MetroPlus Health

Policy and Procedure

Title: Unspecified Polymerase Chain Reaction Testing	**Division: Medical Management** **Department: Utilization Management**
Approval Date: 8/29/2022	**LOB: Medicaid, Medicare, HIV SNP, CHP, MetroPlus Gold, Goldcare I&II, Market Plus, Essential, HARP**
Effective Date: 8/29/2022	**Policy Number: UM-MP340**
Review Date: 12/17/2025	**Cross Reference Number:**
Retired Date:	**Page 1 of 4**

1. POLICY DESCRIPTION:

Nucleic Acid Amplification Tests (NAATs)/pathogen-specific PCR testing are performed in clinically appropriate settings, especially when culture is difficult. The available CPT codes for NAATs/PCR tests include specific organisms, panels of organisms based on diagnosis groups and non-specific codes.

As per NYS Laboratory Manual Policy Guidelines, "orders for laboratory tests must indicate the diagnosis, symptomatology, suspected condition or reason for the encounter, either by use of the appropriate ICD-10-CM code or a narrative description. Non-specific coding does not satisfy this requirement."

Panels and specific codes should be utilized. In the event a non-specific code is required, medical documentation will be necessary in confirming medical necessity. Expanded panels are defined as > 5 pathogens and typically apply only to GI, PNP and RP panels or for immune-compromised patients.

This policy describes MetroPlusHealth's coverage for unspecific code of 87798- INFECTIOUS AGENT DETECTION BY NUCLEIC ACID (DNA OR RNA), NOT OTHERWISE SPECIFIED; AMPLIFIED PROBE TECHNIQUE, EACH ORGANISM for urogenital/anogenital panels.

2. RESPONSIBLE PARTIES:

Medical Management Administration, Utilization Management, Integrated Care Management, Pharmacy, Claim Department, Providers Contracting.

3. DEFINITIONS:

4. POLICY:

87798 may be considered medically necessary:

1. There is no available code or panel to bill and the microbiology test is required for the submitted diagnosis
2. The submitted units are consistent with the organism and does not reflect unbundling of an existing panel

87798 is not covered when:

1. There is already a specific code for the requested test or panel
2. The test is not medically necessary for the condition

   a. The test is not consistent with accepted diagnostic protocols for the condition
3. The test is billed in combination with a specific CPT code for the same intended use
4. The test is billed on the same DOS for >2 units for the same intended use

5. LIMITATIONS/ EXCLUSIONS:

Non- Covered ICD-10 Codes (not all-inclusive)

CODE	Description
N39.0-N39.9	Urinary Tract Infection*
Z11.8	Encounter for screening for other infectious and parasitic diseases

* When clinically appropriate: Detection of adenovirus in cases of cystitis is usually done by NAAT. This testing is typically available at tertiary academic centers or reference laboratories. Polyoma BK virus nephropathy is best diagnosed by quantitative molecular determination of circulating virus in blood rather than detection of virus in urine. Such tests are usually performed in tertiary medical centers or reference laboratories. The ICD 10 N30-N30.9 should be billed in addition to the general UTI code.

6. APPLICABLE PROCEDURE CODES:

A unit limitation of 2 per DOS will be implemented as there are specific CPT codes for most organisms with ano/urogenital infections.

CPT	Description
87798	Infectious Agent detection by Nucleic Acid (DNA or RNA), Not Otherwise Specified; Amplified Probe Technique, Each Organism

7. APPLICABLE DIAGNOSIS CODES:

8. REFERENCES:

https://www.idsociety.org/practice-guideline/laboratory-diagnosis-of-infectious-diseases/

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REVISION LOG:

REVISIONS	DATE
Creation date	8/29/2022
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Annual Review	9/23/2024
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Date:

Approved:

David Ackman

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Sanjiv Shah MD

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Chief Medical Officer

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Medical Guideline Disclaimer:

 The treating physician or primary care provider must submit MetroPlus Health Plan clinical evidence that the patient meets the criteria for the treatment or surgical procedure. Without this documentation and information, Metroplus Health Plan will not be able to properly review the request for prior authorization. The clinical review criteria expressed in this policy reflects how MetroPlus Health Plan determines whether certain services or supplies are medically necessary. MetroPlus Health Plan established the clinical review criteria based upon a review of currently available clinical information(including clinical outcome studies in the peer-reviewed published medical literature, regulatory status of the technology, evidence-based guidelines of public health and health research agencies, evidence-based guidelines and positions of leading national health professional organizations, views of physicians practicing in relevant clinical areas, and other relevant factors). MetroPlus Health Plan expressly reserves the right to revise these conclusions as clinical information changes, and welcomes further relevant information. Each benefit program defines which services are covered. The conclusion that a particular service or supply is medically necessary does not constitute a representation or warranty that this service or supply is covered andor paid for by MetroPlus Health Plan, as some programs exclude coverage for services or supplies that MetroPlus Health Plan considers medically necessary. If there is a discrepancy between this guidelines and a member's benefits program, the benefits program will govern. In addition, coverage may be mandated by applicable legal requirements of a state, the Federal Government or the Centers for Medicare & Medicaid Services (CMS) for Medicare and Medicaid members. All coding and website links are accurate at time of publication. MetroPlus Health Plan has adopted the herein policy in providing management, administrative and other services to our members, related to health benefit plans offered by our organization.