Payment Policy: **Polymerase Chain Reaction Respiratory Viral Panel Testing**  
Reference Number: TX.PP.150  
Last Review Date: 01/20

See Important Reminder at the end of this policy for important regulatory and legal information.

**Description**
The purpose of this policy is to define the appropriate places of service (POS) for performing respiratory viral panels by polymerase chain reaction testing. Multiplex PCR testing done outside the recommended places of service will not be considered to be medically necessary.

**Policy/Criteria**
It is the policy of Superior HealthPlan that respiratory viral panels (RVPs) are covered for an immunocompromised or an otherwise high-risk member when testing is performed in an inpatient hospital or an emergency department or during an admission for observation. Examples of conditions which might place members at high-risk for respiratory complications include ongoing cancer treatment with chemotherapeutic agents or transplant status on anti-rejection medications.

RVPs may also be covered when a member is critically ill and is in a healthcare setting that cares for critically ill patients. This includes inpatient hospitals, emergency departments, and in the context of an admission for observation. The IDSA recommends that “clinicians should use multiplex RT-PCR assays targeting a panel of respiratory pathogens, including influenza viruses, in hospitalized immunocompromised patients” and that “clinicians can consider using multiplex RT-PCR assays targeting a panel of respiratory pathogens, including influenza viruses, in hospitalized patients who are not immunocompromised if it might influence care (e.g., aid in cohorting decisions, reduce testing, or decrease antibiotic use).”

**Background**
Polymerase chain reaction (PCR) respiratory viral panels (RVP) may detect the RNA or DNA of multiple types of respiratory viruses as a single test, often through a nasal, nasopharyngeal, or oropharyngeal swab. Viral pathogens are the most common cause of respiratory tract infections. PCR testing is effective for confirming respiratory viral infections with very high sensitivity and specificity. Rhinovirus, parainfluenza virus, coronavirus, adenovirus, respiratory syncytial virus, Coxsackie virus, human metapneumovirus, and influenza virus account for most cases of viral respiratory infections. Multiplex PCR testing can detect numerous respiratory viruses; that number varies with the type and brand of testing being performed. However, the diagnostic role and importance of these multi-pathogen panels in identifying specific viruses in the setting of a respiratory infection is quite limited because the care and management of the patient is not altered based upon the pathogen identified, if any. For example, the child with a URI, cough, and wheezing who might be positive for RSV would not be managed any differently than the child with parainfluenza virus, adenovirus, rhinovirus, human metapneumovirus, enterovirus, Coxsackie virus, or coronavirus.
PAYMENT POLICY
Polymerase Chain Reaction Respiratory Viral Panel Testing

Respiratory Viral Panels Codes and Description

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>CPT Code Description</th>
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<tbody>
<tr>
<td>87631</td>
<td>Infectious agent detection by nucleic acid (DNA or RNA); respiratory virus (e.g., adenovirus, influenza virus, coronavirus, metapneumovirus, parainfluenza virus, respiratory syncytial virus, rhinovirus), includes multiplex reverse transcription, when performed, and multiplex amplified probe technique, multiple types or subtypes, 3-5 targets.</td>
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<tr>
<td>87632</td>
<td>Infectious agent detection by nucleic acid (DNA or RNA); respiratory virus (e.g., adenovirus, influenza virus, coronavirus, metapneumovirus, parainfluenza virus, respiratory syncytial virus, rhinovirus), includes multiplex reverse transcription, when performed, and multiplex amplified probe technique, multiple types or subtypes, 6-11 targets</td>
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<tr>
<td>87633</td>
<td>Infectious agent detection by nucleic acid (DNA or RNA); respiratory virus (e.g., adenovirus, influenza virus, coronavirus, metapneumovirus, parainfluenza virus, respiratory syncytial virus, rhinovirus), includes multiplex reverse transcription, when performed, and multiplex amplified probe technique, multiple types or subtypes, 12-25 targets</td>
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Respiratory Viral Panels are payable in the following place of service:

<table>
<thead>
<tr>
<th>Place of Service Code</th>
<th>Place of Service Name</th>
<th>Place of Service Description</th>
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<tbody>
<tr>
<td>21</td>
<td>Inpatient Hospital</td>
<td>A facility other than psychiatric which primarily provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions.</td>
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<tr>
<td>22*</td>
<td>Outpatient Hospital (Observation)</td>
<td>A portion of a hospital which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.</td>
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<tr>
<td>23</td>
<td>Emergency Room – Hospital</td>
<td>A portion of a hospital where emergency diagnosis and treatment of illness or injury is provided.</td>
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*NOTE: PCR testing in an outpatient place of service are reimbursable only when performed as part of the diagnostic work-up for a patient admitted for Observation.

Coding Implications
This policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2019, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.
PAYMENT POLICY
Polymerase Chain Reaction Respiratory Viral Panel Testing

Reviews, Revisions, and Approvals

<table>
<thead>
<tr>
<th>Policy developed</th>
<th>Date</th>
<th>Approval Date</th>
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<tr>
<td>Added language to clarify places of service in which testing will be reimbursed for immunocompromised members.</td>
<td>01/20</td>
<td>01/20</td>
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</table>

Date

Policy developed 09/19
Approval 10/19

Added language to clarify places of service in which testing will be reimbursed for immunocompromised members. 01/20
Approval 01/20

References

3. Hayes Precision Medicine Research Brief, “FilmArray Respiratory Panel and FilmArray Respiratory Panel 2 (BioFire Diagnostics LLC),” September 2019

Important Reminder
This payment policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant payment areas affected by this payment policy; and other available payment information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this payment policy. This payment policy is consistent with standards of medical practice current at the time that this payment policy was approved.

The purpose of this policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This payment policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this payment policy. This payment policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this payment policy and any applicable legal or
PAYMENT POLICY
Polymerase Chain Reaction Respiratory Viral Panel Testing

regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this payment policy, and additional payment policies may be developed and adopted as needed, at any time.

This payment policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This payment policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this payment policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This payment policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this payment policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.

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