


MEDICAL POLICY	Fecal Analysis of Gastrointestinal Microbiome (Medicare Only)
Effective Date: 1/1/2023	Medical Policy Number: 373
 1/1/2023	Medical Policy Committee Approved Date: 12/2022
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>Fecal Analysis Testing (Panels and Analyte Testing)</i>	Company medical policy for Fecal Analysis of Gastrointestinal Microbiome (All Lines of Business Except Medicare) I. These services are considered not medically necessary for Medicare based on the Company medical policy. <i>See Policy Guidelines below.</i>

POLICY GUIDELINES

Examples of fecal analysis panels include:

- GI Effects Comprehensive Stool Profile, by Genova Diagnostics
- Comprehensive Digestive Stool Analysis (CDSA), by Genova Diagnostics

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- GA-map Dysbiosis Test by BIOHIT Healthcare

Medicare and Medical Necessity

Medicare requires diagnostic laboratory tests be ordered by a provider who is treating the member for a specific medical problem **and** who will use the test results in the direct management of that specific medical problem.^{1,2} Thus, diagnostic testing must have established clinical utility and analytic validity.

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

Please bill the most appropriate unlisted code for GI microbiome fecal analysis panels. If any of the following codes are billed individually as part of a GI panel, this is considered unbundling and the claim will deny as incorrect coding:

For Microbiology Fecal Profiles:

87045	87102	87328
87046	87177	87329
87075	87209	

Comprehensive Fecal Profile:

82274	83520	87177
82542	83993	87209
82653	84311	87328
82656	87045	87329
82715	87046	87336
82725	87075	
82784	87102	

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CPT/HCPCS CODES

Medicare Only	
<p>Unlisted Codes</p> <p>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.</p>	
81599	Unlisted multianalyte assay with algorithmic analysis
89240	Unlisted miscellaneous pathology test

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.

REFERENCES

1. 42 CFR §410.32(a); Available at: <https://www.govinfo.gov/content/pkg/CFR-2011-title42-vol2/pdf/CFR-2011-title42-vol2-sec410-32.pdf>
2. Medicare Benefit Policy Manual, Ch. 15 – Covered Medical and Other Health Services, §80.1 - Clinical Laboratory Services; Available at: <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf>