Priority Health	BILLING POLICY No. 164
Diagnostic testing of influenza	
Date of origin: Sept 2025	**Review dates: 3/2026, 6/2026**

DEFINITIONS

This policy outlines coverage criteria for diagnostic testing of influenza in outpatient, inpatient, and emergency settings. Influenza testing assists in timely diagnosis, appropriate treatment, and avoidance of unnecessary antibiotic use. Coverage is based on CMS guidelines and evidence-based clinical practice standards.

For Medicare

For indications that do not meet the 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

Documentation must support medical necessity, including presenting symptoms and clinical rationale.

Reimbursement specifics

Coverage Criteria

Influenza diagnostic testing is covered when:

1. Patient presents with signs and symptoms consistent with influenza (e.g., acute onset of fever, cough, sore throat, myalgia, headache, or fatigue).
2. When influenza activity is documented in the community or geographic area, coverage is allowed for only one of the following (not both):

   • One rapid influenza test — either a point-of-care rapid nucleic acid amplification test (NAAT) or a rapid antigen test;

   OR

   • One standard nucleic acid amplification test (NAAT).

Non-Covered Services

- Screening or surveillance testing for influenza in asymptomatic individuals is not covered.
- Repeat testing for influenza within the same illness episode is generally not covered unless medically justified (e.g., inconclusive results or specimen collection error).
- Simultaneous use of multiple influenza test methodologies on the same specimen without clinical justification is not covered.
- Multiplex respiratory panels are not covered for routine outpatient evaluation of otherwise healthy, low-risk patients unless results will impact treatment.

Coding specifics

CPT Codes:

Applicable CPT codes include but are not limited to:

- 87804 – Infectious agent antigen detection by immunoassay with direct optical observation; influenza.
- 87502–87504 – Infectious agent detection by nucleic acid (DNA or RNA); influenza virus.
- 87631–87633 – Respiratory virus multiplex panels

CCI edits:

- 87804 → bundles when billing A & B separately → use 59/XS for second unit.
- 87502–87504 → cannot bill with multiplex panel codes (87631–87633) (mutually exclusive edits).
- 87631–87633 → comprehensive codes that include influenza → individual flu PCR codes will deny if billed together.

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive.

- 86710 - Antibody; influenza virus
- 87254 - Virus isolation; centrifuge enhanced (shell vial) technique, includes identification with immunofluorescence stain, each virus
- 87275 - Infectious agent antigen detection by immunofluorescent technique; influenza B virus
- 87276 - Infectious agent antigen detection by immunofluorescent technique; influenza A virus
- 87400 - Infectious agent antigen detection by immunoassay technique, (eg, enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], fluorescence immunoassay [FIA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative; Influenza, A or B, each
- 87501 - Infectious agent detection by nucleic acid (DNA or RNA); influenza virus, includes reverse transcription, when performed, and amplified probe technique, each type or subtype
- 87502 - Infectious agent detection by nucleic acid (DNA or RNA); influenza virus, for multiple types or sub-types, includes multiplex reverse transcription, when performed, and multiplex amplified probe technique, first 2 types or sub-types
- 87503 - Infectious agent detection by nucleic acid (DNA or RNA); influenza virus, for multiple types or sub-types, includes multiplex reverse transcription, when performed, and multiplex amplified probe technique, each additional influenza virus type or sub-type beyond 2 (List separately in addition to code for primary procedure)
- 87631 - Infectious agent detection by nucleic acid (DNA or RNA); respiratory virus (eg, 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
- 87804 - Infectious agent antigen detection by immunoassay with direct optical (ie, visual) observation; Influenza
- 87812 - Infectious agent antigen detection by immunoassay with direct optical (ie, visual) observation; severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) and influenza virus types A and B

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.
- Many of these tests are CLIA-waived — must append QW modifier if performed in waived labs.
- If multiple respiratory tests are billed together, CCI edits often require modifier 59 (or appropriate X-modifier) to show distinct samples/services.

  Documentation must support medical necessity for why multiple tests/panels were ordered.

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

L38916 – Respiratory Pathogen Panel Testing - https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?lcdid=38916&ver=8&bc=0

CDC Guidelines: "Rapid Diagnostic Testing for Influenza: Information for Health Professionals." https://www.cdc.gov/flu/hcp/testing-methods/clinician_guidance_ridt.html

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 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 with 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
Sept 2025	New policy – effective Oct 16, 2025
March 2026	Added code 87812
June 2026	Reviewed, no changes