Priority Health	BILLING POLICY No. 152
Diagnosis of Vaginitis	
Date of origin: Aug 2025	**Review dates: None yet recorded**

DEFINITION

Vaginitis refers to inflammation of the vagina, often leading to symptoms such as discharge, itching, and discomfort. This condition can arise when the natural balance of vaginal bacteria is disrupted, which may be due to infections or other factors, including decreased estrogen levels, particularly after menopause, and certain skin conditions.

There are two primary types of vaginitis to be aware of:

1. **Infectious Vaginitis**: This type is typically caused by infections, such as bacterial vaginosis, yeast infections (candidiasis), or trichomoniasis.

2. **Non-infectious Vaginitis**: This category includes atrophic vaginitis, which results from decreased estrogen levels, as well as irritant or allergic reactions to various products, such as douches or soaps.

MEDICAL POLICY

Infectious Disease Molecular Panels # 91643

Related billing policies

Lab and Pathology No. 015

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

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).

Coding specifics

The following procedure codes are provided for reference only. This list may not be exhaustive and the inclusion of any code in this policy does not indicate that the associated service is covered or non-covered.

Benefit coverage is determined by the specific member benefit plan document and applicable laws, which may mandate coverage for certain services. Additionally, the presence of any code does not guarantee reimbursement or claim payment.

81513: Infectious disease, bacterial vaginosis, quantitative real-time amplification of RNA markers for Atopobium vaginae, Gardnerella vaginalis, and Lactobacillus species, utilizing vaginal-fluid specimens, algorithm reported as a positive or negative result for bacterial vaginosis

81514: Infectious disease, bacterial vaginosis and vaginitis, quantitative real-time amplification of DNA markers for Gardnerella vaginalis, Atopobium vaginae, Megasphaera type 1, Bacterial Vaginosis Associated Bacteria-2 (BVAB-2), and Lactobacillus species (L. crispatus and L. jensenii), utilizing vaginal-fluid specimens, algorithm reported as a positive or negative for high likelihood of bacterial vaginosis, includes separate detection of Trichomonas vaginalis and/or Candida species (C. albicans, C. tropicalis, C. parapsilosis, C. dubliniensis), Candida glabrata, Candida krusei, when reported

81515: Infectious disease, bacterial vaginosis and vaginitis, real-time PCR amplification of DNA markers for Atopobium vaginae, Atopobium species, Megasphaera type 1, and Bacterial Vaginosis Associated Bacteria-2 (BVAB-2), utilizing vaginal-fluid specimens, algorithm reported as positive or negative for high likelihood of bacterial vaginosis, includes separate detection of Trichomonas vaginalis and Candida species (C. albicans, C. tropicalis, C. parapsilosis, C. dubliniensis), Candida glabrata/Candida krusei, when reported

82120: Amines, vaginal fluid, qualitative

83986: pH; body fluid, not otherwise specified

87070: Culture, bacterial; any other source except urine, blood or stool, aerobic, with isolation and presumptive identification of isolates

87149: Culture, typing; identification by nucleic acid (DNA or RNA) probe, direct probe technique, per culture or isolate, each organism probed

87150: Culture, typing; identification by nucleic acid (DNA or RNA) probe, amplified probe technique, per culture or isolate, each organism probed

87210: Smear, primary source with interpretation; wet mount for infectious agents (eg, saline, India ink, KOH preps)

87480: Infectious agent detection by nucleic acid (DNA or RNA); Candida species, direct probe technique

87481: Infectious agent detection by nucleic acid (DNA or RNA); Candida species, amplified probe technique

87482: Infectious agent detection by nucleic acid (DNA or RNA); Candida species, quantification

87510: Infectious agent detection by nucleic acid (DNA or RNA); Gardnerella vaginalis, direct probe technique

87511: Infectious agent detection by nucleic acid (DNA or RNA); Gardnerella vaginalis, amplified probe technique

87512: Infectious agent detection by nucleic acid (DNA or RNA); Gardnerella vaginalis, quantification

87660: Infectious agent detection by nucleic acid (DNA or RNA); Trichomonas vaginalis, direct probe technique

87661: Infectious agent detection by nucleic acid (DNA or RNA); Trichomonas vaginalis, amplified probe technique

87797: Infectious agent detection by nucleic acid (DNA or RNA), not otherwise specified; direct probe technique, each organism

87798: Infectious agent detection by nucleic acid (DNA or RNA), not otherwise specified; amplified probe technique, each organism

87799: Infectious agent detection by nucleic acid (DNA or RNA), not otherwise specified; quantification, each organism

87800: Infectious agent detection by nucleic acid (DNA or RNA), multiple organisms; direct probe(s) technique

87801: Infectious agent detection by nucleic acid (DNA or RNA), multiple organisms; amplified probe(s) technique

87808: Infectious agent antigen detection by immunoassay with direct optical (ie, visual) observation; Trichomonas vaginalis

87905: Infectious agent enzymatic activity other than virus (eg, sialidase activity in vaginal fluid)

0330U: Infectious agent detection by nucleic acid (DNA or RNA), vaginal pathogen panel, identification of 27 organisms, amplified probe technique, vaginal swab

Q0111: Wet mounts, including preparations of vaginal, cervical or skin specimens

According to instructions in the CPT book, identification by colony morphology, growth on a selective media, gram stains, or up to three of the following: catalase, oxidase, indole, and/or urease testing, all define presumptive testing.

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.

Documentation of the following is clearly stated in the medical record:

- Specific clinical indications for testing (i.e., clinical suspicion of a pathogen as the cause of the member's condition)

- Why the evaluation for more than one pathogen by molecular testing is necessary for clinical management of the member or why testing for a single pathogen is not reasonable and necessary for the specific infection, individual or indication.

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 manual page for modifier use here.

- Modifier 59 – Distinct Procedure/Service
- Modifier 90 - Reference (outside laboratory)
- Modifier 91 – Repeat clinical diagnostic laboratory test
- Modifier QW – Clinical Laboratory Improvement Amendments (CLIA) waived test(s)

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.

REFERENCES

https://www.emblemhealth.com/content/dam/emblemhealth/pdfs/provider/reimbursement-policies/vaginitis-emblemhealth.pdf

https://www.wpsgha.com/guides-resources/view/120

https://www.wpsgha.com/guides-resources/view/35

DISCLAIMER

CMS and/or MDHHS guidelines apply unless otherwise specified in this policy or provider manual. Where such guidance is absent, this policy applies. 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