Histocompatibility Testing (NCD 190.1)

Guideline Number: MPG135.08
Approval Date: April 13, 2022

Terms and Conditions

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Related Medicare Advantage Policy Guideline

- Molecular Pathology Procedures for Human Leukocyte Antigen (HLA) Typing

Related Medicare Advantage Reimbursement Policies

- Clinical Laboratory Improvement Amendments (CLIA) ID Requirement Policy, Professional
- Laboratory Services Policy, Professional

Related Medicare Advantage Coverage Summaries

- Laboratory Tests and Services
- Organ and Tissue Transplants

Policy Summary

See Purpose

Overview

Histocompatibility testing involves the matching or typing of the human leucocyte antigen (HLA).

Guidelines

This testing is safe and effective when it is performed on patients:

- In preparation for a kidney transplant;
- In preparation for bone marrow transplantation;
- In preparation for blood platelet transfusions (particularly where multiple infusions are involved); or
- Who are suspected of having ankylosing spondylitis.

This testing is covered under Medicare when used for any of the indications listed above and if it is reasonable and necessary for the patient. It is covered for ankylosing spondylitis in cases where other methods of diagnosis would not be appropriate or have yielded inconclusive results.

Note: In all cases where ankylosing spondylitis is indicated as the reason for the test, documentation from the physician supporting the medical necessity of the test must be made available upon request.

Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this guideline does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

CPT Code	Description
86812	HLA typing; A, B, or C (e.g., A10, B7, B27), single antigen
86813	HLA typing; A, B, or C, multiple antigens
86816	HLA typing; DR/DQ, single antigen
86817	HLA typing; DR/DQ, multiple antigens
86821	HLA typing; lymphocyte culture, mixed (MLC)
86825	Human leukocyte antigen (HLA) crossmatch, non-cytotoxic (e.g., using flow cytometry); first serum sample or dilution
86826	Human leukocyte antigen (HLA) crossmatch, non-cytotoxic (e.g., using flow cytometry); each additional serum sample or sample dilution (List separately in addition to primary procedure)

References

CMS National Coverage Determinations (NCDs)

NCD 190.1 Histocompatibility Testing

CMS Claims Processing Manual

Chapter 3; § 90.3 Stem Cell Transplantation
Chapter 4; § 231.11 Billing for Allogeneic Stem Cell Transplants
Chapter 16; § 20 Calculation of Payment Rates - Clinical Laboratory Test Fee Schedules; § 40 Billing for Clinical Laboratory Tests
Chapter 32; § 90 Stem Cell Transplantation

CMS Transmittal(s)

Transmittal 2033, Change Request 10473, Dated 02/16/2018 (ICD-10 and Other Coding Revisions to National Coverage Determinations (NCDs))
Transmittal 2039, Change Request 10473, Dated 02/28/2018 (ICD-10 and Other Coding Revisions to National Coverage Determinations (NCDs))
Transmittal 11083, Change Request 12482, Dated 10/29/2021 (International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determination (NCDs) – April 2022 (CR 2 of 2 for April 2022))
Transmittal 11264, Change Request 12606, Dated 02/10/2022 (International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determinations (NCDs) – July 2022)

Guideline History/Revision Information

Revisions to this summary document do not in any way modify the requirement that services be provided and documented in accordance with the Medicare guidelines in effect on the date of service in question.

Date	Summary of Changes
04/13/2022	**Related Policies** • Removed reference link to the Medicare Advantage Policy Guideline titled *Clinical Diagnostic Laboratory Services* **Supporting Information** • Updated *References* section to reflect the most current information • Archived previous policy version MPG135.07

Purpose

The Medicare Advantage Policy Guideline documents are generally used to support UnitedHealthcare Medicare Advantage claims processing activities and facilitate providers' submission of accurate claims for the specified services. The document can be used as a guide to help determine applicable:

- Medicare coding or billing requirements, and/or
- Medical necessity coverage guidelines; including documentation requirements.

UnitedHealthcare follows Medicare guidelines such as NCDs, LCDs, LCAs, and other Medicare manuals for the purposes of determining coverage. It is expected providers retain or have access to appropriate documentation when requested to support coverage. Please utilize the links in the References section below to view the Medicare source materials used to develop this resource document. This document is not a replacement for the Medicare source materials that outline Medicare coverage requirements. Where there is a conflict between this document and Medicare source materials, the Medicare source materials will apply.

Terms and Conditions

The Medicare Advantage Policy Guidelines are applicable to UnitedHealthcare Medicare Advantage Plans offered by UnitedHealthcare and its affiliates.

These Policy Guidelines are provided for informational purposes, and do not constitute medical advice. Treating physicians and healthcare providers are solely responsible for determining what care to provide to their patients. Members should always consult their physician before making any decisions about medical care.

Benefit coverage for health services is determined by the member specific benefit plan document* and applicable laws that may require coverage for a specific service. The member specific benefit plan document identifies which services are covered, which are excluded, and which are subject to limitations. In the event of a conflict, the member specific benefit plan document supersedes the Medicare Advantage Policy Guidelines.

Medicare Advantage Policy Guidelines are developed as needed, are regularly reviewed and updated, and are subject to change. They represent a portion of the resources used to support UnitedHealthcare coverage decision making. UnitedHealthcare may modify these Policy Guidelines at any time by publishing a new version of the policy on this website. Medicare source materials used to develop these guidelines include, but are not limited to, CMS National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Medicare Benefit Policy Manual, Medicare Claims Processing Manual, Medicare Program Integrity Manual, Medicare Managed Care Manual, etc. The information presented in the Medicare Advantage Policy Guidelines is believed to be accurate and current as of the date of publication and is provided on an "AS IS" basis. Where there is a conflict between this document and Medicare source materials, the Medicare source materials will apply.

You are responsible for submission of accurate claims. Medicare Advantage Policy Guidelines are intended to ensure that coverage decisions are made accurately based on the code or codes that correctly describe the health care services provided. UnitedHealthcare Medicare Advantage Policy Guidelines 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 or guarantee claims payment.

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