

**DRAFT Medical Coverage Policy | Genetic Testing**  
for Diagnosis and Management of Mental Health  
Conditions



**EFFECTIVE DATE:** 01/01/2024  
**POLICY LAST UPDATED:** 10/18/2023

## OVERVIEW

Individual genes have been shown to be associated with risk of psychiatric disorders and specific aspects of psychiatric drug treatment such as drug metabolism, treatment response, and risk of adverse events. Commercially available testing panels include several of these genes and are intended to aid in the diagnosis and management of mental health disorders.

The following tests are addressed in this policy:

- Cytochrome P450 1A2 Genotype (Mayo Clinic) CPT code 0031U
- Genecept Assay (Genomind) CPT code 81479
- GeneSight Psychotropic panel (Myriad Neuroscience) CPT code 0345U
- Genomind® Professional PGx Express™ CORE (Genomind, Inc.) CPT code 0175U
- IDgenetix® (Castle Biosciences, Inc.) CPT code 0411U
- Medication Management Neuropsychiatric Panel (RCA Laboratory Services LLC d/b/a GENETWORx) CPT code 0392U
- Mental Health DNA Insight panel (Pathway Genomics) CPT code 81479
- Neuropharmagen (AB-Biotics) CPT code 81479
- Proove Opioid Risk Assay (Proove Biosciences) CPT code 81479
- Psych HealthPGx Panel (RPRD Diagnostics) CPT code 0173U
- Psychotropic Pharmacogenomics Gene Panel (Mayo Clinic) CPT code 81479
- STA<sup>2</sup>R - SureGene Test for Antipsychotic and Antidepressant Response (SureGene) CPT code 81479

## MEDICAL CRITERIA

Not applicable

## PRIOR AUTHORIZATION

### Medicare Advantage Plans and Commercial Products

For services in this policy that do not have a specific CPT code an Unlisted CPT code should be used (See Coding Section for details). All Unlisted genetic testing CPT codes require prior authorization to determine what service is being rendered and if the service is covered or not medically necessary. See the Related Policies section.

**Note:** Laboratories are not allowed to obtain clinical authorization or participate in the authorization process on behalf of the ordering physician. Only the ordering physician shall be involved in the authorization, appeal or other administrative processes related to prior authorization/medical necessity.

In no circumstance shall a laboratory or a physician/provider use a representative of a laboratory or anyone with a relationship to a laboratory and/or a third party to obtain authorization on behalf of the ordering physician, to facilitate any portion of the authorization process or any subsequent appeal of a claim where the authorization process was not followed and/or a denial for clinical appropriateness was issued, including any element of the preparation of necessary documentation of clinical appropriateness. If a laboratory or a third party is found to be supporting any portion of the authorization process, BCBSRI will deem the action a violation of this policy and severe action will be taken up to and including termination from the BCBSRI

provider network. If a laboratory provides a laboratory service that has not been authorized, the service will be denied as the financial liability of the participating laboratory and may not be billed to the member.

## **POLICY STATEMENT**

### **Medicare Advantage Plans and Commercial Products**

The following tests are covered:

- GeneSight® Psychotropic Panel - CPT code 0345U
- IDgenetix® - CPT code 0411U (New Code Effective 10/01/2023. For Dates of Service prior to 10/01/2023, CPT code 81479 must be used)
- Psychotropic Pharmacogenomics Gene Panel – CPT code 81479

The following tests are not covered for Medicare Advantage Plans and not medically necessary for Commercial Products as the evidence is insufficient to determine that the technology results in an improvement in the net health outcome:

- Cytochrome P450 1A2 Genotype (Mayo Clinic)
- Genecept Assay (Genomind)
- Genomind® Professional PGx Express™ CORE (Genomind, Inc.)
- Medication Management Neuropsychiatric Panel (RCA Laboratory Services LLC d/b/a GENETWORx)
- Mental Health DNA Insight Panel (Pathway Genomics)
- Neuropharmagen (AB-Biotics)
- Proove Opioid Risk Assay (Proove Biosciences)
- Psych HealthPGx Panel (RPRD Diagnostics)
- STA<sup>2</sup>R - SureGene Test for Antipsychotic and Antidepressant Response (SureGene)

### **Commercial Products**

Some genetic testing services are not covered and a contract exclusion for any self-funded group that has excluded the expanded coverage of biomarker testing related to the state mandate, R.I.G.L. §27-19-81 described in the Biomarker Testing Mandate policy. For these groups, a list of which genetic testing services are covered with prior authorization, are not medically necessary or are not covered because they are a contract exclusion can be found in the Coding section of the Genetic Testing Services or Proprietary Laboratory Analyses policies. Please refer to the appropriate Benefit Booklet to determine whether the member's plan has customized benefit coverage. Please refer to the list of Related Policies for more information.

## **COVERAGE**

Benefits may vary between groups and contracts. Please refer to the appropriate Benefit Booklet, Evidence of Coverage, or Subscriber Agreement for laboratory tests or not medically necessary/not covered benefits/coverage.

## **BACKGROUND**

This policy assesses whether genetic testing for the diagnosis and management of mental health conditions is clinically useful. To make a clinical management decision that improves the net health outcome; the balance of benefits and harms must be better when the test is used to manage the condition than when another test or no test is used. The net health outcome can be improved if patients receive correct therapy, or more effective therapy, or avoid unnecessary therapy, or avoid unnecessary testing.

The primary goal of pharmacogenomics testing and personalized medicine is to achieve better clinical outcomes compared to managing the condition with the standard of care. Drug response varies greatly between individuals, and genetic factors are known to play a role. However, in most cases, the genetic variation only explains a modest portion of the variance in the individual response because clinical outcomes are also affected

by a wide variety of factors including alternate pathways of metabolism and patient- and disease-related factors that may affect absorption, distribution, and elimination of the drug.

Therefore, assessment of clinical utility of a pharmacogenetic test cannot be made by a chain of evidence from clinical validity data alone. In such cases, evidence evaluation requires studies that directly demonstrate that the use of the pharmacogenomic test to make management decisions alters clinical outcomes; it is not sufficient to demonstrate that the test predicts a disorder or a phenotype. Direct evidence of clinical utility is provided by studies that compare health outcomes for patients managed with or without the test. Because these are intervention studies, the preferred evidence is from randomized controlled trials.

Clinical laboratories may develop and validate tests in-house and market them as a laboratory service; laboratory-developed tests (LDTs) must meet the general regulatory standards of the Clinical Laboratory Improvement Amendments (CLIA). The tests discussed in this section are available under the auspices of CLIA. Laboratories that offer LDTs must be licensed by CLIA for high-complexity testing. To date, the U.S. Food and Drug Administration has chosen not to require any regulatory review of this test.

Examples of commercially available panels include the following:

- Cytochrome P450 1A2 Genotype (Mayo Clinic)
- Genecept™ Assay (Genomind)
- GeneSight® Psychotropic panel (Assurex Health)
- Genomind® Professional PGx Express™ CORE (Genomind, Inc.)
- IDgenetix® (Castle Biosciences, Inc.)
- Medication Management Neuropsychiatric Panel (RCA Laboratory Services LLC d/b/a GENETWORx)
- Mental Health DNA Insight™ panel (Pathway Genomics)
- IDgenetix® (Castle Biosciences, Inc.)
- Neuropharmagen (AB-Biotics)
- Proove Opioid Risk Assay (Proove Biosciences)
- Psych HealthPGx Panel (RPRD Diagnostics)
- Psychotropic Pharmacogenomics gene panel (Mayo Clinic)
- STA2R test (SureGene Test for Antipsychotic and Antidepressant Response; Clinical Reference Laboratory)

The GeneSight® Psychotropic panel, IDgenetix® and Psychotropic Pharmacogenomics Gene Panel are pharmacogenomic tests that analyze clinically important genetic variations in DNA. The results can inform physicians about genes that may impact how a particular patient metabolizes or responds to certain medications.

### **Documentation Requirements**

The medical record must clearly reflect the following:

- The patient has a diagnosis for which pharmacologic therapy is reasonable and necessary, and the drug or drugs that the clinician is considering using must be reasonable and necessary for the treatment of the patient's diagnosis.
- The clinician has made an initial personalized decision for the patient based on the patient's diagnosis, the patient's other medical conditions, other medications the patient is taking, professional judgement, clinical science and basic science pertinent to the drug (e.g. mechanism of action, side effects), the patient's past medical history and when pertinent family history and the patient's preferences and values.
- The provider performing the service must have a record of what drug(s) is/are being considered and for what indication(s).

For adult patients with Major Depressive Disorder (MDD) who receive Neuropharmagen testing guided drug treatment, the evidence includes 2 RCTs. Relevant outcomes are symptoms, changes in disease status, morbid events, functional outcomes, health status measures, quality of life, and treatment-related morbidity. The 2 RCTs compared response ( $\geq 50\%$  decrease in HAM-D17) and remission ( $\text{HAM-D17} \leq 7$ ) with antidepressant therapy informed by Neuropharmagen test results to antidepressant therapy selected without Neuropharmagen test results (i.e. SOC). The single-blinded RCT by Han et al (2018) reported statistically significant improvement in response (72% of 52 vs. 44% of 48;  $p=.01$ ) but no statistically significant improvement in remission (46% of 52 vs. 26% of 48;  $p=.07$ ) in the Neuropharmagen arm compared to SOC at 8 weeks among patients with MDD. The study reported early dropout of 25% in guided-care and 38% in the standard care arm and used last observation carried forward (LOCF) approach in the ITT analysis of effectiveness. Use of LOCF assumes data are missing completely at random, which is unlikely to hold in this analysis. Also, the study did not report registration in any clinical trial database. The single-blinded RCT by Perez et al (2017) reported non-statistically significant improvement in response (45% of 141 vs. 40% of 139;  $p=.39$ ) and remission (34% of 141 vs. 33% of 139;  $p=.87$ ) in the Neuropharmagen arm compared to SOC at 12 weeks among patients with MDD. Response and remission data were missing for 9% of patients in the guided care group and 14% in the SOC group. None of these trials provided adequate evidence. Both studies have major limitations in design and conduct and in consistency and precision. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who are evaluated for diagnosis or risk of a mental illness who receive genetic testing for risk of that disorder, the evidence includes various observational studies (cohort, case-control, genome-wide association study). Relevant outcomes are changes in disease status, morbid events, functional outcomes, health status measures, quality of life, and treatment-related morbidity. Most studies evaluated the association between genotype and mental health disorders or gene-drug interactions among patients with risk for mental health conditions. No studies were identified that evaluated whether testing for variants changed clinical management or affected health outcomes. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals with a mental illness other than depression who are undergoing drug treatment who receive genetic testing for genes associated with medication pharmacokinetics and pharmacodynamics, the evidence includes a systematic review and meta-analysis and RCTs evaluating associations between specific genes and outcomes of drug treatment. Relevant outcomes are symptoms, changes in disease status, morbid events, functional outcomes, health status measures, quality of life, and treatment-related morbidity. The systematic review and meta-analysis by Hartwell et al (2020) included 7 RCTs and reported no significant moderating effect of rs1799971, a single nucleotide polymorphism (SNP) that encodes a non-synonymous substitution (Asn40Asp) in the mu-opioid receptor gene, OPRM1 on response to naltrexone treatment of alcohol use disorder. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

Specific variants included in the STA<sup>2</sup>R test (SureGene Test for Antipsychotic and Antidepressant Response; Clinical Reference Laboratory) were not easily identified from the manufacturer's website.

## **CODING**

### **Medicare Advantage Plans and Commercial Products**

The following CPT code(s) are covered:

GeneSight® Psychotropic Panel

**0345U** Psychiatry (eg, depression, anxiety, attention deficit hyperactivity disorder [ADHD]), genomic analysis panel, variant analysis of 15 genes, including deletion/duplication analysis of CYP2D6 (Code: Effective 10/01/2022. For Dates of Service prior to 10/1/2022, Unlisted CPT code 81479 must be used.)

IDgenetix®

**0411U** Psychiatry (eg, depression, anxiety, attention deficit hyperactivity disorder [ADHD]), genomic analysis panel, variant analysis of 15 genes, including deletion/duplication analysis of CYP2D6 (New Code Effective 10/01/2023; for Dates of Service prior to 10/01/2023, CPT code 81479 (Unlisted molecular pathology procedure) should be filed)

\*While there may be specific CPT codes for some of the components of the panel testing above, claims for the entire panel must be filed with CPT codes 0345U, 0411U or 81479 according to the Dates of Service outlined above.

The following CPT code(s) are not covered for Medicare Advantage Plans and not medically necessary for Commercial Products:

Psych HealthPGx Panel

**0173U** Psychiatry (ie, depression, anxiety), genomic analysis panel, includes variant analysis of 14 genes

Genomind® Professional PGx Express™ CORE

**0175U** Psychiatry (eg, depression, anxiety), genomic analysis panel, variant analysis of 15 genes

Psych HealthPGx Panel

**0173U** Psychiatry (ie, depression, anxiety), genomic analysis panel, includes variant analysis of 14 genes

Genomind® Professional PGx Express™ CORE

**0175U** Psychiatry (eg, depression, anxiety), genomic analysis panel, variant analysis of 15 genes

Cytochrome P450 1A2 Genotype

**0031U** CYP1A2 (cytochrome P450 family 1, subfamily A, member 2)(eg, drug metabolism) gene analysis, common variants (ie, \*1F, \*1K, \*6, \*7)

Medication Management Neuropsychiatric Panel

**0392U** Drug metabolism (depression, anxiety, attention deficit hyperactivity disorder [ADHD]), gene-drug interactions, variant analysis of 16 genes, including deletion/duplication analysis of CYP2D6, reported as impact of gene-drug interaction for each drug (New Code Effective 7/01/2023)

\*For all other testing referenced in this policy:

There is not a specific CPT code, therefore, claims should be filed with Unlisted CPT code **81479**.

**81479** Unlisted molecular pathology procedure

While there may be specific CPT codes for some of the components of the panel testing in this policy, claims for the entire panel must be filed with the Unlisted CPT code noted above.

## RELATED POLICIES

Biomarker Testing Mandate

Genetic Testing Services

Proprietary Laboratory Analyses (PLA)

Unlisted Procedures

## PUBLISHED

Provider Update, January 2023, September 2023, November 2023

Provider Update, February 2022

Provider Update, March 2021

Provider Update, February 2020

Provider Update, January 2019



## REFERENCES

1. Centers for Medicare and Medicaid Services (CMS). Local Coverage Determination (LCD): MolDX: Pharmacogenomics Testing, CGS Administrators, LLC (L38394)
2. Centers for Medicare and Medicaid Services (CMS). Local Coverage Article: Billing and Coding: MolDX: Pharmacogenomics Testing, CGS Administrators, LLC (A58324)
3. Centers for Medicare and Medicaid Services (CMS). Local Coverage Determination (LCD): MolDX: Pharmacogenomics Testing, Noridian Healthcare Solutions, LLC (L38335)
4. Centers for Medicare and Medicaid Services (CMS). Local Coverage Article: Billing and Coding: MolDX: Pharmacogenomics Testing, Noridian Healthcare Solutions, LLC (A57384)
5. Koyama E, Zai CC, Bryushkova L, et al. Predicting risk of suicidal ideation in youth using a multigene panel for impulsive aggression. *Psychiatry Res.* Mar 2020;285: 112726. PMID 31870620
6. Ghafouri-Fard S, Taheri M, Omrani MD, et al. Application of Single-Nucleotide Polymorphisms in the Diagnosis of Autism Spectrum Disorders: A Preliminary Study with Artificial Neural Networks. *J Mol Neurosci.* Aug 2019; 68(4): 515-521. PMID 30937628
7. Ran L, Ai M, Wang W, et al. Rare variants in SLC6A4 cause susceptibility to major depressive disorder with suicidal ideation in Han Chinese adolescents and young adults. *Gene.* Feb 05 2020; 726: 144147. PMID 31629822
8. Wan L, Zhang G, Liu M, et al. Sex-specific effects of methylenetetrahydrofolate reductase polymorphisms on schizophrenia with methylation changes. *Compr Psychiatry.* Oct 2019; 94: 152121. PMID 31476590
9. Zhu D, Yin J, Liang C, et al. CACNA1C (rs1006737) may be a susceptibility gene for schizophrenia: An updated meta-analysis. *Brain Behav.* Jun 2019; 9(6):e01292. PMID 31033230
10. Schroter K, Brum M, Brunkhorst-Kanaan N, et al. Longitudinal multi-level biomarker analysis of BDNF in major depression and bipolar disorder. *Eur Arch Psychiatry Clin Neurosci.* Mar 2020; 270(2): 169-181. PMID 30929061
11. Chen X, Wang M, Zhang Q, et al. Stress response genes associated with attention deficit hyperactivity disorder: A case-control study in Chinese children. *Behav Brain Res.* May 02 2019; 363: 126-134. PMID 30707907
12. Zhang L, Hu XZ, Benedek DM, et al. Genetic predictor of current suicidal ideation in US service members deployed to Iraq and Afghanistan. *J Psychiatr Res.* Jun 2019; 113: 65-71. PMID 30904785
13. Gaynes BN, Warden D, Trivedi MH, et al. What did STAR\*D teach us? Results from a large-scale, practical, clinical trial for patients with depression. *Psychiatr Serv.* Nov 2009; 60(11): 1439-45. PMID 19880458
14. Bonin L. Pediatric unipolar depression: Epidemiology, clinical features, assessment, and diagnosis. 2021; [https://www.uptodate.com/contents/pediatric-unipolar-depression-epidemiology-clinical-features-assessment-and-diagnosis?topicRef=1231&source=related\\_link](https://www.uptodate.com/contents/pediatric-unipolar-depression-epidemiology-clinical-features-assessment-and-diagnosis?topicRef=1231&source=related_link). Accessed June 4, 2022.
15. Source Bloomberg news, August 14 2019.
16. Rohan KJ, Rough JN, Evans M, et al. A protocol for the Hamilton Rating Scale for Depression: Item scoring rules, Rater training, and outcome accuracy with data on its application in a clinical trial. *J Affect Disord.* Aug 2016; 200: 111-8. PMID 27130960
17. CADTH Common Drug Reviews. Aripiprazole (Abilify): Depression, Major Depressive Disorder (MDD). Ottawa (ON): Canadian Agency for Drugs and Technologies in Health, Copyright (c) CADTH 2016.; 2016.
18. Spielmans GI, McFall JP. A comparative meta-analysis of Clinical Global Impressions change in antidepressant trials. *J Nerv Ment Dis.* Nov 2006; 194(11): 845-52. PMID 17102709
19. Sheehan DV, Harnett-Sheehan K, Raj BA. The measurement of disability. *Int Clin Psychopharmacol.* Jun 1996; 11 Suppl 3: 89-95. PMID 8923116
20. Leon AC, Olfson M, Portera L, et al. Assessing psychiatric impairment in primary care with the Sheehan Disability Scale. *Int J Psychiatry Med.* 1997; 27(2): 93-105. PMID 9565717
21. Brown L, Vranjkovic O, Li J, et al. The clinical utility of combinatorial pharmacogenomic testing for patients with depression: a meta-analysis. *Pharmacogenomics.* Jun 2020; 21(8): 559-569. PMID 32301649

22. Jokic M, Vandersluis S, Higgins C, et al. Multi-gene Pharmacogenomic Testing That Includes Decision-Support Tools to Guide Medication Selection for Major Depression: A Health Technology Assessment. *Ont Health Technol Assess Ser.* 2021; 21(13): 1-214. PMID 34484487
23. Tiwari AK, Zai CC, Altar CA, et al. Clinical utility of combinatorial pharmacogenomic testing in depression: A Canadian patient- and rater-blinded, randomized, controlled trial. *Transl Psychiatry.* Mar 14 2022; 12(1): 101. PMID 35288545
24. Greden JF, Parikh SV, Rothschild AJ, et al. Impact of pharmacogenomics on clinical outcomes in major depressive disorder in the GUIDED trial: A large, patient-and rater-blinded, randomized, controlled study. *J Psychiatr Res.* Apr 2019; 111: 59-67. PMID 30677646
25. Winner JG, Carhart JM, Altar CA, et al. A prospective, randomized, double-blind study assessing the clinical impact of integrated pharmacogenomic testing for major depressive disorder. *Discov Med.* Nov 2013; 16(89): 219-27. PMID 24229738
26. International Conference on Harmonization. Statistical principles for clinical trials: E9. 1998. <https://www.fda.gov/media/71336/download>. Accessed June 8, 2022.
27. Newell DJ. Intention-to-treat analysis: implications for quantitative and qualitative research. *Int J Epidemiol.* Oct 1992; 21(5): 837-41. PMID 1468842
28. Bradley P, Shiekh M, Mehra V, et al. Improved efficacy with targeted pharmacogenetic-guided treatment of patients with depression and anxiety: A randomized clinical trial demonstrating clinical utility. *J Psychiatr Res.* Jan 2018; 96: 100-107. PMID 28992526
29. Olson MC, Maciel A, Garipey JF, et al. Clinical Impact of Pharmacogenetic-Guided Treatment for Patients Exhibiting Neuropsychiatric Disorders: A Randomized Controlled Trial. *Prim Care Companion CNS Disord.* Mar 16 2017; 19(2). PMID 28314093
30. Vilches S, Tuson M, Vieta E, et al. Effectiveness of a Pharmacogenetic Tool at Improving Treatment Efficacy in Major Depressive Disorder: A Meta-Analysis of Three Clinical Studies. *Pharmaceutics.* Sep 02 2019; 11(9). PMID 31480800
31. Han C, Wang SM, Bahk WM, et al. A Pharmacogenomic-based Antidepressant Treatment for Patients with Major Depressive Disorder: Results from an 8-week, Randomized, Single-blinded Clinical Trial. *Clin Psychopharmacol Neurosci.* Nov 30 2018; 16(4): 469-480. PMID 30466219
32. Perez V, Salavert A, Espadaler J, et al. Efficacy of prospective pharmacogenetic testing in the treatment of major depressive disorder: results of a randomized, double-blind clinical trial. *BMC Psychiatry.* Jul 14 2017; 17(1): 250. PMID 28705252
33. Espadaler J, Tuson M, Lopez-Ibor JM, et al. Pharmacogenetic testing for the guidance of psychiatric treatment: a multicenter retrospective analysis. *CNS Spectr.* Aug 2017; 22(4): 315-324. PMID 27098095
34. Lachin JM. Fallacies of last observation carried forward analyses. *Clin Trials.* Apr 2016; 13(2): 161-8. PMID 26400875
35. Hartwell EE, Feinn R, Morris PE, et al. Systematic review and meta-analysis of the moderating effect of rs1799971 in OPRM1, the mu-opioid receptor gene, on response to naltrexone treatment of alcohol use disorder. *Addiction.* Aug 2020; 115(8): 1426-1437. PMID 31961981
36. Kampangkaew JP, Spellicy CJ, Nielsen EM, et al. Pharmacogenetic role of dopamine transporter (SLC6A3) variation on response to disulfiram treatment for cocaine addiction. *Am J Addict.* Jul 2019; 28(4): 311-317. PMID 31087723
37. Naumova D, Grizenko N, Sengupta SM, et al. DRD4 exon 3 genotype and ADHD: Randomised pharmacodynamic investigation of treatment response to methylphenidate. *World J Biol Psychiatry.* Jul 2019; 20(6): 486-495. PMID 29182037
38. Jukic MM, Smith RL, Haslemo T, et al. Effect of CYP2D6 genotype on exposure and efficacy of risperidone and aripiprazole: a retrospective, cohort study. *Lancet Psychiatry.* May 2019; 6(5): 418-426. PMID 31000417
39. Caudle KE, Klein TE, Hoffman JM, et al. Incorporation of pharmacogenomics into routine clinical practice: the Clinical Pharmacogenetics Implementation Consortium (CPIC) guideline development process. *Curr Drug Metab.* Feb 2014; 15(2): 209-17. PMID 24479687

40. Hicks JK, Bishop JR, Sangkuhl K, et al. Clinical Pharmacogenetics Implementation Consortium (CPIC) Guideline for CYP2D6 and CYP2C19 Genotypes and Dosing of Selective Serotonin Reuptake Inhibitors. *Clin Pharmacol Ther.* Aug 2015; 98(2): 127-34. PMID 25974703
41. Hicks JK, Sangkuhl K, Swen JJ, et al. Clinical pharmacogenetics implementation consortium guideline (CPIC) for CYP2D6 and CYP2C19 genotypes and dosing of tricyclic antidepressants: 2016 update. *Clin Pharmacol Ther.* Jul 2017; 102(1): 37-44. PMID 27997040
42. International Society of Psychiatric Genetics. Genetic Testing and Psychiatric Disorders: A Statement from the International Society of Psychiatric Genetics. Accessed June 3, 2022.
43. Bousman CA, Bengesser SA, Aitchison KJ, et al. Review and Consensus on Pharmacogenomic Testing in Psychiatry. *Pharmacopsychiatry.* Jan 2021; 54(1): 5-17. PMID 33147643

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