UnitedHealthcare®

Reimbursement Policy

Lymphocyte Mitogen Response Assays (NCD 190.8)

Policy Number	190.8	Approved By	UnitedHealthcare Medicare Reimbursement Policy Committee	Current Approval Date	03/12/2014

IMPORTANT NOTE ABOUT THIS REIMBURSEMENT POLICY

This policy is applicable to UnitedHealthcare Medicare Advantage Plans offered by UnitedHealthcare and its affiliates.

You are responsible for submission of accurate claims. This reimbursement policy is intended to ensure that you are reimbursed based on the code or codes that correctly describe the health care services provided. UnitedHealthcare reimbursement policies use Current Procedural Terminology (CPT®*), Centers for Medicare and Medicaid Services (CMS), or other coding guidelines. References to CPT or other sources are for definitional purposes only and do not imply any right to reimbursement.

This reimbursement policy applies to all health care services billed on CMS 1500 forms and, when specified, to those billed on UB04 forms (CMS 1450). Coding methodology, industry-standard reimbursement logic, regulatory requirements, benefits design and other factors are considered in developing reimbursement policy.

This information is intended to serve only as a general resource regarding UnitedHealthcare's reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly, UnitedHealthcare may use reasonable discretion in interpreting and applying this policy to health care services provided in a particular case. Further, the policy does not address all issues related to reimbursement for health care services provided to UnitedHealthcare enrollees. Other factors affecting reimbursement may supplement, modify or, in some cases, supersede this policy. These factors may include, but are not limited to: legislative mandates, the physician or other provider contracts, and/or the enrollee's benefit coverage documents. Finally, this policy may not be implemented exactly the same way on the different electronic claims processing systems used by UnitedHealthcare due to programming or other constraints; however, UnitedHealthcare strives to minimize these variations.

UnitedHealthcare may modify this reimbursement policy at any time by publishing a new version of the policy on this Website. However, the information presented in this policy is accurate and current as of the date of publication.

Table of Contents

Application

This reimbursement policy applies to services reported using the Health Insurance Claim Form CMS-1500 or its electronic equivalent or its successor form, and services reported using facility claim form CMS-1450 or its electronic equivalent or its successor form. This policy applies to all products, all network and non-network physicians, and other health care professionals.

The HCPCS/CPT code(s) may be subject to Correct Coding Initiative (CCI) edits. This policy does not take

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precedence over CCI edits. Please refer to the CCI for correct coding guidelines and specific applicable code combinations prior to billing UnitedHealthcare. It is not enough to link the procedure code to a correct, payable ICD-9-CM diagnosis code. The diagnosis must be present for the procedure to be paid. Compliance with the provisions in this policy is subject to monitoring by pre-payment review and/or post-payment data analysis and subsequent medical review. The effective date of changes/additions/deletions to this policy is the committee meeting date unless otherwise indicated. Fee schedules, relative value units, conversion factors, and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein.

Summary

Overview

The lymphocyte mitogen response assay measures the immune response of patient peripheral blood lymphocytes.

Reimbursement Guidelines

It is a covered test under Medicare when it is medically necessary to assess lymphocytic function in diagnosed immunodeficiency diseases and to monitor immunotherapy.

It is not covered when it is used to monitor the treatment of cancer, because its use for that purpose is experimental.

CPT / HCPCS Codes

Code	Description
86352	Cellular function assay involving stimulation (e.g., mitogen or antigen) and detection of biomarker (e.g., ATP)
86353	Lymphocyte transformation, mitogen (phytomitogen) or antigen induced blastogenesis

References Included (but not limited to):

CMS NCD

NCD 190.8 Lymphocyte Mitogen Response Assays

CMS LCD(s)

Numerous LCDs

CMS Benefit Policy Manual

Chapter 15; § 10 Supplementary Medical Insurance (SMI) Provisions), § 80.1 Clinical Laboratory Services

CMS Claims Processing Manual

Chapter 16; § 30 Special Payment Considerations, § 40 Billing for Clinical Laboratory Tests, § 70 Clinical Laboratory Improvement Amendments (CLIA) Requirements

CMS Transmittals

Transmittal 2838, Change Request 8548, Dated 12/13/2013 (January 2014 Integrated Outpatient Code Editor (I/OCE) Specifications Version 15)

UnitedHealthcare Medicare Advantage Coverage Summaries

Laboratory Tests and Services

UnitedHealthcare Reimbursement Policies

Preventive Lab Services

Others

2014 CPT-4 and HCPCS Codes Subject to CLIA Edits, CMS Website

Lymphocyte Mitogen Response Assays (NCD 190.8)

History

Date	Revisions
03/12/2014	Annual review for MRP Committee presentation and approval as above
03/27/2013	Annual review for MRP Committee presentation and approval
08/08/2012	MRP committee approved

