

# CONCERT GENETICS GENETIC TESTING: EPILEPSY, NEURODEGENERATIVE, AND NEUROMUSCULAR DISORDERS

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See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

## OVERVIEW

Genetic testing for hereditary epilepsy, neurodegenerative, and neuromuscular disorders may be used to establish or confirm a diagnosis in a patient who has signs and/or symptoms of a genetic disorder, for whom clinical evaluation and other standard laboratory tests/imaging/etc. have been non-diagnostic or inconclusive. Confirming a genetic diagnosis may inform clinical management and/or eliminate the need for further diagnostic workup. This document addresses genetic testing for epilepsy, neurodegenerative, and neuromuscular genetic diseases.

## POLICY REFERENCE TABLE

### Coding Implications

This clinical policy references Current Procedural Terminology (CPT<sup>®</sup>). CPT is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2023, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

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The tests and associated laboratories and CPT codes contained within this document serve only as examples to help users navigate claims and corresponding criteria; as such, they are not comprehensive and are not a guarantee of coverage or non-coverage. Please see the [Concert Genetics Platform](#) for a comprehensive list of registered tests.

<a href="#">Criteria Sections</a>	Example Tests; Labs	Common CPT Codes	Common ICD Codes	<a href="#">Ref</a>
<b><a href="#">Comprehensive Neuromuscular Disorders Panel</a></b>				
<a href="#">Comprehensive Neuromuscular Disorders Panel</a>	Comprehensive Neuromuscular Panel (PreventionGenetics, part of Exact Sciences)	81161, 81404, 81405, 81406, 81479	G12, G13, G23-G26, G31, G32, G36, G37	22, 27, 31, 34
	Comprehensive Neuromuscular Disorders Panel (Invitae)			
	Neuromuscular Disorders Panel (GeneDx)			
<b><a href="#">Comprehensive Ataxia Panel</a></b>				
<a href="#">Comprehensive Ataxia Panel</a>	Genomic Unity Ataxia Repeat Expansion Analysis (Variantyx, Inc.)	0216U	G11.1, G11.19,	12
	Genomic Unity Comprehensive Ataxia Analysis (Variantyx, Inc.)	0217U	G11.8, G11.9, Z82.0	
	Ataxia Xpanded Panel (GeneDx)	81185, 81189,		
	Ataxia Panel (Blueprint Genetics)	81286, 81403, 81404, 81479		
<b><a href="#">Spinal Muscular Atrophy</a></b>				
<a href="#">SMN1 Sequencing and/or Deletion/Duplication Analysis</a>	SMN1 Diagnostic Testing (by MLPA) (PerkinElmer Genomics)	81329, 81401	G12, Z84.81	7
	SMN1 Sequencing Analysis (Fulgent Genetics)	81336, 81405		
	Genomic Unity SMN1/2 Analysis (Variantyx Inc.)	0236U		

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<a href="#">SMN2 Deletion/Duplication Analysis</a>	SMN2 Deletion/Duplication (GeneDx)	81401		
<b><a href="#">Rett Syndrome</a></b>				
<a href="#">MECP2 Sequencing and/or Deletion/Duplication Analysis</a>	MECP2 Full Gene Sequencing and Deletion/Duplication (Invitae)	81302, 81304	F70-F79, F80, F81, F82, F84, F88, F89, Z13.4, Z82.79, Z84	36, 37
	MECP2 Gene Sequencing & Del/Dup (GeneDx)			
	Genomic Unity MECP2 Analysis (Variantyx, Inc.)	0234U		
<b><a href="#">Epilepsy</a></b>				
<a href="#">Epilepsy Multigene Panel</a>	Comprehensive Epilepsy Panel (Blueprint Genetics)	81185, 81189, 81302, 81406, 81419, 81479	G40.001-G40.919	32
	Comprehensive Epilepsy Panel (GeneDx)			
	Infantile Epilepsy Panel (GeneDx)			
	Childhood-Onset Epilepsy Panel (GeneDx)			
	Invitae Epilepsy Panel (Invitae)			
<b><a href="#">CADASIL</a></b>				
<a href="#">NOTCH3 Sequencing and/or Deletion/Duplication Analysis</a>	NOTCH3 Full Gene Sequencing and Deletion/Duplication (Invitae)	81406, 81479	I67.850, F02.80, F02.81	38
<b><a href="#">Alzheimer Disease</a></b>				
<a href="#">PSEN1, PSEN2, and APP Sequencing and/or Deletion/Duplication Analysis</a>	PSEN1 Full Gene Sequencing and Deletion/Duplication (Invitae)	81405, 81479	F03, G30, G31.1, R41.0, R41.81, Z13.858, Z82.0, Z84.81	4, 5
	Alzheimer's Disease, Familial via the PSEN2 Gene (PreventionGenetics, part of Exact Sciences)	81406, 81479		

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	APP Full Gene Sequencing and Deletion/Duplication (Invitae)	81406, 81479		
	Alzheimer's Disease, Familial, Panel (PreventionGenetics, part of Exact Sciences)	81405, 81406, 81479		
	Hereditary Alzheimer's Disease Panel (Invitae)			
<a href="#">APOE Variant Analysis for Alzheimer's Disease</a>	APOE Single Gene Test (Blueprint Genetics)	81401, 81479, S3852		2
<b><u><a href="#">Amyotrophic Lateral Sclerosis (ALS)</a></u></b>				
<a href="#">Amyotrophic Lateral Sclerosis (ALS) Multigene Panel</a>	Amyotrophic Lateral Sclerosis (ALS) Panel (PreventionGenetics, part of Exact Sciences)	81179, 81403, 81404, 81405, 81406, 81407, 81479, S3800	G12.21	10, 42
	Amyotrophic Lateral Sclerosis Panel (Invitae)			
<b><u><a href="#">Duchenne and Becker Muscular Dystrophy</a></u></b>				
<a href="#">DMD Sequencing and/or Deletion/Duplication Analysis</a>	DMD Full Gene Sequencing and Deletion/Duplication (Invitae)	81161	G71.01, R62.59, Z84.81	11, 26
	Duchenne/Becker MD (DMD) Gene Sequencing (GeneDx)	81408		
	Genomic Unity DMD Gene Analysis (Variantyx)	0218U		
<b><u><a href="#">Facioscapulohumeral Muscular Dystrophy (FSHD)</a></u></b>				
<a href="#">D4Z4 Haplotype Analysis, and/or SMCHD1 and DNMT3B Sequencing and/or Deletion/Duplication Analysis or Multigene Panel</a>	FSHD1 Southern Blot Test (Quest Diagnostics)	81404	G71.02, Z84.81	1, 25
	FSHD-(FSHD1 & FSHD2) Detection of Abnormal Alleles with Interpretation - 4qA/4qB Haplotyping (University of Iowa Hospitals and Clinics - Department of Pathology)	81404		
	Facioscapulohumeral Muscular Dystrophy 2 via the SMCHD1 Gene (PreventionGenetics, part of Exact Sciences)	81479		

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	DNMT3B Full Gene Sequencing And Deletion/Duplication (Invitae)			
	FSHD-(FSHD1 & FSHD2) Detection of Abnormal Alleles with Interpretation (University of Iowa Hospitals and Clinics - Department of Pathology)	81404, 81479		
<b><u>Friedreich's Ataxia</u></b>				
<a href="#"><u>FXN Repeat Analysis and/or Sequencing Analysis</u></a>	Friedreich Ataxia (FXN) Repeat Expansion Test (Athena Diagnostics)	81284, 81285	G11, Z84.81	9, 12
	Friedreich Ataxia (FXN) DNA Sequencing Test (Athena Diagnostics)	81286, 81404		
	Genomic Unity FXN Analysis (Variantyx Inc)	0233U		
<b><u>Huntington's Disease (HD)</u></b>				
<a href="#"><u>HTT Repeat Analysis</u></a>	Huntington Disease (HTT) Genetic Testing (Repeat Expansion) (LabCorp)	81271, 81274	G10, Z84.81	8, 13, 39
<b><u>Inherited Peripheral Neuropathy (Charcot-Marie-Tooth and Hereditary Neuropathy with Liability to Pressure Palsies)</u></b>				
<a href="#"><u>PMP22 Sequencing and/or Deletion/Duplication Analysis or Multigene Panel</u></a>	PMP22 Del/Dup Analysis (GeneDx)	81324	G60.0, G60.8, G60.9	3, 14
	PMP22 Gene Sequencing (GeneDx)	81325		
	Charcot-Marie Tooth (CMT) - Comprehensive Panel (PreventionGenetics, part of Exact Sciences)	81448		
	Charcot-Marie-Tooth Panel (GeneDx)			
<b><u>Limb-Girdle Muscular Dystrophies (LGMD)</u></b>				
<a href="#"><u>Limb Girdle Muscular Dystrophy Multigene Panel</u></a>	Limb-Girdle Muscular Dystrophy Panel (GeneDx)	81405, 81406, 81408, 81479	G71.0, Z13.71, Z82.0, Z84.81	6, 43
	Limb-Girdle Muscular Dystrophy Panel (Invitae)			
<b><u>Myotonic Dystrophy</u></b>				
<a href="#"><u>DMPK and/or CNBP</u></a>	Myotonic Dystrophy 1 (DMPK) Genetic	81234, 81239,	G71.11,	15, 16,

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<a href="#">(ZNF9) Repeat Analysis</a>	Testing (Repeat Expansion) (LabCorp)	81401, 81404, S3853	Z84.81	17, 18, 35
	Myotonic Dystrophy 2 (ZNF9 / CNBP) Genetic Testing (Repeat Expansion) (LabCorp)	81187, S3853		
<b><a href="#">Hereditary Dystonia</a></b>				
<a href="#">Hereditary Dystonia Multigene Panel</a>	Dystonia Panel (GeneDx)	81404, 81405, 81406, 81407, 81408, 81479	G24.1, G24.9	19
	Dystonia Panel (PreventionGenetics, part of Exact Sciences)			
	Dystonia Comprehensive Panel (Invitae)			
<b><a href="#">Parkinson Disease</a></b>				
<a href="#">Parkinson Disease Multigene Panel</a>	Parkinson Disease Panel (BluePrint Genetics)	81479	G20	20, 33, 41
	Parkinson Disease Panel (GeneDx)			
	Invitae Parkinson Disease and Parkinsonism Panel (Invitae)			
<b><a href="#">Hereditary Spastic Paraplegia</a></b>				
<a href="#">Hereditary Spastic Paraplegia Multigene Panel</a>	Comprehensive Hereditary Spastic Paraplegia Panel (GeneDx)	81448	G11.4, G82.2	21
	Hereditary Spastic Paraplegia Comprehensive Panel (Invitae)			
<b><a href="#">Congenital Myasthenic Syndrome</a></b>				
<a href="#">Congenital Myasthenic Syndromes Multigene Panel</a>	Congenital Myasthenic Syndrome Panel (PreventionGenetics, part of Exact Sciences)	81406, 81407, 81479	G70.2	22
	Congenital Myasthenic Syndrome Panel (Invitae)			
<b><a href="#">Myotonia Congenita</a></b>				
<a href="#">CLCN1 Sequencing and/or Deletion/Duplication Analysis</a>	Myotonia Congenita via the CLCN1 Gene (PreventionGenetics, part of Exact Sciences)	81406, 81479	G71.12	23, 40
	CLCN1 Full Gene Sequencing and Deletion/Duplication (Invitae)			

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<u>Hypokalemic Periodic Paralysis</u>				
<a href="#"><u>CACNAIS and SCN4A Sequencing and/or Deletion/Duplication Analysis, or Periodic Paralysis Multigene Panel</u></a>	CACNAIS Full Gene Sequencing and/or Deletion/Duplication (Invitae)	81406, 81479	E87.6, G72.3	24
	SCN4A Full Gene Sequencing and/or Deletion/Duplication (Invitae)			
<u>Other Covered Epilepsy, Neurodegenerative, and Neuromuscular Disorders</u>				
<a href="#"><u>Other Covered Epilepsy, Neuromuscular, and Neurodegenerative Disorders</u></a>	See list below	81400, 81401, 81402, 81403, 81404, 81405, 81406, 81407, 81408, 81479		28, 29, 30

## OTHER RELATED POLICIES

This policy document provides criteria for genetic testing for hereditary neurodegenerative and neuromuscular diseases. Please refer to:

- **Genetic Testing: Prenatal Diagnosis (via amniocentesis, CVS, or PUBS) and Pregnancy Loss** for coverage related to prenatal and pregnancy loss diagnostic genetic testing for tests intended to diagnose genetic conditions following amniocentesis, chorionic villus sampling, PUBS, or pregnancy loss.
- **Genetic Testing: Prenatal and Preconception Carrier Screening** for criteria related to prenatal carrier screening, preimplantation testing of embryos, or preconception carrier screening (including carrier screening for Duchenne/Becker muscular dystrophy and SMA).
- **Genetic Testing: Pharmacogenetics** for criteria related to genetic testing prior to the initiation of drug treatment with carbamazepine.
- **Genetic Testing: Metabolic, Endocrine, and Mitochondrial Disorders** for criteria related to genetic testing for mitochondrial disorders.
- **Genetic Testing: Prenatal Diagnosis (via amniocentesis, CVS, or PUBS) and Pregnancy Loss** for coverage related to prenatal and pregnancy loss diagnostic genetic testing.
- **Genetic Testing: Preimplantation Genetic Testing** for criteria related to genetic testing of embryos prior to in vitro fertilization.

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- **Genetic Testing: General Approach to Genetic and Molecular Testing** for criteria related to epilepsy, neuromuscular, and neurodegenerative disorders not specifically discussed in this or another non-general policy.

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## CRITERIA

It is the policy of health plans affiliated with Centene Corporation<sup>®</sup> that the specific genetic testing noted below is **medically necessary** when meeting the related criteria:

### COMPREHENSIVE NEUROMUSCULAR DISORDERS PANEL

- I. Comprehensive neuromuscular panel analysis to establish a genetic diagnosis for a neuromuscular disorder (81161, 81404, 81405, 81406, 81479) is considered **medically necessary** when:
  - A. The member/enrollee displays at least one of the following:
    1. Neonatal respiratory insufficiency, with sudden episodic apnea and cyanosis, **OR**
    2. Neonatal joint contractures (e.g., arthrogryposis multiplex congenita), **OR**
    3. Stridor, feeding difficulties, poor suck/cry, choking spells, eyelid ptosis, or facial, bulbar, or generalized weakness in [neonates](#), **OR**
    4. Abnormal muscle fatigability/weakness, **OR**
    5. Delayed motor milestones, **OR**
    6. Eyelid ptosis or extraocular muscle weakness, **OR**
    7. Facial and bulbar weakness with nasal speech and difficulties in coughing and swallowing, **OR**
    8. Spinal deformity or muscle atrophy, **OR**
    9. Abnormal electromyography (EMG) testing showing a defect in neuromuscular transmission, **AND**
  - B. One of the following:



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1. The member/enrollee's presentation is not consistent with a neuromuscular disorder for which targeted or single-gene analysis (e.g., *SMNI*, *DMD*, *PMP22*) is appropriate, **OR**
  2. The member/enrollee underwent targeted or single-gene analysis for a neuromuscular disorder (e.g., *SMNI*, *DMD*, *PMP22*) and the results were non-diagnostic.
- II. Comprehensive neuromuscular panel analysis to establish a genetic diagnosis for a neuromuscular disorder (81161, 81404, 81405, 81406, 81479) is considered **investigational** for all other indications.

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## COMPREHENSIVE ATAXIA PANEL

- I. Comprehensive ataxia panel analysis to establish a genetic diagnosis of an ataxia (81185, 81189, 81286, 81403, 81404, 81479, 0216U, 0217U) is considered **medically necessary** when:
  - A. The member/enrollee displays one or more of the following:
    1. Poorly coordinated gait and finger/hand movements, **OR**
    2. Weakness of the eye muscles (ophthalmoplegia), **OR**
    3. Dysarthria, **OR**
    4. Eye movement abnormalities (nystagmus, abnormal saccade movements), **AND**
  - B. Non-genetic causes of ataxia have been ruled out (e.g., alcoholism, vitamin deficiencies, multiple sclerosis, vascular disease, primary or metastatic tumors, and paraneoplastic disease associated with occult carcinoma of the ovary, breast, or lung, and spinal muscular atrophy).
- II. Comprehensive ataxia panel analysis to establish a genetic diagnosis of an ataxia (81185, 81189, 81286, 81403, 81404, 81479, 0216U, 0217U) is considered **investigational** for all other indications.

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## **SPINAL MUSCULAR ATROPHY**

### ***SMN1* Sequencing and/or Deletion/Duplication Analysis**

- I. *SMN1* sequencing and/or deletion/duplication analysis (81329, 81336, 81401, 81405, 0236U) to establish or confirm a diagnosis of spinal muscular atrophy is considered **medically necessary** when:
  - A. The member/enrollee has a positive newborn screen for SMA, **OR**
  - B. The member/enrollee has any of the following:
    1. History of motor difficulties, especially with loss of skills, **OR**
    2. Proximal to distal muscle weakness, **OR**
    3. Hypotonia, **OR**
    4. Areflexia/hyporeflexia, **OR**
    5. Tongue fasciculations, **OR**
    6. Hand tremor, **OR**
    7. Recurrent lower respiratory tract infections or severe bronchiolitis in the first few months of life, **OR**
    8. Evidence of motor unit disease on electromyogram.
- II. *SMN1* sequencing and/or deletion/duplication analysis (81329, 81336, 81401, 81405, 0236U) to establish or confirm a diagnosis of spinal muscular atrophy is considered **investigational** for all other indications.

### ***SMN2* Deletion/Duplication Analysis**

- I. *SMN2* deletion/duplication analysis (81401) is considered **medically necessary** when:
  - A. The member/enrollee has a diagnosis of spinal muscular atrophy.
- II. *SMN2* deletion/duplication analysis (81401) is considered **investigational** for all other indications.

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## RETT SYNDROME

### ***MECP2* Sequencing and/or Deletion/Duplication Analysis**

- I. *MECP2* sequencing and/or deletion/duplication analysis (81302, 81304, 0234U) to establish or confirm a diagnosis of Rett syndrome is considered **medically necessary** when:
  - A. The member/enrollee experienced a period of developmental regression (range: ages 1-4 years) followed by recovery or stabilization (range: ages 2-10 years), **AND**
  - B. The member/enrollee has at least one of the following:
    1. Partial or complete loss of acquired purposeful hand skills, **OR**
    2. Partial or complete loss of acquired spoken language or language skill (e.g., babble), **OR**
    3. Gait abnormalities: impaired (dyspraxic) or absence of ability, **OR**
    4. Stereotypic hand movements including hand wringing/squeezing, clapping/tapping, mouthing, and washing/rubbing automatisms, **AND**
  - C. The member/enrollee does **not** have either of the following:
    1. Brain injury secondary to peri- or postnatal trauma, neurometabolic disease, or severe infection that causes neurological problems, **OR**
    2. Grossly abnormal psychomotor development in the first six months of life, with early milestones not being met.
- II. *MECP2* sequencing and/or deletion/duplication analysis (81302, 81304, 0234U) to establish or confirm a diagnosis of Rett syndrome is considered **investigational** for all other indications.

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## **EPILEPSY**

### **Epilepsy Multigene Panel**

- I. The use of an epilepsy multigene panel (81185, 81189, 81302, 81406, 81419, 81479) is considered **medically necessary** when:
  - A. The member/enrollee has a history of unexplained epilepsy (i.e., seizures not caused by acquired etiology such as trauma, infection, structural brain abnormality, and/or stroke).
- II. The use of an epilepsy multigene panel (81185, 81189, 81302, 81406, 81419, 81479) is considered **investigational** for all other indications.

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## **CADASIL**

### ***NOTCH3* Sequencing and/or Deletion/Duplication Analysis**

- I. *NOTCH3* sequencing and/or deletion/duplication analysis (81406, 81479) to establish or confirm a diagnosis of CADASIL (cerebral autosomal dominant arteriopathy with subcortical infarcts and leukoencephalopathy) is considered **medically necessary** when:
  - A. The member/enrollee has a family history of stroke and/or vascular dementia consistent with an [autosomal dominant pattern of inheritance](#), **OR**
  - B. The member/enrollee has at least one of the following clinical features of CADASIL:
    1. Transient ischemic attacks and ischemic stroke, **OR**
    2. Cognitive impairment, manifesting initially with executive dysfunction, with a concurrent stepwise deterioration due to recurrent strokes to vascular dementia, **OR**
    3. Migraine with aura (mean age of onset of 30 years), **OR**
    4. Psychiatric disturbances, most frequently mood disturbances and apathy, **OR**

- C. The member/enrollee has at least one of the following brain imaging findings of CADASIL:
1. Symmetric and progressive white matter hyperintensities, often involving the anterior temporal lobes and external capsules, **OR**
  2. Lacunes of presumed vascular origin, **OR**
  3. Recent subcortical infarcts, **OR**
  4. Dilated perivascular spaces, sometimes referred to as subcortical lacunar lesions, **OR**
  5. Brain atrophy, **OR**
  6. Cerebral microbleeds.
- II. *NOTCH3* sequencing and/or deletion/duplication analysis (81406, 81479) to establish or confirm a diagnosis of CADASIL (cerebral autosomal dominant arteriopathy with subcortical infarcts and leukoencephalopathy) is considered **investigational** for all other indications.

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## ALZHEIMER DISEASE

### ***PSEN1, PSEN2, and APP* Sequencing and/or Deletion/Duplication Analysis**

- I. *PSEN1* (81405, 81479), *PSEN2* (81406, 81479), and/or *APP* (81406, 81479) sequencing and/or deletion/duplication analysis to establish a diagnosis or determine future risk to develop [early-onset Alzheimer disease](#) is considered **medically necessary** when:
  - A. The member/enrollee is 18 years of age or older, **AND**
  - B. The member/enrollee is asymptomatic\*, **AND**
    1. Has a family history of dementia that is consistent with an [autosomal dominant pattern of inheritance](#), **AND**
      - a) Has at least one relative with a history of [early-onset Alzheimer disease](#), **OR**
  - C. The member/enrollee is symptomatic with dementia, **AND**

1. Was diagnosed with dementia at 65 years of age or younger, **AND**
  - a) Has a [close relative](#) diagnosed with dementia, **OR**
  - b) Has an unknown family history (e.g., adoption), **OR**
2. Was diagnosed with dementia at 66 years or older, **AND**
  - a) Has a family history of dementia that is consistent with an [autosomal dominant pattern of inheritance](#), **AND**
  - b) Has at least one [close relative](#) who was diagnosed with dementia at 65 years of age or younger.
- II. Genetic testing for Alzheimer’s disease via other genes is considered **investigational**.\*\*
- III. *PSEN1* (81405, 81479), *PSEN2* (81406, 81479), and/or *APP* (81406, 81479) sequencing and/or deletion/duplication analysis to establish the diagnosis or determine future risk to develop [early-onset Alzheimer disease](#) is considered **investigational** for all other indications.

\*Predictive testing should only be performed in the setting and context of thorough pre- and post-test counseling

\*\*Please see clinical guidelines “*APOE* Variant Analysis for Alzheimer’s Disease” for criteria for *APOE* testing

### ***APOE* Variant Analysis for Alzheimer’s Disease**

- I. *APOE* variant analysis (81401, 81479, S3852) is considered **medically necessary** when:
  - A. The member/enrollee is being evaluated for treatment with monoclonal antibodies directed against aggregated forms of beta amyloid (such as Leqembi).
- II. *APOE* variant analysis (81401, 81479, S3852) is considered **investigational** for all other indications

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## AMYOTROPHIC LATERAL SCLEROSIS (ALS)

### Amyotrophic Lateral Sclerosis (ALS) Multigene Panel

- I. Multigene panel analysis to establish a genetic etiology of amyotrophic lateral sclerosis (ALS) (81179, 81403, 81404, 81405, 81406, 81407, 81479, S3800) is considered **medically necessary** when:
  - A. The member/enrollee displays all of the following:
    1. Evidence of lower motor neuron (LMN) degeneration, **AND**
    2. Evidence of upper motor neuron (UMN) degeneration, **AND**
    3. Progressive spread of symptoms, **AND**
    4. No evidence of other disease processes that could explain the LMN and UMN degeneration, **AND**
  - B. The panel includes, at a minimum, the following genes: *C9orf72*, *SOD1*, *FUS*, and *TARDBP*.
- II. Multigene panel analysis to establish a genetic etiology of amyotrophic lateral sclerosis (ALS) (81179, 81403, 81404, 81405, 81406, 81407, 81479, S3800) is considered **investigational** for all other indications.

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## DUCHENNE AND BECKER MUSCULAR DYSTROPHY

### DMD Sequencing and/or Deletion/Duplication Analysis

- I. *DMD* sequencing and/or deletion/duplication analysis (81161, 81408, 0218U) to establish or confirm a diagnosis of Duchenne muscular dystrophy (DMD) or Becker muscular dystrophy (BMD) is considered **medically necessary** when:
  - A. The member/enrollee has all of the following clinical characteristics of DMD:
    1. Progressive symmetric muscular weakness - proximal greater than distal, often with calf hypertrophy (enlargement), **AND**
    2. Symptoms presenting before age five years, **AND**

3. Wheelchair dependency before age 13 years, **AND**
  4. Elevated serum creatine kinase concentration, typically more than 10 times the normal levels, **OR**
- B. The member/enrollee has all of the following clinical characteristics of BMD:
1. Elevated serum creatine kinase concentration, typically more than 5 times the normal levels, **AND**
    - a) At least one of the following:
      - (1) Progressive symmetric muscle weakness (proximal more so than distal) often with calf hypertrophy (weakness of quadriceps femoris in some cases the only sign), **OR**
      - (2) Activity-induced cramping, **OR**
      - (3) Flexion contractures of the elbows, **OR**
      - (4) Wheelchair dependency after age 16 years, **OR**
      - (5) Preservation of neck flexor muscle strength, **OR**
- C. The member/enrollee is asymptomatic (male reproductive system or female reproductive system), **AND**
1. Has a biological sibling with a clinical diagnosis of Duchenne or Becker muscular dystrophy, **OR**
  2. Has a biological mother that is an obligate carrier for Duchenne or Becker muscular dystrophy, **OR**
- D. The member/enrollee is asymptomatic with a female reproductive system, **AND**
1. Has a [first- or second-degree relative](#) with a clinical diagnosis of Duchenne or Becker muscular dystrophy.
- II. *DMD* sequencing and/or deletion/duplication analysis (81161, 81408, 0218U) to establish a diagnosis of Duchenne muscular dystrophy (DMD) or Becker muscular dystrophy (BMD) is considered **investigational** for all other indications.

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## **FACIOSCAPULOHUMERAL MUSCULAR DYSTROPHY (FSHD)**

### **D4Z4 Haplotype Analysis, and/or *SMCHD1* and *DNMT3B* Sequencing and/or Deletion/Duplication Analysis or Multigene Panel**

- I. D4Z4 haplotype analysis (81404), and/or *SMCHD1* (81479) and *DNMT3B* (81479) sequencing and/or deletion/duplication analysis or multigene panel analysis (81404, 81479) to establish or confirm a diagnosis of facioscapulohumeral muscular dystrophy is considered **medically necessary** when:
  - A. The member/enrollee displays any of the following:
    1. Weakness (which is often asymmetric) that predominantly involves the facial, scapular stabilizer, or foot dorsiflexor muscles without associated ocular or bulbar muscle weakness, **OR**
    2. Progression of weakness after pregnancy, **OR**
    3. Prior diagnosis of inflammatory myopathy that was refractory to immunosuppression.
- II. D4Z4 haplotype analysis (81404), and/or *SMCHD1* (81479) and *DNMT3B* sequencing and/or deletion/duplication analysis (81479) or multigene panel analysis (81404, 81479) to establish or confirm a diagnosis of facioscapulohumeral muscular dystrophy is considered **investigational** for all other indications.

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## **FRIEDREICH'S ATAXIA**

### ***FXN* Repeat Analysis and/or Sequencing Analysis**

- I. *FXN* repeat analysis (81284, 81285, 0233U) and/or sequencing analysis (81286, 81404) to establish or confirm a diagnosis of Friedreich's Ataxia is considered **medically necessary** when:
  - A. The member/enrollee has at least two of the following:
    1. Progressive ataxia of the gait and limbs (e.g., cerebellar ataxia), **OR**

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2. Dysarthria, **OR**
  3. Decrease in/loss of position sense and/or vibration sense in lower limbs, **OR**
  4. Pyramidal weakness of the legs, **OR**
  5. Extensor plantar responses/Babinski signs, **OR**
  6. Muscle weakness, **OR**
  7. Scoliosis, **OR**
  8. Pes cavus (flat feet), **OR**
  9. Hypertrophic nonobstructive cardiomyopathy, **OR**
  10. Glucose intolerance or diabetes mellitus, **OR**
  11. Optic atrophy and/or deafness, **AND**
- B. Non-genetic causes of ataxia have been ruled out (e.g., alcoholism, vitamin deficiencies, multiple sclerosis, vascular disease, tumors), **OR**
- C. The member/enrollee is asymptomatic\*, **AND**
1. Has a biological sibling with Friedreich's ataxia.
- II. *FXN* repeat analysis (81284, 81285, 0233U) and/or sequencing analysis (81286, 81404) to establish or confirm a diagnosis of Friedreich's Ataxia is considered **investigational** for all other indications.

\* Predictive testing should only be performed in the setting and context of thorough pre- and post-test counseling

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## HUNTINGTON'S DISEASE

### ***HTT* Repeat Analysis**

- I. *HTT* repeat analysis to establish a diagnosis or for predictive testing of Huntington's disease (HD) (81271, 81274) is considered **medically necessary** when:

- A. The member/enrollee displays clinical features of Huntington’s disease (i.e., progressive motor disability featuring chorea, where voluntary movement may also be affected), **OR**
  - B. The member/enrollee has a clinical diagnosis of Huntington’s Disease, **OR**
  - C. The member/enrollee is undergoing predictive testing\*, **AND**
    - 1. The member/enrollee is presymptomatic/asymptomatic, **AND**
    - 2. The member/enrollee is 18 years of age or older, **AND**
      - a) The member/enrollee has a [close relative](#) with CAG trinucleotide repeat expansion of 27 or more in *HTT*, **OR**
      - b) The member/enrollee has a [first-degree relative](#) with a clinical diagnosis of HD without prior genetic testing.
- II. *HTT* repeat analysis to establish a diagnosis or for predictive testing of Huntington’s disease (HD) (81271, 81274) is considered **investigational** for all other indications.

\* Predictive testing should only be performed in the setting and context of thorough pre- and post-test counseling.

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## **INHERITED PERIPHERAL NEUROPATHIES (EXAMPLES: CHARCOT-MARIE-TOOTH DISEASE AND HEREDITARY NEUROPATHY WITH LIABILITY TO PRESSURE PALSIES)**

### ***PMP22* Sequencing and/or Deletion/Duplication Analysis or Multigene Panel**

- I. *PMP22* sequencing and/or deletion/duplication analysis (81324, 81325) or multigene panel analysis (81448) to establish a genetic diagnosis of an inherited peripheral neuropathy is considered **medically necessary** when:
  - A. The member/enrollee displays one or more of the following:
    - 1. Distal muscle weakness and atrophy, **OR**
    - 2. Pes cavus foot deformity, **OR**
    - 3. Weak ankle dorsiflexion, **OR**

4. Depressed tendon reflexes, **OR**
  5. Recurrent acute focal sensory and motor neuropathies mainly at entrapment sites, **OR**
  6. Painless nerve palsy after minor trauma or compression, **OR**
  7. Evidence on physical examination of previous nerve palsy such as focal weakness, atrophy, or sensory loss, **OR**
  8. Complete spontaneous recovery from neuropathies.
- II. *PMP22* sequencing and/or deletion/duplication analysis (81324, 81325) or multigene panel analysis (81448) to establish a genetic diagnosis of an inherited peripheral neuropathy is considered **investigational** for all other indications.

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## **LIMB-GIRDLE MUSCULAR DYSTROPHY (LGMD)**

### **Limb-girdle Muscular Dystrophy Multigene Panel**

- I. Multigene panel analysis to establish a diagnosis of limb-girdle muscular dystrophy (81405, 81406, 81408, 81479) is considered **medically necessary** when:
  - A. The member/enrollee displays slowly progressive, symmetrical weakness, **AND**
  - B. The member/enrollee has any of the following features:
    1. Limb-girdle pattern of weakness affecting proximal muscles of the arms and legs, **OR**
    2. Scapuloperoneal weakness, **OR**
    3. Distal weakness, **OR**
    4. Elevated serum creatine kinase levels, **OR**
  - C. The member/enrollee is asymptomatic, **AND**
    1. The member/enrollee has a [close relative](#) diagnosed with limb-girdle muscular dystrophy whose genetic status is unavailable.

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- II. Multigene panel analysis to establish a diagnosis of limb-girdle muscular dystrophy (81405, 81406, 81408, 81479) is considered **investigational** for all other indications.

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## MYOTONIC DYSTROPHY

### *DMPK* and/or *CNBP* (*ZNF9*) Repeat Analysis

- I. *DMPK* repeat analysis (81234, 81239, 81401, 81404, S3853) and/or *CNBP* repeat analysis (81187, S3853) to establish a diagnosis of myotonic dystrophy is considered **medically necessary** when:
- A. The member/enrollee meets either of the following:
1. The member/enrollee is a [neonate](#) with two or more of the following:
    - a) Hypotonia, **OR**
    - b) Facial muscle weakness, **OR**
    - c) Generalized weakness, **OR**
    - d) Positional malformations, including clubfoot, **OR**
    - e) Respiratory insufficiency, **OR**
  2. The member/enrollee is any age and displays any one of the following:
    - a) Muscle weakness, especially of the distal leg, hand, neck, and face, **OR**
    - b) [Myotonia](#), which often manifests as the inability to quickly release a hand grip (grip myotonia), **OR**
    - c) Posterior subcapsular cataracts, **OR**
    - d) Cardiac conduction defects or progressive cardiomyopathy, **OR**
    - e) Insulin insensitivity, **OR**
    - f) Hypogammaglobulinemia, **OR**

- B. The member/enrollee is asymptomatic, **AND**
  - 1. The member/enrollee is 18 years of age or older, **AND**
  - 2. The member/enrollee has a [first-degree relative](#) with Myotonic dystrophy type 1 or 2.
- II. *DMPK* repeat analysis (81234, 81239, 81401, 81404, S3853) and *CNBP* repeat analysis (81187, S3853) to establish a diagnosis of myotonic dystrophy is considered **investigational** for all other indications.

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## HEREDITARY DYSTONIA

### Hereditary Dystonia Multigene Panel

- I. Multigene panel analysis to establish a genetic diagnosis of hereditary dystonia (81404, 81405, 81406, 81407, 81408, 81479) is considered **medically necessary** when:
  - A. The member/enrollee has a clinical presentation consistent with dystonia or patterns of abnormal, repetitive, dystonic movements.
- II. Multigene panel analysis to establish a genetic diagnosis of hereditary dystonia (81404, 81405, 81406, 81407, 81408, 81479) is considered **investigational** for all other indications.

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## PARKINSON DISEASE

### Parkinson Disease Multigene Panel

- I. Multigene panel testing (81479) to establish a genetic diagnosis of Parkinson disease is considered **medically necessary** when:
  - A. The member/enrollee has a clinical diagnosis of Parkinson disease, **AND**
  - B. The member/enrollee has a family history of Parkinson disease.

- II. Multigene panel testing (81479) to establish a genetic diagnosis of Parkinson disease is considered **investigational** for all other indications.

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## HEREDITARY SPASTIC PARAPLEGIA

### Hereditary Spastic Paraplegia Multigene Panel

- I. Multigene panel analysis to establish a genetic diagnosis of hereditary spastic paraplegia (81448) is considered **medically necessary** when:
  - A. The member/enrollee has any of the following:
    1. Lower-extremity spasticity especially in hamstrings, quadriceps, adductors, and gastrocnemius-soleus muscles, **OR**
    2. Weakness especially in the iliopsoas, hamstring, and tibialis anterior, **OR**
    3. Lower-extremity hyperreflexia and extensor plantar responses, **OR**
    4. Mildly impaired vibration sensation in the distal lower extremities.
- II. Multigene panel analysis to establish a genetic diagnosis of hereditary spastic paraplegia (81448) is considered **investigational** for all other indications.

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## CONGENITAL MYASTHENIC SYNDROMES

### Congenital Myasthenic Syndromes Multigene Panel

- I. Multigene panel analysis to establish a genetic diagnosis of congenital myasthenic syndromes (81406, 81407, 81479) is considered **medically necessary** when:
  - A. The member/enrollee has any of the following:
    1. Neonatal respiratory insufficiency, with sudden episodic apnea and cyanosis, **OR**
    2. Neonatal joint contractures (e.g., arthrogryposis multiplex congenita), **OR**

3. Stridor, feeding difficulties, poor suck/cry, choking spells, eyelid ptosis, and/or facial, bulbar, or generalized weakness in [neonates](#), **OR**
  4. Abnormal muscle fatigability/weakness, **OR**
  5. Delayed motor milestones, **OR**
  6. Eyelid ptosis or extraocular muscle weakness, **OR**
  7. Facial and bulbar weakness with nasal speech and difficulties in coughing and swallowing, **OR**
  8. Spinal deformity or muscle atrophy, **OR**
  9. Abnormal electromyography (EMG) testing showing a defect in neuromuscular transmission.
- II. Multigene panel analysis to establish a genetic diagnosis of congenital myasthenic syndromes (81406, 81407, 81479) is considered **investigational** for all other indications.

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## MYOTONIA CONGENITA

### ***CLCN1* Sequencing and/or Deletion/Duplication Analysis**

- I. *CLCN1* sequencing and/or deletion/duplication analysis (81406, 81479) to establish a genetic diagnosis of myotonia congenita is considered **medically necessary** when:
  - A. The member/enrollee has any of the following:
    1. Episodes of muscle stiffness ([myotonia](#)) or cramps beginning in early [childhood](#) that are alleviated by brief exercise, **OR**
    2. Myotonic contraction is elicited by percussion of muscles, **OR**
    3. Electromyography (EMG) performed with needle electrodes discloses characteristic showers of spontaneous electrical activity (myotonic bursts).
- II. *CLCN1* sequencing and/or deletion/duplication analysis (81406, 81479) to establish a genetic diagnosis of myotonia congenita is considered **investigational** for all other indications.



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## **HYPOKALEMIC PERIODIC PARALYSIS**

### ***CACNAIS* and *SCN4A* Sequencing and/or Deletion/Duplication Analysis, or Periodic Paralysis Multigene Panel**

- I. *CACNAIS* and *SCN4A* sequencing and/or deletion/duplication analysis, or Periodic Paralysis Multigene Panel (81406, 81479) to establish a genetic diagnosis of periodic paralysis is considered **medically necessary** when:
  - A. Alternative causes of hypokalemia have been excluded (e.g., renal, adrenal, thyroid dysfunction; renal tubular acidosis; diuretic and laxative abuse), **AND**
  - B. The member/enrollee has had two or more attacks of muscle weakness with documented serum potassium less than 3.5 mEq/L, **OR**
  - C. The member/enrollee has had one attack of muscle weakness, **AND**
    1. Has a [close relative](#) who has had one attack of muscle weakness with documented serum potassium less than 3.5 mEq/L, **OR**
  - D. The member/enrollee has three or more of the following features:
    1. Onset of symptoms in the first or second decade, **OR**
    2. Muscle weakness involving at least 1 limb lasting longer than two hours, **OR**
    3. The presence of triggers (previous carbohydrate rich meal, symptom onset during rest after exercise, stress), **OR**
    4. Improvement in symptoms with potassium intake, **OR**
    5. A family history of a clinical or genetic diagnosis of hypokalemic periodic paralysis in a [close relative](#), **OR**
    6. Positive long exercise test.
- II. *CACNAIS* and *SCN4A* sequencing and/or deletion/duplication analysis, or Periodic Paralysis Multigene Panel (81406, 81479) to establish a genetic diagnosis of periodic paralysis is considered **investigational** for all other indications.

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## OTHER COVERED EPILEPSY, NEUROMUSCULAR, AND NEURODEGENERATIVE DISORDERS

- I. Genetic testing to establish or confirm one of the following epilepsy, neuromuscular, and neurodegenerative conditions to guide management is considered **medically necessary** when the member/enrollee demonstrates clinical features\* consistent with the disorder (the list is not meant to be comprehensive, see II below):
  - A. [AADC deficiency](#)
  - B. [Hereditary Transthyretin Amyloidosis](#)
  - C. [X-linked Adrenoleukodystrophy](#)
  - D. [L1 Syndrome](#)
  - E. [SCN9A Neuropathic Pain Syndromes](#)
  - F. [Cerebral Cavernous Malformation, Familial](#)
  - G. [STAC3 Disorder](#).
- II. Genetic testing to establish or confirm the diagnosis of all other epilepsy, neurodegenerative, and neuromuscular disorders not specifically discussed within this or another medical policy will be evaluated by the criteria outlined in *General Approach to Genetic and Molecular Testing* (see policy for criteria).

\*Clinical features for a specific disorder may be outlined in resources such as [GeneReviews](#), [OMIM](#), [National Library of Medicine](#), [Genetics Home Reference](#), or other scholarly source.

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## DEFINITIONS

1. **Close relatives** include first, second, and third degree blood relatives on the same side of the family:
  - a. **First-degree relatives** are parents, siblings, and children
  - b. **Second-degree relatives** are grandparents, aunts, uncles, nieces, nephews, grandchildren, and half siblings

- c. **Third-degree relatives** are great grandparents, great aunts, great uncles, great grandchildren, and first cousins
2. **Early-onset Alzheimer disease** is defined as Alzheimer disease occurring in an individual under age 65
3. A **neonate** is a baby who is four weeks old or younger
4. **Childhood** is the period of development until the 18th birthday.
5. **Myotonia** is defined as impaired relaxation of skeletal muscle after voluntary contraction.
6. **Autosomal dominant** inheritance patterns are generally characterized by the following traits\*:
  - a. There are individuals with the condition in multiple generations of a family
  - b. Individuals who do not have the condition do not have children with the condition
  - c. Individuals with the condition have a parent with the condition

\*Factors such as incomplete penetrance (when not all individuals with a genetic variant develop symptoms) and variable expressivity (when symptoms/signs or severity of the condition vary from person to person) can complicate the identification of this pattern of inheritance.

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## BACKGROUND AND RATIONALE

### Comprehensive Neuromuscular Disorders Panel

*American Association of Neuromuscular & Electrodiagnostic Medicine (AANEM)*

The American Association of Neuromuscular & Electrodiagnostic Medicine (AANEM) developed a position statement in 2016 regarding the clinical usefulness of genetic testing in the diagnosis of neuromuscular disease. “The AANEM believes that genetic testing and arriving at a specific molecular diagnosis is critical to providing high quality care to NM [neuromuscular] patients.” The same statement also remarks: “There is a role for single gene testing in cases with characteristic phenotypes, in addition to larger gene panels...”. (p. 1007)

*Winder et al (2020)*

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Winder et al published a study in 2020 in *Neurology: Genetics*, which reported results of genetic testing of 25,356 individuals who were suspected to have a neuromuscular disorder. Twenty percent of the cohort was found to have a definitive molecular diagnosis. (p. 3) The authors comment: “Multigene NGS [next generation sequencing] analysis advances the interpretation of heterogeneity for any single clinical disorder and also helps refine differential diagnoses. Panels can also be useful for individuals for whom a single-gene test cannot be confidently selected because of a mild or uncharacteristic phenotype”. (p. 7) Regarding the utility of a larger, multi-gene panel, the authors also note that “...in 2,501 instances in which a clinician received a negative result for a single-gene or small panel test and subsequently pursued testing using a larger panel, a positive diagnostic result was obtained for 200 individuals.” (p. 7)

*Nicolau et al (2021)*

In 2021, recommendations for genetic testing of muscle and neuromuscular junction disorders were proposed by Nicolau et al (peer reviewed by *American Association of Neuromuscular & Electrodiagnostic Medicine (AANEM)*). They state that the overall approach to genetic testing in inherited muscle and neuromuscular junction disorders is guided by the patient's phenotype. First and foremost, clinicians must identify those whose phenotypes suggest a myopathy that requires targeted genetic testing (i.e., myotonic dystrophies, FSHD, OPMD, OPDM, DMD, and mitochondrial myopathies). In the remainder of patients, the best initial step is a gene panel encompassing a large number of genes related to myopathy and CMSs, and which also includes copy number variation analysis. (p. 264)

*GeneReviews: Congenital Myasthenic Syndromes Overview*

GeneReviews is an expert-authored review of current literature on a genetic disease, and goes through a rigorous editing and peer review process before being published online.

An individual with a congenital myasthenic syndrome (CMS) typically presents with a history of fatigable weakness involving ocular, bulbar, and limb muscles with onset at or shortly after birth or in early childhood, usually in the first two years. Rarely, onset is in the second to third decade of life.

Neonatal presentation:

- Respiratory insufficiency with sudden, episodic apnea and cyanosis are common findings in neonates.
- Neonates with CMS can have multiple joint contractures (often described as arthrogryposis multiplex congenita) resulting from a lack of fetal movement in utero.
- Other major findings in the neonatal period may include feeding difficulties, poor suck and cry, choking spells, eyelid ptosis, and facial, bulbar, and generalized weakness. Stridor in infancy may be an important clue to CMS.
- In some individuals, long face, narrow jaw, and a high-arched palate have been reported.

Childhood presentation: Individuals with onset later in childhood show abnormal muscle fatigability, with difficulty in running or climbing stairs.

- Motor milestones may be delayed.
- Affected individuals present with fluctuating eyelid ptosis and fixed or fluctuating extraocular muscle weakness. Ptosis may involve one or both eyelids.
- Facial and bulbar weakness with nasal speech and difficulties in coughing and swallowing may be present.
- Spinal deformity or muscle atrophy may occur.

### **Comprehensive Ataxia Panel**

*American College of Medical Genetics and Genomics (ACMG)*

ACMG (2013, p. 673) stated the following in regard to “establishing the diagnosis of hereditary ataxia:

- Detection on neurological examination of typical clinical signs including poorly coordinated gait and finger/hand movements, dysarthria (incoordination of speech), and eye movement abnormalities such as nystagmus, abnormal saccade movements, and ophthalmoplegia.
- Exclusion of nongenetic causes of ataxia.
- Documentation of the hereditary nature of the disease by finding a positive family history of ataxia, identifying an ataxia-causing mutation, or recognizing a clinical phenotype characteristic of a genetic form of ataxia”

“Differential diagnosis of hereditary ataxia includes acquired, nongenetic causes of ataxia, such as alcoholism, vitamin deficiencies, multiple sclerosis, vascular disease, primary or metastatic tumors, and paraneoplastic diseases associated with occult carcinoma of the ovary, breast, or lung, and the idiopathic degenerative disease multiple system atrophy (spinal muscular atrophy). The possibility of an acquired cause of ataxia needs to be considered in each individual with ataxia because a specific treatment may be available.”

### **Spinal Muscular Atrophy**

#### ***SMN1* Sequencing and/or Deletion/Duplication Analysis and *SMN2* Deletion/Duplication Analysis**

*GeneReviews: Spinal Muscular Atrophy*

GeneReviews is an expert-authored review of current literature on a genetic disease, and goes through a rigorous editing and peer review process before being published online. The recommendations for genetic testing for Spinal Muscular Atrophy are as follows:

- Newborn Screening (NBS) for spinal muscular atrophy (SMA) is primarily based on real-time PCR that detects the common *SMN1* deletion and may also detect *SMN2* copy number on dried blood spots. Follow-up molecular genetic testing confirmation of a positive NBS result is recommended.
- A symptomatic individual who has EITHER atypical findings associated with later-onset SMA OR infantile-onset SMA that has not been treated (either because NBS was not performed or because it yielded a false negative result) molecular genetic testing approaches can include single-gene testing (*SMN1*) or use of a multigene panel that includes *SMN1*, *SMN2*, and other genes of interest.
  - History of motor difficulties, especially with loss of skills
  - Proximal > distal muscle weakness
  - Hypotonia
  - Areflexia/hyporeflexia
  - Tongue fasciculations
  - Hand tremor
  - Recurrent lower respiratory tract infections or severe bronchiolitis in the first few months of life
  - Evidence of motor unit disease on electromyogram

Gene-targeted deletion/duplication analysis to determine *SMN2* copy number can be performed to provide additional information for clinical correlation if the diagnosis of SMA is confirmed on molecular genetic testing.

### **Rett Syndrome - *MECP2* Sequencing and/or Deletion/Duplication Analysis**

*American College of Medical Genetics and Genomics (ACMG)*

The American College of Medical Genetics and Genomics (2013) revised its evidence-based guidelines for clinical genetics evaluation of autism spectrum disorders. Testing for *MECP2* genetic variants was recommended as part of the diagnostic workup of those with a female reproductive system who present with an autistic phenotype. Routine *MECP2* testing in those with a male reproductive system with autism spectrum disorders was not recommended). However, geneticists should be alert to the features of *MECP2* duplications and consider *MECP2* duplication testing in boys with autism and such features. (p. 402)

*GeneReviews: MECP2 Disorders*

Concert Genetics Genetic Testing: Epilepsy, Neurodegenerative, and  
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GeneReviews is an expert-authored review of current literature on a genetic disease, and goes through a rigorous editing and peer review process before being published online.

The clinical findings found in those with a female reproductive system with *MECP2* disorder (for both classic and variant Rett syndrome) include the following:

- Most distinguishing finding: A period of regression (range: ages 1-4 years) followed by recovery or stabilization (range ages 2-10 years; mean age 5 years)
- Main findings:
  - Partial or complete loss of acquired purposeful hand skills
  - Partial or complete loss of acquired spoken language or language skill (e.g., babble)
  - Gait abnormalities: impaired (dyspraxic) or absence of ability
  - Stereotypic hand movements including hand wringing/squeezing, clapping/tapping, mouthing, and washing/rubbing automatisms
- Exclusionary findings
  - Brain injury secondary to peri- or postnatal trauma, neurometabolic disease, or severe infection that causes neurological problems
  - Grossly abnormal psychomotor development in the first six months of life, with early milestones not being met

## **Epilepsy Multigene Panel**

*National Society of Genetic Counselors*

The National Society of Genetic Counselors (NSGC) published evidence-based practice guidelines for individuals with unexplained epilepsy (Smith et al, 2022). The NSGC recommendations are as follows (page 4):

- Individuals with unexplained epilepsy should be offered genetic testing, without limitation of age.
- Multi-gene, comprehensive testing, such as exome sequencing, genome sequencing or a multigene panel as a first-tier test is strongly recommended\*

Per the practice guideline, the multi-gene panel should have a minimum of 25 genes and include copy number analysis. However, specific genes to be included in such panels were not outlined in the guidelines. For this reason, the number of genes included in the multi-gene panel was not added to the clinical criteria. In rare situations, an epilepsy panel of less than 25 genes may be performed, in which case alternate criteria should be used (please refer to Concert Genetics medical policy “General Approach to Genetic and Molecular Testing”).

## **CADASIL - *NOTCH3* Sequencing and/or Deletion/Duplication Analysis**

### *GeneReviews: CADASIL*

GeneReviews is an expert-authored review of current literature on a genetic disease, and goes through a rigorous editing and peer review process before being published online.

CADASIL should be suspected in individuals with unexplained white matter hyperintensities and a family history of stroke and/or vascular dementia; however, lack of an apparent family history of CADASIL does not preclude the diagnosis. The following clinical signs and neuroimaging findings can be observed in CADASIL.

#### Clinical signs

- Transient ischemic attacks and ischemic stroke
- Cognitive impairment, manifesting initially with executive dysfunction, with a concurrent stepwise deterioration due to recurrent strokes to vascular dementia
- Migraine with aura, with a mean age of onset of 30 years
- Psychiatric disturbances, most frequently mood disturbances and apathy

#### Brain imaging

- Symmetric and progressive white matter hyperintensities, often involving the anterior temporal lobes and external capsules
- Lacunes of presumed vascular origin
- Recent subcortical infarcts
- Dilated perivascular spaces, sometimes referred to as subcortical lacunar lesions
- Brain atrophy
- Cerebral microbleeds

The diagnosis of CADASIL is established in a proband either by identification of a heterozygous pathogenic (or likely pathogenic) variant in *NOTCH3* by molecular genetic testing or, if molecular genetic testing is not definitive, by detection of characteristic findings by electron microscopy and immunohistochemistry of a skin biopsy.

## **Alzheimer Disease - *PSEN1*, *PSEN2*, and *APP* Sequencing and/or Deletion/Duplication Analysis**

*American College of Medical Genetics and Genomics (ACMG) and National Society of Genetic Counselors (NSGC)*



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The American College of Medical Genetics jointly with the National Society of Genetic Counselors (2011) issued a joint practice guideline, which was reaffirmed and reclassified as a practice resource in 2019. These guidelines state that:

- Pediatric testing for AD should not occur.
- Prenatal testing for AD is not advised if the patient intends to continue a pregnancy with a mutation.
- Testing for genes associated with early-onset autosomal dominant AD should be offered in the following situations:
  - A symptomatic individual with EOAD [early-onset Alzheimer disease] in the setting of a family history of dementia or the setting of an unknown family history (eg, adoption).
  - Autosomal dominant family history of dementia with one or more cases of EOAD.
  - A relative with a mutation consistent with EOAD (currently *PSEN1/2* or *APP*). (p. 601)

Alzheimer genetics is traditionally subdivided into early onset (EOAD) and late onset (LOAD). EOAD has an onset before age 60–65 years and accounts for 1–5% of all cases. LOAD has an onset after age 60–65 years and is the predominant form of AD (p. 598).

Ideally, an affected family member should be tested first. If no affected family member is available for testing and an asymptomatic individual remains interested in testing despite counseling about the low likelihood of an informative result (a positive result for a pathogenic mutation), he/she should be counseled according to the recommended protocol. (p. 601)

### **Alzheimer Disease - *APOE* Variant Analysis for Alzheimer’s Disease**

#### *Food and Drug Administration (FDA)*

In the “highlights of prescribing information” document created by the FDA for monoclonal antibodies treatment directed against aggregated forms of beta amyloid, including Leqembi, the following is recommended: “Patients treated with this class of medications, including Leqembi, who are ApoE e4 homozygotes have a higher incidence of ARIA [amyloid related imaging abnormalities], including symptomatic and serious ARIA, compared to heterozygotes and noncarriers. Testing for ApoE e4 status should be performed prior to initiation of treatment to inform the risk of developing ARIA.” (p. 1)

## **Amyotrophic Lateral Sclerosis - Familial Amyotrophic Lateral Sclerosis (FALS) Multigene Panel**

*Roggenbuck, et al*

The ALS Genetic Testing and Counseling Guidelines Expert Panel published evidence based consensus guidelines (2023) for genetic testing. They state that all persons with ALS should be offered a gene panel including C9orf72, SOD1, FUS, TARDBP, and additional genes strongly and definitively associated with ALS by ClinGen. (p. 6)

*GeneReviews: Amyotrophic Lateral Sclerosis Overview*

GeneReviews is an expert-authored review of current literature on a genetic disease, and goes through a rigorous editing and peer review process before being published online. The recommendations for genetic testing for Amyotrophic Lateral Sclerosis are as follows:

It is estimated that about 10%-15% of individuals with ALS have genetic ALS. Some of the genetic forms of ALS may confer particular clinical characteristics, although intra- and interfamilial variability of age at onset and disease progression is common.

The diagnosis of ALS requires characteristic clinical features and specific findings on electrodiagnostic testing, as well as exclusion of other health conditions with related manifestations. Criteria for diagnosis include:

- The presence of all of the following:
  - Evidence of lower motor neuron (LMN) degeneration by clinical, electrophysiologic, or neuropathologic examination
  - Evidence of upper motor neuron (UMN) degeneration by clinical examination
  - Progressive spread of symptoms or signs within a region or to other regions, as determined by history or examination
- Together with the absence of both of the following:
  - Electrophysiologic or pathologic evidence of other disease processes that could explain the signs of LMN and/or UMN degeneration
  - Neuroimaging evidence of other disease processes that could explain the observed clinical and electrophysiologic signs

Clinical evidence of UMN and LMN signs in the four regions of the central nervous system (i.e., brain stem, cervical, thoracic, or lumbosacral spinal cord) can be obtained through detailed or focused history and physical and neurologic examinations.

The following genes are listed as the most common genes causing ALS: *C9orf72*, *SOD1*, *FUS*, and *TARDBP*.

## **Duchenne and Becker Muscular Dystrophy - *DMD* Sequencing and/or Deletion/Duplication Analysis**

### *DMD Care Considerations Working Group*

The DMD Care Considerations Working Group (2018), selected by the CDC, created guidelines for the diagnosis and management of DMD, stating the following:

“Because approximately 70% of individuals with DMD have a single-exon or multi-exon deletion or duplication in the dystrophin gene, dystrophin gene deletion and duplication testing is usually the first confirmatory test. Testing is best done by multiplex ligation dependent probe amplification (MLPA) or comparative genomic hybridisation array, since use of multiplex PCR can only identify deletions. Identification of the boundaries of a deletion or duplication mutation by MLPA or comparative genomic hybridisation array might indicate whether the mutation is predicted to preserve or disrupt the reading frame. If deletion or duplication testing is negative, genetic sequencing should be done to screen for the remaining types of mutations that are attributed to DMD (approximately 25–30%). These mutations include point mutations (nonsense or missense), small deletions, and small duplications or insertions, which can be identified using next-generation sequencing. Finally, if genetic testing does not confirm a clinical diagnosis of DMD, then a muscle biopsy sample should be tested for the presence of dystrophin protein by immunohistochemistry of tissue cryosections or by western blot of a muscle protein extract.” (p. 254)

### *GeneReviews: Dystrophinopathies*

GeneReviews is an expert-authored review of current literature on a genetic disease, and goes through a rigorous editing and peer review process before being published online.

A dystrophinopathy should be suspected in an individual with the following clinical and laboratory test findings that support the diagnosis of DMD, BMD, or DMD-associated DCM – especially when they occur in addition to a positive family history compatible with X-linked inheritance. Findings are most commonly noted in those with a male reproductive system, but those with a female reproductive system may also be affected.

### Duchenne muscular dystrophy (DMD)

- Progressive symmetric muscle weakness (proximal > distal) often with calf hypertrophy
- Symptoms present before age five years
- Wheelchair dependency before age 13 years

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All patients with DMD have serum creatine phosphokinase levels that are greater than 10X normal values.

Becker muscular dystrophy (BMD):

- Progressive symmetric muscle weakness (proximal > distal) often with calf hypertrophy; weakness of quadriceps femoris in some cases the only sign
- Activity-induced cramping (present in some individuals)
- Flexion contractures of the elbows (if present, late in the course)
- Wheelchair dependency (after age 16 years); although some individuals remain ambulatory into their 30s and in rare cases into their 40s and beyond
- Preservation of neck flexor muscle strength (differentiates BMD from DMD)

All patients with BMD have serum creatine phosphokinase levels that are greater than 5X normal values.

### **Facioscapulohumeral Muscular Dystrophy (FSHD) - *FSHD1* Deletion/Duplication or Haplotype Analysis and/or *SMCHD1* and *DNMT3B* Sequencing and/or Deletion Analysis or Multigene Panel**

*American Academy of Neurology and American Association of Neuromuscular & Electrodiagnostic Medicine*

The American Academy of Neurology and American Association of Neuromuscular & Electrodiagnostic Medicine guidelines (2015) on FSHD state that genetic testing can confirm the diagnosis in many patients with FSHD type 1 and further state that if the patient tests negative for the D4Z4 contraction, testing for FSHD type 2 or other myopathies can be done. In the setting of atypical or sporadic cases, genetic confirmation is important for genetic counseling, especially with the recent discovery of 2 genetically distinct forms of FSHD. They recommend that clinicians should obtain genetic confirmation of *FSHD1* in patients with atypical presentations... (p. 360)

*GeneReviews-Facioscapulohumeral Muscular Dystrophy*

GeneReviews is an expert-authored review of current literature on a genetic disease, and goes through a rigorous editing and peer review process before being published online.

Facioscapulohumeral muscular dystrophy (FSHD) should be suspected in individuals with the following:

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- Weakness that predominantly involves the facial, scapular stabilizer, or foot dorsiflexor muscles without associated ocular or bulbar muscle weakness. Weakness is often asymmetric.
- Progression of weakness after pregnancy
- Prior diagnosis with inflammatory myopathy that was refractory to immunosuppression
- Family history of FSHD

Per GeneReviews, the diagnosis of FSHD1 is established in a proband with characteristic clinical features by identification of a heterozygous pathogenic contraction of the D4Z4 repeat array in the subtelomeric region of chromosome 4q35 on a chromosome 4 permissive haplotype. Molecular genetic testing for a heterozygous pathogenic variant in *SMCHD1* or *DNMT3B* can be pursued in individuals with at least one permissive chromosome 4 haplotype (e.g., 4A161, 4A159, 4A168, 4A166H) and hypomethylation of D4Z4.

### **Friedreich's Ataxia - *FXN* Repeat Analysis and/or Sequencing Analysis**

*American College of Medical Genetics*

The American College of Medical Genetics (ACMG, 2013) states the following regarding testing for hereditary ataxias:

“Establishing the diagnosis of hereditary ataxia requires:

- Detection on neurological examination of typical clinical signs including poorly coordinated gait and finger/hand movements, dysarthria (incoordination of speech), and eye movement abnormalities such as nystagmus, abnormal saccade movements, and ophthalmoplegia.
- Exclusion of nongenetic causes of ataxia
- Documentation of the hereditary nature of the disease by finding a positive family history of ataxia, identifying an ataxia-causing mutation, or recognizing a clinical phenotype characteristic of a genetic form of ataxia.” (p. 673)

“Differential diagnosis of hereditary ataxia includes acquired, nongenetic causes of ataxia, such as alcoholism, vitamin deficiencies, multiple sclerosis, vascular disease, primary or metastatic tumors, and paraneoplastic diseases associated with occult carcinoma of the ovary, breast, or lung, and the idiopathic degenerative disease multiple system atrophy (spinal muscular atrophy). The possibility of an acquired cause of ataxia needs to be considered in each individual with ataxia because a specific treatment may be available.” (p. 673)

*GeneReviews: Friedreich Ataxia*

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GeneReviews is an expert-authored review of current literature on a genetic disease, and goes through a rigorous editing and peer review process before being published online.

Friedreich ataxia (FRDA) should be suspected in individuals with a combination\* of the following clinical features and family history:

- Neurologic findings, typically with onset before age 25 years\*\*.
  - Progressive ataxia of gait and limbs
  - Dysarthria
  - Decrease in/loss of position sense and/or vibration sense in lower limbs
  - Pyramidal weakness of the legs, extensor plantar responses
- Musculoskeletal features
  - Muscle weakness
  - Scoliosis
  - Pes cavus
- Hypertrophic non-obstructive cardiomyopathy
- Endocrinologic features
  - Glucose intolerance
  - Diabetes mellitus
- Optic atrophy and/or deafness
- Family history consistent with autosomal recessive inheritance Note: Absence of a family history of autosomal recessive inheritance does not preclude the diagnosis.

\* Concert Genetics interprets a combination of these clinical features, here, to mean at least two.

\*\* In atypical cases, onset may be delayed

## **Huntington's Disease - *HTT* Repeat Analysis**

### *GeneReviews-Huntington Disease*

GeneReviews is an expert-authored review of current literature on a genetic disease, and goes through a rigorous editing and peer review process before being published online. The recommendations for genetic testing for Huntington disease are as follows:

Huntington disease (HD) should be suspected in individuals with any of the following:

- Progressive motor disability featuring chorea. Voluntary movement may also be affected.
- Mental disturbances including cognitive decline, changes in personality, and/or depression
- Family history consistent with autosomal dominant inheritance

Testing is performed by targeted analysis of CAG repeats within the *HTT* gene.

At-risk asymptomatic adult family members may seek testing in order to make personal decisions regarding reproduction, financial matters, and career planning. For asymptomatic minors at risk for adult-onset conditions for which early treatment would have no beneficial effect on disease morbidity and mortality, predictive genetic testing is considered inappropriate, primarily because it negates the autonomy of the child with no compelling benefit. In a family with an established diagnosis of HD, it is appropriate to consider testing of symptomatic individuals regardless of age.

#### *Huntington's Disease Society of America (HDSA)*

The Huntington's Disease Society of America (HDSA) established a protocol for safe and effective testing of Huntington's Disease, both in the predictive (asymptomatic) setting and for those who have symptoms. Specifically, they state that "confirmatory testing by analysis of the HD gene is offered at or after the time of the clinical diagnosis of HD. The presence of a CAG repeat expansion in a person with HD symptoms confirms the clinical impression and supports a diagnosis of HD". (p. 13) Additionally, it is stated that "minors should not undergo genetic testing unless there is a medically compelling reason such as a clinical diagnosis or a strong suspicion of HD". (p. 16)

#### *National Society of Genetic Counselors*

The National Society of Genetic Counselors (NSGC) issued a statement in 2018 which encourages deferring predictive genetic testing of minors for adult-onset conditions when results will not impact childhood medical management or significantly benefit the child. Predictive testing should optimally be deferred until the individual has the capacity to weigh the associated risks, benefits, and limitations of this information, taking his/her circumstances, preferences, and beliefs into account to preserve his/her autonomy and right to an open future.

### **Inherited Peripheral Neuropathy (Charcot-Marie-Tooth and Hereditary Neuropathy with Liability to Pressure Palsies) - *PMP22* Sequencing and/or Deletion/Duplication Analysis or Multigene Panel**

GeneReviews is an expert-authored review of current literature on a genetic disease, and goes through a rigorous editing and peer review process before being published online.

#### *GeneReviews: Charcot-Marie-Tooth Hereditary Neuropathy Overview*

Individuals with CMT [Charcot-Marie-Tooth] manifest symmetric, slowly progressive distal motor neuropathy of the arms and legs usually beginning in the first to third decade and resulting

in weakness and atrophy of the muscles in the feet and/or hands. The affected individual typically has distal muscle weakness and atrophy, weak ankle dorsiflexion, depressed tendon reflexes, and *pes cavus* foot deformity (i.e., high-arched feet).

“Establishing a specific genetic cause of CMT hereditary neuropathy can aid in discussions of prognosis ...and genetic counseling.”

*GeneReviews: Hereditary Neuropathy with Liability to Pressure Palsies*

Hereditary neuropathy with liability to pressure palsies (HNPP) should be suspected in individuals with the following clinical findings, electrophysiologic studies, imaging studies, and family history.

Typical clinical findings:

- Recurrent acute focal sensory and motor neuropathies mainly at entrapment sites
- Painless nerve palsy after minor trauma or compression
- Evidence on physical examination of previous nerve palsy such as focal weakness, atrophy, or sensory loss
- Complete spontaneous recovery from neuropathies (in 50% of occurrences) within weeks

“The diagnosis of HNPP is established in a proband with suggestive findings by identification of either the 1.5-megabase (Mb) recurrent deletion or a novel deletion involving *PMP22* (in 80%), or a pathogenic (or likely pathogenic) *PMP22* sequence variant (in 20%) by molecular genetic testing.”

### **Limb Girdle Muscular Dystrophy Multigene Panel**

*American Academy of Neurology and American Association of Neuromuscular and Electrodiagnostic Medicine*

The American Academy of Neurology and the American Association of Neuromuscular and Electrodiagnostic Medicine (2014) issued evidenced-based guidelines for the diagnosis and treatment of limb-girdle and distal dystrophies. These guidelines included a systematic review, which identified common features of limb-girdle muscular dystrophy (LGMD) including slowly progressive symmetrical weakness. The age of onset is highly variable but usually adolescence to early adulthood.

The guidelines also note that although limb-girdle pattern of weakness affecting proximal muscles of the arms and legs is the most common presentation, other patterns, including scapulo-peroneal weakness and distal weakness, are not rare. (p. 1454)



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These guidelines note that “serum CK levels vary widely between patients with the same disorder, ranging from normal to greater than 10 times above normal levels, and can be as much as 100 times normal in some cases.” (p. 1455)

*UpToDate: Limb-girdle Muscular Dystrophy*

For patients suspected of having LGMD, broad genetic testing (rather than muscle biopsy) has moved to the forefront of diagnostic investigations. Broad genetic testing should be obtained with an LGMD or neuromuscular gene panel, which analyzes multiple genes associated with LGMDs and other muscular dystrophies/myopathies.

## **Myotonic Dystrophy**

### ***DMPK* and/or *CNBP* (ZNF9) Repeat Analysis**

*Myotonic Dystrophy Foundation*

More than 65 leading myotonic dystrophy (DM) clinicians in Western Europe, the UK, Canada and the US joined in a process started in Spring 2015 and concluded in Spring 2017 to create the Consensus-based Care Recommendations for Adults with Myotonic Dystrophy Type 1, which included this recommendation for genetic testing:

“DM1 via molecular genetic testing as the first line of investigation for any patient suspected of having DM1. Muscle biopsy should no longer be performed as a diagnostic test when there is clear clinical suspicion of DM1. Patients with more than 50 CTG repeats in the 3’ untranslated region of the *DMPK* gene on chromosome 19 are considered to have DM1. False-negative genetic testing results can occur, even in a family with an established DM1 diagnosis; expert referral is recommended”. (p. 32)

Fifteen leading myotonic dystrophy (DM) clinicians from western Europe, Canada and the United States have created the Consensus-based Care Recommendations for Adults with Myotonic Dystrophy Type 2, which included this recommendation for genetic testing:

“DM2 via DNA-based genetic testing as the first line of investigation for any patient suspected of having DM2. When there is clear clinical suspicion of DM2, muscle biopsy should no longer be performed as a diagnostic test. Patients with more than 75 CCTG in intron 1 of the *CNBP* gene in chromosome 3q21.3 can be considered to have DM2. Patients with repeats in the 28-75 range gray zone are unclear. DM2 repeat sizing in tissues other than blood and/or segregation studies in the family may be valuable in addressing potential pathogenicity. False-negative genetic testing results can occur, even

in a family with an established DM2 diagnosis. Expert referral is recommended.” (page 22).

*American College of Medical Genetics*

ACMG published technical standards and guidelines for myotonic dystrophy type 1 in 2009 and reaffirmed in 2015. In it, they state: “Indications for genetic testing: This test is often used for symptomatic confirmatory diagnostic testing and predictive testing, after the identification of the mutation in an affected family member. (p. 553).

*GeneReviews-Myotonic Dystrophy Type 1 and Myotonic Dystrophy Type 2*

GeneReviews is an expert-authored review of current literature on a genetic disease, and goes through a rigorous editing and peer review process before being published online. They suggest that Myotonic dystrophy type 1 (DM1) should be suspected in adults with the following:

- Muscle weakness, especially of the distal leg, hand, neck, and face
- Myotonia (sustained muscle contraction), which often manifests as the inability to quickly release a hand grip (grip myotonia)
- Posterior subcapsular cataracts detectable as red and green iridescent opacities on slit lamp examination

DM1 should be suspected in neonates with some combination of the following:

- Hypotonia
- Facial muscle weakness
- Generalized weakness
- Positional malformations including clubfoot
- Respiratory insufficiency

DM2 should be suspected in individuals with the following findings:

- Muscle weakness
- Myotonia (sustained muscle contraction) that can manifest as:
  - grip myotonia (the inability to release a tightened fist quickly) occurring as early as the first decade of life
  - percussion myotonia (sustained contraction after tapping a muscle with a reflex hammer)
  - leg myotonia, especially while climbing a staircase or trying to run fast
  - electrical myotonia (repetitive spontaneous discharges observed on EMG).
  - Note: The myotonia in individuals with DM2 is not always detectable by EMG and may require an extensive EMG examination of several muscle groups including proximal and paraspinal muscles

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- Posterior subcapsular cataracts detectable as nonspecific vacuoles and opacities on direct ophthalmoscopy or as pathognomonic posterior subcapsular red and green iridescent opacities on slit lamp examination
- Cardiac conduction defects or progressive cardiomyopathy
- Insulin insensitivity
- Hypogammaglobulinemia

“For asymptomatic minors at risk for adult-onset conditions for which early treatment would have no beneficial effect on disease morbidity and mortality, predictive genetic testing is considered inappropriate, primarily because it negates the autonomy of the child with no compelling benefit. Further, concern exists regarding the potential adverse effects that such information may have on family dynamics, the risk of discrimination and stigmatization in the future, and the anxiety that such information may cause.”

## **Hereditary Dystonia Multigene Panel**

### *GeneReviews-Hereditary Dystonia Overview*

GeneReviews is an expert-authored review of current literature on a genetic disease, and goes through a rigorous editing and peer review process before being published online.

Dystonia is defined as “a movement disorder characterized by sustained or intermittent muscle contractions causing abnormal, often repetitive movements and/or postures. Dystonic movements are typically patterned and twisting, and may be associated with tremor. Dystonia is often initiated or worsened by voluntary action and associated with overflow muscle activation. Most forms of dystonia tend to worsen initially.” Multiple genes have been implicated in hereditary dystonia, representing a variety of inheritance patterns such as autosomal dominant, autosomal recessive, mitochondrial, and X-linked inheritance.

## **Parkinson Disease Multigene Panel**

### *GeneReviews - Parkinson Disease Overview*

GeneReviews is an expert-authored review of current literature on a genetic disease, and goes through a rigorous editing and peer review process before being published online.

Per the Parkinson Disease GeneReviews, establishing a specific genetic cause of Parkinson disease:

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- Can aid in discussions of causation, recurrence risks, and research eligibility.
- May provide some information about phenotype including prognosis of a particular monogenic cause of Parkinson disease.
- Usually involves evaluation of medical and family histories, and molecular genetic testing. Physical examination may be less helpful in suggesting a specific genetic cause because of the overlap of clinical features.

*Gasser et al (2023)*

This review article states the following: “The identification of disease-causing mutations or strong risk factors for Parkinson’s disease in genes encoding proteins such as  $\alpha$ -synuclein (*SNCA*), leucine-rich repeat kinase-2 (*LRRK2*), or glucocerebrosidase (*GBA1*) has led to a better understanding of the different components of disease pathogenesis. Many gene and mutation-specific targeted disease-modifying treatments are under development and several studies are underway. It is, therefore, important to raise awareness among patients and their families and to offer genetic testing, at least to those patients who are considering to participate in innovative trials.” (p. 777)

*Cook, et al. (2020)*

In this analysis of the Parkinson’s disease genetic testing market in 2020, the authors highlighted variability and lack of consensus among available gene panels, along with a lack of clear professional guidelines for clinicians: "There have been no specific guidelines regarding which genes should be tested in the clinical setting for Parkinson's disease (PD) or parkinsonism. We evaluated the types of clinical genetic testing offered for PD.... The panels were notable for their differences in size, ranging from 5 to 62 genes. Five genes for variant query were included in all panels (*SNCA*, *PRKN*, *PINK-1*, *PARK7 (DJI)*, and *LRRK2*). Notably, the addition of the *VPS35* and *GBA* genes was variable.... We have identified marked heterogeneity in commercial gene tests offered for PD, specifically for multigene panels... Our findings highlight the urgent need for expert opinion on which genes and variants commercial laboratory services should consider for general PD panels and other PD-related panels." (p. 107)

## **Hereditary Spastic Paraplegia Multigene Panel**

*GeneReviews-Hereditary Spastic Paraplegia Overview*

GeneReviews is an expert-authored review of current literature on a genetic disease, and goes through a rigorous editing and peer review process before being published online.

The predominant signs and symptoms of hereditary spastic paraplegia (HSP) are lower-extremity weakness and spasticity. Individuals with HSP demonstrate the following:

- Bilateral lower-extremity spasticity (especially in hamstrings, quadriceps, adductors, and gastrocnemius-soleus muscles)
- Weakness (especially in the iliopsoas, hamstring, and tibialis anterior muscles)
- Spasticity and weakness are variable. Some individuals have spasticity and no demonstrable weakness, whereas others have spasticity and weakness in approximately the same proportions.
- Lower-extremity hyperreflexia and extensor plantar responses
- Impaired vibration sensation in the distal lower extremities

They suggest a multi-gene panel as the genetic testing strategy most likely to identify the genetic cause of the condition at the most reasonable cost while limiting identification of variants of uncertain significance and pathogenic variants in genes that do not explain the underlying phenotype.

## **Congenital Myasthenic Syndrome - Congenital Myasthenic Syndromes Multigene Panel**

### *GeneReviews-Congenital Myasthenic Syndromes Overview*

GeneReviews is an expert-authored review of current literature on a genetic disease, and goes through a rigorous editing and peer review process before being published online.

GeneReviews comments on the onset of myasthenic syndromes as follows:

- Neonatal presentation: Some myasthenic symptoms are present at birth. Symptoms include:
  - Respiratory insufficiency with sudden, episodic apnea and cyanosis are common findings in neonates.
  - Neonates with CMS can have multiple joint contractures (often described as arthrogryposis multiplex congenita) resulting from a lack of fetal movement in utero.
  - Other major findings in the neonatal period may include feeding difficulties, poor suck and cry, choking spells, eyelid ptosis, and facial, bulbar, and generalized weakness. Stridor in infancy may be an important clue to CMS.
  - In some individuals, long face, narrow jaw, and a high-arched palate have been reported.
- Childhood presentation: Individuals with onset later in childhood show abnormal muscle fatigability, with difficulty in running or climbing stairs. Symptoms include:
  - Motor milestones may be delayed.

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- Affected individuals present with fluctuating eyelid ptosis and fixed or fluctuating extraocular muscle weakness. Ptosis may involve one or both eyelids.
- Facial and bulbar weakness with nasal speech and difficulties in coughing and swallowing may be present.
- Spinal deformity or muscle atrophy may occur.

An individual with a congenital myasthenic syndrome (CMS) typically presents with a history of fatigable weakness involving ocular, bulbar, and limb muscles with onset at or shortly after birth or in early childhood, usually in the first two years. Rarely, onset is in the second to third decade of life.

### **Myotonia Congenita - *CLCN1* Sequencing and/or Deletion/Duplication Analysis**

#### *GeneReviews-Myotonia Congenita*

GeneReviews is an expert-authored review of current literature on a genetic disease, and goes through a rigorous editing and peer review process before being published online.

Per GeneReviews, there are no consensus clinical diagnostic criteria for myotonia congenita (sometimes referred to as "chloride channel myotonia") that have been published. Myotonia congenita should be suspected in individuals with the following clinical and laboratory findings:

#### Clinical findings and medical history

- Episodes of muscle stiffness (myotonia) or cramps beginning in early childhood
- Alleviation of stiffness by brief exercise (known as the "warm-up" effect)
- Myotonic contraction elicited by percussion of muscles

#### Laboratory findings

- Electromyography performed with needle electrodes discloses characteristic showers of spontaneous electrical activity (myotonic bursts).

#### *Myotonia Congenita - National Institutes of Health (NIH)*

In this review of Myotonia Congenita (MC), the authors state the following:

Genetic testing is considered the gold standard. Biochemical investigations are usually unremarkable, although mild elevations of creatinine kinase have been described up to three to four times the upper limit of normal. Electromyography is a useful tool in the diagnosis of MC however, it is time-consuming, uncomfortable, and results in an overlap between the different

channelopathies. There is no electromyographical difference between the two types of MC. Given the widespread availability of genetic testing, muscle biopsy is now rarely performed, but it may show heterogeneous muscle fibers with increased numbers of nuclei and absent type 2B fibers. A muscle biopsy is not necessary to establish a diagnosis of MC.

### **Hypokalemic Periodic Paralysis - *CACNA1S* and *SCN4A* Sequencing and/or Deletion/Duplication Analysis, or Periodic Paralysis Multigene Panel**

#### *GeneReviews - Hypokalemic Periodic Paralysis*

GeneReviews is an expert-authored review of current literature on a genetic disease, and goes through a rigorous editing and peer review process before being published online.

The diagnosis of hypoPP (hypokalemic periodic paralysis) is established in a proband who meets the consensus diagnostic criteria for primary hypokalemic periodic paralysis:

- Two or more attacks of muscle weakness with documented serum potassium less than 3.5 mEq/L  
OR
- One attack of muscle weakness in the proband and one attack of weakness in one relative with documented serum potassium less than 3.5 mEq/L  
OR
- Three or more of the following six clinical/laboratory features:
  - Onset in the first or second decade
  - Duration of attack (muscle weakness involving at least 1 limbs) longer than two hours
  - The presence of triggers (previous carbohydrate rich meal, symptom onset during rest after exercise, stress)
  - Improvement in symptoms with potassium intake
  - A family history of the condition or genetically confirmed skeletal calcium or sodium channel mutation
  - Positive long exercise test AND
- Exclusion of other causes of hypokalemia (renal, adrenal, thyroid dysfunction; renal tubular acidosis; diuretic and laxative abuse)

When the phenotypic and laboratory findings suggest the diagnosis of hypoPP, the recommended approach is the use of a multigene panel.

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Policy developed.	03/23	03/23
<p>Semi-annual review. Updated title to reflect V1.2024 version. Overview, coding, reference-table, background and references updated. Throughout policy: replaced “coverage criteria” with “criteria. For Overview: added “establish or”; removed “the disease, but conventional diagnostic methods...” and added “genetic disorder, for whom clinical evidence...”; removed “the” and replaced with “a genetic”; removed “alter some aspects” and replaced with “inform clinical”; removed “may” and replaced with “/or”; added “epilepsy”. For Policy Reference Table: changed “Neuromuscular NGS Panel...” to “Comprehensive Neuromuscular Disorders Panel”; added “Rett Syndrome”; added “MECP2 Sequencing...”; changed “Childhood Onset Epilepsy Panel...” to “Comprehensive Epilepsy Panel...”; added “CADASIL”; added “NOTCH3...”; changed “TREM2, and other Variant Analysis” to “Variant Analysis for Alzheimer’s Disease”; changed “DMD Deletion/Duplication Analysis” to “DMD Full Gene Sequencing...” and “Duchenne/Becker MD...”; changed “DMPK Repeat Analysis” to “Myotonic Dystrophy...”. For Comprehensive Neuromuscular Disorders Panel: under I.A. removed “clinical features of a” and replaced with “at least one of the following”; added I.A.1. “Neonatal respiratory...”; added I.A.2. “Neonatal joint contractures...”; added I.A.3. “Stridor, feeding difficulties...”; added I.A.4. “Abnormal muscle...”; added I.A.5. “Abnormal muscle...”; added I.A.6. “Eyelid ptosis...”; added I.A.7. “Facial and bulbar...”; added I.A.8. “Spinal deformity...”; added I.A.9. “Abnormal electromyography...”; in I.B.1. removed “member/enrollee” and replaced with “member/enrollee’s presentation”; removed “highly suspected...” and replaced with “consistent with a”; added “targeted or”; removed “would be more” and replaced with “is”; under I.B.2. removed “previously underwent” and replaced with “underwent targeted”; removed “did not definitively” and replaced with “were non-diagnostic”. For Comprehensive Ataxia Panel: removed “clinical features of spinocerebellar ataxia”. For Spinal Muscular Atrophy: removed “clinical features of SMA”. Added “Rett Syndrome” panel. Added “CADASIL” panel. For Alzheimer’s Disease Panel: removed “or Multigene Panel”; under I. removed “or multigene panel...”; under I.B.1. removed “The member/enrollee has a close relative...” and replaced with “Has a family history of dementia...”; under I.B.1.a. added “Has at least one relative...”; under I.C.1. removed “Has a diagnosis of dementia...” and replaced with “Was diagnosed with dementia”; under I.C.2. removed “Has a diagnosis” and replaced with “Was diagnosed with”; removed “One or more close relatives...” and added “that is consistent with an autosomal dominant pattern...”; added I.C.2.b. “Has at least one close relative...”; added II. “Genetic testing for Alzheimer’s...”. For APOE Variant Analysis for Alzheimer’s Disease Panel: added “APOE variant analysis” and removed “or TREM2...”; removed statement “*Predictive testing...” and added “is considered medically necessary...”; added I.A. “The member/enrollee is being evaluated...”; added II. “APOE variant analysis...”. For Amyotrophic Lateral Sclerosis (ALS) Panel: Changed title from “Familial Amyotrophic Lateral Sclerosis (FALS) Multigene Panel” to “Amyotrophic Lateral Sclerosis (ALS) Multigene Panel; and removed “familial” throughout the panel wording; removed “clinical</p>	10/23	10/23



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<p>features of ALS:”; and removed “FALS” and replaced with “ALS”. For Duchenne and Becker Muscular Dystrophy Panel: removed I.A. “The member/enrollee is a male, AND”; replaced “findings” with “characteristics”; under I.A.2. replaced “For BMD, the member/enrollee meets the following” with “The following clinical characteristics of BMD”; under I.A.2.b. replaced “Any” with “At least one”; for I.A.2.B. added “(male or female)”; for I.A.2.B.1. removed “and/or molecular”; for I.A.2.C. replaced “a” with “an asymptomatic”. For Facioscapulohumeral Muscular Dystrophy (FSHD) Panel: under I.A. removed “clinical features of FSHD:”; under I.A.3. removed “FSHD with” and “AND” and removed “The member/enrollee does not have a first degree relative...”. For Friedreich’s Ataxia Panel: under I.A.1. replaced “The member/enrollee has: with “Has” and removed “diagnosed”; under I.B. replaced “meets both” with “has at least two”; under I.B.1. replaced “The member/enrollee has been diagnosed...” with “Progressive ataxia...”; added I.B.2. “Dysarthria”; added I.B.3. “Decrease in/loss of position...”; added I.B.4. “Pyramidal weakness...”; added I.B.5. “Extensor plantar...”; added I.B.6. “Muscle weakness...”; added I.B.7. “Scoliosis, OR”; added I.B.8. “Pes cavus...”; added I.B.9. “Hypertrophic...”; added I.B.10. “Glucose intolerance...”; added I.B.11. “Optic atrophy...”. For Huntington’s Disease Panel: under I.A. removed “Progressive” and replaced with “clinical features of Huntington’s Disease...”; removed I.A.1. “Cognitive decline...”; removed I.A.2. “Changes in personality...”; removed I.A.3. “Depression...”; in I.A.B. removed “Family history...” and added “The member/enrollee has a clinical diagnosis...”. For Inherited Peripheral Neuropathies Panel: under I.A. removed “does not have a clinical diagnosis...” and replaced with “displays one or more of the following”; in I.B. removed “The” and replaced with “If a panel is ordered...”. For Myotonic Dystrophy Panel: in I.A. added “is symptomatic and”; in I.A.2. removed “clinical features...”. For Hereditary Dystonia Panel: under I.A. removed “all of the following...” and added “clinical presentation consistent with...”. For Parkinson Disease, Parkinson Disease Multigene Panel: changed name from LRRK2 Sequencing and/or Deletion/Duplication Analysis...” to “Parkinson Disease Multigene Panel”; in I. added “Multigene”; in I.B. added “The member/enrollee has a”; removed I.C. “The panel includes...”; in II. added “Multigene”. For Hereditary Spastic Paraplegia Multigene Panel: in I.A.4. removed “AND...”. For Congenital Myasthenic Syndromes Multigene Panel: under I.A. removed “a history...”; added “1. Neonatal respiratory insufficiency...”; added “2. Neonatal joint contractures...”; added “3. Stridor...”; added “4. Abnormal muscle fatigability/weakness...”; added “5. Delayed motor milestones...”; added “6. Eyelid ptosis...”; added “7. Facial...”; added “8. Spinal deformity...”; added “9. Abnormal electromyography...”. For CLCN1 Sequencing and/or Deletion/Duplication Analysis Panel: under I.A. replaced “episodes” with “any of the following”; in I.A.1. added “Episodes” and replaced “AND” with “OR”; in I.B. removed “AND”; in I.B.2. removed “Serum creatine kinase...” and added “OR”; removed statement Myotonia is defined...”. For CACNA1S and SCN4A Sequencing and/or Deletion/Duplication Analysis, added to the title “or Periodic Paralysis Multigene Panel”; in I. and II. added “or Periodic Paralysis Multigene Panel”. For Other Covered Epilepsy, Neuromuscular, and Neurodegenerative Disorders Panel: under I.</p>		

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<p>added “A. AADC deficiency”; under II. added “and Molecular”. For Notes/And Definitions: added “7. Myotonia...”, “8. Autosomal dominant...”; added statement “*Factors such as...”. For Background and Rationale: replaced “inheritance patterns” to “genetic testing”; added “GeneReviews: Congenital Myasthenic Syndromes Overview...”; added “Rett Syndrome – MECP2 Sequencing...”; added “CADASIL-NOTCH3 Sequencing...”; removed “Disease- APOE...”; added “Alzheimer Disease...”; For Facioscapulohumeral Muscular Dystrophy (FSHD) - <i>FSHD1</i> Deletion/Duplication or Haplotype Analysis and/or <i>SMCHD1</i> and <i>DNMT3B</i> Sequencing and/or Deletion Analysis or Multigene Panel: removed “and no first degree relative...”. For Huntington’s Disease- HTT Repeat Analysis: replaced “National Society...” with “Huntington’s Disease...”; added “The Huntington’s Disease Society of America...”. For Inherited Peripheral Neuropathy (Charcot-Marie-Tooth and Hereditary Neuropathy with Liability to Pressure Palsies) - <i>PMP22</i> Sequencing and/or Deletion/Duplication Analysis or Multigene Panel: added “Establishing a specific genetic cause...”; added “The diagnosis of HNPP...”. For Limb Girdle Muscular Dystrophy Multigene Panel: removed “(presenting at highly variable ages.)” and added “The age of onset...”. For <i>DMPK</i> and/or <i>CNBP</i> (<i>ZNF9</i>) Repeat Analysis Panel: replaced “2021” with “2009 and reaffirmed in 2015”; removed “The test is also useful...”. For Parkinson Disease - <i>LRRK2</i> Sequencing and/or Deletion/Duplication Analysis and Parkinson Disease Multigene Panel: removed “Usefulness of Genetic Testing...”; added “Genetic testing for Parkinson’s Disease...”; removed “in Parkinson Disease...”; added “offered for PD...”. For Myotonia Congenita - <i>CLCN1</i> Sequencing and/or Deletion/Duplication Analysis: added “Per GeneReviews...”; removed “Serum creatine kinase...”; added “Myotonia Congenita...”; removed “Electromyography performed with needle...” and added “Electromyography is a useful tool...”.</p>		
<p>Semi-annual review. Updated title to reflect V2.2024 version. In Known Familial Variant Analysis for Epilepsy, Neurodegenerative, and Neuromuscular disorders criteria, moved criteria to policy “Genetic Testing: General Approach to Genetic and Molecular Testing” to consolidate criteria for known familial variant tests. In <i>HTT</i> Repeat Analysis criteria, added age restriction for testing (18 or older). In Amyotrophic Lateral Sclerosis (ALS) Multigene Panel criteria, removed age restriction for testing (18 or older) given there are childhood onset forms of ALS. In <i>PMP22</i> Sequencing and/or Deletion/Duplication Analysis or Multigene Panel criteria, removed minimum gene list; at present there is limited rationale for inclusion. In <i>PSEN1</i>, <i>PSEN2</i>, and <i>APP</i> Sequencing and/or Deletion/Duplication Analysis criteria, Clarified age requirement for symptomatic individuals diagnosed at or over age 66 (previous criteria stated “any age”). Minor rewording for clarity throughout. Coding, reference-table, background and references updated.</p>	04/24	04/24

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### **Important Reminder**

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions, and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

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**Note: For Medicaid member/enrollees**, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

**Note: For Medicare member/enrollees**, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs and LCDs and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at <http://www.cms.gov> for additional information.

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