

Lymphocyte Mitogen Response Assays (NCD 190.8)

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Policy Summary

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Overview

The lymphocyte mitogen response assay measures the immune response of patient peripheral blood lymphocytes.

Guidelines

It is a covered test under Medicare when it is medically necessary to assess lymphocytic function in diagnosed immunodeficiency diseases and to monitor immunotherapy.

It is not covered when it is used to monitor the treatment of cancer, because its use for that purpose is experimental.

Nationally Non-Covered Indications:

Compliance with the provisions in this policy is subject to monitoring by post payment data analysis and subsequent medical review. Title XVIII of the Social Security Act, Section 1862(a)(1)(A) states " ...no Medicare payment shall be made for items or services which are not reasonable and necessary for the diagnosis and treatment of illness or injury...". Furthermore, it has been longstanding CMS policy that "tests that are performed in the absence of signs, symptoms, complaints, or personal history of disease or injury are not covered unless explicitly authorized by statute".

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
86352	Cellular function assay involving stimulation (e.g., mitogen or antigen) and detection of biomarker (e.g., ATP)
86353	Lymphocyte transformation, mitogen (phytomitogen) or antigen induced blastogenesis

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Non-Covered Diagnosis Code

[Non-Covered Diagnosis Codes List](#)

This list contains diagnosis codes that are never covered when given as the primary reason for the test. If a code from this section is given as the reason for the test and you know or have reason to believe the service may not be covered, call UnitedHealthcare to issue an Integrated Denial Notice (IDN) to the member and you. The IDN informs the member of their liability for the non-covered service or item and appeal rights. You must make sure the member has received the IDN prior to rendering or referring for non-covered services or items in order to collect payment.

References

CMS National Coverage Determinations (NCDs)

[NCD 190.8 Lymphocyte Mitogen Response Assays](#)

CMS Local Coverage Determinations (LCDs) and Articles

LCD	Article	Contractor	Medicare Part A	Medicare Part B
L34914 Assays for Vitamins and Metabolic Function	A56416 Billing and Coding: Assays for Vitamins and Metabolic Function	Novitas	AR, CO, DC, DE, LA, MD, MS, NJ, NM, OK, PA, TX	AR, CO, DC, DE, LA, MD, MS, NJ, NM, OK, PA, TX
L33418 Assays for Vitamins and Metabolic Function	A56485 Billing and Coding: Assays for Vitamins and Metabolic Function	Palmetto	AL, GA, NC, SC, TN, VA, WV	AL, GA, NC, SC, TN, VA, WV

CMS Benefit Policy Manual

[Chapter 15; § 80.1 Clinical Laboratory Services](#)

CMS Claims Processing Manual

[Chapter 16; § 20 Calculation of Payment Rates - Clinical Laboratory Test Fee Schedules; § 40 Billing for Clinical Laboratory Tests](#)

CMS Transmittal(s)

[Transmittal 1388, Change Request 8691, Dated May 23, 2014 \(ICD-10 Conversion/Coding Infrastructure Revisions/ICD-9 Updates to National Coverage Determinations \(NCDs\)-Maintenance CR\)](#)

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
04/01/2021	Template Update <ul style="list-style-type: none"> Reformatted policy; transferred content to new template
01/13/2021	<ul style="list-style-type: none"> Routine review; no change to guidelines Archived previous policy version MPG198.05

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.

Medicare Advantage Policy Guidelines are the property of UnitedHealthcare. Unauthorized copying, use, and distribution of this information are strictly prohibited.

*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](#).