

On November 21, 2023, the Centers for Medicare and Medicaid Services (CMS) approved a State Plan Amendment, effective October 30, 2023, which provides that rapid whole genome sequencing (rWGS) testing in an inpatient hospital setting is paid at a fee schedule amount outside of the All Patient Refined Diagnosis Related Group (APR-DRG).

Specifically, effective October 30, 2023 through June 30, 2026, rWGS testing provided in the inpatient hospital setting is excluded from the DRG (Diagnosis Related Group) payment. An additional payment for medically necessary rWGS will be made to a hospital when established clinical criteria is met. Costs associated with rWGS are to be billed separately from the inpatient episode. Hospital reimbursement will be made according to the Medicaid laboratory fee schedule. rWGS is permitted to be separately reimbursed outside of the APR-DRG payment when billed by the Hospital on a CMS 1500 claim form with the appropriate HCPCS procedure code and will be reimbursed at the appropriate AHCCCS fee schedule rate for that code.

AHCCCS will reimburse for rWGS to Medicaid recipients who meet the following requirements (as well as any additional requirements to be specified in AHCCCS policy):

- are under one year of age , and
- have a complex or acute illness of unknown etiology who are receiving inpatient treatment in a hospital ICU or high-acuity pediatric care unit.

See the following chart for rWGS code and rate:

CPT Code	Description	Fee Schedule
0094U	0094U Genome (e.g., unexplained constitutional or heritable disorder or syndrome), rapid sequence analysis	<a href="#">Rates Effective October 1, 2023</a>

Effective for dates of service on or after October 30, 2023, AHCCCS will establish a separate payment methodology to reimburse hospitals for costs associated with rWGS testing when the test is provided in an inpatient hospital setting prior to discharge, clinical criteria are met, and prior authorization is obtained.

To receive reimbursement for rWGS, the facility is required to submit a separate invoice using the CMS 1500 claim form. The hospital’s National Provider Identifier (NPI) must be reported as the billing provider with place of service 02 (Inpatient Hospital) reported in the service location field or loop. The beneficiary’s inpatient hospital attending provider should be entered in the rendering provider form locator or loop, and the rWGS ordering provider should be reported in the ordering/referring provider locator or loop.

Resources: [Arizona Senate Bill 1726](#), enacted 5/11/23;  
[www.azleg.gov/legtext/56leg/1R/summary/S.1726-2816APPROP\\_ASENACTED.DOCX.htm](http://www.azleg.gov/legtext/56leg/1R/summary/S.1726-2816APPROP_ASENACTED.DOCX.htm)