

XomeDx Medical Necessity Attestation Form
for those eligible under the
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit

Date	
Patient name	
Date of birth	
Medicaid plan & ID number	

Section 1905(a)(29) of the Social Security Act requires states to cover “necessary health care, diagnostic services, treatment, and other measures to correct or ameliorate defects along with physical and mental illnesses and other conditions discovered by the screening services, whether or not such services are covered under the State plan” under EPSDT. Medical necessity must be determined on a case-by-case basis, considering the child’s individual needs. States can establish their own parameters for medical necessity so long as those parameters are not more restrictive than the federal statute. Coverage is requested for whole exome sequencing (WES) for this Medicaid beneficiary, as the service is medically necessary under EPSDT, as outlined below.

I certify that the requested diagnostic service is medically necessary under EPSDT, is being ordered in accordance with generally accepted standards of medical practice, and the following are true:

- ✓ The patient is under age 21
- ✓ The patient has undergone informed consent and counseling with a specialist with expertise in the conditions and/or relevant genes for which testing is being considered
- ✓ The patient’s clinical presentation does not fit a well-described syndrome for which single-gene or single targeted panel test is available, but genetic etiology is the likely explanation
- ✓ The patient’s clinical presentation is consistent with indications for which WES is recommended by professional society guidelines and/or peer-reviewed, published literature
- ✓ WES is more efficient or economical than the separate single-gene tests or panels that would be recommended based on the differential diagnosis
- ✓ WES test results are expected to directly influence clinical decision-making and/or clinical outcome as follows:

Ordering provider signature
(or authorized representative)

Ordering provider printed name
(or authorized representative)

Background on whole exome sequencing (WES):

Most known genetic mutations that cause human disease occur in exons, which are individual pieces of DNA that provide instructions for making proteins. These protein-making pieces of DNA are collectively called the exome and comprise less than 2% of the human genome. WES is a highly efficient diagnostic test that identifies variations in the exons of all genes, rather than testing only one or a few genes at a time.¹

WES has been available as a clinical diagnostic tool since 2011 and, over the past decade, WES has increasingly been used as the single genetic test which can provide a timely diagnosis to inform appropriate care. Major insurers, including UnitedHealthcare, Cigna, and BCBS Texas, have covered WES since 2016 for patients with neurodevelopmental disorders suspected to be genetic in nature.² Today, over 90% of commercially insured lives in the US and Medicaid beneficiaries in 28 states have coverage for WES for suspected genetic disease when the clinical presentation is nonspecific and does not fit a well-defined syndrome for which a specific or targeted gene test is available.³

In addition, professional society guidelines from the American College of Medical Genetics and Genomics (ACMG), the National Society of Genetic Counselors (NSGC), and the American Epilepsy Society (AES) all support the use of WES as a first-line diagnostic test for a variety of indications.

WES is medically necessary for diagnosing, managing, and treating this patient. Establishing a diagnosis based on clinical signs and symptoms is often challenging given the genetic and phenotypic heterogeneity associated with rare genetic disease. This patient's clinical presentation is nonspecific and does not fit a well-defined syndrome for which a specific or targeted gene test is available. Without a definitive diagnosis, this patient's care team cannot develop an optimal treatment plan to correct or ameliorate their condition. Earlier diagnosis and interventions provide improved outcomes and can avoid loss of function for many neurodevelopmental disorders.

Previous standard of care tests, including chromosomal microarray, single gene, and multi-gene panel tests, provided substantially lower diagnostic yields and clinical utility at a typically much higher cumulative cost. Utilizing tests other than WES would only serve to extend the diagnostic odyssey, thereby delaying diagnosis and optimal treatment for this patient. Denying coverage for this test may expose the patient to ineffective therapies, irreversible deterioration of their condition, and unnecessary iterative testing and procedures.⁴

Supported by clinical practice guidelines

The use of WES is supported by the evidence-based clinical practice guidelines of the American College of Medical Genetics and Genomics (ACMG), the National Society of Genetic Counselors (NSGC), and the American Epilepsy Society (AES).

ACMG published evidence-based guidelines strongly recommending whole exome or whole genome sequencing (WGS) for patients with (a) one or more congenital anomalies (CA) with onset before age one year or (b) developmental delays (DD) or intellectual disability (ID) with onset before age 18 years in the peer-reviewed medical journal *Genetics in Medicine* on July 1, 2021.⁴ This guideline is based on a comprehensive systematic review of published evidence, including an analytic framework for evaluating outcomes of WES for patients with CA/DD/ID.⁵

In October 2022, NSGC released an evidence-based guideline strongly recommending WES as a first-tier test for individuals with unexplained epilepsy regardless of age. This guideline was based on a systematic evidence review of peer-reviewed literature which included 40 studies with over

3,000 patients who had exome sequencing and demonstrated a genetic diagnosis led to changes in clinical management.⁶ Additionally, the guideline discussed that expanding access to genetic testing may “lead to a decrease in existing health disparities,” but acknowledged insurance reimbursement remains a barrier.⁷ Notably, the NSGC guideline was endorsed by the AES in Sept 2022.

The *ACMG 2021 Guidelines* and the *NSGC 2022 Guidelines* powerfully demonstrate the medical necessity and clinical utility of WES in clinical scenarios like that of this patient. These guidelines are available for review online:

ACMG 2021 Guidelines - [https://www.gimjournal.org/article/S1098-3600\(21\)05168-6/fulltext](https://www.gimjournal.org/article/S1098-3600(21)05168-6/fulltext)
NSGC 2022 Guidelines - <https://onlinelibrary.wiley.com/doi/10.1002/jgc4.1646>

Individual state definitions of medical necessity may be found here: <https://nashp.org/state-tracker/state-definitions-of-medical-necessity-under-the-medicaid-epsdt-benefit/>

References:

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3. Policy Reporter, 2023
4. Manickam, K., McClain, M.R., Demmer, L.A. *et al*. Exome and genome sequencing for pediatric patients with congenital anomalies or intellectual disability: an evidence-based clinical guideline of the American College of Medical Genetics and Genomics (ACMG). *Genet Med* 23, 2029–2037 (2021). <https://doi.org/10.1038/s41436-021-01242-6>
5. Malinowski, J., Miller, D.T., Demmer, L. *et al*. Systematic evidence-based review: outcomes from exome and genome sequencing for pediatric patients with congenital anomalies or intellectual disability. *Genet Med* 22, 986–1004 (2020). <https://doi.org/10.1038/s41436-020-0771-z>
6. Sheidley, B. R., Malinowski, J., Bergner, A. L., Bier, L., Gloss, D. S., Mu, W., Mulhern, M. M., Partack, E. J., & Poduri, A. (2022). Genetic testing for the epilepsies: A systematic review. *Epilepsia*, 63(2), 375–387. <https://doi.org/10.1111/epi.17141>
7. Smith, L., Malinowski, J., Ceulemans, S., Peck, K., Walton, N., Sheidley, B. R., & Lippa, N. (2022). Genetic testing and counseling for the unexplained epilepsies: An evidence-based practice guideline of the National Society of Genetic Counselors. *J Genet Couns*. <https://doi.org/10.1002/jgc4.1646>