Priority Health	BILLING POLICY No. 151
Helicobacter Pylori (H. Pylori) Testing	
Date of origin: August 2025	**Review dates: None yet recorded**

APPLIES TO

- Commercial
- Medicare follows CMS unless otherwise specified
- Medicaid follows MDHHS unless otherwise specified

DEFINITIONS

H. pylori: A gram-negative bacterium associated with chronic gastritis, peptic ulcer disease, gastric mucosa-associated lymphoid tissue (MALT) lymphoma, and increased risk of gastric cancer. Non-invasive tests for the diagnosis of H. pylori include urea breath testing (UBT), stool antigen testing, and serology.

Urea Breath Test (UBT): Non-invasive diagnostic test for active infection.

Stool Antigen Test (SAT): Immunoassay detecting active infection.

Serology Test: Blood test for antibodies to H. pylori; not reliable for active infection or eradication status.

For Medicare

For indications that do not meet criteria of NCD, local LCD or specific medical policy a Pre-Service Organization Determination (PSOD) will need to be completed. Click here for additional details on PSOD.

POLICY SPECIFIC INFORMATION

Documentation requirements

Complete and thorough documentation to substantiate the procedure performed is the responsibility of the Provider. In addition, the Provider should consult any specific documentation requirements that are necessary of any applicable defined guidelines.

- Clinical notes must support medical necessity, including relevant symptoms, history, or risk factors.
- Test results must be retained in the patient's record.
- For repeat testing, documentation must include reason for repeat and confirmation of adequate washout period after therapy.

Reimbursement specifics

Coverage Criteria

Testing for active H. pylori infection is considered medically necessary when one or more of the following clinical indications are present.

For individuals 18 years of age and older:

1. Dyspepsia without alarm features in patients <60 years of age.
2. Documented history of peptic ulcer disease (gastric or duodenal).
3. Gastric MALT lymphoma.
4. History of endoscopic resection of early gastric cancer (EGC)
5. Gastric intestinal metaplasia (GIM)
6. Post-endoscopic resection of early gastric cancer.
7. Long-term nonsteroidal anti-inflammatory drug (NSAID) use.
8. Unexplained iron deficiency anemia.
9. Idiopathic thrombocytopenic purpura (ITP).
10. Confirmation of eradication following appropriate antimicrobial therapy (≥4 weeks after completion of therapy).
11. Family history of gastric cancer
12. First-generation immigrants from a high prevalence area

For individuals less than 18 years of age:
Urea breath testing or stool antigen testing meets coverage criteria in the following situations:

- Chronic ITP with suspected H. pylori infection
- To measure the success of eradication of H. pylori infection (follow-up measurement at least 4 weeks post-treatment)

For individuals less than 18 years of age:
A biopsy-based endoscopic histology test and either a rapid urease test or a culture with susceptibility testing to diagnose an H. pylori infection meets coverage criteria in the following situations:

- Gastric or duodenal ulcers
- Refractory iron deficiency anemia (when other causes have been ruled out)

Coding specifics

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service.

Covered CPT Codes:

- 83013 – Urea breath test, analysis
- 83014 – Urea breath test, drug administration
- 87338 – H. pylori, stool antigen
- 88342/88305 – Biopsy-based pathology (only when performed during covered endoscopy)
- 78267- Urea Breath Test, C-14 (ISOTOPIC); Acquisition for analysis
- 78268 - Urea Breath Test, C-14 (ISOTOPIC); Analysis

Non-Covered CPT Code:

- 86677 – Antibody; H. pylori
- 83009 - Helicobacter pylori, blood test analysis for urease activity, non-radioactive isotope (e.g., C-hyphen13)

- 86677 - Antibody; Helicobacter pylori [laboratory-based]

Modifiers
Priority Health follows standard billing and coding guidelines which include CMS NCCI. Modifiers should be applied when applicable based on this guidance and only when supported by documentation.

Incorrect application of modifiers will result in denials. The modifier list below may not be an all-inclusive list. Please see our provider's manual page for modifier use here.

- Providers must submit claims using the appropriate CPT/HCPCS codes and an ICD-10-CM diagnosis code supporting medical necessity.
- Use Modifier 90 when laboratory services are performed by a reference lab.

Place of Service

Coverage will be considered for services furnished in the appropriate setting to the patient's medical needs and condition. Authorization may be required. Click here for additional information.

Reimbursement rates
Find reimbursement rates for the codes listed on this page in our standard fee schedules for your contract. Go to the fee schedules (login required).

REFERENCES
https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleid=56382

DISCLAIMER
Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS) and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standard, compliant codes defined by CPT, HCPCS and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document for services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align to these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made
Aug. 2025	New policy – effective Nov. 17, 2025