanded prenatal carrier screening including definitions of the eligible populations and criteria for tests included
 - » Limiting prenatal carrier screening (e.g., once per lifetime with possible exceptions)
- Establishing or updating reimbursement policies for prenatal carrier screening panels
 - » Adapting reimbursement policies from commercial insurers; for example, requiring panels to be billed using a single procedure code (e.g., 81479, unlisted molecular pathology procedure). This may be more cost effective in at least some instances, depending on the state's reimbursement methodology for 81479

- » While procedure code 81443 represents a panel of at least 15 genes, we identified several tests for 14 genes or fewer billed using combinations of procedure codes
- » Combinations of procedure codes for tests for 14 genes or fewer had average estimated expenditures of up to \$3,163 per test. For context, this amount is higher than the full Medicare fee schedule amount for 81443 (\$2,448.56)⁹ and can be much higher than reported self-pay prices (e.g., “\$0 to \$239 per test” for certain qualifying patients from one laboratory³⁰)
 - Coding each component of the prenatal carrier screening panel can lead to a test of fewer than 15 genes reimbursing more than a test of 15 genes or more
- Reviewing paid claims for genetic tests involving 81408 to determine if they meet existing coverage criteria and referring for post-payment review if there are concerns

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PROJECT TEAM

For more information, please contact:
centerebp@ohsu.edu

MARCUS BACHHUBER, MD, MSHP,
FACP, FASAM
Associate Professor

ALLISON LEOF, PHD
Senior Policy Analyst

GÜLCAN ÇIL, PHD
Senior Statistician

JAMI HOFFMAN, BA
Project Coordinator

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APPENDIX A: RESULTS

TABLE A1

Coverage Policies for Commercial Payers

Payer (Year)	Coverage Criteria
Commercial	
Aetna (2026) ²⁰	“Aetna considers prenatal and preconception carrier screening medically necessary when the following criteria are met: 1. Expanded (panel) carrier screening: unless previously performed, panel must include cystic fibrosis (CF), spinal muscular atrophy (SMA), and/or hemoglobinopathies for individuals/couples who are pregnant or planning a pregnancy; and 2. Results of the test will be used in management of the pregnancy, potentially affected fetus, or for family planning.”
Carelon (2026) ²²	“Standard carrier screening Cystic fibrosis and spinal muscular atrophy Standard screening for cystic fibrosis (CFTR testing) and spinal muscular atrophy (SMN1 testing) using accepted gene variant sets is considered medically necessary in the following scenarios: • All pregnant individuals • An individual considering reproduction Hemoglobinopathies Standard screening for hemoglobinopathies (HBA1/HBA2 and HBB testing) using hemoglobin electrophoresis or molecular genetic testing is considered medically necessary in the following scenarios IF no prior testing results (hemoglobin electrophoresis and/or HBA1/HBA2 and HBB gene analysis) are available for interpretation: • All pregnant individuals • An individual considering reproduction Expanded carrier screening Multigene or single-gene carrier screening is considered medically necessary when ALL of the following criteria are met: • ONE or more of the following apply: ○ One or both individuals have ancestry (e.g., Ashkenazi Jewish, Finnish, French Canadian, among others) known to be at increased risk for certain conditions, other than cystic fibrosis, spinal muscular atrophy, and hemoglobinopathies

Payer (Year)	Coverage Criteria
	○ One or both individuals do not have access to a biological family history due to reasons such as adoption or use of a reproductive donor as documented in the member's medical record ○ The individual and their reproductive partner are known or suspected to be consanguineous as documented in the member's medical record* • The condition(s) included in the screening test have at least a 1 in 100 carrier frequency* • The genetic disorder(s) being evaluated have gene-disease clinical validity AND pathogenic variants in the gene(s) are associated with significant morbidity and/or mortality in affected individuals • The test has sufficiently high sensitivity and specificity to guide clinical decision making • Knowledge of the pathogenic variant(s) may be used for management of either the pregnancy or the potentially affected fetus or child, or for family planning *Note: Conditions on multigene panels can have carrier frequencies less than 1 in 100 for a consanguineous partnership."
Cigna (2026) ²¹	"Preconception or prenatal carrier screening panels are considered medically necessary when ALL of the following criteria are met: • The panel assesses carrier status for ALL of the following conditions: ○ cystic fibrosis (CF) ○ hemoglobinopathies (i.e., beta thalassemia, alpha thalassemia, sickle cell disease) ○ spinal muscular atrophy (SMA) ○ any condition for which the individual is at elevated risk (e.g., family history of a condition; individual's reproductive partner is a carrier of a condition; individual's ethnicity/country of origin increases their risk of being a carrier of a condition) • The panel utilizes the recommended methodology to maximize the detection of carriers for all conditions in the panel (e.g., dosage analysis for SMA). • The individual must not have had previous testing of any genes on the panel (exceptions may be made on a case-by-case basis if CF and/or SMA were previously performed). • The individual is of reproductive age and has capacity and intention to reproduce. Preconception or prenatal Ashkenazi Jewish carrier screening using a targeted panel (CPT® code 81412) is considered medically necessary when BOTH of the following criteria are met: • The individual is planning a pregnancy or is currently pregnant.

Payer (Year)	Coverage Criteria
	• At least one reproductive partner of a couple is of Ashkenazi Jewish descent. (Note: If only one partner of a couple is of Ashkenazi Jewish descent, testing should start in that individual when possible.)”
United Healthcare (2026) ²³	“Reproductive Carrier Screening panels of up to six genes are proven and medically necessary. Reproductive Carrier Screening panels of up to 15 genes are proven and medically necessary when an individual and/or their reproductive partner meet at least one of the following criteria: • Ashkenazi Jewish ancestry (individual/reproductive partner has at least one parent or grandparent of Ashkenazi Jewish descent); or • A biological First-Degree Relative or Second-Degree Relative has been affected by one or more of the condition evaluated by the panel The following are unproven and not medically necessary due to insufficient evidence of efficacy: • Reproductive Carrier Screening panels comprising 16 or more genes • Carrier Screening for all other indications Note: It is strongly recommended that reproductive Carrier Screening panels include screening for cystic fibrosis (CFTR) and spinal muscular atrophy (SMN1).”

Abbreviations. CF: cystic fibrosis; SMA: spinal muscular atrophy.

TABLE A2

Utilization of High-Complexity Genetic Testing in 50 State Medicaid Programs and the District of Columbia, 2024

State	Number of Tests ^a	Number of Units of 81408, per 10,000 Member Months	Other Genetic Test Procedure(s) Performed at Same Time, % ^b	Estimated Expenditures on 81408 Only, \$	Estimated Total Test Expenditures, \$ ^c	Average Estimated Expenditure per Test, \$
US	50,470	8.2	93.9%	\$80,445,719	\$147,823,677	\$3,120
AK	—	—	—	\$305	\$1,047	\$1,047
AL	66	0.6	92.4%	\$25,037	\$56,234	\$922
AR	1,102	20.5	98.7%	\$1,121,699	\$3,343,662	\$3,073
AZ	133	0.8	85.7%	\$237,077	\$546,352	\$4,793
CA	14,674	15.7	92.6%	\$25,116,943	\$47,851,123	\$3,522
CO	186	2.1	90.9%	\$352,216	\$653,546	\$3,867
CT	108	1.1	85.2%	\$131,920	\$203,205	\$2,209
DC	—	—	—	\$305	\$374	\$374
DE	371	24.9	97.3%	\$111,482	\$510,204	\$1,413
FL	5,145	21.9	97.1%	\$1,543,062	\$6,206,361	\$1,242
GA	176	1.1	84.1%	\$57,306	\$216,627	\$1,464
HI	40	1.2	90.0%	\$67,000	\$131,719	\$3,659
IA	90	1.8	92.2%	\$166,945	\$269,238	\$3,244
ID	110	5.4	92.7%	\$295,706	\$445,278	\$4,365
IL	1,681	0.9	97.4%	\$4,011,374	\$5,971,781	\$3,648
IN	282	1.5	96.8%	\$750,572	\$1,046,762	\$3,834
KS	100	3.6	96.0%	\$191,468	\$309,320	\$3,222
KY	728	7.6	93.4%	\$1,403,423	\$2,907,970	\$4,276
LA	62	0.4	75.8%	\$153,289	\$199,544	\$4,246
MA	117	0.8	75.2%	\$116,669	\$240,937	\$2,738
MD	629	6.7	87.8%	\$188,483	\$1,331,936	\$2,413
ME	—	—	—	\$7,000	\$17,159	\$4,290
MI	3,592	20.1	97.0%	\$5,302	\$5,399,387	\$1,549
MN	384	4.4	87.2%	\$668,276	\$1,246,969	\$3,722
MO	321	3.5	94.7%	\$620,474	\$1,084,872	\$3,569
MS	—	—	—	\$5,685	\$8,842	\$1,768
MT	379	21.4	91.6%	\$821,339	\$1,463,218	\$4,217
NC	1,045	0.4	91.1%	\$986,869	\$1,878,779	\$1,974

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State	Number of Tests ^a	Number of Units of 81408, per 10,000 Member Months	Other Genetic Test Procedure(s) Performed at Same Time, % ^b	Estimated Expenditures on 81408 Only, \$	Estimated Total Test Expenditures, \$ ^c	Average Estimated Expenditure per Test, \$
ND	11	1.3	—	\$17,349	\$35,916	\$4,490
NE	119	4.0	90.8%	\$225,797	\$407,028	\$3,769
NH	—	—	—	\$2,800	\$5,558	\$2,779
NJ	157	1.2	79.6%	\$193,745	\$427,736	\$3,422
NM	1,215	23.8	98.4%	\$2,400,724	\$4,365,507	\$3,650
NV	17	0.3	88.2%	\$30,867	\$66,109	\$4,407
NY	1,920	2.1	96.4%	\$2,909,880	\$5,229,395	\$2,827
OH	3,321	20.4	92.2%	\$9,481,095	\$14,054,352	\$4,590
OK	269	4.5	97.4%	\$872,746	\$1,219,097	\$4,653
OR	558	5.7	91.6%	\$1,432,973	\$2,277,952	\$4,458
PA	355	1.5	75.2%	\$411,541	\$836,887	\$3,134
RI	—	0.4	—	\$11,505	\$27,460	\$3,432
SC	1,209	11.5	96.9%	\$1,844,053	\$2,961,926	\$2,529
SD	—	—	—	\$4,991	\$10,017	\$3,339
TN	3,265	0.4	90.0%	\$3,132,607	\$5,791,484	\$1,971
TX	5,600	17.6	97.3%	\$17,298,446	\$24,614,987	\$4,520
UT	13	—	—	\$21,680	\$29,979	\$2,998
VA	342	2.0	79.8%	\$92,545	\$418,666	\$1,534
VT	—	—	—	\$7,920	\$11,350	\$2,838
WA	445	2.9	88.3%	\$729,877	\$1,229,760	\$3,129
WI	81	0.7	77.8%	\$152,138	\$227,068	\$3,604
WV	16	0.5	81.3%	\$12,332	\$30,468	\$2,344
WY	—	—	—	\$877	\$2,531	\$2,531

Notes. “—” indicates that there were either no claims identified or fewer claims identified than are allowed to be reported according to the Centers for Medicare & Medicaid Services’ privacy policy and the value is therefore suppressed. ^aA test refers to all genetic testing procedures occurring for the same patient, on the same day of service, and by the same provider including at least 1 unit of 81408. Each test can include multiple units of 81408. ^b Refers to the percentage of claims for 81408 that also include other genetic testing procedures for the same patient, on the same day of service, and by the same provider (sometimes referred to as unbundling). ^c Refers to estimated expenditures for all genetic testing procedures for all tests including at least 1 unit of 81408.

Source. Center analysis of Medicaid claims and encounter data from the Transformed Medicaid Statistical Information System maintained by the Centers for Medicare & Medicaid Services for calendar year 2024.

TABLE A3

Most Common Genetic Testing Procedures Billed With High-Complexity Genetic Testing (81408), 2024

Tests, % ^a	Procedure Code	Gene (Clinical Syndrome)
80.6%	81220	<i>CFTR</i> (cystic fibrosis)
77.3%	81161	<i>DMD</i> (Duchenne muscular dystrophy)
76.6%	81405	Tier 2 molecular pathology procedure, level 6 (various)
75.9%	81329	<i>SMN1</i> (spinal muscular atrophy)
75.6%	81243	<i>FMR1</i> (fragile X syndrome)
69.5%	81401	Tier 2 molecular pathology procedure, level 2 (various)
68.1%	81257	<i>HBA1</i> and <i>HBA2</i> (alpha thalassemia)
68.0%	81400	Tier 2 molecular pathology procedure, level 1 (various)
66.9%	81260	<i>ELP1</i> (Riley-Day syndrome)
66.7%	81361	<i>HBB</i> (beta thalassemia)
58.2%	81200	<i>ASPA</i> (Canavan disease)
58.1%	81255	<i>HEXA</i> (Tay-Sachs disease)
57.4%	81251	<i>GBA</i> (Gaucher disease)
13.7%	81406	Tier 2 molecular pathology procedure, level 7 (various)
12.7%	81404	Tier 2 molecular pathology procedure, level 5 (various)
11.1%	81407	Tier 2 molecular pathology procedure, level 8 (various)

Notes. ^a Tests are defined as all genetic testing procedures performed for the same patient, on the same day of service, by the same provider, as 1 or more unit of 81408. This column represents the percentage of tests including 81408 that also include the given procedure code. Only procedure codes present in greater than 10% of tests with 81408 are shown in this table.

Source. Center analysis of T-MSIS analytical files for 50 states and the District of Columbia, 2024.

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Center for Evidence-based Policy

3030 S Moody Avenue, Suite 250
Portland, OR 97201

Phone: (503) 494-2182
Fax: (503) 494-3807

centerforevidencebasedpolicy.org