

BLUE CROSS OF NORTHEASTERN PA "BCNEPA" MEDICAL POLICY BULLETIN	MANUAL: MEDICAL POLICY
	REFERENCE NO.: MPO-490-0172
EFFECTIVE DATE August 1, 2014	SUBJECT: Serologic Diagnosis of Celiac Disease

Blue Cross of Northeastern Pennsylvania ("BCNEPA") Medical Policy

Medical policy is not an authorization, certification, explanation of benefits or a contract. Benefits and eligibility are determined before medical policy and claims payment policy are applied. Policies are provided for informational purposes only and are developed to assist in administering plan benefits and do not constitute medical advice. Treating providers are solely responsible for medical advice and treatment. Policies are based on research of current medical literature and review of common medical practices in the treatment and diagnosis of disease. Medical practices and information are constantly changing and BCNEPA may review and revise its medical policies periodically. Also, due to the rapid pace of changing technology and the advent of new medical procedures, BCNEPA may not have a policy to address every procedure. In those cases, BCNEPA may review other sources of information including, but not limited to, current medical literature and other medical resources, such as Technology Evaluation Center Assessments (TEC) published by the Blue Cross Blue Shield Association. BCNEPA may also consult with health care providers possessing particular expertise in the services at issue.

I. DESCRIPTION:

Celiac disease, also referred to as celiac sprue or gluten-sensitive enteropathy, is a relatively common disorder with variable clinical expression. It is defined as inflammation of the small intestine resulting from an immunologic intolerance to gluten; i.e., the proteins derived from wheat, barley, and rye. The symptoms of the disease are markedly variable and can be broadly subdivided into intestinal and extraintestinal manifestations; the latter is thought to be related to nutrient malabsorption.

Celiac disease is currently diagnosed by a positive small intestinal biopsy with consistent history and serologic results. A variety of serologic tests are available; some may be more accurate than others or more appropriate for use in certain patient populations.

II. BENEFIT POLICY STATEMENT:

BCNEPA makes decisions on coverage based on Policy Bulletins, benefit plan documents, and the member's medical history and condition. Benefits may vary based on product line, group or contract, therefore, Member benefits must be verified. In the event of a conflict between the Member's benefit plan document and topics addressed in Medical Policy Bulletins (i.e., specific contract exclusions), the Member's benefit plan document always supersedes the information in the Medical Policy Bulletins. BCNEPA determines medical necessity only if the benefit exists and no contract exclusions are applicable.

Benefits are determined by the terms of the Member's specific benefit plan document [i.e., the Fully Insured policy, the Administrative Services Only (ASO) agreement applicable to the Self-Funded Plan Participant, or the Individual Policy] that is in effect at the time services are rendered.

III. MEDICAL POLICY STATEMENT:

Coverage is subject to the terms, conditions, and limitations of the member's contract.

- A. BCNEPA will provide coverage for the serologic diagnosis of Celiac disease when medically necessary.
 - 1. Serologic measurement of tissue transglutaminase or antiendomysial antibodies may be considered medically necessary in patients with signs or symptoms suggestive of celiac disease.
 - 2. Use of more than one antibody test is considered not medically necessary.
 - 3. Serologic measurement of antigliadin antibodies may be considered medically necessary in children less than 24 months of age with signs or symptoms suggestive of celiac disease.
 - 4. HLA-DQ2 and HLA-DQ8 testing may be considered medically necessary to rule out celiac disease in patients with discordant serologic and histologic (biopsy) findings or if persistent symptoms warrant testing despite negative serology and histology.
 - 5. HLA-DQ2 and HLA-DQ8 testing is considered not medically necessary when serologic testing is positive or when small intestinal biopsy is appropriate.

- B. BCNEPA will not provide coverage for the following serologic tests in the diagnosis of Celiac disease as they are considered investigational and, therefore, not covered because the safety and effectiveness of these services cannot be established by review of the available published peer-reviewed literature:
 - 1. Serologic measurement of deamidated gliadin peptide antibodies in patients with signs or symptoms suggestive of celiac disease.
 - 2. Screening of asymptomatic at risk patient groups for celiac disease using one or more serologic IgA or IgG measures.
 - 3. Population screening for celiac disease using one or more serologic IgA or IgG measures.

IV. DEFINITIONS:

N/A

CODING:

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The five character codes included in the **Blue Cross of Northeastern Pennsylvania's Medical Policy** are obtained from Current Procedural Terminology (CPT*), copyright 2013 by the American Medical Association (AMA). CPT is developed by the AMA as a listing of descriptive terms and five character identifying codes and modifiers for reporting medical services and procedures.

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- **The identification of a code in this section does not denote coverage or separate reimbursement.**
 - Covered procedure codes are dependent upon meeting criteria of the policy and appropriate diagnosis code.
 - The following list of codes may not be all-inclusive, and are subject to change at any time.
 - Benefits are determined by the terms of the Member's specific benefit plan document [i.e., the Fully Insured policy, the Administrative Services Only (ASO) agreement applicable to the Self-Funded Plan Participant, or the Individual Policy] that is in effect at the time services are rendered.
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PROCEDURE CODES

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