UnitedHealthcare® Medicare Advantage
Reimbursement Policy
CMS 1500
UB04
Policy Number 2025R9069A

Molecular Syndromic Panels for Infectious Disease Pathogen Identification Testing
Policy, Professional and Facility

IMPORTANT NOTE ABOUT THIS REIMBURSEMENT POLICY

This policy is applicable to UnitedHealthcare Medicare Advantage Plans offered by UnitedHealthcare and its affiliates.

You are responsible for submission of accurate claims. This reimbursement policy is intended to ensure that you are reimbursed based on the code or codes that correctly describe the health care services provided. UnitedHealthcare Medicare Advantage reimbursement policies use Current Procedural Terminology (CPT®*), Centers for Medicare and Medicaid Services (CMS), or other coding guidelines. References to CPT or other sources are for definitional purposes only and do not imply any right to reimbursement.

This reimbursement policy applies to all health care services billed on UB04 forms (CMS 1450) and to those billed on CMS 1500 forms. Coding methodology, industry-standard reimbursement logic, regulatory requirements, benefits design and other factors are considered in developing reimbursement policy.

This information is intended to serve only as a general resource regarding UnitedHealthcare's Medicare Advantage reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly, UnitedHealthcare Medicare Advantage may use reasonable discretion in interpreting and applying this policy to health care services provided in a particular case. Further, the policy does not address all issues related to reimbursement for health care services provided to UnitedHealthcare Medicare Advantage enrollees. Other factors affecting reimbursement may supplement, modify or, in some cases, supersede this policy. These factors may include, but are not limited to: legislative mandates, the facility or other provider contracts, the enrollee's benefit coverage documents**, and/or other reimbursement, medical or drug policies. Finally, this policy may not be implemented exactly the same way on the different electronic claims processing systems used by UnitedHealthcare Medicare Advantage due to programming or other constraints; however, UnitedHealthcare Medicare Advantage strives to minimize these variations.

UnitedHealthcare Medicare Advantage may modify this reimbursement policy at any time to comply with changes in CMS policy and other national standard coding guidelines by publishing a new version of the reimbursement policy on this website. However, the information presented in this reimbursement policy is accurate and current as of the date of publication. UnitedHealthcare Medicare Advantage encourages physicians and other health care professionals to keep current with any CMS policy changes and/or billing requirements by referring to the CMS or your local carrier website regularly. Facilities can sign up for regular distributions for policy or regulatory changes directly from CMS and/or your local carrier. UnitedHealthcare's Medicare Advantage reimbursement policies do not include notations regarding prior authorization requirements.

** For more information on a specific enrollee's benefit coverage, please call the customer service number on the back of the member ID card.

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Application

This reimbursement policy applies to all Medicare Advantage products and for network provider services reported using the UB04 and CMS 1500 form or its electronic equivalent or its successor form.

Policy

Overview

According to the Centers for Medicare and Medicaid Services (CMS), laboratory procedures should be reported with the Current Procedural Terminology (CPT®) or Healthcare Common Procedure Coding System (HCPCS) codes that most comprehensively describe the services performed. If a laboratory procedure produces multiple reportable test results, only a single HCPCS/CPT code shall be reported for the procedure. If there is no HCPCS/CPT code that describes the procedure, the laboratory shall report a miscellaneous or unlisted procedure code (Not Otherwise Classified (NOC) Code**)** with a single unit of service.

UnitedHealthcare Medicare Advantage uses this policy to determine whether multiple CPT and/or HCPCS codes for Molecular (DNA/RNA) Syndromic Panel testing reported together by the Same Individual Physician or Health Care Professional for the same member on the same date of service are eligible for separate reimbursement.

Reimbursement Guidelines

A Molecular Syndromic Panel simultaneously detects multiple different pathogens associated with similar and overlapping clinical symptomatology. A test panel is a single test with multiple components and is characterized by a single unit of service (UOS =1). A panel must not be separated and billed as individual components, even if the test identifies multiple distinct pathogens or targets.

UnitedHealthcare Medicare Advantage will only consider for reimbursement a single molecular syndromic panel procedure code, a panel procedure code with one additional single pathogen component procedure code, or two single pathogen component codes billed separately without the applicable panel procedure code, when reported for a given member on the same date of service for the same intended use. Alternatively, Molecular Syndromic Infectious Disease panels may be reported with a CPT code and a DEX Z-Code if one has been obtained.

When two or more codes within a given Panel Group OR from two *related* Panel Groups (i.e., Groups 1 and 6 which pertain to Respiratory panels, or Groups 2 and 7 which pertain to Gastrointestinal panels) are submitted for the same member on the same date of service for the same (or highly similar) intended use, UnitedHealthcare will not consider for reimbursement the codes submitted after the first service.

Test Panel Types and Categorization:
Molecular syndromic infectious disease pathogen identification panel types:

- Respiratory (RP) and Pneumonia (PNP) Panels
- Gastrointestinal (GI) Panels
- Urogenital/Anogenital (UG/AG) Panels
- Meningoencephalitis (ME) Panels
- Bloodstream Infection (BSI) Panels
- Urinary Tract Infection (UTI) Panels

Multiple pathogen Molecular Syndromic Panel tests are categorized into panel Groups 1-7 as follows:

- Group 1 - Targeted Respiratory Panel
- Group 2 - Targeted Gastrointestinal Panels
- Group 3 - Meningoencephalitis Panels
- Group 4 - Bloodstream Infection Panels
- Group 5 - Urogenital/Anogenital Panels
- Group 6 - Expanded Respiratory and Pneumonia Panels

- Group 7- Expanded Gastrointestinal Panels

The single infectious pathogen tests are categorized into Group 8:

- Group 8 - Single Pathogen Procedure codes

Test Panel Components:
The test panel is a single test with multiple components and is characterized by a single unit of service (UOS =1). A panel cannot be unbundled and billed as individual components regardless of whether the test reports multiple individual pathogens and/or targets. If additional organisms are not included in a panel, testing for those organisms separately may be considered for reimbursement when ordered in addition to the panel and supported by documentation in the medical record.

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Group 8 Single Pathogen Tests:

The Group 8 single pathogen procedure codes are not separately reimbursed for the same member on the same date of service when >1 is billed in combination with another CPT or PLA code from Groups 1 – 7 for the same intended use.

Additionally, the Group 8 CPT codes are not separately reimbursed for the same member on the same date of service when >2 are billed for the same intended use.

Claims Submission Requirements if submitting with a DEX Z-Code:

If choosing to submit a claim for a Molecular Syndromic Panel for Infectious Disease Pathogen Identification Test with a DEX Z-Code, please refer to the UnitedHealthcare Medicare Advantage Molecular Pathology Policy, Professional and Facility - Reimbursement Policy for instructions.

Definitions	
DEX Z-Code™ Identifiers	Unique and proprietary 5-character alpha-numeric codes assigned within the DEX Diagnostics Exchange.
Molecular (DNA/RNA) syndromic panels	A Molecular (DNA/RNA) syndromic panel ('panel' as defined in the policy is a test that detects >1 pathogen) for infectious disease pathogen identification testing are the tests within the scope of Local Coverage Article A58710. A 'syndromic panel' is further defined as one that simultaneously detects multiple different pathogens associated with similar and overlapping clinical symptomatology.
Panel Test	A test that detects >1 pathogen.
Proprietary Laboratory Analysis (PLA) Codes	These codes describe proprietary clinical laboratory analyses and can be either provided by a single (“sole source”) laboratory or licensed or marketed to multiple providing laboratories (e.g., cleared or approved by the Food and Drug Administration (FDA)). These codes include advanced diagnostic laboratory tests (ADLTs) and clinical diagnostic laboratory tests (CDLTs) as defined under the Protecting Access to Medicare Act (PAMA) of 2014.
Same Individual Physician or Health Care Professional	The same individual rendering health care services reporting the same National Provider Identifier (NPI) number.
Not Otherwise Classified (NOC) Codes	Codes used to report an item or service for which no specific code exists. Sometimes referred to as “unlisted” or “miscellaneous” codes.

Questions and Answers	
1	**Q:** Is it appropriate to report multiple codes using modifier 59 when different pathogens are tested on a single specimen? **A:** Testing on a single specimen should be reported with a single code. If additional organisms are not included in a panel, testing for those organisms separately for the same indication (intended use) may be reimbursable in limited circumstances. In the rare situation that separate specimens(s) are tested on the same patient on the same date of service for distinctly separate indications, the initial specimen is reported without a modifier and an additional code may be reported with an appropriate modifier for the additional specimen tested. The use of a modifier to identify a different indication on the same date of service must be supported by the test requisition form and documentation. Per the CMS National Correct Coding policy if the single procedure is performed, only one unit of service may be reported. Modifiers should not be used to report multiple codes when a single specimen is tested.

Resources

- American Medical Association, Current Procedural Terminology (CPT®) and associated publications and services
- NCCI Policy Manual for Medicare Services, Chapter 10, Pathology/Laboratory Services
- Local Coverage Article A58710 Billing and Coding: Molecular Syndromic Panels for Infectious Disease Pathogen Identification Testing

History

10/1/2025	Policy implemented by UnitedHealthcare Medicare Advantage