HOTLINE: Effective April 5, 2021

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.

Hotline Page #	Test Number	Summary of Changes by Test Name	Name Change	Methodology	Performed/Reported Schedule	Specimen Requirements	Reference Interval	Interpretive Data	Note	CPT Code	Component Change	Other Interface Change	New Test	Inactive
2	2013034	Alpha Subunit, Free, Pituitary Glycoprotein Hormones (PGH)			x	x								
3	0093142	Antimicrobial Level - Doxycycline, Serum												x
2	3003818	Cytochrome b5 Reductase Enzyme Activity											x	
3	2011017	Fibroblast Growth Factor 23 (FGF23), Plasma												x
3	2004686	Hemoglobin Lepore (HBD/HBB Fusion) 3 Mutations												x
2	3003816	Intact Fibroblast Growth Factor 23 (FGF23), Serum											x	
3	2011015	Methemoglobin Reductase, Blood												x

2013034 **Alpha Subunit, Free, Pituitary Glycoprotein Hormones (PGH)** **A SUB PGH**

Performed: Varies
Reported: 6-13 days

Specimen Required: Collect: Serum Separator Tube (SST) or Plain Red. Also acceptable: Lavender (K_2 EDTA), or pink (K_2 EDTA).
Specimen Preparation: Separate from cells ASAP or within 2 hours of collection. Transfer 1 mL serum or plasma to an ARUP Standard Transport Tube. (Min: 0.25 mL) Freeze immediately.
Test is not performed at ARUP; separate specimens must be submitted when multiple tests are ordered.
Storage/Transport Temperature: Frozen.
Stability (collection to initiation of testing): Ambient: 24 hours; Refrigerated: 24 hours; Frozen: 6 months

New Test
Available Now
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3003818 **Cytochrome b5 Reductase Enzyme Activity** **CYTOB5 RED**

Methodology: Quantitative Spectrophotometry
Performed: Varies
Reported: 3-6 days

Specimen Required: Collect: Yellow (ACD solution A or B). Also acceptable: Lavender (EDTA).
Specimen Preparation: Transport 6 mL whole blood in the original tube. (Min: 1 mL)
Test is not performed at ARUP; separate specimens must be submitted when multiple tests are ordered.
Storage/Transport Temperature: Refrigerated.
Stability (collection to initiation of testing): Ambient: Unacceptable; Refrigerated: 18 days; Frozen: Unacceptable

Reference Interval: By Report

CPT Code(s): 82657

New York DOH Approved.

HOTLINE NOTE: Refer to the Test Mix Addendum for interface build information.

New Test
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3003816 **Intact Fibroblast Growth Factor 23 (FGF23), Serum** **IFGF23**

Methodology: Quantitative Chemiluminescent Immunoassay
Performed: Varies
Reported: 3-10 days

Specimen Required: Collect: Serum Separator Tube (SST). Also acceptable: Plain red.
Specimen Preparation: Transfer 0.5 mL serum to an ARUP Standard Transport Tube. (Min: 0.25 mL)
Test is not performed at ARUP; separate specimens must be submitted when multiple tests are ordered.
Storage/Transport Temperature: Frozen. Also acceptable: Refrigerated.
Stability (collection to initiation of testing): Ambient: Unacceptable; Refrigerated: 2 weeks; Frozen: 3 months

Reference Interval: By Report

CPT Code(s): 83520

New York DOH Approved.

HOTLINE NOTE: Refer to the Test Mix Addendum for interface build information.

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The following will be discontinued from ARUP's test menu on April 5, 2021.
Replacement test options are supplied if applicable.

Test Number	Test Name	Refer To Replacement
0093142	Antimicrobial Level - Doxycycline, Serum	
2011017	Fibroblast Growth Factor 23 (FGF23), Plasma	Intact Fibroblast Growth Factor 23 (FGF23), Serum (3003816)
2004686	Hemoglobin Lepore (HBD/HBB Fusion) 3 Mutations	Deletion/Duplication Analysis by MLPA (3003144)
2011015	Methemoglobin Reductase, Blood	Cytochrome b5 Reductase Enzyme Activity (3003818)