Common Lab ICD10 Codes Quick Guide (updated 10.20.23)

CalMHSA has provided a selected set of ICD10 Codes for commonly used labs in psychiatric/behavioral health to assist providers to choose a billing code accepted by Medicare and/or Medi-Cal.

We understand that codes can change, and while CalMHSA will attempt to maintain an updated version, we will not be held accountable for the content. Of note, these ICD10 codes are not comprehensive of all potentially usable codes for each test. We have not vetted this information with other lab vendors (eg LabCorp etc). We recommend that if there are any specific questions/concerns, that you contact your county lab vendor directly for the most updated and relevant information.

Quest has provided a set of quick guides for the following labs that have restrictions on the type of code that can be used:

Non-specific labs codes that CANNOT be used:

- Non-specific diagnosis codes that cannot be used by Medi-Cal
- Non-specific diagnosis codes that cannot be used by Medicare

Specific Lab Code Suggestions:

- Blood Count
- Lipid Testing
- Thyroid Testing
- Hemoglobin A1c/Glycated Hemoglobin
- Vitamin B12
- Vitamin D
- Controlled Substance Monitoring
- Quantiferon
- HcG and Prolactin

Have no known restrictions, though use code that best represents medical necessity:

- BMP/CMP/Metabolic Panel
- Lithium
- Valproic Acid
- Folate

Two codes that several county admin/billing have suggest as potential acceptable options, given universality:
Z79.899- Other Long-term (current) drug therapy
Z51.81- Encounter for therapeutic drug level monitoring

References
Below are Quest's Medi-Cal and Medicare coding and guideline links where you can download additional client bulletins. If looking for more guidance, please take a look at these references or talk to your lab vendor for more guidance.

Medical Coverage and Coding:
https://www.questdiagnostics.com/healthcare-professionals/billing-coding/medicaid-limited-coverage-policies

Medicare Coverage and Coding:
https://www.questdiagnostics.com/healthcare-professionals/billing-coding/medicare-coverage-guides/je-noridian

Preventative Medicare Coverage and Coding:
https://www.questdiagnostics.com/healthcare-professionals/billing-coding/medicare-coverage-guides/preventive-guidelines

Client Bulletin

March 2023

Medi-Cal ICD-10 Diagnosis Code Requirements

Medi-Cal policy states that providers may not submit the following nonspecific diagnosis codes when billing for laboratory procedures:

ICD-10 CM Diagnosis Code	ICD-10 CM Diagnosis Code Description	ICD-10 CM Diagnosis Code	ICD-10 CM Diagnosis Code Description
Z00.00	Encounter for general adult medical examination without abnormal findings	Z01.10	Encounter for examination of ears and hearing without abnormal findings
Z00.5	Encounter for examination of potential donor of organ and tissue	Z01.89	Encounter for other specified special examinations
Z00.6	Encounter for examination for normal comparison and control in clinical research program	Z02.1	Encounter for pre-employment examination
Z00.8	Encounter for other general examination	Z02.3	Encounter for examination for recruitment to armed forces
Z01.00	Encounter for examination of eyes and vision without abnormal findings		

There are some exceptions regarding the CPT-4 codes for HIV testing: 86701-86703, 87389, 87390 and 87806. These CPT-4 codes may be billed with any ICD-10-CM diagnosis code. For additional exceptions, see the Medi-Cal manual.

In addition, certain laboratory procedures require specific ICD-10-CM diagnosis codes. This information is communicated in separate Quest Diagnostics Client Bulletins as well as in the Medi-Cal Provider Manual. For additional information and exceptions on Medi-Cal's nonspecific diagnosis policy, visit www.medi-cal.ca.gov

We depend on our clients to provide us with the patient's complete insurance information and valid ICD-10-CM diagnosis codes.

We will be requesting from you a specific ICD-10-CM code(s) if one is not provided on the laboratory requisition.

If you have any questions, please contact your Quest Diagnostics sales representative.

Disclaimer: The CPT codes provided are based on AMA guidelines and are for informational purposes only. CPT coding is the sole responsibility of the billing party. Please direct any questions regarding coding to the payer being billed. Diagnoses must always be documented in the patient's medical record.

The ultimate responsibility belongs to the ordering physician to correctly assign the patient's diagnosis based on the patient's history, symptoms and medical conditions.

Non-covered ICD-10-CM Codes for All Lab NCDs

This section lists codes that are never covered by Medicare for a diagnostic lab testing service. If a code from this section is given as the reason for the test, the test may be billed to the Medicare beneficiary without billing Medicare first because the service is not covered by statute,in most instances because it is performed for screening purposes and is not within an exception.The beneficiary, however, does have a right to have the claim submitted to Medicare, upon request.

The ICD-10-CM codes in the table below can be viewed on CMS' website as part of Downloads: Lab Code List, at
http://www.cms.gov/Medicare/Coverage/CoverageGenInfo/LabNCDsICD10.html

Code	Description
R99	Ill-defined and unknown cause of mortality
Z00.00	Encounter for general adult medical examination without abnormal findings
Z00.01	Encounter for general adult medical examination with abnormal findings
Z00.110	Health examination for newborn under 8 days old
Z00.111	Health examination for newborn 8 to 28 days old
Z00.121	Encounter for routine child health examination with abnormal findings
Z00.129	Encounter for routine child health examination without abnormal findings
Z00.5	Encounter for examination of potential donor of organ and tissue
Z00.6	Encounter for examination for normal comparison and control in clinical research program
Z00.70	Encounter for examination for period of delayed growth in childhood without abnormal findings
Z00.71	Encounter for examination for period of delayed growth in childhood with abnormal findings
Z00.8	Encounter for other general examination
Z02.0	Encounter for examination for admission to educational institution
Z02.1	Encounter for pre-employment examination
Z02.2	Encounter for examination for admission to residential institution
Z02.3	Encounter for examination for recruitment to armed forces
Z02.4	Encounter for examination for driving license
Z02.5	Encounter for examination for participation in sport
Z02.6	Encounter for examination for insurance purposes
Z02.71	Encounter for disability determination
Z02.79	Encounter for issue of other medical certificate
Z02.81	Encounter for paternity testing

***October 2022 Changes**
ICD-10-CM Version – Red

Code	Description
Z02.82	Encounter for adoption services
Z02.83	Encounter for blood-alcohol and blood-drug test
Z02.89	Encounter for other administrative examinations
Z02.9	Encounter for administrative examinations, unspecified
Z04.6	Encounter for general psychiatric examination, requested by authority
Z04.81	Encounter for examination and observation of victim following forced sexual exploitation
Z04.82	Encounter for examination and observation of victim following forced labor exploitation
Z04.89	Encounter for examination and observation for other specified reasons
Z04.9	Encounter for examination and observation for unspecified reason
Z11.0	Encounter for screening for intestinal infectious diseases
Z11.1	Encounter for screening for respiratory tuberculosis
Z11.2	Encounter for screening for other bacterial diseases
Z11.3	Encounter for screening for infections with a predominantly sexual mode of transmission
Z11.4	Encounter for screening for human immunodeficiency virus [HIV]
Z11.51	Encounter for screening for human papillomavirus (HPV)
Z11.52	Encounter for screening for COVID-19
Z11.59	Encounter for screening for other viral diseases
Z11.6	Encounter for screening for other protozoal diseases and helminthiases
Z11.7	Encounter for testing for latent tuberculosis infection
Z11.8	Encounter for screening for other infectious and parasitic diseases
Z11.9	Encounter for screening for infectious and parasitic diseases, unspecified
Z12.0	Encounter for screening for malignant neoplasm of stomach
Z12.10	Encounter for screening for malignant neoplasm of intestinal tract, unspecified
Z12.13	Encounter for screening for malignant neoplasm of small intestine
Z12.2	Encounter for screening for malignant neoplasm of respiratory organs
Z12.6	Encounter for screening for malignant neoplasm of bladder
Z12.71	Encounter for screening for malignant neoplasm of testis
Z12.72	Encounter for screening for malignant neoplasm of vagina
Z12.73	Encounter for screening for malignant neoplasm of ovary
Z12.79	Encounter for screening for malignant neoplasm of other genitourinary organs
Z12.81	Encounter for screening for malignant neoplasm of oral cavity
Z12.82	Encounter for screening for malignant neoplasm of nervous system
Z12.83	Encounter for screening for malignant neoplasm of skin
Z12.89	Encounter for screening for malignant neoplasm of other sites
Z12.9	Encounter for screening for malignant neoplasm, site unspecified

***October 2022 Changes**
ICD-10-CM Version – Red

Code	Description
Z13.0	Encounter for screening for diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism
Z13.21	Encounter for screening for nutritional disorder
Z13.220	Encounter for screening for lipoid disorders
Z13.228	Encounter for screening for other metabolic disorders
Z13.29	Encounter for screening for other suspected endocrine disorder
Z13.30	Encounter for screening examination for mental health and behavioral disorders, unspecified
Z13.31	Encounter for screening for depression
Z13.32	Encounter for screening for maternal depression
Z13.39	Encounter for screening examination for other mental health and behavioral disorders
Z13.40	Encounter for screening for unspecified developmental delays
Z13.41	Encounter for autism screening
Z13.42	Encounter for screening for global developmental delays (milestones)
Z13.49	Encounter for screening for other developmental delays
Z13.5	Encounter for screening for eye and ear disorders
Z13.71	Encounter for nonprocreative screening for genetic disease carrier status
Z13.79	Encounter for other screening for genetic and chromosomal anomalies
Z13.810	Encounter for screening for upper gastrointestinal disorder
Z13.811	Encounter for screening for lower gastrointestinal disorder
Z13.818	Encounter for screening for other digestive system disorders
Z13.820	Encounter for screening for osteoporosis
Z13.828	Encounter for screening for other musculoskeletal disorder
Z13.83	Encounter for screening for respiratory disorder NEC
Z13.84	Encounter for screening for dental disorders
Z13.850	Encounter for screening for traumatic brain injury
Z13.858	Encounter for screening for other nervous system disorders
Z13.88	Encounter for screening for disorder due to exposure to contaminants
Z13.89	Encounter for screening for other disorder
Z13.9	Encounter for screening, unspecified
Z36.0	Encounter for antenatal screening for chromosomal anomalies
Z36.1	Encounter for antenatal screening for raised alphafetoprotein level
Z36.2	Encounter for other antenatal screening follow-up
Z36.3	Encounter for antenatal screening for malformations
Z36.4	Encounter for antenatal screening for fetal growth retardation

Code	Description
Z36.5	Encounter for antenatal screening for isoimmunization
Z36.81	Encounter for antenatal screening for hydrops fetalis
Z36.82	Encounter for antenatal screening for nuchal translucency
Z36.83	Encounter for fetal screening for congenital cardiac abnormalities
Z36.84	Encounter for antenatal screening for fetal lung maturity
Z36.85	Encounter for antenatal screening for Streptococcus B
Z36.86	Encounter for antenatal screening for cervical length
Z36.87	Encounter for antenatal screening for uncertain dates
Z36.88	Encounter for antenatal screening for fetal macrosomia
Z36.89	Encounter for other specified antenatal screening
Z36.8A	Encounter for antenatal screening for other genetic defects
Z36.9	Encounter for antenatal screening, unspecified
Z40.00	Encounter for prophylactic removal of unspecified organ
Z40.01	Encounter for prophylactic removal of breast
Z40.02	Encounter for prophylactic removal of ovary(s)
Z40.09	Encounter for prophylactic removal of other organ
Z40.8	Encounter for other prophylactic surgery
Z40.9	Encounter for prophylactic surgery, unspecified
Z41.1	Encounter for cosmetic surgery
Z41.2	Encounter for routine and ritual male circumcision
Z41.3	Encounter for ear piercing
Z41.8	Encounter for other procedures for purposes other than remedying health state
Z41.9	Encounter for procedure for purposes other than remedying health state, unspecified
Z46.1	Encounter for fitting and adjustment of hearing aid
Z56.0	Unemployment, unspecified
Z56.2	Threat of job loss
Z56.3	Stressful work schedule
Z56.4	Discord with boss and workmates
Z56.5	Uncongenial work environment
Z56.6	Other physical and mental strain related to work
Z56.81	Sexual harassment on the job
Z56.82	Military deployment status
Z56.89	Other problems related to employment
Z56.9	Unspecified problems related to employment
Z57.0	Occupational exposure to noise

***October 2022 Changes**
ICD-10-CM Version – Red

Code	Description
Z57.1	Occupational exposure to radiation
Z57.2	Occupational exposure to dust
Z57.31	Occupational exposure to environmental tobacco smoke
Z57.39	Occupational exposure to other air contaminants
Z57.4	Occupational exposure to toxic agents in agriculture
Z57.5	Occupational exposure to toxic agents in other industries
Z57.6	Occupational exposure to extreme temperature
Z57.7	Occupational exposure to vibration
Z57.8	Occupational exposure to other risk factors
Z57.9	Occupational exposure to unspecified risk factor
Z58.6	Inadequate drinking-water supply
Z59.00	Homelessness unspecified
Z59.01	Sheltered homelessness
Z59.02	Unsheltered homelessness
Z59.1	Inadequate housing
Z59.2	Discord with neighbors, lodgers and landlord
Z59.3	Problems related to living in residential institution
Z59.41	Food insecurity
Z59.48	Other specified lack of adequate food
Z59.5	Extreme poverty
Z59.6	Low income
Z59.7	Insufficient social insurance and welfare support
Z59.811	Housing instability, housed, with risk of homelessness
Z59.812	Housing instability, housed, homelessness in past 12 months
Z59.819	Housing instability, housed unspecified
Z59.89	Other problems related to housing and economic circumstances
Z59.9	Problem related to housing and economic circumstances, unspecified
Z60.2	Problems related to living alone
Z62.21	Child in welfare custody
Z71.0	Person encountering health services to consult on behalf of another person
Z74.1	Need for assistance with personal care
Z74.2	Need for assistance at home and no other household member able to render care
Z74.3	Need for continuous supervision
Z74.8	Other problems related to care provider dependency
Z74.9	Problem related to care provider dependency, unspecified

***October 2022 Changes**
ICD-10-CM Version – Red

Code	Description
Z75.5	Holiday relief care
Z76.0	Encounter for issue of repeat prescription
Z76.1	Encounter for health supervision and care of foundling
Z76.2	Encounter for health supervision and care of other healthy infant and child
Z76.3	Healthy person accompanying sick person
Z76.4	Other boarder to healthcare facility
Z76.81	Expectant parent(s) prebirth pediatrician visit
Z80.1	Family history of malignant neoplasm of trachea, bronchus and lung
Z80.2	Family history of malignant neoplasm of other respiratory and intrathoracic organs
Z80.49	Family history of malignant neoplasm of other genital organs
Z80.51	Family history of malignant neoplasm of kidney
Z80.52	Family history of malignant neoplasm of bladder
Z80.59	Family history of malignant neoplasm of other urinary tract organ
Z80.6	Family history of leukemia
Z80.7	Family history of other malignant neoplasms of lymphoid, hematopoietic and related tissues
Z80.8	Family history of malignant neoplasm of other organs or systems
Z80.9	Family history of malignant neoplasm, unspecified
Z81.0	Family history of intellectual disabilities
Z81.1	Family history of alcohol abuse and dependence
Z81.2	Family history of tobacco abuse and dependence
Z81.3	Family history of other psychoactive substance abuse and dependence
Z81.4	Family history of other substance abuse and dependence
Z81.8	Family history of other mental and behavioral disorders
Z82.0	Family history of epilepsy and other diseases of the nervous system
Z82.1	Family history of blindness and visual loss
Z82.2	Family history of deafness and hearing loss
Z82.3	Family history of stroke
Z82.41	Family history of sudden cardiac death
Z82.49	Family history of ischemic heart disease and other diseases of the circulatory system
Z82.5	Family history of asthma and other chronic lower respiratory diseases
Z82.61	Family history of arthritis
Z82.62	Family history of osteoporosis
Z82.69	Family history of other diseases of the musculoskeletal system and connective tissue
Z82.71	Family history of polycystic kidney

Code	Description
Z82.79	Family history of other congenital malformations, deformations and chromosomal abnormalities
Z82.8	Family history of other disabilities and chronic diseases leading to disablement, not elsewhere classified
Z83.0	Family history of human immunodeficiency virus [HIV] disease
Z83.1	Family history of other infectious and parasitic diseases
Z83.2	Family history of diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism
Z83.3	Family history of diabetes mellitus
Z83.41	Family history of multiple endocrine neoplasia [MEN] syndrome
Z83.49	Family history of other endocrine, nutritional and metabolic diseases
Z83.511	Family history of glaucoma
Z83.518	Family history of other specified eye disorder
Z83.52	Family history of ear disorders
Z83.6	Family history of other diseases of the respiratory system
Z83.71	Family history of colonic polyps
Z83.79	Family history of other diseases of the digestive system
Z84.0	Family history of diseases of the skin and subcutaneous tissue
Z84.1	Family history of disorders of kidney and ureter
Z84.2	Family history of other diseases of the genitourinary system
Z84.3	Family history of consanguinity
Z84.81	Family history of carrier of genetic disease
Z84.89	Family history of other specified conditions

Code	Description
Z02.5	Encounter for examination for participation in sport
Z02.6	Encounter for examination for insurance purposes
Z02.71	Encounter for disability determination
Z02.79	Encounter for issue of other medical certificate
Z02.81	Encounter for paternity testing
Z02.82	Encounter for adoption services
Z02.83	Encounter for blood-alcohol and blood-drug test
Z02.89	Encounter for other administrative examinations
Z02.9	Encounter for administrative examinations, unspecified
Z04.6	Encounter for general psychiatric examination, requested by authority
Z04.81	Encounter for examination and observation of victim following forced sexual exploitation
Z04.82	Encounter for examination and observation of victim following forced labor exploitation
Z04.89	Encounter for examination and observation for other specified reasons
Z04.9	Encounter for examination and observation for unspecified reason
Z11.0	Encounter for screening for intestinal infectious diseases
Z11.1	Encounter for screening for respiratory tuberculosis
Z11.2	Encounter for screening for other bacterial diseases
Z11.3	Encounter for screening for infections with a predominantly sexual mode of transmission
Z11.4	Encounter for screening for human immunodeficiency virus [HIV]
Z11.51	Encounter for screening for human papillomavirus (HPV)
Z11.59	Encounter for screening for other viral diseases
Z11.6	Encounter for screening for other protozoal diseases and helminthiases
Z11.7	Encounter for testing for latent tuberculosis infection
Z11.8	Encounter for screening for other infectious and parasitic diseases
Z11.9	Encounter for screening for infectious and parasitic diseases, unspecified
Z12.0	Encounter for screening for malignant neoplasm of stomach

Code	Description
Z12.10	Encounter for screening for malignant neoplasm of intestinal tract, unspecified
Z12.13	Encounter for screening for malignant neoplasm of small intestine
Z12.2	Encounter for screening for malignant neoplasm of respiratory organs
Z12.6	Encounter for screening for malignant neoplasm of bladder
Z12.71	Encounter for screening for malignant neoplasm of testis
Z12.72	Encounter for screening for malignant neoplasm of vagina
Z12.73	Encounter for screening for malignant neoplasm of ovary
Z12.79	Encounter for screening for malignant neoplasm of other genitourinary organs
Z12.81	Encounter for screening for malignant neoplasm of oral cavity
Z12.82	Encounter for screening for malignant neoplasm of nervous system
Z12.83	Encounter for screening for malignant neoplasm of skin
Z12.89	Encounter for screening for malignant neoplasm of other sites
Z12.9	Encounter for screening for malignant neoplasm, site unspecified
Z13.0	Encounter for screening for diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism
Z13.21	Encounter for screening for nutritional disorder
Z13.220	Encounter for screening for lipoid disorders
Z13.228	Encounter for screening for other metabolic disorders
Z13.29	Encounter for screening for other suspected endocrine disorder
Z13.30	Encounter for screening examination for mental health and behavioral disorders, unspecified
Z13.31	Encounter for screening for depression
Z13.32	Encounter for screening for maternal depression
Z13.39	Encounter for screening examination for other mental health and behavioral disorders
Z13.40	Encounter for screening for unspecified developmental delays
Z13.41	Encounter for autism screening
Z13.42	Encounter for screening for global developmental delays (milestones)
Z13.49	Encounter for screening for other developmental delays

Code	Description
Z13.5	Encounter for screening for eye and ear disorders
Z13.71	Encounter for nonprocreative screening for genetic disease carrier status
Z13.79	Encounter for other screening for genetic and chromosomal anomalies
Z13.810	Encounter for screening for upper gastrointestinal disorder
Z13.811	Encounter for screening for lower gastrointestinal disorder
Z13.818	Encounter for screening for other digestive system disorders
Z13.820	Encounter for screening for osteoporosis
Z13.828	Encounter for screening for other musculoskeletal disorder
Z13.83	Encounter for screening for respiratory disorder NEC
Z13.84	Encounter for screening for dental disorders
Z13.850	Encounter for screening for traumatic brain injury
Z13.858	Encounter for screening for other nervous system disorders
Z13.88	Encounter for screening for disorder due to exposure to contaminants
Z13.89	Encounter for screening for other disorder
Z13.9	Encounter for screening, unspecified
Z36.0	Encounter for antenatal screening for chromosomal anomalies
Z36.1	Encounter for antenatal screening for raised alphafetoprotein level
Z36.2	Encounter for other antenatal screening follow-up
Z36.3	Encounter for antenatal screening for malformations
Z36.4	Encounter for antenatal screening for fetal growth retardation
Z36.5	Encounter for antenatal screening for isoimmunization
Z36.81	Encounter for antenatal screening for hydrops fetalis
Z36.82	Encounter for antenatal screening for nuchal translucency
Z36.83	Encounter for fetal screening for congenital cardiac abnormalities
Z36.84	Encounter for antenatal screening for fetal lung maturity
Z36.85	Encounter for antenatal screening for Streptococcus B
Z36.86	Encounter for antenatal screening for cervical length
Z36.87	Encounter for antenatal screening for uncertain dates

Code	Description
Z36.88	Encounter for antenatal screening for fetal macrosomia
Z36.89	Encounter for other specified antenatal screening
Z36.8A	Encounter for antenatal screening for other genetic defects
Z36.9	Encounter for antenatal screening, unspecified
Z40.00	Encounter for prophylactic removal of unspecified organ
Z40.01	Encounter for prophylactic removal of breast
Z40.02	Encounter for prophylactic removal of ovary(s)
Z40.09	Encounter for prophylactic removal of other organ
Z40.8	Encounter for other prophylactic surgery
Z40.9	Encounter for prophylactic surgery, unspecified
Z41.1	Encounter for cosmetic surgery
Z41.2	Encounter for routine and ritual male circumcision
Z41.3	Encounter for ear piercing
Z41.8	Encounter for other procedures for purposes other than remedying health state
Z41.9	Encounter for procedure for purposes other than remedying health state, unspecified
Z46.1	Encounter for fitting and adjustment of hearing aid
Z56.0	Unemployment, unspecified
Z56.2	Threat of job loss
Z56.3	Stressful work schedule
Z56.4	Discord with boss and workmates
Z56.5	Uncongenial work environment
Z56.6	Other physical and mental strain related to work
Z56.81	Sexual harassment on the job
Z56.82	Military deployment status
Z56.89	Other problems related to employment
Z56.9	Unspecified problems related to employment
Z57.0	Occupational exposure to noise
Z57.1	Occupational exposure to radiation

Code	Description
Z57.2	Occupational exposure to dust
Z57.31	Occupational exposure to environmental tobacco smoke
Z57.39	Occupational exposure to other air contaminants
Z57.4	Occupational exposure to toxic agents in agriculture
Z57.5	Occupational exposure to toxic agents in other industries
Z57.6	Occupational exposure to extreme temperature
Z57.7	Occupational exposure to vibration
Z57.8	Occupational exposure to other risk factors
Z57.9	Occupational exposure to unspecified risk factor
Z59.0	Homelessness
Z59.1	Inadequate housing
Z59.2	Discord with neighbors, lodgers and landlord
Z59.3	Problems related to living in residential institution
Z59.4	Lack of adequate food and safe drinking water
Z59.5	Extreme poverty
Z59.6	Low income
Z59.7	Insufficient social insurance and welfare support
Z59.8	Other problems related to housing and economic circumstances
Z59.9	Problem related to housing and economic circumstances, unspecified
Z60.2	Problems related to living alone
Z62.21	Child in welfare custody
Z71.0	Person encountering health services to consult on behalf of another person
Z74.1	Need for assistance with personal care
Z74.2	Need for assistance at home and no other household member able to render care
Z74.3	Need for continuous supervision
Z74.8	Other problems related to care provider dependency
Z74.9	Problem related to care provider dependency, unspecified
Z75.5	Holiday relief care

Code	Description
Z76.0	Encounter for issue of repeat prescription
Z76.1	Encounter for health supervision and care of foundling
Z76.2	Encounter for health supervision and care of other healthy infant and child
Z76.3	Healthy person accompanying sick person
Z76.4	Other boarder to healthcare facility
Z76.81	Expectant parent(s) prebirth pediatrician visit
Z80.1	Family history of malignant neoplasm of trachea, bronchus and lung
Z80.2	Family history of malignant neoplasm of other respiratory and intrathoracic organs
Z80.49	Family history of malignant neoplasm of other genital organs
Z80.51	Family history of malignant neoplasm of kidney
Z80.52	Family history of malignant neoplasm of bladder
Z80.59	Family history of malignant neoplasm of other urinary tract organ
Z80.6	Family history of leukemia
Z80.7	Family history of other malignant neoplasms of lymphoid, hematopoietic and related tissues
Z80.8	Family history of malignant neoplasm of other organs or systems
Z80.9	Family history of malignant neoplasm, unspecified
Z81.0	Family history of intellectual disabilities
Z81.1	Family history of alcohol abuse and dependence
Z81.2	Family history of tobacco abuse and dependence
Z81.3	Family history of other psychoactive substance abuse and dependence
Z81.4	Family history of other substance abuse and dependence
Z81.8	Family history of other mental and behavioral disorders
Z82.0	Family history of epilepsy and other diseases of the nervous system
Z82.1	Family history of blindness and visual loss
Z82.2	Family history of deafness and hearing loss
Z82.3	Family history of stroke
Z82.41	Family history of sudden cardiac death
Z82.49	Family history of ischemic heart disease and other diseases of the circulatory

Code	Description
	system
Z82.5	Family history of asthma and other chronic lower respiratory diseases
Z82.61	Family history of arthritis
Z82.62	Family history of osteoporosis
Z82.69	Family history of other diseases of the musculoskeletal system and connective tissue
Z82.71	Family history of polycystic kidney
Z82.79	Family history of other congenital malformations, deformations and chromosomal abnormalities
Z82.8	Family history of other disabilities and chronic diseases leading to disablement, not elsewhere classified
Z83.0	Family history of human immunodeficiency virus [HIV] disease
Z83.1	Family history of other infectious and parasitic diseases
Z83.2	Family history of diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism
Z83.3	Family history of diabetes mellitus
Z83.41	Family history of multiple endocrine neoplasia [MEN] syndrome
Z83.49	Family history of other endocrine, nutritional and metabolic diseases
Z83.511	Family history of glaucoma
Z83.518	Family history of other specified eye disorder
Z83.52	Family history of ear disorders
Z83.6	Family history of other diseases of the respiratory system
Z83.71	Family history of colonic polyps
Z83.79	Family history of other diseases of the digestive system
Z84.0	Family history of diseases of the skin and subcutaneous tissue
Z84.1	Family history of disorders of kidney and ureter
Z84.2	Family history of other diseases of the genitourinary system
Z84.3	Family history of consanguinity
Z84.81	Family history of carrier of genetic disease
Z84.89	Family history of other specified conditions

Blood Counts

CBC

CPT: 85004, 85007, 85008, 85013, 85014, 85018, 85025, 85027, 85032, 85048, 85049

CMS National Coverage Policy

Coverage Indications, Limitations, and/or Medical Necessity
Blood counts are used to evaluate and diagnose diseases relating to abnormalities of the blood or bone marrow. These include primary disorders such as anemia, leukemia, polycythemia, thrombocytosis and thrombocytopenia. Many other conditions secondarily affect the blood or bone marrow, including reaction to inflammation and infections, coagulopathies, neoplasms and exposure to toxic substances. Many treatments and therapies affect the blood or bone marrow, and blood counts may be used to monitor treatment effects.

The complete blood count (CBC) includes a hemogram and differential white blood count (WBC). The hemogram includes enumeration of red blood cells, white blood cells, and platelets, as well as the determination of hemoglobin, hematocrit, and indices.

The symptoms of hematological disorders are often nonspecific, and are commonly encountered in patients who may or may not prove to have a disorder of the blood or bone marrow. Furthermore, many medical conditions that are not primarily due to abnormalities of blood or bone marrow may have hematological manifestations that result from the disease or its treatment. As a result, the CBC is one of the most commonly indicated laboratory tests.

In patients with possible hematological abnormalities, it may be necessary to determine the hemoglobin and hematocrit, to calculate the red cell indices, and to measure the concentration of white blood cells and platelets. These measurements are usually performed on a multichannel analyzer that measures all of the parameters on every sample. Therefore, laboratory assessments routinely include these measurements.

Indications
Indications for a CBC or hemogram include red cell, platelet, and white cell disorders. Examples of these indications are enumerated individually below.

1. Indications for a CBC generally include the evaluation of bone marrow dysfunction as a result of neoplasms, therapeutic agents, exposure to toxic substances, or pregnancy. The CBC is also useful in assessing peripheral destruction of blood cells, suspected bone marrow failure or bone marrow infiltrate, suspected myeloproliferative, myelodysplastic, or lymphoproliferative processes, and immune disorders.
2. Indications for hemogram or CBC related to red cell (RBC) parameters of the hemogram include signs, symptoms, test results, illness, or disease that can be associated with anemia or other red blood cell disorder (e.g., pallor, weakness, fatigue, weight loss, bleeding, acute injury associated with blood loss or suspected blood loss, abnormal menstrual bleeding, hematuria, hematemesis, hematochezia, positive fecal occult blood test, malnutrition, vitamin deficiency, malabsorption, neuropathy, known malignancy, presence of acute or chronic disease that may have associated anemia, coagulation or hemostatic disorders, postural dizziness, syncope, abdominal pain, change in bowel habits, chronic marrow hypoplasia or decreased RBC production, tachycardia, systolic heart murmur, congestive heart failure, dyspnea, angina, nailbed deformities, growth retardation, jaundice, hepatomegaly, splenomegaly, lymphadenopathy, ulcers on the lower extremities).
3. Indications for hemogram or CBC related to red cell (RBC) parameters of the hemogram include signs, symptoms, test results, illness, or disease that can be associated with polycythemia (for example, fever, chills, ruddy skin, conjunctival redness, cough, wheezing, cyanosis, clubbing of the fingers, orthopnea, heart murmur, headache, vague cognitive changes including memory changes, sleep apnea, weakness, pruritus, dizziness, excessive sweating, visual symptoms, weight loss, massive obesity, gastrointestinal bleeding, paresthesias, dyspnea, joint symptoms, epigastric distress, pain and erythema of the fingers or toes, venous or arterial thrombosis, thromboembolism, myocardial infarction, stroke, transient ischemic attacks, congenital heart disease, chronic obstructive pulmonary disease, increased erythropoietin production associated with neoplastic, renal or hepatic disorders, androgen or diuretic use, splenomegaly, hepatomegaly, diastolic hypertension.)

Blood Counts

CPT: 85004, 85007, 85008, 85013, 85014, 85018, 85025, 85027, 85032, 85048, 85049

CMS National Coverage Policy (continued)

4. Specific indications for CBC with differential count related to the WBC include signs, symptoms, test results, illness, or disease associated with leukemia, infections or inflammatory processes, suspected bone marrow failure or bone marrow infiltrate, suspected myeloproliferative, myelodysplastic or lymphoproliferative disorder, use of drugs that may cause leukopenia, and immune disorders (e.g., fever, chills, sweats, shock, fatigue, malaise, tachycardia, tachypnea, heart murmur, seizures, alterations of consciousness, meningismus, pain such as headache, abdominal pain, arthralgia, odynophagia, or dysuria, redness or swelling of skin, soft tissue bone, or joint, ulcers of the skin or mucous membranes, gangrene, mucous membrane discharge, bleeding, thrombosis, respiratory failure, pulmonary infiltrate, jaundice, diarrhea, vomiting, hepatomegaly, splenomegaly, lymphadenopathy, opportunistic infection, such as oral candidiasis.)
5. Specific indications for CBC related to the platelet count include signs, symptoms, test results, illness, or disease associated with increased or decreased platelet production and destruction, or platelet dysfunction (e.g., gastrointestinal bleeding, genitourinary tract bleeding, bilateral epistaxis, thrombosis, ecchymosis, purpura, jaundice, petechiae, fever, heparin therapy, suspected DIC, shock, pre-eclampsia, neonate with maternal ITP, massive transfusion, recent platelet transfusion, cardiopulmonary bypass, hemolytic uremic syndrome, renal diseases, lymphadenopathy, hepatomegaly, splenomegaly, hypersplenism, neurologic abnormalities, viral or other infection, myeloproliferative, myelodysplastic, or lymphoproliferative disorder, thrombosis, exposure to toxic agents, excessive alcohol ingestion, autoimmune disorder (SLE, RA).
6. Indications for hemogram or CBC related to red cell (RBC) parameters of the hemogram include, in addition to those already listed, thalassemia, suspected hemoglobinopathy, lead poisoning, arsenic poisoning, and spherocytosis.
7. Specific indications for CBC with differential count related to the WBC include, in addition to those already listed, storage diseases; mucopolysaccharidoses, and use of drugs that cause leukocytosis such as G-CSF or CM-CSF.
8. Specific indications for CBC related to platelet count include, in addition to those already listed, May-Hegglin syndrome and Wiskott-Aldrich syndrome.

Limitations

1. Testing of patients who are asymptomatic, or who do not have a condition that could be expected to result in a hematological abnormality, is screening and is not a covered service.
2. In some circumstances it may be appropriate to perform only a hemoglobin or hematocrit to assess the oxygen carrying capacity of the blood. When the ordering provider requests only a hemoglobin or hematocrit, the remaining components of the CBC are not covered.
3. When a blood count is performed for an end-stage renal disease (ESRD) patient, and is billed outside the ESRD rate, documentation of the medical necessity for the blood count must be submitted with the claim. 4. In some patients presenting with certain signs, symptoms or diseases, a single CBC may be appropriate. Repeat testing may not be indicated unless abnormal results are found, or unless there is a change in clinical condition. If repeat testing is performed, a more descriptive diagnosis code (e.g., anemia) should be reported to support medical necessity. However, repeat testing may be indicated where results are normal in patients with conditions where there is a continued risk for the development of hematologic abnormality.
4. In some patients presenting with certain signs, symptoms or diseases, a single CBCmay be appropriate. Repeat testing may not be indicated unless abnormal results arefound, or unless there is a change in clinical condition. If repeat testing is performed, amore descriptive diagnosis code (e.g., anemia) should be reported to support medicalnecessity. However, repeat testing may be indicated where results are normal inpatients with conditions where there is a continued risk for the development ofhematologic abnormality.

Blood Counts

CPT: 85004, 85007, 85008, 85013 , 85014, 85018, 85025, 85027, 85032, 85048, 85049

The ICD10 codes listed below are the top diagnosis codes currently utilized by ordering physicians for the limited coverage test highlighted above that are also listed as medically supportive under Medicare's limited coverage policy. **If you are ordering this test for diagnostic reasons that are not covered under Medicare policy, an Advance Beneficiary Notice form is required.**
Note—Bolded diagnoses below have the highest utilization

There is a frequency associated with this test. Please refer to the Limitations or Utilization Guidelines section on previous page(s).

Code	Description
D50.9	Iron deficiency anemia, unspecified
D64.9	Anemia, unspecified
E03.9	Hypothyroidism, unspecified
E11.65	Type 2 diabetes mellitus with hyperglycemia
E11.9	Type 2 diabetes mellitus without complications
E53.8	Deficiency of other specified B group vitamins
E55.9	**Vitamin D deficiency, unspecified**
E78.00	Pure hypercholesterolemia, unspecified
E78.2	**Mixed hyperlipidemia**
E78.5	**Hyperlipidemia, unspecified**
I10	**Essential (primary) hypertension**
I25.10	Atherosclerotic heart disease of native coronary artery without angina pectoris
N39.0	Urinary tract infection, site not specified
R53.83	Other fatigue
R73.01	Impaired fasting glucose
R73.03	Prediabetes
R73.09	Other abnormal glucose
R73.9	Hyperglycemia, unspecified
R79.89	Other specified abnormal findings of blood chemistry
Z79.899	**Other long term (current) drug therapy**

Visit **QuestDiagnostics.com/MLCP** to view current limited coverage tests, reference guides, and policy information.
To view the complete policy and the full list of codes, please refer to the CMS website reference www.cms.gov ▶

Last updated: 10/01/22

Lipid Testing

CPT: 80061, 82465, 83700, 83701, 83704, 83718, 83721, 84478

CMS National Coverage Policy

Coverage Indications, Limitations, and/or Medical Necessity
Lipoproteins are a class of heterogeneous particles of varying sizes and densities containing lipid and protein. These lipoproteins include cholesterol esters and free cholesterol, triglycerides, phospholipids and A, C, and E apoproteins. Total cholesterol comprises all the cholesterol found in various lipoproteins.

Factors that affect blood cholesterol levels include age, sex, body weight, diet, alcohol and tobacco use, exercise, genetic factors, family history, medications, menopausal status, the use of hormone replacement therapy, and chronic disorders such as hypothyroidism, obstructive liver disease, pancreatic disease (including diabetes), and kidney disease.

In many individuals, an elevated blood cholesterol level constitutes an increased risk of developing coronary artery disease. Blood levels of total cholesterol and various fractions of cholesterol, especially low density lipoprotein cholesterol (LDL -C) and high density lipoprotein cholesterol (HDL-C) are useful in assessing and monitoring treatment for that risk in patients with cardiovascular and related diseases. Blood levels of the above cholesterol components including triglyceride have been separated into desirable, borderline and high-risk categories by the National Heart, Lung, and Blood Institute in their report in 1993. These categories form a useful basis for evaluation and treatment of patients with hyperlipidemia. Therapy to reduce these risk parameters includes diet, exercise and medication, and fat weight loss, which is particularly powerful when combined with diet and exercise.

Indications
The medical community recognizes lipid testing as appropriate for evaluating atherosclerotic cardiovascular disease.
Conditions in which lipid testing may be indicated include:

- Assessment of patients with atherosclerotic cardiovascular disease
- Evaluation of primary dyslipidemia
- Any form of atherosclerotic disease, or any disease leading to the formation of atherosclerotic disease
- Diagnostic evaluation of diseases associated with altered lipid metabolism, such as: nephrotic syndrome, pancreatitis, hepatic disease, and hypo and hyperthyroidism
- Secondary dyslipidemia, including diabetes mellitus, disorders of gastrointestinal absorption, chronic renal failure
- Signs or symptoms of dyslipidemias, such as skin lesions
- As follow-up to the initial screen for coronary heart disease (total cholesterol + HDL cholesterol) when total cholesterol is determined to be high (>240 mg/dL), or borderline-high (200-240 mg/dL) plus two or more coronary heart disease risk factors, or an HDL cholesterol <35 mg/dL.

To monitor the progress of patients on anti-lipid dietary management and pharmacologic therapy for the treatment of elevated blood lipid disorders, total cholesterol, HDL cholesterol and LDL cholesterol may be used. Triglycerides may be obtained if this lipid fraction is also elevated or if the patient is put on drugs (for example, thiazide diuretics, beta blockers, estrogens, glucocorticoids, and tamoxifen) which may raise the triglyceride level.

When monitoring long-term anti-lipid dietary or pharmacologic therapy and when following patients with borderline high total or LDL cholesterol levels, it may be reasonable to perform the lipid panel annually. A lipid panel at a yearly interval will usually be adequate while measurement of the serum total cholesterol or a measured LDL should suffice for interim visits if the patient does not have hypertriglyceridemia.

Lipid Testing

CPT: 80061, 82465, 83700, 83701, 83704, 83718, 83721, 84478

CMS National Coverage Policy (continued)

Any one component of the panel or a measured LDL may be reasonable and necessary up to six times the first year for monitoring dietary or pharmacologic therapy. More frequent total cholesterol HDL cholesterol, LDL cholesterol and triglyceride testing may be indicated for marked elevations or for changes to anti-lipid therapy due to inadequate initial patient response to dietary or pharmacologic therapy. The LDL cholesterol or total cholesterol may be measured three times yearly after treatment goals have been achieved.

Electrophoretic or other quantitation of lipoproteins may be indicated if the patient has a primary disorder of lipoid metabolism.

Effective January 1, 2005, the Medicare law expanded coverage to cardiovascular screening services. Several of the procedures included in this NCD may be covered for screening purposes subject to specified frequencies. See 42 CFR 410.17 and section 100, chapter 18, of the Claims Processing Manual, for a full description of this benefit.

Limitations

Lipid panel and hepatic panel testing may be used for patients with severe psoriasis which has not responded to conventional therapy and for which the retinoid etretinate has been prescribed and who have developed hyperlipidemia or hepatic toxicity. Specific examples include erythrodermia and generalized pustular type and psoriasis associated with arthritis. Routine screening and prophylactic testing for lipid disorder are not covered by Medicare. While lipid screening may be medically appropriate, Medicare by statute does not pay for it. Lipid testing in asymptomatic individuals is considered to be screening regardless of the presence of other risk factors such as family history, tobacco use, etc.

Once a diagnosis is established, one or several specific tests are usually adequate for monitoring the course of the disease. Less specific diagnoses (for example, other chest pain) alone do not support medical necessity of these tests.

When monitoring long-term anti-lipid dietary or pharmacologic therapy and when following patients with borderline high total or LDL cholesterol levels, it is reasonable to perform the lipid panel annually. A lipid panel at a yearly interval will usually be adequate while measurement of the serum total cholesterol or a measured LDL should suffice for interim visits if the patient does not have hypertriglyceridemia.

Any one component of the panel or a measured LDL may be medically necessary up to six times the first year for monitoring dietary or pharmacologic therapy. More frequent total cholesterol HDL cholesterol, LDL cholesterol and triglyceride testing may be indicated for marked elevations or for changes to anti-lipid therapy due to inadequate initial patient response to dietary or pharmacologic therapy. The LDL cholesterol or total cholesterol may be measured three times yearly after treatment goals have been achieved.
If no dietary or pharmacological therapy is advised, monitoring is not necessary.

When evaluating non-specific chronic abnormalities of the liver (for example, elevations of transaminase, alkaline phosphatase, abnormal imaging studies, etc.), a lipid panel would generally not be indicated more than twice per year.

Lipid Testing

CPT: 80061, 82465, 83700, 83701, 83704, 83718, 83721, 84478

The ICD10 codes listed below are the top diagnosis codes currently utilized by ordering physicians for the limited coverage test highlighted above that are also listed as medically supportive under Medicare's limited coverage policy. **If you are ordering this test for diagnostic reasons that are not covered under Medicare policy, an Advance Beneficiary Notice form is required.**
Note—Bolded diagnoses below have the highest utilization

There is a frequency associated with this test. Please refer to the Limitations or Utilization Guidelines section on previous page(s).

Code	Description
E03.8	Other specified hypothyroidism
E03.9	**Hypothyroidism, unspecified**
E11.22	Type 2 diabetes mellitus with diabetic chronic kidney disease
E11.65	Type 2 diabetes mellitus with hyperglycemia
E11.69	Type 2 diabetes mellitus with other specified complication
E11.9	**Type 2 diabetes mellitus without complications**
E66.9	Obesity, unspecified
E78.00	Pure hypercholesterolemia, unspecified
E78.1	Pure hyperglyceridemia
E78.2	**Mixed hyperlipidemia**
E78.49	Other hyperlipidemia
E78.5	**Hyperlipidemia, unspecified**
I10	**Essential (primary) hypertension**
I11.9	Hypertensive heart disease without heart failure
I12.9	Hypertensive chronic kidney disease with stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease
I25.10	Atherosclerotic heart disease of native coronary artery without angina pectoris
R79.89	Other specified abnormal findings of blood chemistry
R79.9	Abnormal finding of blood chemistry, unspecified
Z13.6	Encounter for screening for cardiovascular disorders
Z79.899	Other long term (current) drug therapy

Visit **QuestDiagnostics.com/MLCP** to view current limited coverage tests, reference guides, and policy information.

To view the complete policy and the full list of codes, please refer to the CMS website reference

www.cms.gov ▶

Last updated: 10/01/22

Thyroid Testing

CPT: 84436, 84439, 84443, 84479

CMS National Coverage Policy

Coverage Indications, Limitations, and/or Medical Necessity
Thyroid function studies are used to delineate the presence or absence of hormonal abnormalities of the thyroid and pituitary glands. These abnormalities may be either primary or secondary and often but not always accompany clinically defined signs and symptoms indicative of thyroid dysfunction.

Laboratory evaluation of thyroid function has become more scientifically defined. Tests can be done with increased specificity, thereby reducing the number of tests needed to diagnose and follow treatment of most thyroid disease. Measurements of serum sensitive thyroid-stimulating hormone (TSH) levels, complemented by determination of thyroid hormone levels [free thyroxine (fT-4) or total thyroxine (T4) with Triiodothyronine (T3) uptake] are used for diagnosis and follow-up of patients with thyroid disorders. Additional tests may be necessary to evaluate certain complex diagnostic problems or on hospitalized patients, where many circumstances can skew tests results. When a test for total thyroxine (total T4 or T4 radioimmunoassay) or T3 uptake is performed, calculation of the free thyroxine index (FTI) is useful to correct for abnormal results for either total T4 or T3 uptake due to protein binding effects.

Indications
Thyroid function tests are used to define hyper function, euthyroidism, or hypofunction of thyroid disease. Thyroid testing may be reasonable and necessary to:

- Distinguish between primary and secondary hypothyroidism
- Confirm or rule out primary hypothyroidism
- Monitor thyroid hormone levels (for example, patients with goiter, thyroid nodules, or thyroid cancer)
- Monitor drug therapy in patients with primary hypothyroidism
- Confirm or rule out primary hyperthyroidism
- Monitor therapy in patients with hyperthyroidism

Thyroid function testing may be medically necessary in patients with disease or neoplasm of the thyroid and other endocrine glands. Thyroid function testing may also be medically necessary in patients with metabolic disorders; malnutrition; hyperlipidemia; certain types of anemia; psychosis and non-psychotic personality disorders; unexplained depression; ophthalmologic disorders; various cardiac arrhythmias; disorders of menstruation; skin conditions; myalgias; and a wide array of signs and symptoms, including alterations in consciousness; malaise; hypothermia; symptoms of the nervous and musculoskeletal system; skin and integumentary system; nutrition and metabolism; cardiovascular; and gastrointestinal system.

It may be medically necessary to do follow-up thyroid testing in patients with a history of malignant neoplasm of the endocrine system and in patients on long-term thyroid drug therapy.

Limitations
Testing may be covered up to two times a year in clinically stable patients; more frequent testing may be reasonable and necessary for patients whose thyroid therapy has been altered or in whom symptoms or signs of hyperthyroidism or hypothyroidism are noted.

Thyroid Testing

CPT: 84436, 84439, 84443, 84479

The ICD10 codes listed below are the top diagnosis codes currently utilized by ordering physicians for the limited coverage test highlighted above that are also listed as medically supportive under Medicare's limited coverage policy. **If you are ordering this test for diagnostic reasons that are not covered under Medicare policy, an Advance Beneficiary Notice form is required.**
Note—Bolded diagnoses below have the highest utilization

There is a frequency associated with this test. Please refer to the Limitations or Utilization Guidelines section on previous page(s).

Code	Description
D64.9	Anemia, unspecified
E03.8	Other specified hypothyroidism
E03.9	**Hypothyroidism, unspecified**
E04.2	Nontoxic multinodular goiter
E05.90	Thyrotoxicosis, unspecified without thyrotoxic crisis or storm
E06.3	Autoimmune thyroiditis
E11.65	Type 2 diabetes mellitus with hyperglycemia
E11.69	Type 2 diabetes mellitus with other specified complication
E11.9	**Type 2 diabetes mellitus without complications**
E78.00	Pure hypercholesterolemia, unspecified
E78.2	**Mixed hyperlipidemia**
E78.49	Other hyperlipidemia
E78.5	**Hyperlipidemia, unspecified**
E89.0	Postprocedural hypothyroidism
I10	**Essential (primary) hypertension**
R53.82	Chronic fatigue, unspecified
R53.83	Other fatigue
R73.03	Prediabetes
R94.6	Abnormal results of thyroid function studies
Z79.899	Other long term (current) drug therapy

Visit **QuestDiagnostics.com/MLCP** to view current limited coverage tests, reference guides, and policy information.

To view the complete policy and the full list of codes, please refer to the CMS website reference www.cms.gov ▶

Last updated: 10/01/22

Hemoglobin A1c

Glycated Hemoglobin/Glycated Protein

CPT: 82985, 83036

CMS National Coverage Policy

Coverage Indications, Limitations, and/or Medical Necessity
The management of diabetes mellitus requires regular determinations of blood glucose levels. Glycated hemoglobin/protein levels are used to assess long-term glucose control in diabetes. Alternative names for these tests include glycated or glycosylated hemoglobin or Hgb, hemoglobin glycated or glycosylated protein, and fructosamine.

Glycated hemoglobin (equivalent to hemoglobin A1) refers to total glycosylated hemoglobin present in erythrocytes, usually determined by affinity or ion-exchange chromatographic methodology. Hemoglobin A1c refers to the major component of hemoglobin A1, usually determined by ion-exchange affinity chromatography, immunoassay or agar gel electrophoresis. Fructosamine or glycated protein refers to glycosylated protein present in a serum or plasma sample. Glycated protein refers to measurement of the component of the specific protein that is glycated usually by colorimetric method or affinity chromatography.

Glycated hemoglobin in whole blood assesses glycemic control over a period of 4-8 weeks and appears to be the more appropriate test for monitoring a patient who is capable of maintaining long-term, stable control. Measurement may be medically necessary every 3 months to determine whether a patient's metabolic control has been on average within the target range. More frequent assessments, every 1-2 months, may be appropriate in the patient whose diabetes regimen has been altered to improve control or in whom evidence is present that intercurrent events may have altered a previously satisfactory level of control (for example, post-major surgery or as a result of glucocorticoid therapy). Glycated protein in serum/plasma assesses glycemic control over a period of 1-2 weeks. It may be reasonable and necessary to monitor glycated protein monthly in pregnant diabetic women. Glycated hemoglobin/protein test results may be low, indicating significant, persistent hypoglycemia, in nesidioblastosis or insulinoma, conditions which are accompanied by inappropriate hyperinsulinemia. A below normal test value is helpful in establishing the patient's hypoglycemic state in those conditions.

Indications
Glycated hemoglobin/protein testing is accepted as medically necessary for management and control of diabetes and to assess hyperglycemia, a history of hyperglycemia or dangerous hypoglycemia. Glycated protein testing may be used in place of glycated hemoglobin in the management of diabetic patients, and is useful in patients with abnormalities of erythrocytes such as hemolytic anemia or hemoglobinopathies.

Limitations
It is not reasonable and necessary to perform glycated hemoglobin tests more often than every three months on a controlled diabetic patient to determine if the patient's metabolic control has been on average within the target range. It is not reasonable and necessary for these tests to be performed more frequently than once a month for diabetic pregnant women. Testing for uncontrolled type one or two diabetes mellitus may require testing more than four times a year. The above Description Section provides the clinical basis for those situations in which testing more frequently than four times per annum is indicated, and medical necessity documentation must support such testing in excess of the above guidelines.

Many analytical methods of glycated hemoglobin show interference from elevated levels of fetal hemoglobin or by variant hemoglobin molecules. When the glycated hemoglobin assay is initially performed in these patients, the laboratory may inform the ordering physician of a possible analytical interference. Alternative testing, including glycated protein, for example, fructosamine, may be indicated for monitoring the degree of glycemic control. It is therefore conceivable that a patient will have both a glycated hemoglobin and glycated protein ordered on the same day. This should be limited to the initial assay of glycated hemoglobin, with subsequent exclusive use of glycated protein. These tests are not considered to be medically necessary for the diagnosis of diabetes.

Hemoglobin A1c

Glycated Hemoglobin/Glycated Protein

CPT: 82985, 83036

The ICD10 codes listed below are the top diagnosis codes currently utilized by ordering physicians for the limited coverage test highlighted above that are also listed as medically supportive under Medicare's limited coverage policy. **If you are ordering this test for diagnostic reasons that are not covered under Medicare policy, an Advance Beneficiary Notice form is required.**
Note—Bolded diagnoses below have the highest utilization

There is a frequency associated with this test. Please refer to the Limitations or Utilization Guidelines section on previous page(s).

Code	Description
E11.21	Type 2 diabetes mellitus with diabetic nephropathy
E11.22	Type 2 diabetes mellitus with diabetic chronic kidney disease
E11.29	Type 2 diabetes mellitus with other diabetic kidney complication
E11.40	Type 2 diabetes mellitus with diabetic neuropathy, unspecified
E11.42	Type 2 diabetes mellitus with diabetic polyneuropathy
E11.59	Type 2 diabetes mellitus with other circulatory complications
E11.65	**Type 2 diabetes mellitus with hyperglycemia**
E11.69	Type 2 diabetes mellitus with other specified complication
E11.8	Type 2 diabetes mellitus with unspecified complications
E11.9	**Type 2 diabetes mellitus without complications**
E79.0	Hyperuricemia without signs of inflammatory arthritis and tophaceous disease
R73.01	**Impaired fasting glucose**
R73.02	Impaired glucose tolerance (oral)
R73.03	**Prediabetes**
R73.09	Other abnormal glucose
R73.9	Hyperglycemia, unspecified
R79.89	Other specified abnormal findings of blood chemistry
R79.9	Abnormal finding of blood chemistry, unspecified
Z79.4	Long term (current) use of insulin
Z79.899	**Other long term (current) drug therapy**

Visit **QuestDiagnostics.com/MLCP** to view current limited coverage tests, reference guides, and policy information.

To view the complete policy and the full list of codes, please refer to the CMS website reference

www.cms.gov ▶

Last updated: 10/01/22

Client Bulletin

Quest Diagnostics™

Reviewed April 2019

Medi-Cal ICD-10 Coverage Policy

Cyanocobalamin (Vitamin B-12)

According to the Pathology: Chemistry section of the Medi-Cal General Medicine provider manual, CPT-4 code 82607 is reimbursable only when an appropriate diagnosis on the claim documents the medical necessity of the test. Cyanocobalamin (vitamin B-12) is reimbursable by Medi-Cal only when billed in conjunction with one of the following ICD-10-CM codes documenting the medical necessity of the test.

ICD-10 Code	Description	ICD-10 Code	Description
A52.15	Late syphilitic neuropathy	K29.50, K29.51	Unspecified chronic gastritis
B70.0	Diphyllobothriasis, intestinal	K50.00-K50.919	Crohn's disease
C16.0-C16.9	Malignant neoplasm of stomach	K86.0	Alcohol-induced chronic pancreatitis
D51.0-D51.9	Vitamin B-12 deficiency anemia	K86.1	Other chronic pancreatitis
D53.1	Other megaloblastic anemias not elsewhere classified	K86.81 K86.89	Exocrine pancreatic insufficiency Other specified diseases of pancreas
D53.9	Unspecified deficiency anemia	K90.0-K90.49	Intestinal malabsorption
D77	Other disorders of blood-forming organs in diseases classified elsewhere	K90.89, K90.9	Other and unspecified intestinal malabsorption
D81.818	Other biotin-dependent carboxylase deficiency	K91.1	Postgastric surgery syndromes
E53.8	Deficiency of other specified B group vitamins	K91.2	Postsurgical malabsorption, not elsewhere classified
F01.50, F01.51	Vascular dementia	M34.83	Systemic sclerosis with polyneuropathy
F02.80, F02.81	Dementia in other diseases classified elsewhere	Q41.0-Q41.9	Congenital absence, atresia, and stenosis of small intestine
F06.8	Other specified mental disorders due to known physiological condition	R20.0-R20.9 R53.0-R53.83	Disturbances of skin sensation Malaise and fatigue
F07.0	Personality change due to known physiological condition	Z93.2	Ileostomy status
G60.9	Hereditary and idiopathic peripheral neuropathy; unspecified	Z93.4	Other artificial opening of gastrointestinal tract status
G63	Polyneuropathy in diseases classified elsewhere	Z97.8	Presence of other specified devices
G65.0-G65.2	Sequela of inflammatory and toxic polyneuropathies	Z98.0 Z98.3	Intestinal bypass and anastomosis status Post-therapeutic collapse of lung status
G93.3	Postviral fatigue syndrome	Z98.62	Peripheral vascular angioplasty status
K14.6	Glossodynia	Z98.890	Other specified post-procedural states
K29.30, K29.31	Chronic superficial gastritis		
K29.40, K29.41	Chronic atrophic gastritis		

For additional information on the above policy, please refer to the Pathology: Chemistry section of the General Medicine provider manual available at medi-cal.ca.gov/manual.

If you have any questions, please contact your Quest Diagnostics sales representative.

Medicare Local Coverage Determination Policy

Vitamin D Assay Testing

Vitamin D; 25 hydroxy

CPT: 82306

CMS Policy for California, Hawaii, and Nevada

Local policies are determined by the performing test location. This is determined by the state in which your performing laboratory resides and where your testing is commonly performed.

Medically Supportive ICD Codes are listed on subsequent page(s) of this document.

Coverage Indications, Limitations, and/or Medical Necessity

Vitamin D is called a "vitamin" because of its exogenous source, predominately from oily fish in the form of vitamin D 2 and vitamin D 3. It is more accurate to consider fat-soluble Vitamin D as a steroid hormone, synthesized by the skin and metabolized by the kidney to an active hormone, calcitriol. Clinical disorders related to vitamin D may arise because of altered availability of the parent vitamin D, altered conversion of vitamin D to its predominant metabolites, altered organ responsiveness to dihydroxylated metabolites and disturbances in the interactions of the vitamin D metabolites with PTH and calcitonin. Normal levels of Vitamin D range from 20 – 50 ng/dl. This LCD identifies the indications and limitations of Medicare coverage and reimbursement for the lab assay.

Indications

Measurement of 25-OH Vitamin D, CPT 82306, level is indicated for patients with: chronic kidney disease stage III or greater; cirrhosis; hypocalcemia; hypercalcemia; hypercalciuria; hypervitaminosis D; parathyroid disorders; malabsorption states; obstructive jaundice; osteomalacia; osteoporosis if:

i. T score on DEXA scan <-2.5 or

ii. History of fragility fractures or

iii. FRAX > 3% 10-year probability of hip fracture or 20% 10-year probability of other major osteoporotic fracture or

iv. FRAX > 3% (any fracture) with T-score <-1.5 or

v. Initiating bisphosphanate therapy (Vit D level should be determined and managed as necessary before bisphosphonate is initiated); osteosclerosis/petrosis; rickets; vitamin D deficiency on replacement therapy related to a condition listed above; to monitor the efficacy of treatment.

Measurement of 1, 25-OH Vitamin D, CPT 82652, level is indicated for patients with:

- unexplained hypercalcemia (suspected granulomatous disease or lymphoma), unexplained hypercalciuria (suspected granulomatous disease or lymphoma), suspected genetic childhood rickets, suspected tumor-induced osteomalacia, nephrolithiasis or hypercalciuria.

Limitations

Testing may not be used for routine or other screening. Both assays of vitamin D need not be performed for each of the above conditions. Often, one type is more appropriate for a certain disease state than another. The most common type of vitamin D deficiency is 25-OH vitamin D. A much smaller percentage of 1,25 dihydroxy vitamin D deficiency exists; mostly, in those with renal disease. Documentation must justify the test(s) chosen for a particular disease entity. Various component sources of 25-OH vitamin D, such as stored D or diet-derived D, should not be billed separately.

Once a beneficiary has been shown to be vitamin D deficient, further testing may be medically necessary only to ensure adequate replacement has been accomplished. If Vitamin D level is between 20 and 50 ng/dl and patient is clinically stable, repeat testing is often unnecessary; if performed, documentation most clearly indicate the necessity of the test. If level <20 ng/dl or > 60 ng/dl, a subsequent level(s) may be reimbursed until the level is within the normal range.

Medicare Local Coverage Determination Policy

Vitamin D Assay Testing

Vitamin D; 25 hydroxy

CPT: 82306

CMS Policy for California, Hawaii, and Nevada

Local policies are determined by the performing test location. This is determined by the state in which your performing laboratory resides and where your testing is commonly performed.

Please refer to the Limitations or Utilization Guidelines section on previous page(s) for frequency information.

The ICD10 codes listed below are the top diagnosis codes currently utilized by ordering physicians for the limited coverage test highlighted above that are also listed as medically supportive under Medicare's limited coverage policy. **If you are ordering this test for diagnostic reasons that are not covered under Medicare policy, an Advance Beneficiary Notice form is required.**
Note—Bolded diagnoses below have the highest utilization

Code	Description
E21.0	Primary hyperparathyroidism
E21.1	Secondary hyperparathyroidism, not elsewhere classified
E21.3	Hyperparathyroidism, unspecified
E55.9	**Vitamin D deficiency, unspecified**
E83.30	Disorder of phosphorus metabolism, unspecified
E83.39	Other disorders of phosphorus metabolism
E83.51	Hypocalcemia
E83.52	Hypercalcemia
K91.2	Postsurgical malabsorption, not elsewhere classified
M81.0	**Age-related osteoporosis without current pathological fracture**
M81.8	Other osteoporosis without current pathological fracture
M85.80	**Other specified disorders of bone density and structure, unspecified site**
N18.30	**Chronic kidney disease**
N18.31	Chronic kidney disease
N18.32	Chronic kidney disease
N18.4	Chronic kidney disease, stage 4 (severe)
N18.5	Chronic kidney disease, stage 5
N25.81	Secondary hyperparathyroidism of renal origin
Z79.4	Long term (current) use of insulin
Z79.899	**Other long term (current) drug therapy**

Visit **QuestDiagnostics.com/MLCP** to view current limited coverage tests, reference guides, and policy information.
To view the complete policy and the full list of medically supportive codes, please refer to the CMS website reference www.cms.gov ▶

Last updated: 10/17/22

Medicare Local Coverage Determination Policy

Controlled Substance Monitoring and Drugs of Abuse Testing

CPT: 80305, 80306, 80307, G0480, G0481, G0482, G0483, G0659

CMS Policy for California, Hawaii, and Nevada

Local policies are determined by the performing test location. This is determined by the state in which your performing laboratory resides and where your testing is commonly performed.

Medically Supportive ICD Codes are listed on subsequent page(s) of this document.

Coverage Indications, Limitations, and/or Medical Necessity

Purpose

Urine drug testing (UDT) provides objective information to assist clinicians in identifying the presence or absence of drugs or drug classes in the body and making treatment decisions.

This policy details:
• The appropriate indications and expected frequency of testing for safe medication management of prescribed substances in risk stratified pain management patients and/or in identifying and treating substance use disorders.
• Designates documentation, by the clinician caring for the beneficiary in the beneficiary's medical record, of medical necessity for, and testing ordered on an individual patient basis;
• Provides an overview of presumptive urine drug testing (UDT) and definitive UDT testing by various methodologies.

This policy addresses UDT for Medicare patients only.

Definitions

As used in this document, the following terminology relates to the basic forms of UDT:

1. **Presumptive/Qualitative Drug Testing (hereafter called "presumptive" UDT)** - Used when medically necessary to determine the presence or absence of drugs or drug classes in a urine sample; results expressed as negative or positive or as a numerical result; includes competitive immunoassays (IA) and thin layer chromatography.
2. **Definitive/Quantitative/Confirmation (hereafter called "definitive" UDT)** - Used when medically necessary to identify specific medications, illicit substances and metabolites; reports the results of analytes absent or present typically in concentrations such as ng/mL; definitive methods include, but are not limited to GC-MS and LC-MS/MS testing methods.
3. **Specimen Validity Testing** - Urine specimen testing to ensure that it is consistent with normal human urine and has not been adulterated or substituted, may include, but is not limited to pH, specific gravity, oxidants and creatinine.
4. **Immunoassay (IA)** - Ordered by clinicians primarily to identify the presence or absence of drug classes and some specific drugs; biochemical tests that measure the presence above a cutoff level of a substance (drug) with the use of an antibody; read by photometric technology.
5. **Point of Care Testing (POCT)** - Used when medically necessary by clinicians caring for the beneficiary for immediate test results for the immediate management of the beneficiary; available when the beneficiary and physician are in the same location; IA test method that primarily identifies drug classes and a few specific drugs; platform consists of cups, dipsticks, cassettes, or strips; read by the human eye, or read by instrument assisted direct optical observation.
6. **Standing Orders** - Test request for a specific patient representing repetitive testing to monitor a condition or disease for a limited number of sequential visits; individualized orders for certain patients for pre-determined tests based on historical use, risk and community trend patient profiles; clinician can alter the standing order.

Note: A "profile" differs from a "panel" in that a profile responds to the clinical risks of a particular patient, whereas a panel may encourage unnecessary or excessive testing when no clinical cause exists for many of the tests.

Controlled Substance Monitoring and Drugs of Abuse Testing

CPT: 80305, 80306, 80307, G0480, G0481, G0482, G0483, G0659

CMS Policy for California, Hawaii, and Nevada (continued)

7. Blanket Orders - Test request that is not for a specific patient; rather, it is an identical order for all patients in a clinician's practice without individualized decision making at every visit.
8. Reflex Testing - Laboratory testing that is performed "reflexively" after initial test results to identify further diagnostic information essential to patient care. This testing is not based on a specific physician's order. Testing performed as a step necessary to complete a physician's order is not considered reflex testing.

Drug Test Methods

The Clinical Laboratory Improvement Amendments (CLIA) regulates laboratory testing and requires clinical labs to be certified by their State as well as the CMS before they can accept human samples for diagnostic testing. Multiple types of CLIA certificates may be obtained based on the complexity of testing a lab conducts. CLIA levels of complexity (CLIA-waived, moderate complexity and high complexity) are addressed only as they relate to the HCPCS code description and the coding/billing guidance to be attached to this document.

A. Presumptive Testing Methods:

1. Presumptive UDT:
Presumptive UDT consist of various platforms including cards, dipsticks, cassettes and cups based on qualitative competitive immunoassay methodology with one or more analytes in the test. A presumptive IA test detects the presence of the amount of drug/substance present in urine above a predetermined "cut-off" value, and may be read by direct optical observation or by instrument assisted direct optical observation.
A positive test result is reported when the concentration of drug is above the cutoff; a negative is reported when the concentration of drug is below the cut-off. Positive test results are presumptive but not necessarily definitive due to sensitivity and cross-reactivity limitations. Negative test results do not necessarily indicate the absence of a drug or substance in the urine specimen. The accuracy of the results of a presumptive UDT will depend on the testing environment, type of test, and training of the individual conducting the test.
This type of test should only be used when results are needed immediately.

2. Presumptive UDT by Instrumented Chemistry Analyzers:
Chemistry analyzers with IA UDT technology can be used in an office or clinical laboratory setting. This test may be used when less immediate test results are required. At no time is IA technology by chemistry analyzer analysis considered confirmatory (definitive) testing.
A presumptive positive IA test detects the presence of a drug/substance in urine at or above the "cut-off" value. If the concentration of the drug is below the cut-off, the result will be negative. Presumptive positive tests are not always true positives due to sensitivity, specificity, and cross-reactivity limitations. Negative test results do not necessarily indicate the absence of a drug or substance in the urine specimen.
FDA approved/cleared test platforms are available in the marketplace as well as, laboratory developed tests (LDTs) such as modified FDA approved/ cleared and non-FDA approved/cleared platforms and/or reagents. LDTs generally have been modified to test at a lower cutoff in order to detect substances that would have been missed at a higher cutoff. For example, a FDA labeled cutoff may be 300 ng/mL and the LDT cutoff for the same drug may be a 100 ng/mL.
Presumptive UDT can be carried out at any validated cut-off concentration. Lowering of the cut-off concentration provides more stringent cutoffs for illicit drugs. LDTs may include non-FDA cleared tests not available in CLIA-waived or moderate complexity tests (e.g. tramadol, tapentadol, carisoprodol, fentanyl, zolpidem). Lowering the cutoff increases the possibility of detecting a drug when the test has been modified from the recipe of the manufacturer.

Controlled Substance Monitoring and Drugs of Abuse Testing

CPT: 80305, 80306, 80307, G0480, G0481, G0482, G0483, G0659

CMS Policy for California, Hawaii, and Nevada (continued)

3. Limitations of Presumptive UDT:

Presumptive UDT testing is limited due to:
◦ Primarily screens for drug classes rather than specific drugs, and therefore, the practitioner may not be able to determine if a different drug within the same class is causing the positive result;
◦ Produces erroneous results due to cross-reactivity with other compounds or does not detect all drugs within a drug class;
◦ Given that not all prescription medications or synthetic/analog drugs are detectable and/or have assays available, it is unclear as to whether other drugs are present when some tests are reported as positive;
◦ Cut-off may be too high to detect presence of a drug
This information could cause a practitioner to make an erroneous assumption or clinical decision.
An IA involves an antibody that reacts best with the stimulating drug, and reacts to a lesser extent (cross-reactive) or not at all with other drugs in the drug class. While presumptive tests vary in their ability to detect illicit drugs such as tetrahydrocannabinol (THC), cocaine, 3,4-methylenedioxy-N-methylamphetamine (MDMA; "ecstasy"), and phencyclidine (PCP), they may not be optimal tests for many prescription drugs, such as: opiates, barbiturates, benzodiazepines and opioids.
For example, opiate reagents are formulated from morphine. Consequently, the cross-reactivity for other opioids and opiates varies based on the manufacturer and lot number. The semisynthetic opioids, hydromorphone and hydrocodone, may contribute to a positive presumptive result, while the semisynthetic opioids, oxycodone and oxymorphone, will not typically be detected even at 300 ng/mL cutoff. Synthetic opioids, such as fentanyl, meperidine and methadone, will not be detected by current opiate IA testing. Consequently, a positive opiate result by IA normally necessitates more specific identification of the substance(s) that account for the positive result, and a negative result does not rule out the presence of opiates or opioids.
Presumptive UDT reagents for benzodiazepine are typically formulated for oxazepam, a metabolite of diazepam (Valium®) and chlordiazepoxide (Librium®), the main benzodiazepines prescribed twenty years ago. However, many of the more than 10 benzodiazepines that are currently available do not cross-react with IA benzodiazepine reagents. In particular, clonazepam and lorazepam give false negative results with presumptive IA tests and may necessitate more specific identification to account for the negative result. Similarly, a positive screening test result may require definitive UDT to identify the specific drug(s).
Synthetic/analog or "designer" drugs manufactured to elude law enforcement require definitive testing for detection. Most commercially available IA reagents fail to detect designer drugs, such as psychedelic phenethylamines even at very high concentrations.
In summary, presumptive IA UDT is often unable to identify specific drugs within many drug classes, particularly within the amphetamine, barbiturate, benzodiazepine, tricyclic antidepressants, and opiate/opioid drug classes. Drugs such as buprenorphine, amphetamines, benzodiazepines, and cocaine/heroin yield false negative IA results due to low cross-reactivity or non-reactivity and drugs such as fentanyl, carisoprodol, tramadol, tapentadol and synthetic designer drugs cannot be detected by presumptive IA. Therefore, it may be medically necessary for clinicians to utilize definitive UDT when the presumptive tests for these drugs are negative.

B. Definitive UDT:

Gas Chromatography coupled with Mass Spectrometry (GC-MS) and Liquid Chromatography coupled with Mass Spectrometry (LC-MS/MS) are complex technologies that use the separation capabilities of gaseous or liquid chromatography with the analytical capabilities of mass spectrometry. These methodologies require the competency of on-site highly trained experts in this technology and interpretation of results. While these tests require different sample preparation and analytical runs, they identify specific drugs, metabolites, and most illicit substances and report the results as absent or present typically in concentrations of ng/mL.
Quantification should not be used to determine adherence with a specific dosage or time of dose of a pain medication or illicit drug for clinical purposes. Rather, the use of quantitative drug data may be important for many reasons such as in a differential patient assessment. For example, when several opioids are present in the urine of a patient prescribed a single opioid, quantification may help the clinician decide whether the presence of the other opioids is consistent with metabolism of the prescribed opioid, opioid contamination during manufacturing, or if more than one drug within a class is being used.

Controlled Substance Monitoring and Drugs of Abuse Testing

CPT: 80305, 80306, 80307, G0480, G0481, G0482, G0483, G0659

CMS Policy for California, Hawaii, and Nevada (continued)

Quantification may also provide information in the setting of illicit drug use. Serial creatinine-corrected quantitative values may assist in the differential assessment of ongoing drug use or cessation of drug use with continued drug excretion.

1. GC-MS

GC-MS can only be performed on molecules that are volatile. If the test drug is not volatile in its own right, it must be modified or derivatized to a volatile form. To derivatize, the test drug must be extracted from the urine, eluted from the extraction device, concentrated, and then reacted with a chemical reagent to make a volatile product. Each drug class may require a different derivatizing agent. For patients on multiple classes of medications, laboratories using GC procedures must make different volatile derivatives in order to perform comprehensive testing. Since a GC column may not be able to separate more than one class of compounds, multiple chromatographic runs on different column types may be required to monitor multiple drug classes. Newer GC-MS instruments often use tandem systems. GC-MS methodology allows for the testing of multiple substances but differs in ease of run.

2. LC-MS/MS

LC-MS/MS is roughly 100 times more sensitive and selective, involves less human steps, provides quicker turn-around time, uses less specimen volume and can test for a larger number of substances simultaneously when compared to GC-MS. After sample preparation, it is injected into the LC-MS/MS. The sample has to undergo hydrolysis to break the glucuronide bond that frees the drug and drug metabolites. Hydrolysis is followed by multiple additional steps including protein precipitation, centrifugation and purification. Deuterium-labeled isotopic internal standards are added to quantify the drugs and drug metabolites.

The sample is injected when the mobile phase is flowing through the chromatographic column. Each drug and drug metabolite interacts with the mobile phase and stationary phase differently and moves at different speeds depending on their chemical properties. In other words, each analyte elutes at different times. Specific drugs and metabolites are identified by their retention time and quantified against isotopic internal standards for each drug and metabolite. Each drug peak has to be compared to drug standards (calibrators) in order to ensure identification.

CLIA-Certified Laboratories

CLIA specifies quality standards for proficiency testing, facility administration, general laboratory systems, pre-analytic, analytic and post-analytic systems, onsite supervision requirements, personnel qualifications and responsibilities, quality control, and quality assessment. High complexity laboratories must ensure that testing is carried out by onsite qualified, trained personnel using validated reliable methods compliant with regulatory procedures (42 CFR Part 493). Both GC-MS and LC-MS/MS require a quality program to monitor the quality and audit the competency of the staff. LC-MS/MS instrument maintenance must be performed daily as well as the validation of instrument performance prior to patient specimens. Final review and approval of GC-MS and LC-MS/MS results must be performed by a qualified clinical laboratory scientist as defined in 42 CFR Part 493.1489 (Testing Personnel Qualifications). A GC-MS or LC-MS/MS laboratory must have a qualified laboratory director, qualified physician, or qualified clinical laboratory scientist, as provided in 42 CFR 493.1443 (Laboratory Director Qualifications).

Assay validation must be consistent with FDA guidelines. Laboratories that use “application notes” from vendors to establish drug validation do not comply with federal standards, and put patients and providers at risk by potentially reporting inaccurate test results. Only FDA 510K cleared test methods may be distributed by vendors.

Purpose of UDT:

Presumptive UDT may be ordered by the clinician caring for a beneficiary when it is necessary to rapidly obtain and/or integrate results into clinical assessment and treatment decisions.

Controlled Substance Monitoring and Drugs of Abuse Testing

CPT: 80305, 80306, 80307, G0480, G0481, G0482, G0483, G0659

CMS Policy for California, Hawaii, and Nevada (continued)

Definitive UDT is reasonable and necessary for the following circumstances:
• Identify a specific substance or metabolite that is inadequately detected by a presumptive UDT; • Definitively identify specific drugs in a large family of drugs; • Identify a specific substance or metabolite that is not detected by presumptive UDT such as fentanyl, meperidine, synthetic cannabinoids and other synthetic/analog drugs; • Identify drugs when a definitive concentration of a drug is needed to guide management (e.g., discontinuation of THC use according to a treatment plan); • Identify a negative, or confirm a positive, presumptive UDT result that is inconsistent with a patient's self-report, presentation, medical history, or current prescribed pain medication plan; • Rule out an error as the cause of a presumptive UDT result; •Identify non-prescribed medication or illicit use for ongoing safe prescribing of controlled substances; and • Use in a differential assessment of medication efficacy, side effects, or drug-drug interactions
Definitive UDT may be reasonable and necessary based on patient specific indications, including historical use, medication response, and clinical assessment, when accurate results are necessary to make clinical decisions. The clinician's rationale for the definitive UDT and the tests ordered must be documented in the patient's medical record.

Drug Testing Panels

A. Presumptive UDT Panels
Presumptive UDT testing typically involves testing for multiple analytes based on the beneficiary's clinical history and risk assessment, and must be documented in the medical record.

B. Definitive UDT Panels
Physician-directed definitive profile testing is reasonable and necessary when ordered for a particular patient based upon historical use and community trends. However, the same physician-defined profile is not reasonable and necessary for every patient in a physician's practice. Definitive UDT orders should be individualized based on clinical history and risk assessment, and must be documented in the medical record.

Specimen Type
Urine or oral fluid is the preferred biologic specimen for testing because of the ease of collection, storage, and cost-effectiveness. UDT cannot detect the dosage of drug ingested/used, the time of use, or the means of delivery (intravenous vs. oral vs. inhaled). Detection time of a substance in urine is typically 1-3 days depending on the drug, rate of metabolism, and rate of excretion. Lipid-soluble drugs, such as marijuana, may remain in body fat and be detected upwards of a week or more.

Parent Drugs and Metabolite

The following chart illustrates parent drugs and their metabolites but may not be totally inclusive of all drugs and metabolites.
Note: Ethanol is a significant drug of abuse. Alcohol metabolites of ethyl glucuronide and ethyl sulfate are typically detected by definitive (GC-MS or LC-MS/MS) UDT, and should only be performed based on clinician's documentation of medical necessity.

Parent Drugs and Metabolite Chart

Drug Class/Drugs	Common Names	General Monitoring Possibilities Subject to Medical Necessity
Alcohol/Alcohol Metabolites Ethyl Glucuronide Ethyl Sulfate	Alcohol	Ethyl Glucuronide Ethyl Sulfate

Controlled Substance Monitoring and Drugs of Abuse Testing

CPT: 80305, 80306, 80307, G0480, G0481, G0482, G0483, G0659

CMS Policy for California, Hawaii, and Nevada (continued)

Barbiturates		
Amobarbital	Amytal Sodium®	Amobarbital
Butabarbital	Butisol Sodium®, Butibel	Butabarbital
Butalbital	Fiorinal®, Fioricet®	Butalbital
Pentobarbital	Nembutal®	Pentobarbital
Phenobarbital	Belladona, Luminal®	Phenobarbital
Secobarbital	Seconal®	Secobarbital
Benzodiazepines		
Alprazolam	Xanax®, Niravam®, Xanor	Alprazolam, Alpha-hydroxyalprazolam
Chlordiazepoxide	Librax®, Libritabs	Nordiazepam, Oxazepam
Clonazepam	Klonopin®	7-Aminoclonazepam
Clorazepate	Tranxene®	Nordiazepam, Oxazepam
Diazepam	Valium®	Diazepam, Nordiazepam, Temazepam, Oxazepam
Lorazepam	Ativan®, Lorax	Lorazepam
Oxazepam	Adumbran, Alepam, Murelax, Serax, Serepax	Oxazepam
Temazepam	Restoril®, Tenox, Euhypnos	Temazepam, Oxazepam
Illicit Drugs		
Cocaine	Blow, Coke, Crack, Snow	Benzoylecgonine
Heroin	Black Tar, Brown Sugar, Dragon, H, Horse, Tar	6-MAM, Morphine
Marijuana	Marinol, Pot, Reefer, Weed	THC-COOH
MDA	Ecstasy, X	Methylenedioxyamphetamine
MDMA	Ecstasy, X	Methylenedioxymethamphetamine, Methylenedioxyamphetamine
Methamphetamine	Crank, Crystal Meth, Didrex®, Eldepryl®, Ice	Methamphetamine, Amphetamine
Phencylclidine (PCP)	Angel Dust	Phencyclidine
Synthetic Cannabinoids	"K2"/"Spice"	
Cathinones	"Bath Salts" Kratom	
General Anesthetic	Ketamine	
Ketamine	Norketamine	

Controlled Substance Monitoring and Drugs of Abuse Testing

CPT: 80305, 80306, 80307, G0480, G0481, G0482, G0483, G0659

CMS Policy for California, Hawaii, and Nevada (continued)

General Anesthetic Ketamine	Ketamine Norketamine	
Muscle Relaxants Carisoprodol Meprobamate	Soma®, Soprodoal Equinal, Miltown®, Meprospan	Carisoprodol, Meprobamate Meprobamate
Neuroleptics Gabapentin Pregabalin	Neurontin® Lyrica®	
Opiates Codeine Hydrocodone Hydromorphone Morphine Oxycodone Oxymorphone	Tylenol® 3 Hycodan®, Lorcet®, Lortab®, Norco® Vicodin®, Vicoprofen® Dilaudid®, Exalgo®, Hymorphan Avinza®, Kadian®, MS Contin®, MSER, MSIR, Roxanol OxyContin®, OxyIR®, Percocet®, Percodan®, Roxicodone®, Tylox® Numorphan®, Opana® ER, Opana®	Codeine, Morphine Hydrocodone, Hydromorphone, Norhydrocodone Hydromorphone Morphine Oxycodone, Oxymorphone, Noroxycodone Oxymorphone
Opioids Buprenorphine Fentanyl Meperidine Methadone Propoxyphene Tapentadol Tramadol	Buprenex®, Butrans®, Suboxone®, Subutex® Actiq®, Duragesic®, Fentora®, Onsolis® Sublimaze Demerol®, Mepergan® Dolophine®, Methadose® Darvocet®, Darvon® Nucynta® Ryzolt®, Ultracet®, Ultram®, Tramadol	Buprenorphine, Norbuprenorphine Fentanyl, Norfentanyl Meperidine, Normeperidine Methadone, EDDP Propoxyphene, Norpropoxyphene Tapentadol, N-Desmethyltapentadol Tramadol, O-Desmethyltramadol
Stimulants Amphetamine Methylphenidate Nicotine	Adderall®, Benzedrine, Dexedrine®, Vyvanse® Concerta®, Focalin®, Methylin®, Ritalin® Nicoderm®, Nicorette®	Amphetamine Methylphenidate, Ritalinic Acid Cotinine

Controlled Substance Monitoring and Drugs of Abuse Testing

CPT: 80305, 80306, 80307, G0480, G0481, G0482, G0483, G0659

CMS Policy for California, Hawaii, and Nevada (continued)

Covered Indications for UDT

Group A – Symptomatic patients, Multiple drug ingestion and/or Patients with unreliable history

A patient who presents in a variety of medical settings with signs or symptoms of substance use toxicity will be treated presumptively to stabilize the patient while awaiting rapid, then definitive testing to determine the cause(s) of the presentation. The need for definitive UDT is based upon rapid test findings, responses to medical interventions, and treatment plan.

A presumptive UDT should be performed as part of the evaluation and management of a patient who presents in an urgent care setting with any one of the following: • Coma • Altered mental status in the absence of a clinically defined toxic syndrome or toxidrome • Severe or unexplained cardiovascular instability (cardiotoxicity) • Unexplained metabolic or respiratory acidosis in the absence of a clinically defined toxic syndrome or toxidrome • Seizures with an undetermined history • To provide antagonist to specific drug

The presumptive findings, definitive drug tests ordered and reasons for the testing must be documented in the patient's medical record.

Group B - Diagnosis and treatment for substance abuse or dependence

A patient in active treatment for substance use disorder (SUD) or monitoring across different phases of recovery may undergo medical management for a variety of medical conditions. A physician who is writing prescriptions for medications to treat either the SUD or other conditions may need to know if the patient is taking substances which can interact with prescribed medications or taking prescribed medications as expected. The risk of drug-drug interactions is inherent to the patient, and may be compounded by prescribed medications.

UDT is a medically necessary and useful component of chemical dependency diagnosis and treatment. The UDT result influences treatment and level of care decisions. Ordered tests and testing methods (presumptive and/or definitive) must match the stage of screening, treatment, or recovery; the documented history; and Diagnostic and Statistical Manual of Mental Disorders (DSM V) diagnosis. For patients with no known indicators of risk for SUDs, the clinician may screen for a broad range of commonly abused drugs using presumptive UDT. For patients with known indicators of risk for SUDs, the clinician may screen for a broad range of commonly abused drugs using definitive UDT.

For patients with a diagnosed SUD, the clinician should perform random UDT, at random intervals in order to properly monitor the patient. Testing profiles must be determined by the clinician based on the following medical necessity guidance criteria: • Patient history, physical examination, and previous laboratory findings • Stage of treatment or recovery; • Suspected abused substance; • Substances that may present high risk for additive or synergistic interactions with prescribed medication (e.g., benzodiazepines, alcohol).

The patient's medical record must include an appropriate testing frequency based on the stage of screening, treatment, or recovery; the rationale for the drugs/drug classes ordered; and the results must be documented in the medical record and used to direct care.

1. Frequency of Presumptive UDT for SUD:

The testing frequency must meet medical necessity and be documented in the clinician's medical record.

a. For patients with 0 to 30 consecutive days of abstinence, presumptive UDT is expected at a frequency of 1 to 3 presumptive UDT per week. More than 3 presumptive panels in one week is not reasonable and necessary and is not covered by Medicare.

b. For patients with 31 to 90 consecutive days of abstinence, presumptive UDT is expected at a frequency of 1 to 3 UDT per week. More than 3 presumptive UDT in one week is not reasonable and necessary and is not be covered by Medicare.

c. For patients with > 90 consecutive days of abstinence, presumptive UDT is expected at a frequency of 1 to 3 UDT in one month. More than 3 physician-directed UDT in one month is not reasonable and necessary and is not covered by Medicare.

2. Frequency of Definitive UDT for SUD:

Depending on the patient's specific substance use history, definitive UDT to accurately determine the specific drugs in the patient's system may be necessary. Definitive testing may be ordered when accurate and reliable results are necessary to integrate treatment decisions and clinical assessment. The frequency and the rational for definitive UDT must be documented in the patient's medical record.

Controlled Substance Monitoring and Drugs of Abuse Testing

CPT: 80305, 80306, 80307, G0480, G0481, G0482, G0483, G0659

CMS Policy for California, Hawaii, and Nevada (continued)

a. For patients with 0 to 30 consecutive days of abstinence, definitive UDT is expected at a frequency not to exceed 1 physician-directed testing profile in one week. More than 1 physician-directed testing profile in one week is not reasonable and necessary and is not covered by Medicare.
b. For patients with 31 to 90 consecutive days of abstinence, definitive UDT is expected at a frequency of 1-3 physician-directed testing profiles in one month. More than 3 UDT in one month is not reasonable and necessary and is not covered by Medicare.
c. For patients with > 90 day of consecutive abstinence, definitive UDT is expected at a frequency of 1-3 physician-directed testing profiles in three months. More than 3 definitive UDT in 3 months is not reasonable and necessary and is not covered by Medicare.

Group C - Treatment for patients on chronic opioid therapy (COT).
A physician who is writing prescriptions for medications to treat chronic pain can manage a patient better if the physician knows whether the patient is consuming another medication or substance, which could suggest the possibility of SUD or lead to drug-drug interactions. Additionally, UDT may help the physician monitor for medication adherence, diversion, efficacy, side effects, and patient safety in general.

1. COT UDT Testing Objectives:
a. Identifies absence of prescribed medication and potential for abuse, misuse, and diversion;
b. Identifies undisclosed substances, such as alcohol, unsanctioned prescription medication, or illicit substances;
c. Identifies substances that contribute to adverse events or drug-drug interactions;
d. Provides objectivity to the treatment plan;
e. Reinforces therapeutic compliance with the patient;
f. Provides additional documentation demonstrating compliance with patient evaluation and monitoring;
g. Provide diagnostic information to help assess individual patient response to medications (e.g., metabolism, side effects, drug-drug interaction, etc.) over time for ongoing management of prescribed medications.

2. Medical Necessity Guidance:
Criteria to establish medical necessity for drug testing must be based on patient-specific elements identified during the clinical assessment, and documented by the clinician in the patient's medical record and minimally include the following elements: ◦ Patient history, physical examination and previous laboratory findings; ◦ Current treatment plan; ◦ Prescribed medication(s) ◦ Risk assessment plan
National pain organizations, physician societies, and the Federation of State Medical Boards recommend a practical approach to definitive UDT for COT. Frequency of testing beyond the baseline presumptive UDT must be based on individual patient needs substantiated by documentation in the patient's medical record. Recommendations for the ordering of presumptive and definitive UDT for patients on COT are as follows:
a. COT Baseline Testing:
Initial presumptive and/or definitive COT patient testing may include amphetamine/ methamphetamine, barbiturates, benzodiazepines, cocaine, methadone, oxycodone, tricyclic antidepressants, tetrahydrocannabinol, opioids, opiates, heroin, and synthetic/analog or "designer" drugs.
b. COT Monitoring Testing:
Ongoing testing may be medically reasonable and necessary based on the patient history, clinical assessment, including medication side effects or inefficacy, suspicious behaviors, self-escalation of dose, doctor-shopping, indications/symptoms of illegal drug use, evidence of diversion, or other clinician documented change in affect or behavioral pattern. The frequency of testing must be based on a complete clinical assessment of the individual's risk potential for abuse and diversion using a validated risk assessment interview or questionnaire and should include the patient's response to prescribed medications and the side effects of medications.
The clinician should perform random UDT at random intervals, in order to properly monitor a patient. UDT testing does not have to be associated with an office visit.

Controlled Substance Monitoring and Drugs of Abuse Testing

CPT: 80305, 80306, 80307, G0480, G0481, G0482, G0483, G0659

CMS Policy for California, Hawaii, and Nevada (continued)

Patients with specific symptoms of medication aberrant behavior or misuse may be tested in accordance with this document's guidance for monitoring patient adherence and compliance during active treatment (<90 days) for substance use or dependence.

3. UDT Frequency Based on Validated Risk Assessment and Stratification*:
Testing must be based on clinician's documented medical necessity and reviewed by the clinician in the management of prescribing/renewing a controlled substance for every risk group outlined below.

Risk Group	Baseline	Frequency of Testing
Low Risk	Prior to Initiation of COT	Random testing 1-2 times every 12 months for prescribed medications, non-prescribed medications that may pose a safety risk if taken with prescribed medications, and illicit substances based on patient history, clinical presentation, and/or community usage.
Moderate Risk	Prior to Initiation of COT	Random testing 1-2 times every 6 months for prescription medications, non-prescribed medication that may pose a safety risk if taken with prescribed medications, and illicit substances, based on patient history, clinical presentation, and/or community usage.
High Risk	Prior to Initiation of COT	Random testing performed 1-3 times every 3 months for prescribed medications, non-prescribed medications that may pose a safety risk if mixed with prescribed and illicit substances based on patient history, clinical presentation and/or community usage.

*Note: Any additional definitive UDT beyond recommendations above must be justified by the clinician in the medical record in situations in which changes in prescribed medications may be needed, such as: ◦ Patient response to prescribed medication suddenly changes ◦ Patient side effect profile changes ◦ To assess for possible drug-drug interactions ◦ Sudden change in patient's medical condition ◦ Patient admits to use of illicit or non-prescribed controlled substance.

Other Covered Services
1. Reflex Testing by Reference Laboratories – since reference laboratories do not have access to patient-specific data, reflex testing under the following circumstances is reasonable and necessary:
a.To verify a presumptive positive UDT using definitive methods that include, but are not limited to GC-MS or LC-MS/MS before reporting the presumptive finding to the ordering clinician and without an additional order from the clinician; or
b.To confirm the absence of prescribed medications when a negative result is obtained by presumptive UDT in the laboratory for a prescribed medication listed by the ordering clinician.

2.Direct to definitive UDT without a presumptive UDT is reasonable and necessary, when individualized for a particular patient.

3.Definitive testing to confirm a negative presumptive UDT result, upon the order of the clinician, is reasonable and necessary in the following circumstances:
a.The result is inconsistent with a patient's self-report, presentation, medical history, or current prescribed medication plan (should be present in the sample);
b.Following a review of clinical findings, the clinician suspects use of a substance that is inadequately detected or not detected by a presumptive UDT; or
c.To rule out an error as the cause of a negative presumptive UDT result.

4. Definitive testing to confirm a presumptive UDT positive result, upon the order of the clinician, is reasonable and necessary when the result is inconsistent with the expected result, a patient's self-report, presentation, medical history, or current prescribed medication plan.

Controlled Substance Monitoring and Drugs of Abuse Testing

CPT: 80305, 80306, 80307, G0480, G0481, G0482, G0483, G0659

CMS Policy for California, Hawaii, and Nevada (continued)

Non-Covered Services

1. Blanket Orders

2. Reflex definitive UDT is not reasonable and necessary when presumptive testing is performed at point of care because the clinician may have sufficient information to manage the patient. If the clinician is not satisfied, he/she must determine the clinical appropriateness of and order specific subsequent definitive testing (e.g., the patient admits to using a particular drug, or the IA cut-off is set at such a point that is sufficiently low that the physician is satisfied with the presumptive test result).

3. Routine standing orders for all patients in a physician's practice are not reasonable and necessary.

4. It is not reasonable and necessary for a physician to perform presumptive POCT and order presumptive IA testing from a reference laboratory. In other words, Medicare will only pay for one presumptive test result per patient per date of service regardless of the number of billing providers.

5. It is not reasonable and necessary for a physician to perform presumptive IA testing and order presumptive IA testing from a reference laboratory with or without reflex testing. Medicare will only pay for one presumptive test result per patient per date of service regardless of the number of billing providers.

6. It is not reasonable and necessary for a reference laboratory to perform and bill IA presumptive UDT prior to definitive testing without a specific physician's order for the presumptive testing.

7. IA testing, regardless of whether it is qualitative or semi-quantitative (numerical), may not be used to "confirm" or definitively identify a presumptive test result obtained by cups, dipsticks, cards, cassettes or other IA testing methods. Definitive UDT provides specific identification and/or quantification typically by GC-MS or LC-MS/MS.

8. Drug testing of two different specimen types from the same patient on the same date of service for the same drugs/metabolites/analytes.

9. UDT for medico-legal and/or employment purposes or to protect a physician from drug diversion charges.

10. Specimen validity testing including, but not limited to, pH, specific gravity, oxidants, creatinine.

Medicare Local Coverage Determination Policy

Controlled Substance Monitoring and Drugs of Abuse Testing

CPT: 80305, 80306, 80307, G0480, G0481, G0482, G0483, G0659

CMS Policy for California, Hawaii, and Nevada

Local policies are determined by the performing test location. This is determined by the state in which your performing laboratory resides and where your testing is commonly performed.

Please refer to the Limitations or Utilization Guidelines section on previous page(s) for frequency information.

The ICD10 codes listed below are the top diagnosis codes currently utilized by ordering physicians for the limited coverage test highlighted above that are also listed as medically supportive under Medicare's limited coverage policy. **If you are ordering this test for diagnostic reasons that are not covered under Medicare policy, an Advance Beneficiary Notice form is required.**
Note—Bolded diagnoses below have the highest utilization

Code	Description
F11.20	Opioid dependence, uncomplicated
F19.20	Other psychoactive substance dependence, uncomplicated
G89.29	**Other chronic pain**
G89.4	**Chronic pain syndrome**
M25.50	Pain in unspecified joint
M47.812	Spondylosis without myelopathy or radiculopathy, cervical region
M47.816	Spondylosis without myelopathy or radiculopathy, lumbar region
M47.817	Spondylosis without myelopathy or radiculopathy, lumbosacral region
M51.36	Other intervertebral disc degeneration, lumbar region
M51.37	Other intervertebral disc degeneration, lumbosacral region
M54.16	Radiculopathy, lumbar region
M54.17	Radiculopathy, lumbosacral region
M54.2	Cervicalgia
M54.5	**Low back pain**
M79.1	Myalgia
M79.2	Neuralgia and neuritis, unspecified
M79.7	Fibromyalgia
Z51.81	Encounter for therapeutic drug level monitoring
Z79.891	**Long term (current) use of opiate analgesic**
Z79.899	**Other long term (current) drug therapy**

Visit **QuestDiagnostics.com/MLCP** to view current limited coverage tests, reference guides, and policy information.

To view the complete policy and the full list of medically supportive codes, please refer to the CMS website reference www.cms.gov ►

Last updated: 10/17/22

Client Bulletin

Quest Diagnostics™

Reviewed December 2017

Medi-Cal Reminder: QuantiFERON ® TB Gold

Interferon Gamma Release Assay (IGRAs)

According to the current Medi-Cal Provider Manual, Interferon Gamma Release Assays, (IGRAs), also known as QuantiFERON® TB Gold®, are reimbursable with CPT-4 code 86480 (tuberculosis test, cell mediated immunity antigen response measurement; gamma interferon) or CPT-4 code 86481 (tuberculosis test, enumeration of gamma interferon-producing T-cells in cell suspension) for the diagnosis of latent tuberculosis infection and tuberculosis disease.

The following policy is based on the Centers for Disease Control and Prevention's "Updated Guidelines for Using Interferon Gamma Release Assays to Detect *Mycobacterium Tuberculosis* Infection – United States, 2010."

IGRAs may be used in all circumstances in which the tuberculin skin test is currently used, including:

- Contact investigations
- Populations with low compliance rates for returning to have tuberculin skin tests read
- Evaluation of patients who have received BCG (Bacillus Calmette-Guerin) (as a vaccine or for cancer therapy)
- Sequential-testing programs for infection control (for example, those for healthcare workers)

This information is reflected on page 3 of the Pathology: Immunology section of the Medi-Cal Provider Manual (path immune 3). For additional information on Medi-Cal's coverage policies, visit www.medi-cal.ca.gov.

If you have any questions, please contact your Quest Diagnostics sales representative.

Disclaimer: The CPT codes provided are based on AMA guidelines and are for informational purposes only. CPT coding is the sole responsibility of the billing party. Please direct any questions regarding coding to the payer being billed.

The above information serves as a reference tool for laboratory services and is not comprehensive. The ordering provider is responsible for determining the appropriate diagnosis codes for each patient. Diagnosis codes must be applicable to the patient's symptoms or conditions and must be consistent with documentation in the patient's medical record.

Client Bulletin

Quest Diagnostics™

Reviewed April 2019

Medi-Cal ICD-10 Coverage Policy

Human Chorionic Gonadotropin (hCG) and Prolactin

According to the Pathology: Chemistry section of the Medi-Cal General Medicine provider manual, CPT-4 codes 84702, 84703, and 84146 are reimbursable only when an appropriate diagnosis on the claim documents the medical necessity of the test.

Testing for quantitative and qualitative levels of human chorionic gonadotropin (hCG) (CPT-4 codes 84702 and 84703) are reimbursable by Medi-Cal only when billed in conjunction with one of the following ICD-10-CM diagnosis codes documenting the medical necessity of the test.

hCG approved ICD-10-CM codes

C38.1–C38.8	C62.10-C62.12	D39.2	O03.0-O03.9	O20.0	Z85.238
C45.1	C62.90-C62.92	N89.8	O04.5-O04.89	R10.2	Z85.29
C48.1	C75.3	N94.89	O09.10-O09.13	Z33.2	Z85.43
C48.8	C78.1	O00.00-O00.91	O11.1-O11.9	Z34.00-Z34.93	Z85.47
C56.1-C56.9	C78.6	O01.0-O01.9	O13.1-O13.9	Z85.068	
C57.4	C79.60-C79.62	O02.0-O02.1	O14.00-O15.9	Z85.07	
C62.00-C62.02	C79.82	O02.81	O16.1-O16.9	Z85.09	

Prolactin level testing (CPT-4 code 84146) should only be ordered when medically indicated, based on patient evaluation. Tests for Prolactin levels ordered for screening or non-indicated disease processes, such as infertility, are not reimbursable. Code 84146 is reimbursable by Medi-Cal only when billed in conjunction with one of the following ICD-10-CM diagnosis codes documenting the medical necessity of the test.

Prolactin approved ICD-10-CM codes

E01.8	E05.90	E22.0-E23.7	I13.0-I13.2	O92.011-O92.79
E02	E05.91	E24.1	I15.0-I15.9	Z33.1
E03.2	E06.0-E06.9	E34.4	N26.2	Z34.00-Z34.93
E03.3	E10.21-E10.29	E89.0	N89.7	
E03.8	E11.21-E11.29	E89.3	N91.0-N93.9	
E03.9	E13.21-E13.29	I12.0-I12.9	O09.00-O09.93	

For additional information on Medi-Cal's coverage policies, please refer to the Medi-Cal Provider Manual available at medi-cal.ca.gov/manual.

If you have any questions, please contact your Quest Diagnostics sales representative.

The above information serves as a reference tool for laboratory services and is not comprehensive. The ordering provider is responsible for determining the appropriate diagnosis codes for each patient. Diagnosis codes must be applicable to the patient's symptoms or conditions and must be consistent with documentation in the patient's medical record.

The CPT codes provided are based on AMA guidelines and are for informational purposes only. CPT coding is the sole responsibility of the billing party. Please direct any questions regarding coding to the payer being billed.