BlueCross BlueShield of Texas

CLINICAL PAYMENT AND CODING POLICY

If a conflict arises between a Clinical Payment and Coding Policy (CPCP) and any plan document under which a member is entitled to Covered Services, the plan document will govern. If a conflict arises between a CPCP and any provider contract pursuant to which a provider participates in and/or provides Covered Services to eligible member(s) and/or plans, the provider contract will govern. "Plan documents" include, but are not limited to, Certificates of Health Care Benefits, benefit booklets, Summary Plan Descriptions, and other coverage documents. BCBSTX may use reasonable discretion interpreting and applying this policy to services being delivered in a particular case. BCBSTX has full and final discretionary authority for their interpretation and application to the extent provided under any applicable plan documents.

Providers are responsible for submission of accurate documentation of services performed. Providers are expected to submit claims for services rendered using valid code combinations from Health Insurance Portability and Accountability Act (HIPAA) approved code sets. Claims should be coded appropriately according to industry standard coding guidelines including, but not limited to: Uniform Billing (UB) Editor, American Medical Association (AMA), Current Procedural Terminology (CPT®), CPT® Assistant, Healthcare Common Procedure Coding System (HCPCS), ICD-10 CM and PCS, National Drug Codes (NDC), Diagnosis Related Group (DRG) guidelines, Centers for Medicare and Medicaid Services (CMS) National Correct Coding Initiative (NCCI) Policy Manual, CCI table edits and other CMS guidelines.

Claims are subject to the code edit protocols for services/procedures billed. Claim submissions are subject to claim review including but not limited to, any terms of benefit coverage, provider contract language, medical policies, clinical payment and coding policies as well as coding software logic. Upon request, the provider is urged to submit any additional documentation.

β - Hemolytic Streptococcus Testing

Policy Number: CPCPLAB053

Version 1.0

Enterprise Medical Policy Committee Approval Date: 1/25/2022

Plan Effective Date: May 1, 2022

Description

BCBSTX has implemented certain lab management reimbursement criteria. Not all requirements apply to each product. Providers are urged to review Plan documents for eligible coverage for services rendered.

Reimbursement Information:

1. Bacterial culture testing from a throat swab for streptococcal infection for a respiratory illness **may be reimbursable** in the following situations:

a. Patients have a modified Centor criteria score of 3 or greater (See Note 1 below); OR
b. Suspected bacterial pharyngitis in the absence of viral features, including cough, oral ulcers, and rhinorrhea; OR
c. After a negative rapid antigen diagnostic test (RADT) in a symptomatic child or adolescent.

2. Blood culture testing for a streptococcal infection **may be reimbursable** in the following situations:
   a. In patients who fail to demonstrate clinical improvement and in those who have progressive symptoms or clinical deterioration after initiation of antibiotic therapy; OR
   b. In cases of suspected prosthetic joint infection.

3. Bacterial culture testing for a streptococcal infection from a skin swab or pus **may be reimbursable** in cases of skin and/or soft tissue infections.

4. Bacterial culture testing for streptococci from a throat swab **is not reimbursable** in cases of suspected viral pharyngitis.

5. Rapid antigen diagnostic testing (RADT) for a streptococcal infection **is not reimbursable** in the following cases:
   a. As a follow-up test to either a positive or negative bacterial culture test for a streptococcal infection; OR
   b. As a screening method in an asymptomatic patient (except in cases of children under the age of three years who have a mitigating circumstance, including a symptomatic family member); OR
   c. In cases of suspected viral pharyngitis.

6. Serological titer testing, αα in cases of suspected acute rheumatic fever or post-streptococcal glomerulonephritis (PSGN), **is not reimbursable**

7. The simultaneous coding for BOTH amplification and direct probes **is not reimbursable.**

8. The following tests **are not reimbursable**:
   a. Panel tests that screen and identify multiple streptococcal strains (*S. pyogenes* [group A], *S. agalactiae* [group B], *S. dysgalactiae* [groups C/G], α-hemolytic streptococcus, and/or γ-hemolytic streptococcus), using either immunoassay or nucleic acid-based assays, such as the Solana Strep Complete Assay and the Lyra Direct Strep Assay; OR
   b. MALDI-TOF identification of streptococcus; OR
   c. Anti-streptolysin O immunoassay (EXCEPT in cases of suspected acute rheumatic fever or post-streptococcal glomerulonephritis (PSGN)); OR
   d. The quantification of any strain of streptococcus using nucleic acid amplification, including PCR; OR
   e. Hyaluronidase activity or anti-hyaluronidase immunoassay (EXCEPT in cases of suspected acute rheumatic fever or post-streptococcal glomerulonephritis (PSGN)); OR
   f. Streptokinase activity or anti-streptokinase immunoassay (EXCEPT in cases of suspected acute rheumatic fever or post-streptococcal glomerulonephritis (PSGN)); OR
   g. Nicotinamide-adenine dinucleotidase activity or anti-nicotinamide-adenine immunoassay

Note 1: Centor criteria includes tonsillar exudates, tender anterior cervical lymphadenopathy, fever, and absence of cough with each criterion being worth one point (Chow, 2018, 2020).

Note 2: For prenatal screening of Group B Streptococcus, please review policy CPCPLAB014

Procedure Codes

Codes
83789, 86060, 86063, 86215, 86317, 86318, 87040, 87070, 87071, 87077, 87081, 87340, 87650, 87651, 87652, 87797, 87798, 87799, 87880

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5/1/2022	New policy