



MEDICAL POLICY STATEMENT

Nevada Medicaid

Policy Name & Number	Date Effective
Cystic Fibrosis Testing - NV MCD -MM-1872	07/01/2026
Policy Type	
MEDICAL	

Medical Policy Statements are derived from literature based on and supported by clinical guidelines, nationally recognized utilization and technology assessment guidelines, other medical management industry standards, and published MCO clinical policy guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased, or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any Evidence of Coverage or Certificate of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other plan policies and procedures.

Medical Policy Statements do not ensure an authorization or payment of services. Please refer to the plan contract (often referred to as the Evidence of Coverage or Certificate of Coverage) for the service(s) referenced in the Medical Policy Statement. Except as otherwise required by law, if there is a conflict between the Medical Policy Statement and the plan contract, then the plan contract will be the controlling document used to make the determination.

According to the rules of Mental Health Parity Addiction Equity Act (MHPAEA), coverage for the diagnosis and treatment of a behavioral health disorder will not be subject to any limitations that are less favorable than the limitations that apply to medical conditions as covered under this policy.

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A. Subject

Cystic Fibrosis Testing

B. Background

Cystic fibrosis (CF) is an autosomal recessive genetic disorder that happens when a person inherits two abnormal cystic fibrosis transmembrane conductance regulator (CFTR) gene, one from each parent. Diagnosis of CF is based upon the finding of genetic and/or functional abnormalities of the CFTR gene (CFTR variants) and is typically associated with progressive lung disease, pancreatic insufficiency, and elevated sweat chloride levels.

Many individuals with CF demonstrate mild or atypical symptoms and can present later in childhood or as adults. Others, may test positive for CF but have no symptoms, a condition known as CFTR-Related Metabolic Syndrome (CRMS). Untreated CF in some can lead to early mortality and infertility. This makes early CF diagnosis and identification of carriers of CF important for early intervention to help manage the disease and make more informed health decisions.

More than 10 million Americans are carriers of a defective CFTR gene and show no symptoms of the disease. Others who do not fit CF diagnostic criteria still go on to develop disease associated with evidence of CFTR dysfunction limited to one organ, known as CFTR-related disorder. Carrier testing may provide an early indication as to whether a person might develop a CFTR-related disorder. Potential parents who test positive as carriers for CF will be able to make educated reproductive decisions, better prepare for birth, and investigate additional testing for CF-related health conditions. A negative screening result does not completely rule out the possibility that a person is a CF carrier. A negative screening test only rules out the specific CF variants that were part of the screen.

Diagnosis of CF is a multistage process. Individuals must have clinical symptoms consistent with CF in at least one organ system, have a positive newborn screen, or have a sibling with CF. In addition, there must be evidence of CFTR dysfunction via elevated sweat chloride, presence of two disease-causing CFTR variants (one from each parent), or abnormal nasal potential difference (NPD). Newborn screening involves immunoreactive trypsinogen (IRT), sweat chloride testing, and genetic testing.

C. Definitions

- **American College of Medical Genetics and Genomics (ACMG)** – A nationally recognized interdisciplinary organization dedicated to the practice of medical genetics. The ACMG regularly posts technical recommendations for genetic diseases, including cystic fibrosis.
- **Autosomal Recessive** – A trait or disorder requiring a deleterious variant in both copies of the gene to express a phenotype.

The MEDICAL Policy Statement detailed above has received due consideration as defined in the MEDICAL Policy Statement Policy and is approved.

- **Carrier** – An individual with a gene variant for a disease or disorder who can pass the variant on to offspring but does not have symptoms or features of the disorder.
- **Cystic Fibrosis Transmembrane Conductance Regulator (CFTR)** – Transmembrane protein that functions as a regulated anion channel to maintain a gradient necessary for normal cell function. Variants that alter the function of the CFTR protein are associated with CF.
- **CFTR-Related Disorder** – A single pathogenic CFTR variant leading to the development of disease limited to one organ system in an individual who does not fit the CF diagnosis.
- **CFTR-Related Metabolic Syndrome (CRMS)** – Infants and children who are asymptomatic but have positive CF screening results. Found in 3-4% of infants with a positive newborn CF screen, CRMS is also known as CF screen positive, inconclusive diagnosis (CFSPID).
- **Immunoreactive Trypsinogen (IRT)** – A pancreatic enzyme precursor measured in newborns to screen for the presence of CF.

D. Policy

- I. Genetic testing for CF is a non-covered benefit. However, CareSource will cover all medically necessary services for individuals under twenty-one years of age based on early and periodic screening, diagnostic and treatment (EPSDT) benefit requirements.
- II. Genetic testing for CF should only be performed once in a lifetime and the results documented in the member's health record. All genetic testing for CF should use currently recommended ACMG CFTR panels.
- III. Diagnostic testing is considered medically necessary when the member meets any of the following criteria:
 - A. clinical presentation of CF
 - B. infertility from oligospermia/azoospermia/congenital bilateral absence of vas deferens (CBAVD)
 - C. infant with meconium ileus or other symptoms indicative of CF but unable to produce adequate amounts of sweat for a sweat chloride test
 - D. infant with an elevated IRT value on newborn screening and a sweat chloride of at least 60 mmol/L or intermediate sweat chloride (between 30 mmol/L and 59 mmol/L)
- IV. Carrier screening is indicated when the member meets any of the following criteria:
 - A. members who are pregnant or of reproductive age with intent and potential to procreate
 - B. members whose partner tests positive while the member is pregnant or intending to become pregnant
 - C. members with a family history of CF
 - D. members where both parents are CF carriers

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- V. The following are not considered medically necessary and will not be covered:
 - A. repeat testing
 - B. gene sequencing of anything other than the CFTR gene

- VI. Fetal testing is generally not considered medically necessary. However, fetal testing is medically necessary with the presence of any of the following:
 - A. Both parents have disease-causing mutations of the CFTR gene.
 - B. Echogenic bowel is detected on ultrasound examination of fetus during pregnancy.
 - C. The mother is a confirmed carrier, and father is unknown or unavailable for testing.

E. Conditions of Coverage

CareSource may request documentation for post-payment review of claims submitted for payment of CF testing. If documentation is not provided, CareSource may recoup previously paid claim(s).

The fact that a physician or other licensed practitioner renders, prescribes, orders, certifies, recommends, approves, or submits a claim for a procedure, item, or service does not, in and of itself, make the procedure, item, or service medically necessary and does not guarantee payment for it.

F. Related Policies/Rules

Genetic Testing and Counseling

G. Review/Revision History

DATE		ACTION
Date Issued	08/13/2025	New market, approved at Committee.
Date Revised	03/25/2026	Review: converted to medical policy. Added non-coverage for adults, EPSDT requirements and CoC language. Approved at Committee.
Date Effective	07/01/2026	
Date Archived		

H. References

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