



REIMBURSEMENT POLICY STATEMENT OHIO MEDICAID

Original Issue Date		Next Annual Review		Effective Date	
12/01/2018		12/01/2019		12/01/2018	
Policy Name				Policy Number	
Molecular Diagnostic Testing for Streptococcus A and B Infection				PY-0452	
Policy Type					
Medical		Administrative		Pharmacy	
REIMBURSEMENT					

Reimbursement Policies prepared by CSMG Co. and its affiliates (including CareSource) 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.

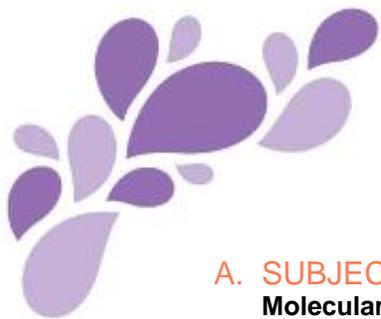
In addition to this Policy, Reimbursement of services is subject to member benefits and eligibility on the date of service, medical necessity, adherence to plan policies and procedures, claims editing logic, provider contractual agreement, and applicable referral, authorization, notification and utilization 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.

CSMG Co. 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.

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A. SUBJECT

Molecular Diagnostic Testing for Streptococcus A and B Infection

B. BACKGROUND

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.

Illnesses caused by Streptococcus A include Pharyngitis (strep throat), Scarlet Fever, Acute Rheumatic Fever and Post Streptococcal Glomerulonephritis. Illnesses caused by Streptococcus B include Bacteremia, Sepsis, Pneumonia, skin and soft tissue infections, bone and joint infections, meningitis (although this is a rare occurrence in adults). Screening for Streptococcus B should be done between 35 and 37 weeks in every pregnant women, as it is most commonly passed to newborns during the birthing process.

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)
- **Medically Necessary**- Health care services or supplies needed to diagnosis or treat an illness, injury, condition, disease or its symptoms and that meet the accepted standards of medicine.

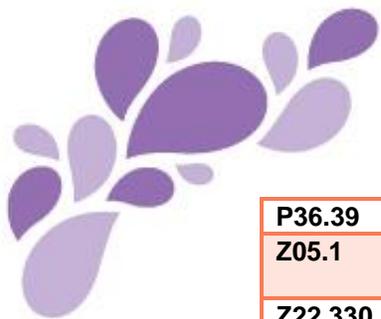
D. POLICY

- I. No Prior Authorization is required for the Molecular Diagnostic Testing by PCR addressed in this policy.
- II. CareSource considers Molecular Diagnostic Testing by PCR for Streptococcus A and Streptococcus B infection medically necessary when submitted with any combination of the CPT and diagnosis codes listed in the Conditions of Coverage in this policy
- III. CareSource does not consider Molecular Diagnostic Testing by PCR for Streptococcus A and Streptococcus B infection to be medically necessary when billed with any other diagnosis code and will not provide reimbursement for those services.
- IV. Conventional testing, such as the rapid strep test (throat culture) for Streptococcus A; cultures of sterile body fluids and/ or vaginal and rectal cultures in pregnant women for Streptococcus B, are viewed as effective, low cost and should be utilized before the higher cost Molecular Diagnostic Testing by PCR.



E. CONDITIONS OF COVERAGE

CODE	DESCRIPTION
87651	Infectious agent detection by nucleic acid (DNA or RNA); Streptococcus, group A, amplified probe technique
87653	Infectious agent detection by nucleic acid (DNA or RNA); Streptococcus, group B, amplified probe technique
A38.0	Scarlet fever with otitis media
A38.1	Scarlet fever with myocarditis
A38.8	Scarlet fever with other complications
A38.9	Scarlet fever, uncomplicated
A40.0	Sepsis due to streptococcus, group A
A40.3	Sepsis due to Streptococcus pneumoniae
A40.8	Other streptococcal sepsis
A40.9	Streptococcal sepsis, unspecified
B95.0	Streptococcus, group A, as the cause of diseases classified elsewhere
G00.2	Streptococcal meningitis
I00	Rheumatic fever without heart involvement
I01.0	Acute rheumatic pericarditis
I01.1	Acute rheumatic endocarditis
I01.2	Acute rheumatic myocarditis
I01.8	Other acute rheumatic heart disease
I01.9	Acute rheumatic heart disease, unspecified
J02.0	Streptococcal pharyngitis
J03.00	Acute streptococcal tonsillitis, unspecified
J03.01	Acute recurrent streptococcal tonsillitis
J13	Pneumonia due to Streptococcus pneumoniae
J15.4	Pneumonia due to other streptococci
J20.2	Acute bronchitis due to streptococcus
M72.6	Necrotizing fasciitis
N00.9	Acute nephritic syndrome with unspecified morphologic changes
A40.1	Sepsis due to streptococcus, group B
B95.1	Streptococcus, group B, as the cause of diseases classified elsewhere
J15.3	Pneumonia due to streptococcus, group B
O99.511	Diseases of the respiratory system complicating pregnancy, first trimester
O99.512	Diseases of the respiratory system complicating pregnancy, second trimester
O99.513	Diseases of the respiratory system complicating pregnancy, third trimester
O99.519	Diseases of the respiratory system complicating pregnancy, unspecified trimester
O99.52	Diseases of the respiratory system complicating childbirth
O99.53	Diseases of the respiratory system complicating the puerperium
O99.820	Streptococcus B carrier state complicating pregnancy
O99.824	Streptococcus B carrier state complicating childbirth
O99.825	Streptococcus B carrier state complicating the puerperium
P23.3	Congenital pneumonia due to streptococcus, group B
P36.0	Sepsis of newborn due to streptococcus, group B
P36.10	Sepsis of newborn due to unspecified streptococci



P36.39	Sepsis of newborn due to other streptococci
Z05.1	Observation and evaluation of newborn for suspected infectious condition ruled out
Z22.330	Carrier of Group B streptococcus

F. RELATED POLICIES/RULES

N/A

G. REVIEW/REVISION HISTORY

DATE		ACTION
Date Issued	12/01/2018	
Date Revised	11/7/2018	Removed O99.5, corrected P36.319 to P36.39
Date Effective		

H. REFERENCES

1. Group B Strep | GBS | Home | Streptococcus | CDC. (2018, May 29). Retrieved July 23, 2018, from www.cdc.gov/groupbstrep.
2. Group A Strep | Home | Group A Streptococcus | GAS | CDC. (2016, September 16). Retrieved July 23, 2018, www.cdc.gov/groupAstrep.

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

