Priority Health	BILLING POLICY No. 156
Infectious Disease Panels	
Date of origin: October 2025	**Review dates:**

APPLIES TO

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

DEFINITION

This billing policy outlines the billing guidelines for submitting claims related to infectious disease panel testing. This policy provides guidance on selecting the correct CPT codes, documenting medical necessity, and correct coding.

MEDICAL POLICY

Infectious Disease Molecular Panels - 91643

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.

Billing details

More than one type of test for the same organism will not be reimbursable for the same date of service or within 7 days

Procedure codes may be subject to NCCI PTP edits, please review those here National Correct Coding Initiative (NCCI) PTP edits

Coding specifics

If the lab uses a testing platform that automatically runs a panel with 12 or more targets, but only some of those organisms meet coverage criteria, billing should reflect only the reimbursable organisms. In this case, submit the claim using the CPT code that best matches the number of covered targets, rather than the full panel code.

A single laboratory procedure shall be reported as one unit of service whether it generates one or multiple results. CPT codes that test for a single infectious agent that employ one procedure, one methodology, or one test kit are reported with one unit of service.

CPT codes that test for multiple infectious agents are reported with one unit of service if one procedure, one methodology, or one test kit is used to perform the test.

Multiple tests to identify the same analyte, marker, or infectious agent are not separately payable. It is not appropriate to report both direct probe and amplified probe technique tests for the same infectious agent.

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.

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.

Must be billed in on of the following POS:

20 Urgent Care

21 Inpatient Hospital

22 Outpatient Hospital

23 Emergency Room

81 Independent Laboratory

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

CMS NCCI Manual
NCCI PTP Edits
https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleid=58963

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
December 2025	Policy Effective