


MEDICAL POLICY	Organic Acid Testing (Medicare Only)
Effective Date: 1/1/2023	Medical Policy Number: 363
 1/1/2023	Medical Policy Committee Approved Date: 10/2022
Medical Officer Date	

See Policy CPT/HCPCS CODE section below for any prior authorization requirements

SCOPE:

Providence Health Plan, Providence Health Assurance, Providence Plan Partners, and Ayin Health Solutions as applicable (referred to individually as “Company” and collectively as “Companies”).

APPLIES TO:

Medicare Only

MEDICARE POLICY CRITERIA

The following Centers for Medicare & Medicaid Service (CMS) guidelines should be utilized for medical necessity coverage determinations. Click the link provided in the table below to access applicable medical necessity criteria. All listed guidelines apply.

Service	Medicare Guidelines
<i>Organic Acid Testing</i>	Company medical policy for Organic Acid Testing (All Lines of Business Except Medicare) I. These services may be considered medically necessary for Medicare when the Company medical policy criteria are met. II. These services are considered not medically necessary for Medicare when the Company medical policy criteria are not met. <i>See Policy Guidelines below.</i>

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POLICY GUIDELINES

Medicare and Medical Necessity

Only medically reasonable and necessary services or items which treat illness or injury are eligible for Medicare coverage, as outlined in *Title XVIII of the Social Security Act, §1862(a)(1)(A)*.

The Company policy for *PHA Medicare Medical Policy Development and Application (MP50)* provides details regarding Medicare’s definition of medical necessity and the hierarchy of Medicare references and resources during the development of medical policies, as well as the Plan’s use of evidence-based processes for policy development. In the absence of Medicare coverage policies (e.g., manual, national coverage determination [NCD], local coverage determination [LCD], article [LCA], etc.) which addresses the medical necessity of a given medical service, Medicare regulatory guidelines do allow Medicare Advantage Organizations (MAOs) to make their own coverage determinations, as long as the MAO applies an objective, evidence-based process, based on authoritative evidence. (*Medicare Managed Care Manual, Ch. 4, §90.5*)

BILLING GUIDELINES

Proper Reporting of Laboratory Panel Tests

According to Company Coding Policy (*Laboratory Panel Billing, 30.0*), when no specific CPT or HCPCS code exists for a panel test, the provider is required to report the panel service using an unlisted code. It is not appropriate for the provider to report the tests in a panel separately as if they were performed individually. This is a misrepresentation of services performed and is not appropriate based on either CPT or Centers for Medicare and Medicaid Services (CMS) guidelines. In a “Healthcare Fraud Prevention Partnership” white paper published in May 2018, CMS identified unbundling of lab panels as an example of fraudulent billing.

General

CPT codes for organic acids (83918, 83919, 83921) may be considered medically necessary when billed with a diagnosis code in the range of E00-E89, or any of the following: Z8639, Z13228, Z8349, G9341. When diagnosis codes other than these are billed, the above CPT codes will deny as **not medically necessary**.

CPT/HCPCS CODES

Medicare Only	
No Prior Authorization Required	
<i>Note:</i> These codes may be considered medically necessary only when billed with one of the diagnosis codes listed above in the “Billing Guidelines” section.	
83918	Organic acids; total, quantitative, each specimen

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83919	Organic acids; qualitative, each specimen
83921	Organic acid, single, quantitative
Unlisted Codes All unlisted codes will be reviewed for medical necessity, correct coding, and pricing at the claim level. If an unlisted code is billed related to services addressed in this policy then it will be denied as not covered .	
81599	Unlisted multianalyte assay with algorithmic analysis

INSTRUCTIONS FOR USE

Company Medical Policies serve as guidance for the administration of plan benefits. Medical policies do not constitute medical advice nor a guarantee of coverage. Company Medical Policies are reviewed annually and are based upon published, peer-reviewed scientific evidence and evidence-based clinical practice guidelines that are available as of the last policy update. The Companies reserve the right to determine the application of Medical Policies and make revisions to Medical Policies at any time. Providers will be given at least 60-days notice of policy changes that are restrictive in nature.

The scope and availability of all plan benefits are determined in accordance with the applicable coverage agreement. Any conflict or variance between the terms of the coverage agreement and Company Medical Policy will be resolved in favor of the coverage agreement.

REGULATORY STATUS

Mental Health Parity Statement

Coverage decisions are made on the basis of individualized determinations of medical necessity and the experimental or investigational character of the treatment in the individual case. In cases where medical necessity is not established by policy for specific treatment modalities, evidence not previously considered regarding the efficacy of the modality that is presented shall be given consideration to determine if the policy represents current standards of care.