MEDICARE COVERAGE OF LABORATORY TESTING

Please remember when ordering laboratory tests that are billed to Medicare/Medicaid or other federally funded programs, the following requirements apply:

1. Only tests that are medically necessary for the diagnosis or treatment of the patient should be ordered. Medicare does not pay for screening tests except for certain specifically approved procedures and may not pay for non-FDA approved tests or those tests considered experimental.
2. If there is reason to believe that Medicare will not pay for a test, the patient should be informed. The patient should then sign an Advance Beneficiary Notice (ABN) to indicate that he or she is responsible for the cost of the test if Medicare denies payment.
3. The ordering physician must provide an ICD-10 diagnosis code or narrative description, if required by the fiscal intermediary or carrier.
4. Organ- or disease-related panels should be billed only when all components of the panel are medically necessary.
5. Both ARUP- and client-customized panels should be billed to Medicare only when every component of the customized panel is medically necessary.
6. Medicare National Limitation Amounts for CPT codes are available through the Centers for Medicare & Medicaid Services (CMS) or its intermediaries. Medicaid reimbursement will be equal to or less than the amount of Medicare reimbursement.

The CPT Code(s) for test(s) profiled in this bulletin are for informational purposes only. The codes reflect our interpretation of CPT coding requirements, based upon AMA guidelines published annually. CPT codes are provided only as guidance to assist you in billing. ARUP strongly recommends that clients reconfirm CPT code information with their local intermediary or carrier. CPT coding is the sole responsibility of the billing party.

The regulations described above are only guidelines. Additional procedures may be required by your fiscal intermediary or carrier.

Delete 2010744 Allergen, Fungi and Molds, Wheat Smut IgE WHEA SMUT

HOT LINE NOTE: Delete this test.

2003036 Aquaporin-4 Receptor Antibody AQP4

*This test performed at ARUP Laboratories.
Reference interval and numeric map changes.
Compliance statement is no longer required and has been removed.

Reference Interval: Effective October 3, 2016

Negative	2.9 U/mL or less
Positive	3.0 U/mL or greater

Interpretive Data:
Approximately 75 percent of patients with neuromyelitis optica (NMO) express antibodies to the aquaporin-4 (AQP4) receptor. Diagnosis of NMO requires the presence of longitudinally extensive acute myelitis (lesions extending over 3 or more vertebral segments) and optic neuritis. While absence of antibodies to the AQP4 receptor does not rule out the diagnosis of NMO, presence of this antibody is diagnostic for NMO.

HOT LINE NOTE: There is a numeric map change associated with this test.
Change the numeric map for component 2003121 Aquaporin-4 Receptor Antibody from XXX to XX.X

HOT LINE NOTE: Remove the reference interval for Indeterminate, 5 U/mL.

2013327 Aquaporin-4 Receptor Antibody by ELISA with Reflex to Aquaporin-4 Receptor Antibody, IgG by IFA AQP4 R

*This test performed at ARUP Laboratories.
Reference interval and numeric map changes.
Compliance statement is no longer required and has been removed.

Reference Interval: Effective October 3, 2016

Test Number	Components	Reference Interval	
2003036	Aquaporin-4 Receptor Antibody		
		Negative	2.9 U/mL or less
		Positive	3.0 U/mL or greater
2013320	Aquaporin-4 Receptor Antibody, IgG by IFA with Reflex to Titer, Serum	Less than 1:10	

Interpretive Data:
Approximately 75 percent of patients with neuromyelitis optica (NMO) express antibodies to the aquaporin-4 (AQP4) receptor. Diagnosis of NMO requires the presence of longitudinally extensive acute myelitis (lesions extending over 3 or more vertebral segments) and optic neuritis. While absence of antibodies to the AQP4 receptor does not rule out the diagnosis of NMO, presence of this antibody is diagnostic for NMO.

HOT LINE NOTE: There is a numeric map change associated with this test.
Change the numeric map for component 2003121 Aquaporin-4 Receptor Antibody from XXX to XX.X

HOT LINE NOTE: Remove the reference interval for Indeterminate, 5 U/mL.

2013601 Autoimmune Encephalitis Reflexive Panel AUTOENCEPH

*This test performed at ARUP Laboratories.
Reference interval, numeric map, and compliance statement changes.

Reference Interval: Effective October 3, 2016

Test Number	Components	Reference Interval
2004221	N-methyl-D-Aspartate Receptor Antibody, IgG, Serum with Reflex to Titer	< 1:10
2001771	Glutamic Acid Decarboxylase Antibody	0.0-5.0 IU/mL
2004890	Voltage-Gated Potassium Channel (VGKC) Antibody	
		Negative: 31 pmol/L or less
		Indeterminate: 32-87 pmol/L
		Positive: 88 pmol/L or greater
2003036	Aquaporin-4 Receptor Antibody	
		Negative: 2.9 U/mL or less
		Positive: 3.0 U/mL or greater
2013320	Aquaporin-4 Receptor Antibody, IgG by IFA with Reflex to Titer, Serum	Less than 1:10
2009456	Leucine-Rich, Glioma-Inactivated Protein 1 Antibody, IgG with Reflex to Titer	Less than 1:10
2009452	Contactin-Associated Protein-2 Antibody, IgG with Reflex to Titer	Less than 1:10

Interpretive Data:
Refer to report.

See Compliance Statement D: www.aruplab.com/CS

HOT LINE NOTE: There is a numeric map change associated with this test.
Change the numeric map for component 2003121 Aquaporin-4 Receptor Antibody from XXX to XX.X

HOT LINE NOTE: Remove the reference interval for Indeterminate, 5 U/mL.

2011052 Beryllium Lymphocyte Proliferation, Blood BE LYM PRO

Specimen Required: Collect: Green (sodium heparin).
Specimen Preparation:. **Specimen must be received at performing laboratory with 24 hours of collection. Do not send to ARUP Laboratories. For direct submission instructions, please contact ARUP Referral Testing at (800) 242-2787, ext. 5145.** Gently invert several times to mix and prevent clotting. Do not centrifuge. Transport 40 mL whole blood in the original collection tube(s). (Min: 30 mL)
Storage/Transport Temperature: **Send Monday – Thursday only. Specimen must be sent directly to performing laboratory.** Room temperature.
Unacceptable Conditions: Centrifuged specimens.
Stability (collection to initiation of testing): Ambient: 30 hours; Refrigerated: Unacceptable; Frozen: Unacceptable

2005749 Chromosome Analysis - Breakage, Ataxia Telangiectasia, Whole Blood BREAKAGEAT

Specimen Required: Collect: Green (sodium heparin).
Specimen Preparation: **Specimen must be received at performing laboratory within 48 hours of collection. Do not send to ARUP Laboratories. For direct submission instructions, please contact ARUP Referral Testing at (800) 242-2787, ext. 5145.** Transport 4 mL whole blood. (Min: 4 mL).
Storage/Transport Temperature: **Send Monday – Thursday only. Specimen must be sent directly to performing laboratory.** Room temperature. Also acceptable: Refrigerated.
Unacceptable Conditions: Clotted specimens.
Stability (collection to initiation of testing): Ambient: 48 hours; Refrigerated: 48 hours; Frozen: Unacceptable

0097688 Chromosome Analysis - Breakage, Fanconi Anemia, Whole Blood BREAKAGE

Specimen Required: Collect: Green (sodium heparin).
Specimen Preparation: **Specimen must be received at performing laboratory within 48 hours of collection. Do not send to ARUP Laboratories. For direct submission instructions, please contact ARUP Referral Testing at (800) 242-2787, ext. 5145.** Transport 4 mL whole blood. (Min: 4 mL).
Storage/Transport Temperature: **Send Monday – Thursday only. Specimen must be sent directly to performing laboratory.** Room temperature. Also acceptable: Refrigerated.
Unacceptable Conditions: Clotted specimens.
Stability (collection to initiation of testing): Ambient: 48 hours; Refrigerated: 48 hours; Frozen: Unacceptable

Delete **0092442 Galactokinase, Blood GALACTOKI**

HOT LINE NOTE: Delete this test. Refer to Galactose-1-Phosphate in Red Blood Cells (0081296)

0099603 Leukocyte Lysosomal Enzyme Screen WCELL

Specimen Required: Collect: Green (sodium or lithium heparin). **Collect Monday-Thursday only.**
Specimen Preparation: **Specimen must be received at performing laboratory within 24 hours of collection. Do not send to ARUP Laboratories. For direct submission instructions please contact ARUP Referral Testing at (800) 242-2787, ext. 5145.** Transport 8 mL whole blood (Min: 2 mL).
Storage/Transport Temperature: **Send Monday – Thursday only. Specimen must be sent directly to performing laboratory.** Room temperature.
Remarks: Patient history form is required.
Stability (collection to initiation of testing): Ambient: 24 hours; Refrigerated: Unacceptable; Frozen: Unacceptable