REIMBURSEMENT POLICY STATEMENT
OHIO MEDICAID

Policy Name	Policy Number	Effective Date
Molecular Diagnostic Testing for Respiratory Virus	PY-0451	01/01/2021-06/30/2021

Policy Type			
Medical	Administrative	Pharmacy	REIMBURSEMENT

Reimbursement Policy Statement: Reimbursement Policies prepared by CareSource and its affiliates are intended to provide a general reference regarding billing, coding and documentation guidelines. Coding methodology, regulatory requirements, industry-standard claims editing logic, benefits design and other factors are considered in developing Reimbursement Policies.

In addition to this Policy, Reimbursement of services is subject to member benefits and eligibility on the date of service, medical necessity, adherence to plan policies and procedures, claims editing logic, provider contractual agreement, and applicable referral, authorization, notification and utilization management guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any federal or state coverage mandate, Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

This Policy does not ensure an authorization or Reimbursement of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced herein. If there is a conflict between this Policy and the plan contract (i.e., Evidence of Coverage), then the plan contract (i.e., Evidence of Coverage) will be the controlling document used to make the determination.

CareSource and its affiliates may use reasonable discretion in interpreting and applying this Policy to services provided in a particular case and may modify this Policy at any time.

According to the rules of Mental Health Parity Addiction Equity Act (MHPAEA), coverage for the diagnosis and treatment of a behavioral health disorder will not be subject to any limitations that are less favorable than the limitations that apply to medical conditions as covered under this policy.

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A. Subject

Molecular Diagnostic Testing for Respiratory Virus

B. Background

Reimbursement policies are designed to assist you when submitting claims to CareSource. They are routinely updated to promote accurate coding and policy clarification. These proprietary policies are not a guarantee of payment. Reimbursement for claims may be subject to limitations and/or qualifications. Reimbursement will be established based upon a review of the actual services provided to a member and will be determined when the claim is received for processing. Health care providers and their office staff are encouraged to use self-service channels to verify member's eligibility.

It is the responsibility of the submitting provider to submit the most accurate and appropriate CPT/HCPCS code(s) for the product or service that is being provided. The inclusion of a code in this policy does not imply any right to reimbursement or guarantee claims payment.

Molecular testing, following a diagnosis or suspected diagnosis can help guide appropriate therapy by identifying specific therapeutic targets and appropriate pharmaceutical interventions. Molecular diagnostic testing utilizes Polymerase Chain Reaction (PCR), a genetic amplification technique that only requires small quantities of DNA, for example, 0.1 mg of DNA from a single cell, to achieve DNA analysis in a shorter laboratory processing time. Knowing the gene sequence, or at minimum the borders of the target segment of DNA to be amplified, is a prerequisite to a successful PCR amplification of DNA.

Molecular Diagnostic testing for the respiratory viruses known as Adenovirus, Influenza Virus, Coronavirus, Metapneumovirus, Parainfluenza Virus, Respiratory Syncytial Virus (RSV) and Rhinovirus can be utilized in the presence of symptoms such as cough, fever, headache, fatigue, rhinorrhea, pharyngitis and a general unwell feeling, that would create a clinical picture of a respiratory virus. Molecular Diagnostic testing for respiratory viruses is not indicated for every patient that presents with these signs and symptoms, as treatment is generally the same for all of the viruses and resolve with little to no pharmacological treatment, except in immunocompromised patients.

All facilities in the United States that perform laboratory testing on human specimens for health assessment or the diagnosis, prevention, or treatment of disease are regulated under the Clinical Laboratory Improvement Amendments of 1988 (CLIA). Waived tests include test systems cleared by the FDA for home use and those tests approved for waiver under the CLIA criteria. Although CLIA requires that waived tests must be simple and have a low risk for erroneous results, this does not mean that waived tests are completely error-proof. CareSource may periodically require review of a provider's office testing policies and procedures when performing CLIA-waived tests.

C. Definitions

- **Polymerase Chain Reaction (PCR)** - A genetic amplification technique also known as a Nucleic Acid Amplification Test (NAAT).

D. Policy

I. Prior authorization is required for the Molecular Diagnostic Testing by PCR addressed in this policy.
   A. Documentation must be submitted with the prior authorization indicating that the lower cost test was performed and a negative result was confirmed.

II. Conventional testing, such as rapid antigen direct tests, direct fluorescent antibody testing and cultures, are viewed as low cost and must be utilized before the higher cost Molecular Diagnostic Testing by PCR.

E. Conditions of Coverage

Reimbursement is dependent on, but not limited to, submitting approved HCPCS and CPT codes along with appropriate modifiers, if applicable. Please refer to the individual fee schedule for appropriate codes.

F. Related Policies/Rules

G. Review/Revision History

	DATE	ACTION
Date Issued	12/01/2018	
Date Revised	12/02/2020	Updated the prior authorization requirement. Removed CPT and ICD-10 codes. Updated definitions and references.
Date Effective	01/01/2021	
Date Archived	06/30/2021	This Policy is no longer active and has been archived. Please note that there could be other Policies that may have some of the same rules incorporated and CareSource reserves the right to follow CMS/State/NCCI guidelines without a formal documented Policy.

H. References

1. NREVSS | Home | National Respiratory and Enteric Virus Surv System | CDC (2020, November 19). Retrieved 11/20/2020 from www.cdc.gov
2. Polymerase Chain Reaction (PCR) (2017, November 09). Retrieved 11/20/2020 from www.ncbi.nlm.nih.gov.

The Reimbursement Policy Statement detailed above has received due consideration as defined in the Reimbursement Policy Statement Policy and is approved.