Select Health Medical Policies

Laboratory Utilization Policies

Table of Contents

Select Health

MEDICAL POLICY

INFECTIOUS DISEASE TESTING: GASTROENTEROLOGY

Policy # SH/LAB−A1
Implementation Date: 11/1/25
Review Dates:
Revision Dates:

Disclaimer:
1. Policies are subject to change without notice.
2. Policies outline coverage determinations for Select Health Commercial, Select Health Medicare (CMS), and Select Health Community Care (Medicaid) plans. Refer to the "Policy" section for more information.

Description

Helicobacter pylori (*H. pylori*) is the most prevalent chronic bacterial infection. It is associated with peptic ulcer disease, chronic gastritis, gastric adenocarcinoma, and gastric mucosa-associated lymphoid tissue lymphoma.

H. pylori testing should only occur in clinical situations where treatment of *H. pylori* will be offered if the test is positive. Indications for *H. pylori* testing and treatment include conditions in which *H. pylori* plays a causative role, such as dyspepsia, peptic ulcer disease, and gastric cancer, specifically adenocarcinoma and mucosa-associated lymphoid tissue (MALT) lymphoma; conditions or demographic features that are associated with an increased risk of gastric cancer; selected hematologic conditions; and situations where *H. pylori* eradication reduces the risk of complications from aspirin or nonsteroidal anti-inflammatory drugs (NSAIDs). The level of evidence supporting *H. pylori* testing and treatment varies according to the specific indication.

Syndromic/Multiplex Gastrointestinal (GI) Pathogen Panels are rapid, molecular diagnostic tests that simultaneously detect multiple bacterial, viral, and parasitic pathogens in a single stool sample from patients with symptoms of infectious gastroenteritis. These panels use techniques like polymerase chain reaction (PCR) to identify the DNA or RNA of various pathogens, offering advantages over traditional methods such as faster results, increased sensitivity, and the ability to detect co-infections. They are particularly useful for patients with severe, prolonged, or travel-related diarrhea, or those with warning signs of serious illness, providing rapid and accurate information for targeted treatment and infection control.

COMMERCIAL PLAN POLICY AND CHIP (CHILDREN'S HEALTH INSURANCE PROGRAM)

Application of coverage criteria is dependent upon an individual's benefit coverage at the time of the request.

I. Helicobacter pylori (H. pylori) Tests

A. Helicobacter pylori (H. pylori) Antibody Tests

Select Health considers H. pylori antibody tests as investigational for all indications.

B. Helicobacter pylori (H. pylori) Urea Breath or Stool Antigen Tests

Select Health considers H. pylori urea breath or stool antigen tests to be medically necessary when the following criteria are met:

1. The member is receiving a test-of-cure after treatment for H. pylori infection

OR

2. The member is 17 years of age or younger, and

a) Has gastric or duodenal ulcers and/or erosions, or

b) Has a first-degree relative with gastric cancer

OR

3. The member is 18 years of age or older, and

a) Is symptomatic (i.e., has current or past signs/symptoms of H. pylori infection), and has at least one of the following:

i. Active peptic ulcer disease (PUD), or
ii. Low-grade gastric mucosa-associated lymphoid tissue (MALT) lymphoma, or
iii. Unexplained iron deficiency (ID) anemia despite an appropriate evaluation, or
iv. Idiopathic thrombocytopenic purpura (ITP), or
v. Personal history of endoscopic resection of early gastric cancer (EGC), or
vi. Personal history of gastric premalignant conditions (including atrophic gastritis, intestinal metaplasia, and dysplasia), or
vii. Personal history of gastric adenocarcinoma, or
viii. Personal history of gastric adenomas or hyperplastic polyps, or
ix. Personal history of autoimmune gastritis, or
x. Past history of PUD; and previous cure of H. pylori infection has not been documented), or
xi. Dyspepsia, with all the following:
   a) Younger than 60 years of age
   b) Does not have dyspepsia alarm features (e.g., vomiting, dysphagia, unintended weight loss, gastrointestinal bleeding, palpable mass or lymphadenopathy)
   c) Has uninvestigated dyspepsia; or

b) Is asymptomatic (i.e., does not have current or past signs/symptoms of H. pylori infection), and has at least one of the following:

i. Is initiating prophylactic low-dose aspirin (e.g., following a major cardiovascular event)
ii. Is initiating chronic treatment with a non-steroidal anti-inflammatory drug (NSAID)
iii. Has a first-degree relative with gastric cancer
iv. Has a hereditary syndrome associated with an increased risk for gastric cancer

OR

4. Is at increased risk for H. pylori infection (e.g., household member with H. pylori infection, race or ethnicity associated with high prevalence of H.Pylori infection/incidence of gastric cancer, or immigration from a region with high incidence of gastric cancer.)

Select Health considers H. pylori urea breath or stool antigen tests as not medically necessary for all other indications, including but not limited to:

- For the evaluation of average risk individuals with GERD or hyperemesis gravidarum
- Children and adolescents with functional abdominal pain or short stature

II. Syndromic/Multiplex Gastrointestinal Pathogen Panels

A. Syndromic/Multiplex Gastrointestinal Pathogen Panels with 11 or Fewer Targets

Select Health considers syndromic/multiplex gastrointestinal pathogen panels with 11 or fewer targets to be medically necessary when the following criteria are met:

1. The member presents in the outpatient setting with suspected infectious gastroenteritis,

   AND

2. The member has at least one of the following:

   a) Immunocompromised status (e.g., HIV/AIDS, immunosuppression therapy, primary immunodeficiency), or
   b) Recent travel to/contact with travelers from an infectious diarrheal disease-endemic area, or
   c) Dysentery (presence of blood or mucus in stool), or
   d) Fever, or
   e) Dehydration, or
   f) Abdominal pain/tenderness, or
   g) Bacteremia, or
   h) Diarrhea persisting longer than 7 days, or
   i) Symptoms of enteric fever

   AND

3. Results of the testing will influence the member's clinical management.

Syndromic/multiplex gastrointestinal pathogen panels with 11 or fewer targets are considered medically necessary once per incident of diarrheal disease, or no more than once per 14-day period.

Syndromic/multiplex gastrointestinal pathogen panels with 11 or fewer targets are considered investigational for all other indications.

B. Syndromic/Multiplex Gastrointestinal Pathogen Panels with 12 or More Targets

Select Health considers syndromic/multiplex gastrointestinal pathogen panels with 12 or more targets to be medically necessary when the following criteria are met:

1. The member presents in the outpatient setting with suspected infectious gastroenteritis,

   AND

2. The member has at least one of the following:

   a) Immunocompromised status (e.g., HIV/AIDS, immunosuppression therapy, primary immunodeficiency), or
   b) Recent travel to/contact with travelers from an infectious diarrheal disease-endemic area, or
   c) Bacteremia, or
   d) Symptoms of enteric fever (i.e., Typhoid/paratyphoid fever)

   AND

3. Results of the testing will influence the member's clinical management.

Syndromic/multiplex gastrointestinal pathogen panels with 12 or more targets are considered medically necessary once per incident of diarrheal disease, or no more than once per 14-day period.

Syndromic/multiplex gastrointestinal pathogen panels with 12 or more targets are considered investigational for all other indications.

SELECT HEALTH MEDICARE (CMS)

Coverage is determined by the Centers for Medicare and Medicaid Services (CMS); if a coverage determination has not been adopted by CMS, and InterQual criteria are not available, the Select Health Commercial policy applies. For the most up-to-date Medicare policies and coverage, please visit their search website http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx?from2=search1.asp& or the manual website

SELECT HEALTH COMMUNITY CARE (MEDICAID)

Select Health Community Care policies typically align with State of Utah Medicaid policy, including use of InterQual. There may be situations where NCD/LCD criteria or Select Health commercial policies are used. For the most up-to-date Medicaid policies and coverage, please visit their website http://health.utah.gov/medicaid/manuals/directory.php or the Utah Medicaid code Look-Up tool

Billing/Coding Information

CPT CODES

83013 Helicobacter pylori; breath test analysis for urease activity, non-radioactive isotope (eg, C-13)

83014 Helicobacter pylori; breath test analysis for urease activity, non-radioactive isotope (eg, C-13); drug administration

86677 Antibody; Helicobacter pylori

87338 Infectious agent antigen detection by immunoassay technique (eg, enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], fluorescence immunoassay [FIA], immunochemiluminometric assay [IMCA]), qualitative or semiquantitative; Helicobacter pylori, stool

87339 Infectious agent antigen detection by immunoassay technique (eg, enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], fluorescence immunoassay [FIA], immunochemiluminometric assay [IMCA]), qualitative or semiquantitative; Helicobacter pylori

87493 Infectious agent detection by nucleic acid (DNA or RNA); Clostridium difficile, toxin gene(s), amplified probe technique

87498 Infectious agent detection by nucleic acid (DNA or RNA); enterovirus, amplified probe technique, including reverse transcription when performed

87500 Infectious agent detection by nucleic acid (DNA or RNA); vancomycin resistance (e.g., enterococcus species van A, van B), amplified probe technique

87505 Infectious agent detection by nucleic acid (DNA or RNA); gastrointestinal pathogen (e.g., Clostridium difficile, E. coli, Salmonella, Shigella, norovirus, Giardia), includes multiplex reverse transcription, when performed, and multiplex amplified probe technique, multiple types or subtypes, 3-5 targets

87506 Infectious agent detection by nucleic acid (DNA or RNA); gastrointestinal pathogen (e.g., Clostridium difficile, E. coli, Salmonella, Shigella, norovirus, Giardia), includes multiplex reverse transcription, when performed, and multiplex amplified probe technique, multiple types or subtypes, 6-11 targets

87551 Infectious agent detection by nucleic acid (DNA or RNA); mycobacteria species, amplified probe technique

Select Health

Infectious Disease Testing: Gastroenterology, Continued

87556 Infectious agent detection by nucleic acid (DNA or RNA); mycobacteria tuberculosis, amplified probe technique

87561 Infectious agent detection by nucleic acid (DNA or RNA); Mycobacteria avium-intracellulare, amplified probe technique

87651 Infectious agent detection by nucleic acid (DNA or RNA); Streptococcus, group A, amplified probe technique

87652 Infectious agent detection by nucleic acid (DNA or RNA); Streptococcus, group A, quantification

87653 Infectious agent detection by nucleic acid (DNA or RNA); Streptococcus, group B, amplified probe technique

87798 Infectious agent detection by nucleic acid (DNA or RNA), not otherwise specified; amplified probe technique, each organism

87799 Infectious agent detection by nucleic acid (DNA or RNA), not otherwise specified; quantification, each organism

87800 Infectious agent detection by nucleic acid (DNA or RNA), multiple organisms; direct probe(s) technique

87801 Infectious agent detection by nucleic acid (DNA or RNA), multiple organisms; amplified probe(s) technique

Key References

1. Shah, S. C., Moss., S. F., & Kao, J. Y. Approach to the diagnosis of *Helicobacter pylori* infection in Adults. UpToDate. Last reviewed: July 2025.

Disclaimer

This document is for informational purposes only and should not be relied on in the diagnosis and care of individual patients. Medical and Coding/Reimbursement policies do not constitute medical advice, plan preauthorization, certification, an explanation of benefits, or a contract. Members should consult with appropriate healthcare providers to obtain needed medical advice, care, and treatment. Benefits and eligibility are determined before medical guidelines and payment guidelines are applied. Benefits are determined by the member's individual benefit plan that is in effect at the time services are rendered.

The codes for treatments and procedures applicable to this policy are included for informational purposes. Inclusion or exclusion of a procedure, diagnosis or device code(s) does not constitute or imply member coverage or provider reimbursement policy. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

Select Health® makes no representations and accepts no liability with respect to the content of any external information cited or relied upon in this policy. Select Health updates its Coverage Policies regularly, and reserves the right to amend these policies without notice to healthcare providers or Select Health members.

Members may contact Customer Service at the phone number listed on their member identification card to discuss their benefits more specifically. Providers with questions about this Coverage Policy may call Select Health Provider Relations at **801-442-3692**.

Select Health

MEDICAL POLICY

INFECTIOUS DISEASE TESTING: GENITOURINARY

Policy # SH/LAB−A2
Implementation Date: 11/1/25
Review Dates:
Revision Dates:

Disclaimer:
1. Policies are subject to change without notice.
2. Policies outline coverage determinations for Select Health Commercial, Select Health Medicare (CMS), and Select Health Community Care (Medicaid) plans. Refer to the "Policy" section for more information.

Description

Infections of the genitourinary tract are a common cause of morbidity in both the general population and in patients with compromised immune systems. Genitourinary (GU) infectious disease testing analyzes urine, genital secretions, or tissue samples to identify bacteria, viruses, or fungi causing GU infections, such as urinary tract infections (UTIs), bacterial vaginosis (BV), trichomoniasis, or yeast infections. Common methods include urinalysis, urine cultures, microscopic examination, nucleic acid amplification tests (NAATs), and direct DNA probes to detect pathogens and their antibiotic resistance.

COMMERCIAL PLAN POLICY AND CHIP (CHILDREN'S HEALTH INSURANCE PROGRAM)

Application of coverage criteria is dependent upon an individual's benefit coverage at the time of the request.

A. Expanded Multiplex Vaginitis/Vaginosis Pathogen Panels

Expanded multiplex vaginitis/vaginosis pathogen panels with more than 6 targets are considered investigational for all indications.

B. Molecular/Multiplex UTI Panels

Molecular/multiplex UTI Panels are investigational for all indications.

C. Targeted Vaginitis/Vaginosis Pathogen Testing

Select Health considers targeted vaginitis/vaginosis pathogen testing via direct probe for Gardnerella vaginalis, Candida albicans, and/or Trichomonas vaginalis, or nucleic acid/PCR tests for bacterial vaginosis, candidiasis, and/or trichomoniasis, or multi-pathogen panel of 6 targets or fewer, with or without chlamydia and/or gonorrhea to be medically necessary when the following criteria are met:

1. The member has at least one of the following:
   a) Abnormal vaginal discharge, or
   b) Vulvovaginal itching, irritation, or redness (e.g., pruritus, erythema, edema), or
   c) Painful sexual intercourse (dyspareunia), or
   d) Painful urination (dysuria), or
   e) Postcoital or contact bleeding.

Targeted vaginitis/vaginosis pathogen testing via direct probe for Gardnerella vaginalis, Candida albicans, and/or Trichomonas vaginalis, or nucleic acid/PCR tests for bacterial vaginosis, candidiasis, and/or trichomoniasis, or multi-pathogen panel of 6 targets or fewer, with or without chlamydia and/or gonorrhea is considered investigational for all other indications, including:

a) Asymptomatic pregnant members (regardless of preterm labor risk).

SELECT HEALTH MEDICARE (CMS)

Coverage is determined by the Centers for Medicare and Medicaid Services (CMS); if a coverage determination has not been adopted by CMS, and InterQual criteria are not available, the Select Health Commercial policy applies. For the most up-to-date Medicare policies and coverage, please visit their search website http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx?from2=search1.asp& or the manual website

SELECT HEALTH COMMUNITY CARE (MEDICAID)

Select Health Community Care policies typically align with State of Utah Medicaid policy, including use of InterQual. There may be situations where NCD/LCD criteria or Select Health commercial policies are used. For the most up-to-date Medicaid policies and coverage, please visit their website http://health.utah.gov/medicaid/manuals/directory.php or the Utah Medicaid code Look-Up tool

Billing/Coding Information

CPT CODES

0321U Detection test by nucleic acid (DNA or RNA) multiplex amplified probe technique for identification of 20 bacterial and fungal organisms associated with genital or urinary tract infection and identification of 16 associated antibiotic-resistance genes

0330U Infectious agent detection by nucleic acid (DNA or RNA), vaginal pathogen panel, identification of 27 organisms, amplified probe technique, vaginal swab

0352U Infectious disease (bacterial vaginosis and vaginitis), multiplex amplified probe technique, for. detection of bacterial vaginosis-associated bacteria (BVAB-2, Atopobium vaginae, and Megasphera

0371U Infectious agent detection by nucleic acid (DNA or RNA), genitourinary pathogen, semiquantitative identification, DNA from 16 bacterial organisms and 1 fungal organism, multiplex amplified probe technique via quantitative polymerase chain reaction (qPCR), urine

0372U Infectious disease (genitourinary pathogens), antibiotic-resistance gene detection, multiplex amplified probe technique, urine, reported as an antimicrobial stewardship risk score

0374U Infectious agent detection by nucleic acid (DNA or RNA), genitourinary pathogens, identification of 21 bacterial and fungal organisms and identification of 21 associated antibiotic-resistance genes, multiplex amplified probe technique, urine

0416U Infectious agent detection by nucleic acid (DNA), genitourinary pathogens, identification of 20 bacterial and fungal organisms, including identification of 20 associated antibiotic-resistance genes, if performed, multiplex amplified probe technique, urine

0504U Infectious disease (urinary tract infection), identification of 17 pathologic organisms, urine, real-time PCR, reported as positive or negative for each organism

0505U Infectious disease (vaginal infection), identification of 32 pathogenic organisms, swab, real-time

Select Health

Infectious Disease Testing: Genitourinary, Continued

PCR, reported as positive or negative for each organism

0557U Oncology (solid organ neoplasia), mRNA, gene expression profiling by massively parallel sequencing for analysis of 51 genes, utilizing formalin-fixed paraffinembedded tissue, algorithm reported as a normalized percentile rank

81513 Infectious disease, bacterial vaginosis, quantitative real-time amplification of RNA markers for Atopobium vaginae, Gardnerella vaginalis, and Lactobacillus species, utilizing vaginal fluid specimens, algorithm reported as a positive or negative result for bacterial vaginosis

81514 Infectious disease, bacterial vaginosis and vaginitis, quantitative real-time amplification of DNA markers for Gardnerella vaginalis, Atopobium vaginae, Megasphaera type 1, Bacterial Vaginosis Associated Bacteria-2 (BVAB-2), and Lactobacillus species (L. crispatus and L. jensenii), utilizing vaginal-fluid specimens, algorithm reported as a positive or negative for high likelihood of bacterial vaginosis, includes separate detection of Trichomonas vaginalis and/or Candida species (C. albicans, C. tropicalis, C. parapsilosis, C. dubliniensis), Candida glabrata, Candida krusei, when reported

87480 Infectious agent detection by nucleic acid (DNA or RNA); Candida species, direct probe technique

87481 Infectious agent detection by nucleic acid (DNA or RNA); Candida species, amplified probe technique

87482 Infectious agent detection by nucleic acid (DNS or RNA); candida species, quantification

87490 Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia trachomatis, direct probe technique

87491 Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia trachomatis, amplified probe technique

87492 Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia trachomatis, quantification

87498 Infectious agent detection by nucleic acid (DNA or RNA); enterovirus, amplified probe technique, includes reverse transcription when performed

87500 Infectious agent detection by nucleic acid (DNA or RNA); vancomycin resistance

87511 Infectious agent detection by nucleic acid (DNA or RNA); Gardnerella vaginalis, amplified probe technique

87512 Infectious agent detection by nucleic acid (DNA or RNA); Gardnerella vaginalis, quantification

87529 Infectious agent detection by nucleic acid (DNA or RNA); Herpes simplex virus, amplified probe technique

87530 Infectious agent detection by nucleic acid (DNA or RNA); Herpes simplex virus, quantification

87532 Infectious agent detection by nucleic acid (DNA or RNA); Herpes virus-6, amplified probe technique

87535 Infectious agent detection by nucleic acid (DNA or RNA); HIV-1, amplified probe technique, includes reverse transcription when performed

87536 Infectious agent detection by nucleic acid (DNA or RNA); HIV-1, quantification, includes reverse transcription when performed

87538 Infectious agent detection by nucleic acid (DNA or RNA); HIV-2, amplified probe technique, includes reverse transcription when performed

87551 Infectious agent detection by nucleic acid (DNA or RNA); Mycobacteria species, amplified probe technique

87556 Infectious agent detection by nucleic acid (DNA or RNA); Mycobacteria tuberculosis, amplified probe technique

87561 Infectious agent detection by nucleic acid (DNA or RNA); Mycobacteria aviumintracellulare, amplified probe technique

87562 Mycobacteria avium-intracellulare, quantification

87563 Infectious agent detection by nucleic acid (DNA or RNA); Mycoplasma genitalium, amplified probe technique

87590 Infectious agent detection by nucleic acid (DNA or RNA); Neisseria gonorrhoeae, direct probe technique

87591 Infectious agent detection by nucleic acid (DNA or RNA); Neisseria gonorrhoeae, amplified probe technique

87592 Infectious agent detection by nucleic acid (DNA or RNA); Neisseria gonorrhoeae, quantification

87640 Infectious agent detection by nucleic acid (DNA or RNA); Staphylococcus aureus, amplified probe technique

87641 Infectious agent detection by nucleic acid (DNA or RNA); Staphylococcus aureus, methicillin resistant, amplified probe technique

87651 Infectious agent detection by nucleic acid (DNA or RNA); Streptococcus, group A, amplified probe technique

87653 Infectious agent detection by nucleic acid (DNA or RNA); Streptococcus, group B, amplified probe technique

87660 Infectious agent detection by nucleic acid (DNA or RNA); Trichomonas vaginalis, direct probe technique

87661 Infectious agent detection by nucleic acid (DNA or RNA); Trichomonas vaginalis, amplified probe technique

87797 Infectious agent detection by nucleic acid (DNA or RNA), not otherwise specified; direct probe technique, each organism

87798 Infectious agent detection by nucleic acid (DNA or RNA), not otherwise specified; amplified probe technique, each organism

87799 Infectious agent detection by nucleic acid (DNA or RNA), not otherwise specified; quantification, each organism

87800 Infectious agent detection by nucleic acid (DNA or RNA), multiple organisms; direct probe(s) technique

Infectious Disease Testing: Genitourinary, Continued

87801 Infectious agent detection by nucleic acid (DNA or RNA), multiple organisms; amplified probe(s) technique

87808 Infectious agent antigen detection by immunoassay with direct optical (ie, visual) observation; Trichomonas vaginalis

87901 Infectious agent genotype analysis by nucleic acid (DNA or RNA); HIV-1, reverse transcriptase and protease

87903 Infectious agent phenotype analysis by nucleic acid (DNA or RNA) with drug resistance tissue culture analysis, HIV-1; first through 10 drugs tested

87904 Infectious agent phenotype analysis by nucleic acid (DNA or RNA) with drug resistance tissue culture analysis, HIV 1; each additional drug tested (List separately in addition to code for primary procedure)

87906 Infectious agent genotype analysis by nucleic acid (DNA or RNA); HIV-1, other region (e.g., integrase, fusion)

Key References

1. Lanfranco, O.A. & Alangaden, G.J. Genitourinary Tract Infections. *Microbiol Spectr*. 2016 Aug;4(4). doi: 10.1128/microbiolspec.DMIH2-0019-2015. PMID: 27726778.

Disclaimer

This document is for informational purposes only and should not be relied on in the diagnosis and care of individual patients. Medical and Coding/Reimbursement policies do not constitute medical advice, plan preauthorization, certification, an explanation of benefits, or a contract. Members should consult with appropriate healthcare providers to obtain needed medical advice, care, and treatment. Benefits and eligibility are determined before medical guidelines and payment guidelines are applied. Benefits are determined by the member's individual benefit plan that is in effect at the time services are rendered.

The codes for treatments and procedures applicable to this policy are included for informational purposes. Inclusion or exclusion of a procedure, diagnosis or device code(s) does not constitute or imply member coverage or provider reimbursement policy. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

Select Health® makes no representations and accepts no liability with respect to the content of any external information cited or relied upon in this policy. Select Health updates its Coverage Policies regularly, and reserves the right to amend these policies without notice to healthcare providers or Select Health members.

Members may contact Customer Service at the phone number listed on their member identification card to discuss their benefits more specifically. Providers with questions about this Coverage Policy may call Select Health Provider Relations at **801-442-3692**.

Select Health

Select Health

MEDICAL POLICY

INFECTIOUS DISEASE TESTING: MULTISYSTEM

Policy # SH/LAB−A3

Implementation Date: 11/1/25
Review Dates:
Revision Dates:

Disclaimer:
1. Policies are subject to change without notice.
2. Policies outline coverage determinations for Select Health Commercial, Select Health Medicare (CMS), and Select Health Community Care (Medicaid) plans. Refer to the "Policy" section for more information.

Description

CMV antibody tests are blood tests that look for antibodies to the cytomegalovirus (CMV) in a person's blood, indicating a past or current infection. By measuring different types of antibodies, like CMV IgG and IgM, the test helps diagnose a CMV infection and can show if the infection is recent or a reactivation of a previous infection.

CMV nucleic acid (PCR) and antigen detection tests detect the presence of the cytomegalovirus, with PCR tests amplifying viral DNA and antigen tests detecting viral proteins like pp65 in leukocytes. Nucleic acid tests offer high sensitivity for early detection and are used to quantify viral load in immunocompromised patients, while antigen tests provide rapid results for preemptive antiviral treatment in transplant recipients but can't be used in patients with leukopenia.

Clinical NGS includes two sequencing strategies: targeted amplicon sequencing and untargeted shotgun metagenomic sequencing. Unlike targeted amplicon sequencing, which only targets specific genes or gene regions, untargeted shotgun metagenomic sequencing targets the entire genetic content of a clinical sample, thus permitting the detection of all potential pathogens. Untargeted metagenomic sequencing (mNGS) is considered challenging for pathogen detection for several reasons, including the complexity of data interpretation, a lack of standardized validation and regulation, and the challenge of establishing definitive clinical utility.

COMMERCIAL PLAN POLICY AND CHIP (CHILDREN'S HEALTH INSURANCE PROGRAM)

Application of coverage criteria is dependent upon an individual's benefit coverage at the time of the request.

A. Cytomegalovirus (CMV) Antibody Tests

Select Health considers cytomegalovirus (CMV) antibody tests as medically necessary when any one of the following is met (1−3):

1. The member is a prospective organ transplant donor or recipient undergoing pre-transplant evaluation, or
2. The member has signs and symptoms of mononucleosis and had negative testing for Epstein-Barr Virus (EBV), or
3. The member is pregnant and has symptoms of active CMV infection or has ultrasound findings consistent with in-utero CMV infection.

Cytomegalovirus (CMV) antibody tests are considered investigational for all other indications.

B. Cytomegalovirus (CMV) Nucleic Acid/PCR or Antigen Detection Tests

Select Health considers cytomegalovirus (CMV) nucleic acid/PCR or antigen detection tests as medically necessary when any one of the following is met: (1−8):

1. The member is immunocompromised, or
2. The member is 12 months of age or younger, and is a prospective organ transplant donor or recipient undergoing pre-transplant evaluation, or
3. The member is undergoing post-transplant monitoring, or
4. The member is a newborn with very low birth weight (less than 1500 grams or 3 lbs 4.9 oz), or
5. The member is a premature newborn (born before 37 weeks 0 days gestation), or
6. The member is an infant with suspected congenital CMV infection (signs/symptoms of congenital CMV infection such as congenital hearing loss, documented maternal CMV infection, or ultrasound findings consistent with in-utero CMV infection), or
7. The member is pregnant and has ultrasound findings consistent with in utero CMV infection, or
8. The member has signs and symptoms of suspected mononucleosis and had negative testing for Epstein-Barr Virus (EBV).

Cytomegalovirus (CMV) nucleic acid/PCR or antigen detection tests are considered investigational for all other indications.

C. Untargeted Metagenomic Sequencing Tests for Pathogen Detection

Untargeted metagenomic sequencing tests for pathogen detection are considered investigational for all indications.

SELECT HEALTH MEDICARE (CMS)

Coverage is determined by the Centers for Medicare and Medicaid Services (CMS); if a coverage determination has not been adopted by CMS, and InterQual criteria are not available, the Select Health Commercial policy applies. For the most up-to-date Medicare policies and coverage, please visit their search website http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx?from2=search1.asp& or the manual website

SELECT HEALTH COMMUNITY CARE (MEDICAID)

Select Health Community Care policies typically align with State of Utah Medicaid policy, including use of InterQual. There may be situations where NCD/LCD criteria or Select Health commercial policies are used. For the most up-to-date Medicaid policies and coverage, please visit their website http://health.utah.gov/medicaid/manuals/directory.php or the Utah Medicaid code Look-Up tool

Select Health

Billing/Coding Information

CPT CODES

0152U Infectious disease (bacteria, fungi, parasites, and DNA viruses), DNA, PCR and next-generation sequencing, plasma, detection of >1,000 potential microbial organisms for significant positive pathogens

0323U DNA and mRNA next-generation sequencing analysis in cerebrospinal fluid specimen for detection of organisms causing disease in central nervous system

0480U Infectious disease (bacteria, viruses, fungi, and parasites), cerebrospinal fluid (CSF), metagenomic next-generation sequencing (DNA and RNA), bioinformatic analysis, with positive pathogen identification

0531U Infectious disease (acid-fast bacteria and invasive fungi), DNA (673 organisms), next generation sequencing, plasma

86644 Antibody; cytomegalovirus (CMV)

86645 Antibody; cytomegalovirus (CMV), IgM

87495 Infectious agent detection by nucleic acid (DNA or RNA); Clostridium difficile, toxin gene(s), amplified probe technique

87496 Infectious agent detection by nucleic acid (DNA or RNA); cytomegalovirus, amplified probe technique

Key References

1. Batool, M., & Galloway-Peña J. Clinical metagenomics-challenges and future prospects. *Front Microbiol*. 2023 Jun 28; 14:1186424. doi: 10.3389/fmicb.2023.1186424. PMID: 37448579; PMCID: PMC10337830.

Disclaimer

This document is for informational purposes only and should not be relied on in the diagnosis and care of individual patients. Medical and Coding/Reimbursement policies do not constitute medical advice, plan preauthorization, certification, an explanation of benefits, or a contract. Members should consult with appropriate healthcare providers to obtain needed medical advice, care, and treatment. Benefits and eligibility are determined before medical guidelines and payment guidelines are applied. Benefits are determined by the member's individual benefit plan that is in effect at the time services are rendered.

The codes for treatments and procedures applicable to this policy are included for informational purposes. Inclusion or exclusion of a procedure, diagnosis or device code(s) does not constitute or imply member coverage or provider reimbursement policy. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

Select Health® makes no representations and accepts no liability with respect to the content of any external information cited or relied upon in this policy. Select Health updates its Coverage Policies regularly, and reserves the right to amend these policies without notice to healthcare providers or Select Health members.

Members may contact Customer Service at the phone number listed on their member identification card to discuss their benefits more specifically. Providers with questions about this Coverage Policy may call Select Health Provider Relations at **801-442-3692**.

Select Health

MEDICAL POLICY

INFECTIOUS DISEASE TESTING: RESPIRATORY

Policy # SH/LAB−A4
Implementation Date: 11/1/25
Review Dates:
Revision Dates:

Disclaimer:
1. Policies are subject to change without notice.
2. Policies outline coverage determinations for Select Health Commercial, Select Health Medicare (CMS), and Select Health Community Care (Medicaid) plans. Refer to the "Policy" section for more information.

Description

The primary testing methods for respiratory infectious diseases are nucleic acid amplification tests (NAATs, including PCR), rapid antigen detection tests (RADTs), culture, serology, and point-of-care multiplex molecular panels.

NAATs, especially real-time PCR, are now the preferred method for detecting respiratory viruses (e.g., influenza, RSV, SARS-CoV-2, adenovirus, parainfluenza, human metapneumovirus, rhinovirus/enterovirus, and coronaviruses) due to their high sensitivity and specificity. The Infectious Diseases Society of America and the American Society for Microbiology recommend NAATs as the principal modality for respiratory viral diagnosis, with multiplex molecular panels allowing simultaneous detection of multiple pathogens and select atypical bacteria (e.g., Mycoplasma pneumoniae, Chlamydia pneumoniae, Bordetella pertussis) from nasopharyngeal swabs, sputum, or bronchoalveolar lavage fluid.

Rapid antigen detection tests are available for influenza, RSV, and SARS-CoV-2, but their sensitivity is lower than molecular methods, especially at low viral loads. The American Academy of Pediatrics notes that molecular assays are preferred in hospitalized patients due to superior sensitivity compared to antigen detection. Urinary antigen tests are used for Streptococcus pneumoniae and Legionella pneumophila.

COMMERCIAL PLAN POLICY AND CHIP (CHILDREN'S HEALTH INSURANCE PROGRAM)

Application of coverage criteria is dependent upon an individual's benefit coverage at the time of the request.

A. Bacterial Respiratory Infection/Pneumonia Target Panels

Select Health considers bacterial respiratory infection/pneumonia panels to be medically necessary when all the following criteria are met (1−3):

1. The member presents in the outpatient setting with signs or symptoms of an acute respiratory infection; and

2. The member has at least <u>one</u> of the following criteria:

   a) New or worsening lung infiltrates, or

   b) Moderate to severe upper respiratory illness, or

   c) Has received empiric antibiotics before obtaining cultures, or

   d) Has possible multidrug-resistant bacteria or polymicrobial infection;

AND

3. Results of the testing will influence the member's clinical management.

Bacterial respiratory infection/pneumonia panels are considered investigational for all other indications.

B. Group A Streptococcus Antibody Tests

Group A streptococcus antibody tests are considered investigational for the purpose of evaluating a member with acute pharyngitis for a possible group A streptococcus infection.

C. Group A Streptococcus Pharyngitis Cultures

Select Health considers a Group A streptococcus pharyngitis culture to be medically necessary when the following criteria are met (1−5):

1. The member is between the ages of 3 years and 18 years; and

2. The member had a negative group A streptococcus rapid antigen detection test (RADT); and

3. The member presents in the outpatient setting with at least one of the following:

   a) Acute pharyngitis, or
   b) Fever, or
   c) Tonsillopharyngeal inflammation, or
   d) Patchy tonsillopharyngeal exudates, or
   e) Palatal petechiae, or
   f) Anterior cervical lymphadenitis, or
   g) Scarlatiniform rash; and

4. The member does not have clinical and epidemiological features that strongly suggest a viral etiology (e.g., cough, rhinorrhea, hoarseness, and oral ulcers); and

5. Results of the testing will influence the member's clinical management.

Group A streptococcus pharyngitis culture is considered investigational for all other indications.

D. Group A Streptococcus Pharyngitis Tests

Select Health considers Group A streptococcus pharyngitis tests to be medically necessary when the following criteria are met (1−3):

1. The member presents in the outpatient setting with at least one of the following:

   a) Acute pharyngitis, or
   b) Fever, or
   c) Tonsillopharyngeal inflammation, or
   d) Patchy tonsillopharyngeal exudates, or
   e) Palatal petechiae, or
   f) Anterior cervical lymphadenitis, or
   g) Scarlatiniform rash; and

2. The member does not have clinical and epidemiological features that strongly suggest a viral etiology (e.g., cough, rhinorrhea, hoarseness, and oral ulcers); and

3. Results of the testing will influence the member's clinical management.

Select Health

Group A streptococcus pharyngitis tests are considered investigational for all other indications.

E. Influenza A and B Antibody Tests

Influenza A and B Antibody Tests are considered investigational for the purpose of diagnosing influenza.

F. Syndromic/Multiplex Respiratory Panels with 6 or More Targets

Select Health considers syndromic/multiplex respiratory panels with 6 or more targets to be medically necessary when the following criteria are met (1−3):

1. The member presents in the outpatient setting with signs or symptoms of an acute respiratory infection; and

2. The member meets at least one of the following criteria:

   a) Immunocompromised, or
   b) Has severe pneumonia, or
   c) Has exacerbations of airway disease; and

3. Results of the testing will influence the member's clinical management.

Syndromic/multiplex respiratory panels with 6 or more targets are considered investigational for all other indications.

SELECT HEALTH MEDICARE (CMS)

Coverage is determined by the Centers for Medicare and Medicaid Services (CMS); if a coverage determination has not been adopted by CMS, and InterQual criteria are not available, the Select Health Commercial policy applies. For the most up-to-date Medicare policies and coverage, please visit their search website http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx?from2=search1.asp& or the manual website

SELECT HEALTH COMMUNITY CARE (MEDICAID)

Select Health Community Care policies typically align with State of Utah Medicaid policy, including use of InterQual. There may be situations where NCD/LCD criteria or Select Health commercial policies are used. For the most up-to-date Medicaid policies and coverage, please visit their website http://health.utah.gov/medicaid/manuals/directory.php or the Utah Medicaid code Look-Up tool

Billing/Coding Information

CPT CODES

0115U Respiratory infectious agent detection by nucleic acid (DNA and RNA), 18 viral types and subtypes and 2 bacterial targets, amplified probe technique, including multiplex reverse transcription for RNA targets, each analyte reported as detected or not detected

0202U Infectious disease (bacterial or viral respiratory tract infection), pathogen-specific nucleic acid (DNA or RNA), 22 targets including severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), qualitative RT-PCR, nasopharyngeal swab, each pathogen reported as detected or not detected

0223U Infectious disease (bacterial or viral respiratory tract infection), pathogen-specific nucleic acid (DNA or RNA), 22 targets including severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), qualitative RT-PCR, nasopharyngeal swab, each pathogen reported as detected or not detected

Infectious Disease Testing: Respiratory Continued

0225U Infectious disease (bacterial or viral respiratory tract infection) pathogen-specific DNA and RNA, 21 targets, including severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), amplified probe technique, including multiplex reverse transcription for RNA targets, each analyte reported as detected or not detected

0240U Targeted genomic sequence analysis panel, solid organ neoplasm, cell-free circulating DNA analysis of 55-74 genes, interrogation for sequence variants, gene copy number amplifications, and gene rearrangements

0556U Infectious disease (bacterial or viral respiratory tract infection), pathogen-specific DNA and RNA by real-time PCR, 12 targets, nasopharyngeal or oropharyngeal swab, including multiplex reverse transcription for RNA targets, each analyte reported as detected or not detected

0563U Infectious disease (bacterial and/or viral respiratory tract infection), pathogen-specific nucleic acid (DNA or RNA), 11 viral targets and 4 bacterial targets, qualitative RT-PCR, upper respiratory specimen, each pathogen reported as positive or negative

0564U Infectious disease (bacterial and/or viral respiratory tract infection), pathogen-specific nucleic acid (DNA or RNA), 10 viral targets and 4 bacterial targets, qualitative RT-PCR, upper respiratory specimen, each pathogen reported as positive or negative

86060 Triiodothyronine T3; reverse

86710 Antibody; influenza virus

87040 Culture, bacterial; blood, aerobic, with isolation and presumptive identification of isolates (includes anaerobic culture, if appropriate)

87070 Culture, bacterial; any other source except urine, blood or stool, aerobic, with isolation and presumptive identification of isolates

87071 Culture, bacterial; quantitative, aerobic with isolation and presumptive identification of isolates, any source except urine, blood or stool

87073 Culture, bacterial; quantitative, anaerobic with isolation and presumptive identification of isolates, any source except urine, blood or stool

87075 Culture, bacterial; any source, except blood, anaerobic with isolation and presumptive identification of isolates

87076 Culture, bacterial; anaerobic isolate, additional methods required for definitive identification, each Isolate

87077 Culture, bacterial; aerobic isolate, additional methods required for definitive identification, each isolate

87081 Culture, presumptive, pathogenic organisms, screening only;

87084 Culture, presumptive, pathogenic organisms, screening only; with colony estimation from density chart

87101 Culture, fungi (mold or yeast) isolation, with presumptive identification of isolates; skin, hair, or nail

87102 Culture, fungi (mold or yeast) isolation, with presumptive identification of isolates; other source (except blood)

Infectious Disease Testing: Respiratory Continued

87103 Culture, fungi (mold or yeast) isolation, with presumptive identification of isolates; blood

87106 Culture, fungi, definitive identification, each organism; yeast

87107 Culture, fungi, definitive identification, each organism; mold

87109 Culture, mycoplasma, any source

87116 Culture, tubercle or other acid-fast bacilli (eg, TB, AFB, mycobacteria) any source, with isolation and presumptive identification of isolates

87118 Culture, mycobacterial, definitive identification, each isolate

87140 Culture, typing; immunofluorescent method, each antiserum

87143 Culture, typing; gas liquid chromatography (GLC) or high pressure liquid chromatography (HPLC) method

87147 Culture, typing; immunologic method, other than immunofluorescence (eg, agglutination grouping), per antiserum

87158 Culture, typing; other methods

87430 Infectious agent antigen detection by immunoassay technique, (eg, enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], fluorescence immunoassay [FIA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative; Streptococcus, group A

87481 Infectious agent detection by nucleic acid (DNA or RNA); Candida species, amplified probe technique

87482 Infectious agent detection by nucleic acid (DNA or RNA); Candida species, quantification

87485 Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia pneumoniae, direct probe technique

87486 Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia pneumoniae, amplified probe technique

87487 Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia pneumoniae, quantification

87498 Infectious agent detection by nucleic acid (DNA or RNA); enterovirus, amplified probe technique, includes reverse transcription when performed

87500 Infectious agent detection by nucleic acid (DNA or RNA); vancomycin resistance (eg, enterococcus species van A, van B), amplified probe technique

87501 Infectious agent detection by nucleic acid (DNA or RNA); influenza virus, includes reverse transcription, when performed, and amplified probe technique, each type or subtype

87502 Infectious agent detection by nucleic acid (DNA or RNA); influenza virus, for multiple types or sub-types, includes multiplex reverse transcription, when performed, and multiplex amplified probe technique, first 2 types or sub-types

87503 Infectious agent detection by nucleic acid (DNA or RNA); influenza virus, for multiple types or sub-types, includes multiplex reverse transcription, when performed, and multiplex amplified probe technique, each additional influenza virus type or sub-type beyond 2 (List separately in

Infectious Disease Testing: Respiratory Continued

addition to code for primary procedure)

87540 Infectious agent detection by nucleic acid (DNA or RNA); Legionella pneumophila, direct probe technique

87541 Infectious agent detection by nucleic acid (DNA or RNA); Legionella pneumophila, amplified probe technique

87542 Infectious agent detection by nucleic acid (DNA or RNA); Legionella pneumophila, quantification

87551 Infectious agent detection by nucleic acid (DNA or RNA); Mycobacteria species, amplified probe technique

87552 Infectious agent detection by nucleic acid (DNA or RNA); Mycobacteria species, quantification

87555 Infectious agent detection by nucleic acid (DNA or RNA); Mycobacteria tuberculosis, direct probe technique

87556 Infectious agent detection by nucleic acid (DNA or RNA); Mycobacteria tuberculosis, amplified probe technique

87560 Infectious agent detection by nucleic acid (DNA or RNA); Mycobacteria avium-intracellulare, direct probe technique

87561 Infectious agent detection by nucleic acid (DNA or RNA); Mycobacteria avium-intracellulare, amplified probe technique

87580 Infectious agent detection by nucleic acid (DNA or RNA); Mycoplasma pneumoniae, direct probe technique

87581 Infectious agent detection by nucleic acid (DNA or RNA); Mycoplasma pneumoniae, amplified probe technique

87582 Infectious agent detection by nucleic acid (DNA or RNA); Mycoplasma pneumoniae, quantification

87631 Infectious agent detection by nucleic acid (DNA or RNA); respiratory virus (eg, adenovirus,

87632 Infectious agent detection by nucleic acid (DNA or RNA); respiratory virus (eg, adenovirus, influenza virus, coronavirus, metapneumovirus, parainfluenza virus, respiratory syncytial virus, rhinovirus), includes multiplex reverse transcription, when performed, and multiplex amplified probe technique, multiple types or subtypes, 6-11 targets

87633 Infectious agent detection by nucleic acid (DNA or RNA); respiratory virus (eg, adenovirus, influenza virus, coronavirus, metapneumovirus, parainfluenza virus, respiratory syncytial virus, rhinovirus), includes multiplex reverse transcription, when performed, and multiplex amplified probe technique, multiple types or subtypes, 12-25 targets

87634 Infectious agent detection by nucleic acid (DNA or RNA); respiratory syncytial virus, amplified probe technique

87635 Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]), amplified probe technique

87636 Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) and influenza virus types A and B, multiplex amplified probe technique

Infectious Disease Testing: Respiratory Continued

87637 Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]), influenza virus types A and B, and respiratory syncytial virus, multiplex amplified probe technique

87640 Infectious agent detection by nucleic acid (DNA or RNA); Staphylococcus aureus, amplified probe technique

87641 Infectious agent detection by nucleic acid (DNA or RNA); Staphylococcus aureus, methicillin resistant, amplified probe technique

87650 Infectious agent detection by nucleic acid (DNA or RNA); Streptococcus, group A, direct probe technique

87651 Infectious agent detection by nucleic acid (DNA or RNA); Streptococcus, group A, amplified probe technique

87652 Infectious agent detection by nucleic acid (DNA or RNA); Streptococcus, group A, amplified probe technique

87653 Infectious agent detection by nucleic acid (DNA or RNA); Streptococcus, group B, amplified probe technique

87797 Infectious agent detection by nucleic acid (DNA or RNA), not otherwise specified; direct probe technique, each organism

87798 Infectious agent detection by nucleic acid (DNA or RNA), not otherwise specified; amplified probe technique, each organism

87799 Infectious agent detection by nucleic acid (DNA or RNA), not otherwise specified; quantification, each organism

87800 Infectious agent detection by nucleic acid (DNA or RNA), multiple organisms; direct probe(s) technique

87801 Infectious agent detection by nucleic acid (DNA or RNA), multiple organisms; direct probe(s) technique

87880 Infectious agent antigen detection by immunoassay with direct optical (ie, visual) observation; Streptococcus, group A

87913 Infectious agent genotype analysis by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]), mutation identification in targeted region(s)

Key References

1. Miller, J.M., Binnicker, M.J., Campbell, S., et al. Guide to Utilization of the Microbiology Laboratory for Diagnosis of Infectious Diseases: 2024 Update by the Infectious Diseases Society of America (IDSA) and the American Society for Microbiology (ASM). Clinical Infectious Diseases: An Official Publication of the Infectious Diseases Society of America. 2024; ciae104. doi:10.1093/cid/ciae104.

Disclaimer

This document is for informational purposes only and should not be relied on in the diagnosis and care of individual patients. Medical and Coding/Reimbursement policies do not constitute medical advice, plan preauthorization, certification, an explanation of benefits, or a contract. Members should consult with appropriate healthcare providers to obtain needed medical advice, care, and treatment. Benefits and eligibility are determined before medical guidelines and payment guidelines are applied. Benefits are determined by the member's individual benefit plan that is in effect at the time services are rendered.

Select Health

Infectious Disease Testing: Respiratory Continued

The codes for treatments and procedures applicable to this policy are included for informational purposes. Inclusion or exclusion of a procedure, diagnosis or device code(s) does not constitute or imply member coverage or provider reimbursement policy. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

Select Health® makes no representations and accepts no liability with respect to the content of any external information cited or relied upon in this policy. Select Health updates its Coverage Policies regularly, and reserves the right to amend these policies without notice to healthcare providers or Select Health members.

Members may contact Customer Service at the phone number listed on their member identification card to discuss their benefits more specifically. Providers with questions about this Coverage Policy may call Select Health Provider Relations at **801-442-3692**.

Select Health

Select Health

MEDICAL POLICY

INFECTIOUS DISEASE TESTING: SCREENING AND PREVENTION

Policy # SH/LAB−A5

Implementation Date: 11/1/25
Review Dates:
Revision Dates:

Disclaimer:
1. Policies are subject to change without notice.
2. Policies outline coverage determinations for Select Health Commercial, Select Health Medicare (CMS), and Select Health Community Care (Medicaid) plans. Refer to the "Policy" section for more information.

Description

Human papillomavirus (HPV) screening plays a central role in infectious disease testing as the primary method for cervical cancer prevention in individuals with a cervix. High-risk HPV (hrHPV) types are responsible for nearly all cases of cervical cancer, and persistent infection with these types is the key risk factor for progression to cervical intraepithelial neoplasia and cancer. The United States Preventive Services Task Force (USPSTF), the American College of Obstetricians and Gynecologists (ACOG), the American Society for Colposcopy and Cervical Pathology (ASCCP), and the Society of Gynecologic Oncology (SGO) all recommend hrHPV testing as a primary screening tool, either alone or in combination with cytology (co-testing), for individuals aged 30–65 years, with screening intervals of 3–5 years depending on the method used.

Group B streptococcus (GBS) screening in infectious disease testing is performed by obtaining a vaginal-rectal swab culture from pregnant women at 36 0/7 to 37 6/7 weeks' gestation. The American Academy of Pediatrics states that this universal antenatal screening is recommended to identify women at risk for transmitting GBS to their newborns, thereby guiding the use of intrapartum antibiotic prophylaxis (IAP) to prevent early-onset GBS disease in neonates.

Universal hepatitis C virus (HCV) screening is recommended for all adults aged ≥18 years at least once in their lifetime, and for all pregnant persons during each pregnancy, except in settings where HCV prevalence is <0.1%. This recommendation is made by the American Association for the Study of Liver Diseases (AASLD) and the Infectious Diseases Society of America (IDSA), as well as the Infectious Diseases Society of America (IDSA) and the American Society for Microbiology (ASM).

COMMERCIAL PLAN POLICY AND CHIP (CHILDREN'S HEALTH INSURANCE PROGRAM)

Application of coverage criteria is dependent upon an individual's benefit coverage at the time of the request.

This policy addresses testing of healthy/asymptomatic individuals for infectious diseases including human papillomavirus (HPV), group B streptococcus (GBS), and hepatitis C virus (HCV). *These criteria are intended for use in the outpatient setting.*

A. Genotyping of High-Risk Human Papillomavirus (HPV) Types for Cervical Cancer Screening

Select Health considers human papillomavirus (HPV) genotyping of high-risk types to be medically necessary when either of the following criteria are met (1 or 2):

1. The member is an individual born with a cervix, who is between the ages of 30 and 65 years; and one of the following (a−c):

   a) Has not had a hysterectomy with removal of the cervix, or

   b) Has a history of high-grade precancerous lesion (i.e., cervical intraepithelial neoplasia [CIN] grade 2 or 3), or

   c) Has a history of cervical cancer

OR

2. The member is an individual born with a cervix, who is younger than 30 or older than 65 years of age, and is at increased risk for cervical cancer (e.g., immunocompromised, HIV infection, in-utero exposure to diethylstilbestrol, history of cervical lesion or cervical cancer).

Human papillomavirus (HPV) genotyping of high-risk types is considered medically necessary once every 5 years, in absence of increased risk factors for cervical cancer (e.g., immunocompromised, HIV infection, in-utero exposure to diethylstilbestrol, history of cervical lesion or cervical cancer).

Human papillomavirus (HPV) genotyping of high- risk types is considered investigational for all other indications, including for the evaluation of genital warts or sexually transmitted infection screening.

B. Genotyping of Low-Risk Human Papillomavirus (HPV) Types

Human papillomavirus (HPV) genotyping of low-risk types is considered investigational for all indications.

C. Group B Streptococcus Screening Tests in Vaginal-Rectal Specimens

Select Health considers Group B Streptococcus screening tests in vaginal-rectal specimens to be medically necessary when the following criteria are met:

1. The member is pregnant, and
2. The pregnancy is between 36 weeks 0 days and 37 weeks and 6 days gestation.

Group B streptococcus screening tests of vaginal-rectal specimens are considered investigational for all other indications, including for pregnant members with GBS bacteriuria during the current pregnancy and for pregnant members with a previous GBS-infected newborn.

D. Hepatitis C Antibody Screening Tests

Select Health considers Hepatitis C antibody screening tests to be medically necessary when the following criteria are met (1−3):

1. The member does not have a known past positive HCV antibody test result*; and

2. The member does not have a known history of chronic HCV infection*; and

3. The member meets at least one of the following (a−e):

   a) The member is pregnant

   OR

   b) The member is an asymptomatic adult between the ages of 18 and 79 years

OR

c) The member is a child 18 months or older, and meets both of the following:

i. The member was perinatally exposed to HCV; and

ii. The member has not been previously tested

OR

d) The member is younger than 18 or older than 79 years of age, and the member is at increased risk of HCV infection (e.g., past or current injection drug use, liver disease, chronic hemodialysis, HIV infection, HIV PrEP use, men who have sex with men, partners of HCV infected individuals, organ transplant donor/recipient)

OR

e) The member requests screening (regardless of age or disclosure of potentially stigmatizing risks).

Hepatitis C antibody screening tests are considered investigational for all other indications.**

*A quantitative HCV-RNA test rather than an HCV-antibody test is recommended to assess for HCV recurrence.

**These criteria do not apply to members with liver disease and/or other signs and symptoms of active hepatitis C virus infection.

E. Hepatitis C Nucleic Acid/PCR Tests

Select Health considers Hepatitis C nucleic acid/PCR tests for the purposes of routine screening or confirmatory testing following a positive HCV antibody screening test to be medically necessary when one of the following criteria is met:

1. The member is immunocompromised (e.g., receives chronic hemodialysis), or
2. The member has a suspected HCV exposure within the past 6 months (regardless of antibody status), or
3. The member has an initial HCV antibody positive test#, or
4. The member is undergoing monitoring for chronic HCV infection (i.e., prior to starting direct-acting antiviral (DAA) treatment, while receiving treatment, or having completed therapy), or
5. The member was exposed to HCV perinatally and is between 2 months and 17 months of age, or
6. The member has a history of HCV infection followed by eradication/sustained virologic response (SVR) and the member has ongoing risk factors for HCV reinfection.##

Hepatitis C nucleic acid/PCR tests for the purposes of routine screening or confirmatory testing following a positive HCV antibody screening test are considered investigational for all other indications.###

#This includes PCR testing as an automatic reflex from initial antibody tests; this approach is considered the most appropriate option for initial HCV screening.

##A quantitative HCV-RNA test rather than an HCV-antibody test is recommended to assess for HCV recurrence.

###These criteria do not apply to members with liver disease and/or other signs and symptoms of active hepatitis C virus infection.

SELECT HEALTH MEDICARE (CMS)

Coverage is determined by the Centers for Medicare and Medicaid Services (CMS); if a coverage determination has not been adopted by CMS, and InterQual criteria are not available, the Select Health Commercial policy applies. For the most up-to-date Medicare policies and coverage, please visit their search website http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx?from2=search1.asp& or the manual website

SELECT HEALTH COMMUNITY CARE (MEDICAID)

Select Health Community Care policies typically align with State of Utah Medicaid policy, including use of InterQual. There may be situations where NCD/LCD criteria or Select Health commercial policies are used. For the most up-to-date Medicaid policies and coverage, please visit their website http://health.utah.gov/medicaid/manuals/directory.php or the Utah Medicaid code Look-Up tool

Billing/Coding Information

CPT CODES

86803 Hepatitis C antibody;

86804 Hepatitis C antibody; confirmatory test (eg, immunoblot)

87520 Infectious agent detection by nucleic acid (DNA or RNA); hepatitis C, direct probe technique

87521 Infectious agent detection by nucleic acid (DNA or RNA); hepatitis C, amplified probe technique, includes reverse transcription when performed

87522 Infectious agent detection by nucleic acid (DNA or RNA); hepatitis C, quantification, includes reverse transcription when performed

87623 Infectious agent detection by nucleic acid (DNA or RNA); Human Papillomavirus (HPV), low-risk types (eg, 6, 11, 42, 43, 44)

87624 Infectious agent detection by nucleic acid (DNA or RNA); Human Papillomavirus (HPV), high-risk types (eg, 16, 18, 31, 33, 35, 39, 45, 51, 52, 56, 58, 59, 68), pooled result

87625 Infectious agent detection by nucleic acid (DNA or RNA); Human Papillomavirus (HPV), types 16 and 18 only, includes type 45, if performed

87653 Infectious agent detection by nucleic acid (DNA or RNA); Streptococcus, group B, amplified probe technique

Key References

1. Bhattacharya, D., Aronsohn, A., Price, J., & Lo Re, V. AASLD-IDSA HCV Guidance Panel. Hepatitis C Guidance 2023 Update: AASLD-IDSA Recommendations for Testing, Managing, and Treating Hepatitis C Virus Infection. *Clin Infect Dis*. 2023 May 25: ciad319. doi: 10.1093/cid/ciad319. Epub ahead of print. PMID: 37229695.
2. Miller, J.M., Binnicker, M.J, Campbell, S., Carroll, K.C., Chapin, K.C., Gonzalez, M.D. … Yao, J.D. Guide to Utilization of the Microbiology Laboratory for Diagnosis of Infectious Diseases: 2024 Update by the Infectious Diseases Society of America (IDSA) and the American Society for Microbiology (ASM). *Clin Infect Dis*. 2024 Mar 5: ciae104. doi: 10.1093/cid/ciae104. Epub ahead of print. PMID: 38442248.
3. Puopolo, K.M., Lynfield, R., & Cummings, J.J. Committee on Fetus and Newborn; Committee on Infectious Diseases. Management of Infants at Risk for Group B Streptococcal Disease. *Pediatrics*. 2019 Aug;144(2): e20191881. doi: 10.1542/peds.2019-1881. Epub 2019 Jul 8. Erratum in: Pediatrics. 2019 Oct;144(4): e20192350. doi: 10.1542/peds.2019-2350. PMID: 31285392.

Disclaimer

This document is for informational purposes only and should not be relied on in the diagnosis and care of individual patients. Medical and Coding/Reimbursement policies do not constitute medical advice, plan preauthorization, certification, an explanation of

Infectious Disease Testing: Screening and Prevention, Continued

benefits, or a contract. Members should consult with appropriate healthcare providers to obtain needed medical advice, care, and treatment. Benefits and eligibility are determined before medical guidelines and payment guidelines are applied. Benefits are determined by the member's individual benefit plan that is in effect at the time services are rendered.

The codes for treatments and procedures applicable to this policy are included for informational purposes. Inclusion or exclusion of a procedure, diagnosis or device code(s) does not constitute or imply member coverage or provider reimbursement policy. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

Select Health® makes no representations and accepts no liability with respect to the content of any external information cited or relied upon in this policy. Select Health updates its Coverage Policies regularly, and reserves the right to amend these policies without notice to healthcare providers or Select Health members.

Members may contact Customer Service at the phone number listed on their member identification card to discuss their benefits more specifically. Providers with questions about this Coverage Policy may call Select Health Provider Relations at **801-442-3692**.

Select Health

Select Health

MEDICAL POLICY

INFECTIOUS DISEASE TESTING: VECTOR-BORNE

Policy # SH/LAB−A6

Implementation Date: 11/1/25
Review Dates:
Revision Dates:

Disclaimer:
1. Policies are subject to change without notice.
2. Policies outline coverage determinations for Select Health Commercial, Select Health Medicare (CMS), and Select Health Community Care (Medicaid) plans. Refer to the "Policy" section for more information.

Description

A wide range of infectious disease testing is available for vector-borne diseases, including those transmitted by ticks, mosquitoes, fleas, lice, and mites. The Infectious Diseases Society of America and the American Society for Microbiology recommend that diagnostic approaches be tailored to the suspected pathogen, clinical syndrome, timing of illness, and exposure history. The most commonly used modalities include:

• Nucleic acid amplification tests (NAATs), such as PCR, for early detection of bacterial and parasitic pathogens (e.g., Borrelia, Anaplasma, Ehrlichia, Babesia) in blood or tissue, especially during the acute phase

• Serologic assays (e.g., indirect immunofluorescence antibody [IFA], enzyme immunoassay [EIA], Western blot) for detection of pathogen-specific IgG or IgM antibodies. Paired acute and convalescent sera are often required for confirmation, particularly for rickettsial diseases and arboviruses

• Microscopy (e.g., Giemsa- or Wright-stained blood smears) for direct visualization of intraerythrocytic or intraleukocytic organisms (e.g., Babesia, Anaplasma, Ehrlichia)

• Immunohistochemical (IHC) staining of tissue biopsies for certain pathogens (e.g., Rickettsia, Ehrlichia)

• Molecular and serologic testing for arboviruses (e.g., West Nile, Powassan, dengue, Zika) is primarily serology-based, with PCR reserved for early infection or CNS involvement

COMMERCIAL PLAN POLICY AND CHIP (CHILDREN'S HEALTH INSURANCE PROGRAM)

Application of coverage criteria is dependent upon an individual's benefit coverage at the time of the request.

A. Lyme Disease (Borrelia burgdorferi) Nucleic Acid/PCR Tests

Select Health considers Lyme disease nucleic acid/PCR testing to be medically necessary when the following criteria are met:

1. The member is seropositive for Lyme disease, and

2. The member has suspected Lyme arthritis, and

3. Results of testing will influence the member's clinical management.

Lyme disease nucleic acid/PCR testing is considered investigational for all other indications, including for the purpose of diagnosing Lyme disease.

B. Lyme Disease (Borrelia burgdorferi) Serum Antibody Tests

Select Health considers Lyme disease serum antibody testing to be medically necessary when the following criteria are met:

1. The member had a plausible exposure to Borrelia burgdorferi, and
2. The member has at least one of the following:
   a) Skin lesion(s) suggestive of, but atypical for erythema migrans, or
   b) Suspected Lyme neuroborreliosis involving either the peripheral or central nervous system, or
   c) Suspected Lyme arthritis, or
   d) Acute myocarditis/pericarditis.

Lyme disease serum antibody testing is considered investigational for all other indications, including:

- Asymptomatic patients following tick bite
- Erythema migrans
- Typical amyotrophic lateral sclerosis
- Relapsing-remitting multiple sclerosis
- Parkinson's disease
- Dementia/cognitive decline
- New-onset seizures
- Nonspecific magnetic resonance imaging (MRI) white matter abnormalities confined to the brain
- Psychiatric illness
- Children presenting with developmental or behavioral disorders
- Chronic cardiomyopathy of unknown cause

C. Other Non-covered Lyme Disease Tests

The use of the following specific Lyme disease tests are considered investigational:

1. Lymphocyte transformation tests
2. Lyme Borrelia Nanotrap Urine Antigen Test
3. Lyme ImmunoBlots IgG
4. Lyme ImmunoBlot IgM

D. Zika Virus Antibody Tests

I. Select Health considers Zika virus antibody tests to be medically necessary when the following criteria are met (I or II):

1. The member is pregnant, and
2. Prenatal ultrasound findings are consistent with congenital Zika virus infection (e.g., microcephaly, ventriculomegaly, or abnormalities of the corpus callosum), and

3. Had a plausible exposure to Zika virus (e.g., traveled to or lives in an area with transmission or had sexual relations with someone who traveled to or lives in an area with transmission).

OR

II. The member is 12 months of age or younger, and

1. The member's mother had laboratory evidence of Zika virus infection during pregnancy; or

2. Has symptoms of congenital Zika virus infection; and

a) The member's biological mother had a plausible exposure to Zika virus.

Zika virus antibody tests are considered investigational for all other indications, including:

- Symptomatic* or asymptomatic pregnant members
- Symptomatic*, non-pregnant members.

*Personal symptoms of Zika virus infection such as fever and conjunctivitis.

E. Zika Virus Nucleic Acid/PCR Tests

Select Health considers Zika virus nucleic acid/PCR tests to be medically necessary when the following criteria are met (1 or 2):

1. The member is pregnant, and

a) Had a plausible exposure to Zika virus (e.g., traveled to or lives in an area with) transmission or sexual relations with someone who traveled to or lives in an area with transmission

OR

2. The member is 12 months of age or younger, and

a) The member's biological mother had laboratory evidence of Zika virus infection during pregnancy, or
b) Has symptoms of congenital Zika virus infection, and
i. The member's biological mother had a plausible exposure to Zika virus (regardless of mother's Zika virus test results)

Zika virus nucleic acid/PCR tests are considered investigational for all other indications, including:

- Symptomatic, non-pregnant members
- Routine pre-conception or prenatal screening.

SELECT HEALTH MEDICARE (CMS)

Coverage is determined by the Centers for Medicare and Medicaid Services (CMS); if a coverage determination has not been adopted by CMS, and InterQual criteria are not available, the Select Health Commercial policy applies. For the most up-to-date Medicare policies and coverage, please visit their search website http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx?from2=search1.asp& or the manual website

SELECT HEALTH COMMUNITY CARE (MEDICAID)

Select Health Community Care policies typically align with State of Utah Medicaid policy, including use of InterQual. There may be situations where NCD/LCD criteria or Select Health commercial policies are used. For the most up-to-date Medicaid policies and coverage, please visit their website http://health.utah.gov/medicaid/manuals/directory.php or the Utah Medicaid code Look-Up tool

Billing/Coding Information

CPT CODES

0152U Infectious disease (bacteria, fungi, parasites, and DNA viruses), DNA, PCR and next-generation sequencing, plasma, detection of >1,000 potential microbial organisms for significant positive pathogens

0323U DNA and mRNA next-generation sequencing analysis in cerebrospinal fluid specimen for detection of organisms causing disease in central nervous system

0480U Infectious disease (bacteria, viruses, fungi, and parasites), cerebrospinal fluid (CSF), metagenomic next-generation sequencing (DNA and RNA), bioinformatic analysis, with positive pathogen identification

0531U Infectious disease (acid-fast bacteria and invasive fungi), DNA (673 organisms), next generation sequencing, plasma

86644 Antibody; cytomegalovirus (CMV)

86645 Antibody; cytomegalovirus (CMV), IgM

87495 Infectious agent detection by nucleic acid (DNA or RNA); Clostridium difficile, toxin gene(s), amplified probe technique

87496 Infectious agent detection by nucleic acid (DNA or RNA); cytomegalovirus, amplified probe technique

Key References

1. Miller, J.M., Binnicker, M.J., Campbell, S., Carroll, K.C., Chapin, K.C., Gonzalez, M.D. … Yao, J.D. Guide to Utilization of the Microbiology Laboratory for Diagnosis of Infectious Diseases: 2024 Update by the Infectious Diseases Society of America (IDSA) and the American Society for Microbiology (ASM). *Clin Infect Dis*. 2024 Mar 5: ciae104. doi: 10.1093/cid/ciae104. Epub ahead of print. PMID: 38442248.
2. Shadick, N., Maher, N., & Hoak, D. Tickborne Diseases of the United States: A Reference Manual for Healthcare Providers Sixth Edition. United States Centers for Disease Control and Prevention (2022).

Disclaimer

This document is for informational purposes only and should not be relied on in the diagnosis and care of individual patients. Medical and Coding/Reimbursement policies do not constitute medical advice, plan preauthorization, certification, an explanation of benefits, or a contract. Members should consult with appropriate healthcare providers to obtain needed medical advice, care, and treatment. Benefits and eligibility are determined before medical guidelines and payment guidelines are applied. Benefits are determined by the member's individual benefit plan that is in effect at the time services are rendered.

The codes for treatments and procedures applicable to this policy are included for informational purposes. Inclusion or exclusion of a procedure, diagnosis or device code(s) does not constitute or imply member coverage or provider reimbursement policy. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

Select Health® makes no representations and accepts no liability with respect to the content of any external information cited or relied upon in this policy. Select Health updates its Coverage Policies regularly, and reserves the right to amend these policies without notice to healthcare providers or Select Health members.

Select Health

Infectious Disease Testing: Vector-Borne, Continued

refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

Select Health® makes no representations and accepts no liability with respect to the content of any external information cited or relied upon in this policy. Select Health updates its Coverage Policies regularly, and reserves the right to amend these policies without notice to healthcare providers or Select Health members.

Members may contact Customer Service at the phone number listed on their member identification card to discuss their benefits more specifically. Providers with questions about this Coverage Policy may call Select Health Provider Relations at **801-442-3692**.

Select Health

Select Health

MEDICAL POLICY

SPECIALTY TESTING: ENDOCRINOLOGY

Policy # SH/LAB−A7
Implementation Date: 11/1/25
Review Dates:
Revision Dates:

Disclaimer:
1. Policies are subject to change without notice.
2. Policies outline coverage determinations for Select Health Commercial, Select Health Medicare (CMS), and Select Health Community Care (Medicaid) plans. Refer to the "Policy" section for more information.

Description
Specialty tests used to diagnose endocrinology conditions are tailored to the suspected disorder and the hormonal axis involved. Key specialty tests include basal hormone measurements, dynamic stimulation or suppression tests, and advanced biochemical assays. For pituitary disorders, measurement of serum prolactin, insulin-like growth factor 1 (IGF-1), and dynamic tests such as the oral glucose tolerance test for growth hormone excess, and dexamethasone suppression or 24-hour urinary free cortisol for Cushing's disease are standard. The Endocrine Society recommends specific protocols for adrenal insufficiency, such as the standard-dose (250 µg) intravenous corticotropin (ACTH) stimulation test, and for hypopituitarism, the use of sensitive and specific hormone assays, including liquid chromatography-mass spectrometry for steroid hormones to reduce assay interference.

For thyroid disorders, thyroid-stimulating hormone (TSH), free thyroxine (fT4), and, when indicated, thyroid autoantibodies are measured. In cases of suspected genetic endocrine syndromes, next-generation sequencing panels are increasingly used to identify pathogenic variants. The American Association of Clinical Endocrinologists emphasizes the importance of precise androgen measurements including total and free testosterone.

COMMERCIAL PLAN POLICY AND CHIP (CHILDREN'S HEALTH INSURANCE PROGRAM)

Application of coverage criteria is dependent upon an individual's benefit coverage at the time of the request.

A. Anti Mullerian Hormone (AMH) Tests

Select Health considers Anti mullerian hormone (AMH) testing to be medically necessary when one of the following criteria is met:

1. The member is being evaluated for ovarian stimulation/in vitro fertilization (IVF), or
2. The member has signs of a disorder of sexual development (e.g., ambiguous genitalia, cryptorchidism, hypospadias), or
3. The member is an adult* being evaluated for polycystic ovary syndrome (PCOS), and
   a) AMH is being used as an alternative to ultrasound to confirm polycystic ovary morphology (PCOM).

Anti mullerian hormone (AMH) testing is considered investigational for all other indications.

*AMH testing is not recommended for evaluation of adolescents for PCOS due to poor specificity.

B. Estradiol Tests

Select Health may consider estradiol testing to be considered medically necessary when one of the following criteria is met:

1. The member has irregular menstruation prior to 40 years of age, or
2. Testing is required to make a definitive clinical diagnosis of menopause due to inadequate menstrual history or hysterectomy without bilateral oophorectomy, or
3. The member is being monitored during estrogen therapy and/or anti-androgen/androgen deprivation therapy, or
4. The member is being monitored for endocrine therapy due to a history of premenopausal hormone receptor positive breast cancer (i.e., ovarian function suppression), or
5. The member has gynecomastia that cannot be attributed to hepatic, renal or thyroid dysfunction, or
6. The member has female factor infertility, and
   a) Irregular menstruation (oligomenorrhea or amenorrhea) and/or anovulation; or
7. The member is female, and
   a) Has signs of hypogonadism, delayed puberty, and/or primary amenorrhea, or
   b) Has signs of precocious puberty (e.g., premature thelarche/breast development).

Estradiol testing is considered investigational for all other indications.

C. Follicle Stimulating Hormone (FSH) Tests

Select Health considers follicle stimulating hormone (FSH) testing to be medically necessary when one of the following criteria is met:

1. Testing is required to make a definitive clinical diagnosis of menopause due to inadequate menstrual history or hysterectomy without bilateral oophorectomy, or
2. The member is being monitored during endocrine therapy for a history of premenopausal hormone receptor positive breast cancer (i.e., ovarian function suppression), or
3. The member is being monitored during treatment with a gonadotropin-releasing hormone (GnRH) agonist, or
4. The member has gynecomastia that is not explained by hepatic, renal or thyroid dysfunction, or
5. The member has one or more of the following:
   a) Signs/symptoms of polycystic ovarian syndrome (PCOS) (irregular menstrual cycles, clinical or biochemical hyperandrogenism), or
   b) Irregular menstruation prior to 40 years of age, or
   c) Male hypogonadism; or
6. The member has male factor infertility, and
   a) Sexual/erectile dysfunction, or
   b) Oligo/azoospermia, or

c) Atrophic testes

OR

7. Evidence of hormonal abnormality upon exam (e.g., gynecomastia, abnormally sized testes)

OR

8. The member has female factor infertility, and

   a) Irregular menstruation (oligomenorrhea or amenorrhea) and/or anovulation.

Follicle stimulating hormone (FSH) testing is considered investigational for all other indications.

D. Free Triiodothyronine (T3) Tests

Select Health considers Free triiodothyronine (T3) testing to be medically necessary when the following criteria are met:

1. The member is receiving combined T3/T4 (liothyronine/levothyroxine) therapy, and
2. The member has a low or suppressed TSH level suggestive of possible over-replacement.

Free triiodothyronine (T3) testing is considered investigational for all other indications, including but not limited to screening of asymptomatic adults without increased risk factors for thyroid dysfunction.

E. Free Thyroxine (T4) Tests or Total Thyroxine (T4) Tests or Free Thyroxine Index (Total T4 and T3 Uptake)

Select Health considers Free Thyroxine (T4) Tests or Total Thyroxine (T4) Tests or Free Thyroxine Index (Total T4 and T3 Uptake) testing to be medically necessary when one of the following criteria is met:

1. The member has an abnormal TSH result**, or
2. The member has signs or symptoms of thyroid dysfunction, or
3. The member is being monitored during treatment for thyroid dysfunction.

Measurement of T3 uptake is considered investigational when performed without total T4.

Free thyroxine index (total T4 and T3 uptake) is considered investigational when performed simultaneously with free T4.

Free Thyroxine (T4) Tests OR Total Thyroxine (T4) Tests OR Free Thyroxine Index (Total T4 and T3 Uptake) testing is considered investigational for all other indications, including but not limited to, screening of members without increased risk factors for thyroid dysfunction.

**This includes free T4 testing performed as an automatic reflex from initial TSH testing; this approach is considered appropriate for initial thyroid dysfunction testing.

F. Luteinizing Hormone (LH) Tests

Select Health considers Luteinizing hormone (LH) testing to be medically necessary when one of the following criteria is met:

1. The member has hypogonadism, or

2. The member has gynecomastia that is not explained by hepatic, renal or thyroid dysfunction, or

3. The member has signs of precocious puberty (e.g., premature thelarche/breast development or premature testicular and penile enlargement), or

4. The member is being monitored during endocrine therapy for a history of premenopausal hormone receptor positive breast cancer (i.e., ovarian function suppression), or

5. The member is being monitored during treatment with a gonadotropin-releasing hormone (GnRH) agonist.

Luteinizing hormone (LH) testing is considered investigational for all other indications.

G. Monogenic Diabetes (Including Maturity Onset Diabetes of the Young (MODY)) Panels

Select Health considers multigene panel analysis to establish or confirm a diagnosis of monogenic diabetes (including maturity-onset diabetes of the young (MODY)) to be medically necessary when the following criteria are met:

1. The member has a diagnosis of diabetes within the first 12 months of life, or
2. The member has a diagnosis of diabetes before 30 years of age, and the member has at least one of the following:

   i. Autoantibody negative, or

   ii. Retained C-peptide levels, or

   iii. The member has a diagnosis of diabetes not characteristic of type 1 or type 2 diabetes and the member has a family history of diabetes consistent with an autosomal dominant pattern of inheritance.

Multigene panel analysis to establish or confirm a diagnosis of monogenic diabetes (maturity-onset diabetes of the young (MODY)) is considered investigational for all other indications.

H. Progesterone Tests

Select Health considers progesterone testing to be medically necessary when <u>one</u> of the following criteria is met:

1. The member has first-trimester bleeding, and
   a) Ultrasound-confirmed intrauterine pregnancy, and
   b) Inconclusive pregnancy viability; or
2. The member is being evaluated for embryo transfer; or
3. The member has regular menstruation, and
   a) Clinical signs of hyperandrogenism (e.g., hirsutism, severe acne, and female pattern hair loss), or
   b) Female factor infertility

Progesterone testing is considered investigational for all other indications.

I. Prolactin Tests

Select Health considers Prolactin testing to be medically necessary when one of the following criteria is met:

1. The member has one or more of the following:
   a) Signs/symptoms of polycystic ovarian syndrome (PCOS) (e.g., irregular menstrual cycles, clinical or biochemical hyperandrogenism), or
   b) Hypogonadism, or
   c) Gynecomastia that is not explained by hepatic, renal or thyroid dysfunction, or
   d) Galactorrhea, or
   e) Low bone mass, or
   f) Signs/symptoms of a pituitary mass (e.g., double vision and/or decreased peripheral vision, or frequent, severe, and prolonged headaches); or
2. The member has female factor infertility, and
   a) Irregular menstruation (oligomenorrhea or amenorrhea) and/or anovulation; or
3. The member is being evaluated for or monitored during treatment of a prolactinoma/hyperprolactinemia or for hypopituitarism; or
4. The member is being monitored during estrogen therapy and/or anti-androgen/androgen deprivation therapy.

Prolactin testing is considered investigational for all other indications.

J. Reverse Triiodothyronine (T3) Tests

Reverse triiodothyronine (T3) testing is considered investigational for all indications including but not limited to screening of asymptomatic adults without increased risk factors for thyroid dysfunction.

K. Testosterone Tests

I. Select Health considers testosterone testing (total and/or free/bioavailable measurements) to be medically necessary when one of the following criteria is met:

1. The member is being monitored during testosterone therapy, anti-androgen/androgen deprivation therapy, or treatment with a gonadotropin-releasing hormone (GnRH) agonist; or
2. The member has irregular menstrual cycles; or
3. The member has clinical signs of hyperandrogenism (e.g., hirsutism, severe acne, and female pattern hair loss); or
4. The member is male and has one or more of the following:
   a) Sexual/erectile dysfunction, or
   b) Infertility due to oligo- or azoospermia, or

c) Signs of hypogonadism (e.g., ambiguous genitalia, small testes/phallus, lack of development of/loss of secondary sex characteristics, decreased muscle mass, gynecomastia, decreased facial/body hair); or

d) Personal history of a condition associated with increased risk for testosterone deficiency; or

e) Signs of precocious puberty (e.g., premature testicular and penile enlargement); or

f) Signs of delayed puberty (e.g., lack of expected development of secondary sex characteristics).

II. Measuring both total and free testosterone simultaneously may be considered medically necessary for evaluation of members with irregular menstrual cycles and/or hyperandrogenism for PCOS, or for male members with signs/symptoms of hypogonadism and a factor known to alter sex hormone binding globulin (SHBG) levels. Measuring both total and free testosterone simultaneously is considered investigational for all other indications.

Testosterone testing is considered investigational for all other indications, including for routine evaluation of age-related low-testosterone in adult men.

L. Thyroid Stimulating Hormone (TSH) Tests

Select Health considers thyroid stimulating hormone (TSH) testing to be medically necessary when one of the following criteria is met:

1. The member has signs or symptoms of thyroid dysfunction, or
2. The member has one or more increased risk factors associated with thyroid dysfunction, or
3. The member is being monitored during treatment for thyroid dysfunction, or
4. The member is being monitored during treatment of thyroid carcinoma including post thyroidectomy, radiation, and suppression.

Thyroid stimulating hormone (TSH) testing is considered investigational for all other indications, including but not limited, to screening of asymptomatic adults without increased risk factors for thyroid dysfunction.

M. Total Triiodothyronine (T3) Tests

Select Health considers Total triiodothyronine (T3) testing to be medically necessary when one of the following criteria is met:

1. The member has an abnormal TSH result[#], or
2. The member has signs or symptoms of hyperthyroidism, or
3. The member is being monitored during treatment for hyperthyroidism.

Total triiodothyronine (T3) testing is considered investigational for all other indications, including but not limited to screening of asymptomatic adults without increased risk factors for thyroid dysfunction.

[#]This includes total T3 testing performed as an automatic reflex from initial TSH testing; this approach is considered appropriate for initial thyroid dysfunction testing.

Specialty Testing: Endocrinology Continued

SELECT HEALTH MEDICARE (CMS)

Coverage is determined by the Centers for Medicare and Medicaid Services (CMS); if a coverage determination has not been adopted by CMS, and InterQual criteria are not available, the Select Health Commercial policy applies. For the most up-to-date Medicare policies and coverage, please visit their search website http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx?from2=search1.asp& or the manual website

SELECT HEALTH COMMUNITY CARE (MEDICAID)

Select Health Community Care policies typically align with State of Utah Medicaid policy, including use of InterQual. There may be situations where NCD/LCD criteria or Select Health commercial policies are used. For the most up-to-date Medicaid policies and coverage, please visit their website http://health.utah.gov/medicaid/manuals/directory.php or the Utah Medicaid code Look-Up tool

Billing/Coding Information

CPT CODES

81245 FLT3 (fms-related tyrosine kinase 3) (eg, acute myeloid leukemia), gene analysis; internal tandem duplication (ITD) variants (ie, exons 14, 15)

82040 Albumin; serum, plasma or whole blood

82166 Anti-mullerian hormone (AMH)

82397 Chemiluminescent assay

82670 Estradiol; total

82681 Estradiol; free, direct measurement (eg, equilibrium dialysis)

83001 Gonadotropin; follicle stimulating hormone (FSH)

83002 Gonadotropin; luteinizing hormone (LH)

83498 Hydroxyprogesterone, 17-d

83519 Immunoassay for analyte other than infectious agent antibody or infectious agent antigen; quantitative, by radioimmunoassay (eg, RIA)

83520 Immunoassay for analyte other than infectious agent antibody or infectious agent antigen; quantitative, not otherwise specified

84144 Progesterone

84146 Prolactin

84270 Sex hormone binding globulin (SHBG)

84402 Testosterone; free

84403 Testosterone; total

84410 Testosterone; bioavailable, direct measurement (eg, differential precipitation)

84436 Thyroxine; total

84437 Thyroxine; requiring elution (eg, neonatal)

84439 Thyroxine; free

84443 Thyroid stimulating hormone (TSH)

84445 Thyroid stimulating immune globulins (TSI)

84479 Thyroid hormone (T3 or T4) uptake or thyroid hormone binding ratio (THBR)

84480 Triiodothyronine T3; total (TT-3)

84481 Triiodothyronine T3; free

84482 Triiodothyronine T3; reverse

86352 Cellular function assay involving stimulation (eg, mitogen or antigen) and detection of biomarker (eg, ATP)

86359 T cells; total count

86360 T cells; absolute CD4 and CD8 count, including ratio

86376 Microsomal antibodies (eg, thyroid or liver-kidney), each

86800 Thyroglobulin antibody

84999 Unlisted chemistry procedure

88341 Immunohistochemistry or immunocytochemistry, per specimen; each additional single antibody stain procedure (List separately in addition to code for primary procedure)

88342 Immunohistochemistry or immunocytochemistry, per specimen; each multiplex antibody stain procedure

88360 Morphometric analysis, tumor immunohistochemistry (eg, Her-2/neu, estrogen receptor/progesterone receptor), quantitative or semiquantitative, per specimen, each single antibody stain procedure; manual

Key References

1. Bornstein, S.R., Allolio, B., Arlt, W., Barthel, A., Don-Wauchope, A., Hammer, G.D. … Torpy, D.J. Diagnosis and Treatment of Primary Adrenal Insufficiency: An Endocrine Society Clinical Practice Guideline. *J Clin Endocrinol Metab*. 2016 Feb;101(2):364-89. doi: 10.1210/jc.2015-1710. Epub 2016 Jan 13. PMID: 26760044; PMCID: PMC4880116.
2. Fleseriu, M., Hashim, I.A., Karavitaki, N., Melmed, S., Murad, M.H., Salvatori, R., & Samuels, M.H. Hormonal Replacement in Hypopituitarism in Adults: An Endocrine Society Clinical Practice Guideline. *J Clin Endocrinol Metab*. 2016 Nov;101(11):3888-3921. doi: 10.1210/jc.2016-2118. Epub 2016 Oct 13. PMID: 27736313.

Disclaimer

This document is for informational purposes only and should not be relied on in the diagnosis and care of individual patients. Medical and Coding/Reimbursement policies do not constitute medical advice, plan preauthorization, certification, an explanation of benefits, or a contract. Members should consult with appropriate healthcare providers to obtain needed medical advice, care, and treatment. Benefits and eligibility are determined before medical guidelines and payment guidelines are applied. Benefits are determined by the member's individual benefit plan that is in effect at the time services are rendered.

The codes for treatments and procedures applicable to this policy are included for informational purposes. Inclusion or exclusion of a procedure, diagnosis or device code(s) does not constitute or imply member coverage or provider reimbursement policy. Please

Specialty Testing: Endocrinology Continued

refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

Select Health® makes no representations and accepts no liability with respect to the content of any external information cited or relied upon in this policy. Select Health updates its Coverage Policies regularly, and reserves the right to amend these policies without notice to healthcare providers or Select Health members.

Members may contact Customer Service at the phone number listed on their member identification card to discuss their benefits more specifically. Providers with questions about this Coverage Policy may call Select Health Provider Relations at **801-442-3692**.

Select Health

Select Health

MEDICAL POLICY

SPECIALTY TESTING: NUTRITION AND METABOLISM

Policy # SH/LAB−A8
Implementation Date: 11/1/25
Review Dates:
Revision Dates:

Disclaimer:
1. Policies are subject to change without notice.
2. Policies outline coverage determinations for Select Health Commercial, Select Health Medicare (CMS), and Select Health Community Care (Medicaid) plans. Refer to the "Policy" section for more information.

Description

Specialty testing for nutrition and metabolism encompasses a range of laboratory, imaging, and functional assessments. The Academy of Nutrition and Dietetics and the American Society for Parenteral and Enteral Nutrition recommend a comprehensive approach that includes biochemical profiles (acid-base balance, renal function, endocrine markers, inflammatory markers, vitamin/mineral levels, lipid profile), anthropometric measurements, and advanced body composition analysis (e.g., DEXA, CT, MRI, ultrasound, bioelectrical impedance, densitometry).

Routine laboratory tests include vitamin D, ferritin, complete blood count, comprehensive metabolic panel, thyroid function, urinalysis, and micronutrient panels. Additional specialty tests may be indicated for suspected malabsorption, food intolerance/allergy, or metabolic disorders, such as gluten intolerance panels, indirect calorimetry for resting metabolic rate, bone mineral density (DEXA), and malabsorption studies.

COMMERCIAL PLAN POLICY AND CHIP (CHILDREN'S HEALTH INSURANCE PROGRAM)

Application of coverage criteria is dependent upon an individual's benefit coverage at the time of the request.

A. Serum 1,25-dihydroxyvitamin D (1,25(OH)2D) Tests

Select Health considers 1,25(OH)2D tests to be medically necessary a maximum of twice per year when the following criteria are met:

1. The member has one or more of the following:

a) Chronic kidney disease, or

b) Hypercalcemia, or

c) Hereditary phosphate-losing disorders, or

d) Oncogenic osteomalacia, or

e) Vitamin D-resistant or pseudovitamin D-deficiency rickets, or

f) A granuloma-forming disorder (e.g., sarcoidosis, tuberculosis, histoplasmosis, Coccidiomycosis, Berylliosis, some lymphomas).

1,25(OH)2D tests are considered investigational for all other indications, Including for the evaluation of vitamin D status.

B. Serum 25-hydroxyvitamin D (25(OH)D) Tests

Select Health considers 25(OH)D tests to be medically necessary a maximum of three times per year when one of the following criteria is met:

1. The member is being monitored during treatment for vitamin D deficiency or insufficiency (serum 25(OH)D levels less than 30 ng/ml), or
2. The member is being monitored during treatment for hypervitaminosis D, or
3. The member has at least one of the following risk factors for vitamin D deficiency:
   a) Chronic kidney disease, or
   b) Liver disease/liver failure, or
   c) Malabsorption syndrome (e.g., Cystic Fibrosis, inflammatory bowel disease, bariatric surgery, radiation enteritis), or
   d) Use of anti-epileptic drugs, glucocorticoids, AIDS/anti-HIV medications, antifungals, or cholestyramine, or
   e) Granuloma-forming disorder (e.g., sarcoidosis, tuberculosis, histoplasmosis, Coccidiomycosis, Berylliosis, some lymphomas); or
4. The member has at least one of the following signs or symptoms of vitamin D deficiency or excess:
   a) Abnormal calcium levels, or
   b) Low serum phosphate levels, or
   c) Elevated parathyroid hormone levels/hyperparathyroidism, or
   d) Decreased bone mineral density (osteopenia, osteoporosis), or
   e) Non-traumatic fracture(s), or
   f) Bone pain, or
   g) Muscle aches and/or proximal muscle weakness

25(OH)D tests are considered investigational for all other indications.

C. Serum Iron (Ferritin, Iron, Iron Binding Capacity, and/or Transferrin Saturation) Tests

I. Select Health considers serum iron tests to be medically necessary a maximum of four times per year when one of the following criteria is met:

1. The member has one or more of the following clinical signs or symptoms of iron deficiency:
   a) Abnormal blood counts suggestive of iron deficiency (e.g., decreased MCV), or
   b) Acute or chronic blood loss (e.g., gastrointestinal or heavy menstrual bleeding, hematuria, frequent blood donation), or
   c) Integumentary abnormalities (pallor/sallow skin coloring, brittle nails, and/or hair loss), or
   d) Unexplained fatigue and/or generalized weakness, or
   e) Pica (abnormal craving to eat non-food materials such as ice or soil), or
   f) Restless leg syndrome, or

Select Health

g) Exertional dyspnea/exercise intolerance (shortness of breath/chest pain with activity), or

h) Tachycardia (rapid heart rate)

OR

2. The member has one of more of the following clinical signs or symptoms of iron overload:

a) Abnormal liver function studies (e.g., elevated liver enzymes), or

b) Liver disease (hepatitis, fibrosis, or cirrhosis), or

c) Hepatocellular carcinoma, or

d) Heart disease (cardiomyopathy, cardiac arrhythmia, or heart failure), or

e) Hypogonadotropic hypogonadism, or

f) Hypopituitarism, or

g) Hypermelanotic pigmentation (bronze skin), or

h) Hyperglycemia, or

i) Diabetes mellitus, or

j) Arthropathy (joint pain, swelling, or chondrocalcinosis)

OR

3. The member has one or more of the following risk factors for iron deficiency or iron overload:

a) Hereditary Hemochromatosis, or

b) Hereditary Hemochromatosis in one or more first-degree relatives, or

c) Hereditary iron deficiency conditions, such as IRIDA (iron-refractory iron deficiency anemia), or

d) Chronic kidney disease, or

e) Chronic liver disease, or

f) Porphyria treatment via hemin therapy, or

g) Reduced iron absorption (e.g., celiac disease, autoimmune gastritis or H. pylori infection, bariatric surgery), or

h) Red blood cell transfusions for chronic anemias (e.g., sickle cell disease, aplastic anemia, myelodysplastic syndrome), or

i) Suspected exposure to excess iron (e.g., occupational, supplement overuse);

OR

4. The member is between 0 and 3 years of age and has risk factors for iron deficiency (e.g., lead exposure, low socioeconomic status, special healthcare needs, prematurity or low birth weight, inadequate iron intake according to dietary history).

II. Select Health considers serum iron tests to be medically necessary once for universal screening for iron deficiency when the following criteria are met:

1. The member is between 8 and 18 years of age, and

2. Has been menstruating for at least one year.

Iron binding capacity testing is considered investigational when performed simultaneously with transferrin testing.

Serum iron testing is considered investigational for all other indications.

D. Serum Vitamin B12 and/or Folate Tests

Select Health considers vitamin B12 and/or folate tests to be medically necessary a maximum of three times per year when one of the following criteria is met:

1. The member is being monitored during treatment for vitamin B12/folate deficiency

OR

2. The member has one or more of the following risk factors for vitamin B12 or folate deficiency:

a) Undernutrition, or

b) Malabsorption (e.g., due to inflammatory bowel disease, gastrectomy, gastric bypass, intestinal resection, pancreatic insufficiency, autoimmune/autoinflammatory diseases, tapeworm infection, pernicious anemia, atrophic gastritis), or

c) Excessive alcohol consumption/alcohol use disorder, or

d) Age of 75 years or older, or

e) Vegan or vegetarian diet, or

f) Use of histamine H2 blockers and/or proton pump inhibitor drugs for at least 1 year, or

g) Use of metformin for at least 4 months, or

h) Genetic disorder affecting vitamin B12 or folate absorption/metabolism (e.g., transcobalamin II deficiency, certain SLC46A1 genetic variants, intrinsic factor deficiency)

OR

3. The member has one or more of the following signs or symptoms of vitamin B12 or folate deficiency:

a) Abnormal blood counts (anemia, leukopenia, pancytopenia, thrombocytopenia, thrombocytosis), or

b) Myalgic encephalomyelitis (chronic fatigue syndrome), or

c) Skin findings of pallor, hyperpigmentation, jaundice, or vitiligo, or

d) Neurological abnormalities (areflexia, gait abnormalities, peripheral neuropathy, loss of proprioception/vibratory sense, olfactory impairment), or

e) Dementia (Alzheimer's or non-Alzheimer's) or dementia-like symptoms, or

f) Glossitis

The use of vitamin B12 and/or folate tests is considered investigational for all other indications.

E. Serum/Plasma Homocysteine Tests

Select Health considers serum/plasma homocysteine testing is considered medically necessary when one of the following criteria is met:

1. The member is being monitored during treatment for homocystinuria, or
2. The member has a biological sibling with homocystinuria, or
3. The member meets both of the following (a and b):

a) One of the following:

i. High myopia, or

ii. Ectopia lentis, or

iii. Thromboembolism, or

iv. Skeletal abnormalities (e.g., Marfanoid features, genu valgum/knock knees, osteoporosis), or

v. Intellectual disability or developmental delay, or

vi. Extrapyramidal signs (e.g., increased motor tone, dystonia), or

vii. A psychiatric disorder, or

vii. Seizures; and

b) It has been at least one year since the member's last test.

The use of serum/plasma homocysteine tests are considered investigational for all other indications, including for confirmation of borderline vitamin B12 or folate deficiency.

SELECT HEALTH MEDICARE (CMS)

Coverage is determined by the Centers for Medicare and Medicaid Services (CMS); if a coverage determination has not been adopted by CMS, and InterQual criteria are not available, the Select Health Commercial policy applies. For the most up-to-date Medicare policies and coverage, please visit their search website http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx?from2=search1.asp& or the manual website

SELECT HEALTH COMMUNITY CARE (MEDICAID)

Select Health Community Care policies typically align with State of Utah Medicaid policy, including use of InterQual. There may be situations where NCD/LCD criteria or Select Health commercial policies are used. For the most up-to-date Medicaid policies and coverage, please visit their website http://health.utah.gov/medicaid/manuals/directory.php or the Utah Medicaid code Look-Up tool

Billing/Coding Information

CPT CODES

82131 Amino acids; single, quantitative, each specimen

82306 Vitamin D; 25 hydroxy, includes fraction(s), if performed

82373 Carbohydrate deficient transferrin

82607 Cyanocobalamin (Vitamin B-12);

Select Health

Specialty Testing: Nutrition and Metabolism, Continued

82652 Vitamin D; 1, 25 dihydroxy, includes fraction(s), if performed

82728 Ferritin

82746 Folic acid; serum

82747 Folic acid; RBC

83090 Homocysteine

83540 Iron

83550 Iron binding capacity

83883 Nephelometry, each analyte not elsewhere specified

84238 Receptor assay; non-endocrine (specify receptor)

84466 Transferrin

86335 Immunofixation electrophoresis; other fluids with concentration (eg, urine, CSF)

Key References

1. Corrigan, M.L., Bobo, E., Rollins, C., & Mogensen, K.M. Academy of Nutrition and Dietetics and American Society for Parenteral and Enteral Nutrition: Revised 2021 Standards of Practice and Standards of Professional Performance for Registered Dietitian Nutritionists (Competent, Proficient, and Expert) in Nutrition Support. *J Acad Nutr Diet*. 2021 Oct;121(10):2071-2086.e59. doi: 10.1016/j.jand.2021.05.026. PMID: 34556313.
2. Daigle, K., Subach, R., & Valliant, M. Academy of Nutrition and Dietetics: Revised 2021 Standards of Practice and Standards of Professional Performance for Registered Dietitian Nutritionists (Competent, Proficient, and Expert) in Sports and Human Performance Nutrition. *J Acad Nutr Diet*. 2021 Sep;121(9):1813-1830.e55. doi: 10.1016/j.jand.2021.04.018. Epub 2021 Jun 26. PMID: 34183294.

Disclaimer

This document is for informational purposes only and should not be relied on in the diagnosis and care of individual patients. Medical and Coding/Reimbursement policies do not constitute medical advice, plan preauthorization, certification, an explanation of benefits, or a contract. Members should consult with appropriate healthcare providers to obtain needed medical advice, care, and treatment. Benefits and eligibility are determined before medical guidelines and payment guidelines are applied. Benefits are determined by the member's individual benefit plan that is in effect at the time services are rendered.

The codes for treatments and procedures applicable to this policy are included for informational purposes. Inclusion or exclusion of a procedure, diagnosis or device code(s) does not constitute or imply member coverage or provider reimbursement policy. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

Select Health® makes no representations and accepts no liability with respect to the content of any external information cited or relied upon in this policy. Select Health updates its Coverage Policies regularly, and reserves the right to amend these policies without notice to healthcare providers or Select Health members.

Members may contact Customer Service at the phone number listed on their member identification card to discuss their benefits more specifically. Providers with questions about this Coverage Policy may call Select Health Provider Relations at **801-442-3692**.

Select Health

Select Health

MEDICAL POLICY

SPECIALTY TESTING: TOXICOLOGY

Policy # SH/LAB−A9
Implementation Date: 11/1/25
Review Dates:
Revision Dates:

Disclaimer:
1. Policies are subject to change without notice.
2. Policies outline coverage determinations for Select Health Commercial, Select Health Medicare (CMS), and Select Health Community Care (Medicaid) plans. Refer to the "Policy" section for more information.

Description

Specialty testing for lead toxicity includes several laboratory assessments, with the primary and most widely accepted test being blood lead level (BLL) measurement. This can be performed on either capillary or venous blood, but confirmatory testing should always use venous samples due to the risk of contamination with capillary samples. The United States Preventive Services Task Force recommends blood lead testing as the standard for both screening and diagnosis of lead toxicity.

Specialty tests for metal toxicity include quantitative measurement of metals in biological specimens using advanced analytical techniques. The most widely used and validated methods are inductively coupled plasma mass spectrometry (ICP-MS) and atomic absorption spectrometry (AAS), including graphite furnace AAS (GFAAS) and electrothermal AAS. These methods allow for sensitive, multi-element detection in matrices such as whole blood, urine, plasma, hair, nails, and tissue biopsies

COMMERCIAL PLAN POLICY AND CHIP (CHILDREN'S HEALTH INSURANCE PROGRAM)

Application of coverage criteria is dependent upon an individual's benefit coverage at the time of the request.

A. Lead Toxicity Testing

Select Health considers lead toxicity testing (blood lead level) to be medically necessary when one of the following criteria is met:

1. The member has a known exposure to lead, or
2. The member is an immigrant, refugee, or adoptee from outside the United States, or
3. The member is being monitored for previously elevated blood lead levels, or
4. The member is 6 years of age or younger, and
   a) Is at increased risk for lead exposure (e.g., lives in or frequents a home built before 1978), or
   b) Has signs/symptoms of lead toxicity (e.g., impaired speech and/or hearing function, decreased memory and learning, lethargy, fatigue, abdominal discomfort, constipation, vomiting, weight loss), or
   c) Is a newborn at risk for lead poisoning due to elevated maternal blood lead levels during gestation

OR

5. The member is 7 years of age or older, and

   a) Is at increased risk for lead exposure (e.g., through inhalation of dust containing lead due to a hobby or professional activity or consumption via contaminated water source), and

   b) Has signs/symptoms of lead toxicity (e.g., impaired speech and/or hearing function, decreased memory and learning, lethargy, fatigue, abdominal discomfort, constipation, vomiting, weight loss)

   OR

6. The member is pregnant or lactating and is at increased risk for lead exposure (e.g., recent immigration to the United States, pica behavior, culturally specific indications, low-income family, potential for inhalation of dust containing lead due to a hobby or professional activity).

The use of urine lead toxicity testing is considered investigational for all indications.

The use of blood lead toxicity testing is considered investigational for all other indications.

B. Metal (Aluminum, Mercury, Arsenic, Cadmium, and Manganese) Toxicity Testing

Select Health considers metal toxicity testing (aluminum, mercury, arsenic, cadmium, and manganese) to be medically necessary when one of the following criteria is met:

1. The member is being monitored for previously abnormal levels of the metal(s) being evaluated,

   OR

2. The member has a known exposure to the metal(s) being evaluated,

   OR

3. The member has one of the following signs/symptoms (regardless of exposure history):

   a) Renal disease that is not explained by other factors, or

   b) Bilateral peripheral neuropathy that is not explained by other factors, or

   c) Acute changes in mental function that is not attributable to another established diagnosis, or

   d) Acute inflammation of the laryngeal or nasal epithelium that is not explained by other factors

   OR

4. The member has non-specific signs/symptoms (e.g., anemia, impaired speech and/or hearing function, lethargy, fatigue, abdominal discomfort, constipation, vomiting), and the member has a plausible exposure to the metal(s) being evaluated (e.g., through a hobby or professional activity, dialysis, or contaminated water or soil).

The use of metal toxicity testing is considered investigational for all other indications.

SELECT HEALTH MEDICARE (CMS)

Coverage is determined by the Centers for Medicare and Medicaid Services (CMS); if a coverage determination has not been adopted by CMS, and InterQual criteria are not available, the Select Health Commercial policy applies. For the most up-to-date Medicare policies and coverage, please visit their search website http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx?from2=search1.asp& or the manual website

SELECT HEALTH COMMUNITY CARE (MEDICAID)

Select Health Community Care policies typically align with State of Utah Medicaid policy, including use of InterQual. There may be situations where NCD/LCD criteria or Select Health commercial policies are used. For the most up-to-date Medicaid policies and coverage, please visit http://health.utah.gov/medicaid/manuals/directory.php or the Utah Medicaid code Look-Up tool.

Billing/Coding Information

CPT CODES

82108 Aluminum
82175 Arsenic
82300 Cadmium
83015 Heavy metal (eg, arsenic, barium, beryllium, bismuth, antimony, mercury); qualitative, any number of analytes
83018 Heavy metal (eg, arsenic, barium, beryllium, bismuth, antimony, mercury); quantitative, each, not elsewhere specified
83655 Lead
83785 Manganese
83825 Mercury, quantitative
83885 Nickel
84202 Protoporphyrin, RBC; quantitative

Key References

1. Barlow, N.L. & Bradberry, S.M. Investigation and monitoring of heavy metal poisoning. *J Clin Pathol*. 2023 Feb;76(2):82-97. doi: 10.1136/jcp-2021-207793. Epub 2022 Dec 12. PMID: 36600633.
2. US Preventive Services Task Force. Screening for Elevated Blood Lead Levels in Children and Pregnant Women: US Preventive Services Task Force Recommendation Statement. *JAMA*. 2019;321(15):1502–1509. doi:10.1001/jama.2019.3326

Disclaimer

This document is for informational purposes only and should not be relied on in the diagnosis and care of individual patients. Medical and Coding/Reimbursement policies do not constitute medical advice, plan preauthorization, certification, an explanation of benefits, or a contract. Members should consult with appropriate healthcare providers to obtain needed medical advice, care, and treatment. Benefits and eligibility are determined before medical guidelines and payment guidelines are applied. Benefits are determined by the member's individual benefit plan that is in effect at the time services are rendered.

The codes for treatments and procedures applicable to this policy are included for informational purposes. Inclusion or exclusion of a procedure, diagnosis or device code(s) does not constitute or imply member coverage or provider reimbursement policy. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

Select Health® makes no representations and accepts no liability with respect to the content of any external information cited or relied upon in this policy. Select Health updates its Coverage Policies regularly, and reserves the right to amend these policies without notice to healthcare providers or Select Health members.

Members may contact Customer Service at the phone number listed on their member identification card to discuss their benefits more specifically. Providers with questions about this Coverage Policy may call Select Health Provider Relations at **801-442-3692**.