MEDICAL POLICY

Medical Policy Title	**Expanded Molecular Testing for Infectious Disease Pathogens in the Outpatient Setting**
Policy Number	**2.02.62**
Current Effective Date	**February 15, 2027**
Next Review Date	**October 2027**

Our medical policies are guides to evaluate technologies or services for medical necessity. Criteria are established through the assessment of evidence based, peer-reviewed scientific literature, and national professional guidelines. Federal and state law(s), regulatory mandates and the member's subscriber contract language are considered first in the determination of a covered service. (Link to Product Disclaimer)

POLICY STATEMENT(S)

I. Expanded molecular testing for infectious disease pathogen identification is **medically necessary** when **ALL** the following criteria are met:

- A. Individual is in the outpatient setting (See Policy Guidelines);
- B. Initial focused diagnostic evaluation has not identified a causative pathogen (e.g., sputum culture, urine culture);
- C. The results of the testing are expected to directly influence clinical management (e.g., antibiotic/antiviral selection) and avoid unnecessary treatment or additional testing;
- D. The number of pathogens tested does not exceed those reasonably necessary to evaluate the member's clinical presentation;
- E. Individual has signs and symptoms of acute infection and **any** of the following indication-specific testing categories are met:
  1. Expanded Respiratory Pathogen testing when **either** of the following criteria are met:
     - a. Individual is being evaluated in the outpatient setting and is considered at risk for hospitalization due to illness severity;
     - b. Individual is considered high risk (i.e., Age ≥ 65, immunocompromised, with significant comorbidities) **or**;
  2. Expanded Genitourinary/Urinary Tract Infection (UTI) testing when **any** of the following criteria are met:
     - a. Individual is being evaluated in the outpatient setting and is considered at risk for hospitalization due to illness severity;
     - b. Individual is considered high risk (i.e., Age ≥ 65, immunocompromised, with significant comorbidities);
     - c. Complicated UTI (e.g. chronic indwelling catheter or ileal conduit);
     - d. Recurrent infections that have failed empiric therapy **or**;

3. Expanded Sexually Transmitted Infection (STI) testing when **any** of the following criteria are met:
    a. Individual is being evaluated in the outpatient setting and is considered at risk for hospitalization due to illness severity;
    b. Documentation supports the individual is considered high risk (i.e., high risk of exposure, age ≥ 65, immunocompromised, significant comorbidities);
    c. There is clinical concern due to a high-risk or symptomatic presentation requiring broad evaluation **or**;
4. Expanded Gastrointestinal Pathogen testing when **all** the following criteria are met:
    a. Individual is being evaluated in the outpatient setting and is considered at risk for hospitalization due to illness severity;
    b. Individual is considered high risk (i.e., Age ≥ 65, immunocompromised, with significant comorbidities, travel outside of the country);
    c. Individual with acute or persistent diarrhea and risk factors or signs of severe disease (e.g., bloody diarrhea, dysentery, dehydration, severe abdominal pain).

II. Expanded molecular testing is **not medically necessary** for **ANY** of the following:
A. Routine screening;
B. Duplicate/repeat panel within the same illness episode or before the appropriate re-test interval;
C. Initial evaluation when standard testing/culture is appropriate (e.g., uncomplicated cystitis);
D. Individual is asymptomatic and without risk factors;
E. Symptoms are mild and self-limited;
F. Documentation does not support clinical utility (e.g. when a single-pathogen test or smaller targeted testing can provide the information necessary for clinical management);
G. Convenience or rapid turnaround time alone.

RELATED POLICIES

Corporate Medical Policy

11.01.15 Medically Necessary Services

Administrative Policy

AP-55 Sexually Transmitted Infection (STI) Testing

POLICY GUIDELINE(S)

I. Expanded molecular testing refers to multiplex molecular assays that evaluate numerous pathogens associated with a clinical syndrome (e.g., respiratory, gastrointestinal, urinary tract, bloodstream, or sexually transmitted infections) from a single patient specimen.

II. Targeted single- or low-target assays (e.g., influenza/RSV/SARS-CoV-2, Chlamydia trachomatis/Neisseria gonorrhoeae NAAT), standard urine culture, or guideline-directed serology are expected within urgent care or in-office settings, as the use of expanded molecular tests should be reserved for settings where rapid identification of polymicrobial infections is critical (i.e., ventilator-associated pneumonia or blood stream infections).

III. If individual and expanded molecular tests are requested on the same date of service, the clinical rationale must be documented to establish that each test is separate and distinct from any other procedure performed on that date.

DESCRIPTION

Targeted diagnostic testing is laboratory testing performed to detect, identify, confirm, or rule out a specific suspected infectious pathogen or a limited number of pathogens based on the patient's clinical presentation, medical history, exposure risk, or other diagnostic information. Expanded molecular testing for infectious disease pathogens involves the use of multiplex molecular diagnostic assays to simultaneously identify multiple microorganisms associated with a clinical syndrome from a single specimen. These tests may include detection of bacterial, viral, fungal, parasitic, and antimicrobial resistance targets and are intended to provide comprehensive pathogen identification beyond traditional targeted diagnostic testing.

Targeted diagnostic testing is most commonly used to confirm or rule out a specific suspected disease, condition, or pathogen when clinical findings point to a likely diagnosis. Common applications include respiratory tract infections, gastrointestinal infections, urinary tract infections, central nervous system infections, bloodstream infections, and sexually transmitted infections and may utilize molecular, culture-based, antigen, serologic, or other laboratory methodologies and is directed toward a focused diagnostic hypothesis.

Advantages of using targeted diagnostic testing:

- Aligns testing with the patient's symptoms and clinical findings.
- Reduces unnecessary broad testing.
- Helps confirm or exclude a suspected disease or infection.
- Identifies the specific condition or pathogen responsible for illness.
- Supports targeted therapy and may reduce inappropriate antimicrobial use.
- Focused testing is less likely to identify incidental findings, asymptomatic colonization, or organisms of uncertain clinical significance.
- Results may be easier to interpret in the clinical context.

Limitations of using targeted diagnostic testing:

- Evaluates only the specific pathogen, condition, or analyte selected for testing.
- May fail to identify the actual cause of illness if the suspected diagnosis is incorrect.
- If initial testing is negative, additional testing may be needed to evaluate alternative diagnoses.
- This can increase diagnostic delays and healthcare utilization.
- When the etiology is uncertain, sequential targeted testing may take longer than broad testing approaches that evaluate multiple pathogens simultaneously.
- Targeted testing only identifies organisms included in the test.

Expanded molecular testing is most commonly used to evaluate infectious disease syndromes in which multiple pathogens may produce similar clinical manifestations. Common applications include respiratory tract infections, gastrointestinal infections, central nervous system infections, bloodstream infections, and sexually transmitted infections where molecular techniques are used to simultaneously detect multiple pathogens from a single specimen, facilitating rapid and comprehensive pathogen identification.

Advantages of using expanded molecular testing:

- Multiple targets can be detected from a single specimen.
- Increases the likelihood of identifying the causative organism when symptoms may be caused by a variety of pathogens.
- Can detect coinfections involving more than one pathogen.
- May facilitate appropriate patient isolation and infection control measures.
- Particularly valuable when symptoms are nonspecific and multiple pathogens could be responsible.

Limitations of expanded molecular testing:

- Higher cost than singleplex assays.
- Detection of an organism does not necessarily indicate active infection.
- Panels may identify colonization or asymptomatic carriage.
- Broad testing may detect organisms of uncertain clinical significance.

Diagnostic stewardship is the coordinated approach to the selection, timing, performance, and interpretation of diagnostic tests to improve patient outcomes, promote appropriate clinical management, reduce unnecessary testing, support antimicrobial stewardship, and optimize the efficient use of healthcare resources. Inappropriate testing can lead to misdiagnosis, detection of colonization rather than active infection, increased healthcare costs and unnecessary antimicrobial use. By promoting appropriate test selection and interpretation, diagnostic stewardship helps ensure

that laboratory results support meaningful clinical decision-making. Testing should be based on the patient's clinical presentation, risk factors, and suspected diagnosis, with consideration given to the benefits and limitations of both targeted diagnostic testing and expanded molecular testing. Broad molecular panels may not be necessary when a focused diagnostic approach is sufficient to answer the clinical question.

SUPPORTIVE LITERATURE

Expanded molecular panels, commonly referred to as syndromic or multiplex assays, are capable of simultaneously detecting viral, bacterial, and parasitic pathogens from a single specimen. These assays offer high analytic sensitivity and rapid turnaround times. However, the primary consideration for their use is not diagnostic performance alone, but whether the additional pathogen information meaningfully influences clinical decision-making and improves patient outcomes. Across respiratory, urinary, sexually transmitted, and gastrointestinal applications, a consistent pattern is demonstrated: expanded molecular panels offer the greatest benefit in patients who are acutely ill, high-risk, or clinically complicated, and when targeted testing has proven inconclusive. In contrast, broad and routine use in mild or uncomplicated outpatient presentations generates findings of uncertain significance and can risk antibiotic overtreatment (Nairz and Weiss 2025; Reddy 2026).

Respiratory Pathogen Panels

Professional society recommendations tend to steer clinicians away from routine use of broad respiratory panel testing when the results will not influence management. Through the Choosing Wisely initiative, the American Society for Clinical Pathology recommends against routinely ordering broad respiratory pathogen panels because specific viral identification rarely alters the treatment for most immunocompetent patients in whom most non-influenza viral infections will resolve on their own and only influenza has a targeted treatment (Greenberg 2020). The American Thoracic Society clinical practice guideline on nucleic acid–based testing for non-influenza viral pathogens in suspected community-acquired pneumonia arrived at similar conclusions, and its evidence review highlights a limited and inconsistent effect on antibiotic use (Evans 2021).

Clinical studies have demonstrated mixed results regarding the impact of multiplex respiratory testing on outcomes. A randomized trial of 432 emergency-department patients with acute lower respiratory tract illness found that the patients who received multiplex PCR testing had a greater likelihood of reduced antibiotic prescribing among patients compared with immunofluorescence testing (Echavarría 2018). In contrast, a multicenter randomized trial of 107 hospitalized patients with lower respiratory tract infection found that reporting multiplex PCR results within 48 hours produced no significant reduction in antibiotic duration and no effect on length of stay compared with the control (Oosterheert 2021).

Observational outpatient data supports a targeted approach. Among 295 adult outpatients undergoing FilmArray respiratory panel testing, a positive influenza result was associated with fewer antibiotic prescriptions, but detection of a non-influenza virus produced no difference in reduction compared to a negative test. This prompted the authors to conclude that influenza-specific testing

alone may be sufficient and more cost-effective than multiplex testing for most outpatients (Green 2016). Nairz and Weiss 2025, published a narrative review of point-of-care testing in primary care similarly concluded that multiplex panels are most useful in severely immunocompromised patients and that routine multiplex use in community-acquired respiratory infections is not recommended unless they can be shown to be a benefit for patient-important outcomes.

As a whole, these findings support restricting expanded respiratory panels to patients with moderate-to-severe illness or elevated risk of deterioration and to high-risk hosts (age ≥ 65, immunocompromised, or with significant comorbidities), where pathogen identification is more likely to alter antiviral or antibiotic decisions and infection-control measures (Greenberg 2020; Nairz and Weiss, 2025).

Genitourinary (GU)/ Urinary Tract Infection (UTI) Panels

Guidelines and reviews emphasize that the increased sensitivity of molecular testing has not produced a proven benefit for uncomplicated infection and may promote overtreatment. The microbiology utilization guide from the Infectious Diseases Society of America and the American Society for Microbiology (IDSA/ASM) explicitly states that expanded urine culture and molecular methods often obtain additional low-count organisms of uncertain clinical significance. It therefore does not recommend routine use across all patient populations and reserves modified workups for chronic or recurrent UTI following discussion with the laboratory (Miller 2024). Likewise, the American Urological Association, Canadian Urological Association and Society of Urodynamics, Female Pelvic Medicine & Urogenital Reconstruction (AUA/CUA/SUFU) recurrent UTI guideline specifies PCR and next-generation sequencing as investigational, pointing out that these techniques identify bacteria in a large portion of asymptomatic controls and warns outright that their use for lower urinary tract symptoms may stimulate antibiotic overtreatment (Anger 2022).

Primary studies mirror these concerns. In a prospective within-subject study of women ≥ 60 years presenting with acute cystitis symptoms, multiplex PCR was positive significantly more often than standard culture (81.6% vs 41.4%), with inconsistent findings in 43.7% of patients. Even so, there was no significant overall difference in how quickly the correct antibiotic therapy was started, and the only real advantage was limited to detecting non–E. coli organisms such as Enterococcus faecalis (Bauer 2025). Reddy 2026 similarly determined that, despite faster turnaround and broader organism detection, the effect of molecular urine diagnostics on clinical outcomes remains uncertain, with particular concern that detection of coexisting urinary-microbiome organisms may lead to overdiagnosis. This evidence supports the exclusion of expanded UTI panels for uncomplicated cystitis and asymptomatic patients, while allowing them in high-risk hosts, complicated UTI (e.g., chronic indwelling catheter or ileal conduit), and recurrent infections that have failed empiric therapy (Miller 2024; Bauerl 2025).

Sexually Transmitted Infection (STI) Panels

Multiplex sexually transmitted infection (STI) assays provide excellent analytic performance and can accurately detect multiple pathogens simultaneously. Karellis 2022 published a systematic review spanning 24 studies and 26,126 individuals, most platforms demonstrated sensitivity and specificity

exceeding 95%, which supports their application in screening, confirmatory testing, and antimicrobial stewardship among suitable populations. Such testing makes the most sense when coinfection is likely or when multiple pathogens need to be ruled out, since coinfection rates climb to 25% or more in high-risk groups (Dichtl 2023).

The chief drawback is that broad panels often identify organisms of uncertain pathogenic significance. A retrospective evaluation by Dichtl 2023 of multiplex STI testing found that the most common secondary discovery were Mycoplasma hominis and Ureaplasma spp.—organisms that the necessity of treatment has been debated as that may simply be benign—prompting the investigators to recommend that only true pathogens be routinely reported for clinical action. A 2026 real-world analysis arrived at the same view, noting that the organisms detected most often (U. parvum, U. urealyticum, M. hominis) frequently occur in asymptomatic people, and concluding that a diagnostic approach centered on clinically significant pathogens can improve appropriate treatment while curbing unnecessary antimicrobial use (Özgen-Top 2026). For these reasons, expanded STI panels are best reserved for high-risk hosts and for symptomatic or high-risk presentations that call for broad evaluation, with all results interpreted in clinical context.

Gastrointestinal Pathogen Panels

Among the major applications of expanded molecular testing, gastrointestinal pathogen panels have demonstrated some of the most consistent evidence for clinical utility. These panels substantially increase pathogen detection rates and have been associated with reductions in downstream diagnostic testing, healthcare utilization, and inappropriate antibiotic exposure, particularly among patients with more significant illness. A large retrospective U.S. outpatient study by Moon 2023, comprised of 36,787 patients found that large multiplex panels (≥ 12 targets) identified a pathogen in 73.1% of tested patients compared with 45.4% using traditional workup, along with faster turnaround, fewer stool tests, a lower likelihood of in-hospital antibiotics, reduced 30-day GI-related follow-up cost, and a lower 30-day GI-related hospitalization risk (1.7% vs 2.7%). In a single-center comparative analysis of more than 15,000 patients, GI panel testing—relative to conventional stool testing—was associated with less endoscopy, less abdominal imaging, and fewer antibiotic prescriptions during the follow-up window (Axelrad 2019). A prospective study pairing multiplex GI testing with an antimicrobial stewardship program showed a significant reduction in inappropriate antibiotic use and better detection of organisms that are difficult to isolate by routine culture (Keske 2018). Despite these benefits, gastrointestinal panels may also detect colonizing organisms or pathogens associated with self-limited disease, creating the potential for unnecessary treatment. The greatest clinical value is observed in patients with severe symptoms, prolonged illness, immunocompromising conditions, significant comorbidities, or other features suggesting a higher likelihood that test results will meaningfully influence clinical management.

PROFESSIONAL SOCIETY GUIDELINE(S)

In 2024 the Infectious Disease Society of America (IDSA) and the American Society for Microbiology (ASM) published the Guide to Utilization of the Microbiology Laboratory for Diagnosis of Infectious Diseases: 2024 Update. The overall theme suggests the provider should choose the most appropriate

testing based on the clinical scenario.

Respiratory Infections:

- Nucleic Acid Amplification Tests (NAAT's) have largely replaced rapid antigen tests and cultures for respiratory virus detection.
- Multiplex syndromic respiratory panels, when used judiciously may provide earlier opportunity for therapeutic optimization than traditional cultures.
- Comprehensive/pneumonia panels used on lower respiratory specimens (including semiquantitative bacterial targets and resistance markers) may optimize therapy earlier than culture but should be used selectively.
- For fastidious pathogens (e.g., Bordetella pertussis), consult the laboratory's test directory before collection; for bacterial culture, first-morning expectorated sputum is preferred, with blood cultures useful in high-risk CAP and those at risk for MRSA or Pseudomonas.

Gastrointestinal infections:

- Fecal testing for causes of infectious gastroenteritis using culture or culture independent methods is indicated for patients with moderate to severe, bloody, febrile, dysenteric, nosocomial, or persistent diarrheal illnesses or immunocompromised patients.
- Culture-independent multiplex molecular panels are reported to be more sensitive than culture (which has a longer TAT and often misses the agent), result in higher rates of detection, and often cost more than culture methods.

Genitourinary infections:

- In the absence of signs and symptoms consistent with urinary tract infections a urine culture is typically not recommended.
- Reflexing to culture based on a positive pyuria screen may be considered. If a reflexive algorithm is implemented, it should be a locally approved policy guided by clinicians and laboratorians.
- Standard testing is urine culture (Gram stain optional, low sensitivity) on midstream or straight-catheter urine, with mycobacterial culture (first-void urine) and specific NAATs for viruses (adenovirus, BK polyomavirus) as indicated.

Sexually transmitted infections:

- For genital/sexually transmitted infections, HIV testing is recommended for all persons with unknown status seeking STI evaluation; many STIs are reportable.
- Managing appropriate and directed therapy is an important strategy in antimicrobial stewardship and resistance development in STI's.
- Some NAAT technologies require a specific manufacturer collection/transport device for STI's, or results could be compromised and specimens rejected. Use devices recommended by the

laboratory.

REGULATORY STATUS

Clinical laboratories may develop and validate tests in-house and market them as a laboratory service. Laboratory-developed tests must meet the general regulatory standards of the Clinical Laboratory Improvement Amendments (CLIA).

Laboratories that offer laboratory-developed tests must be licensed by CLIA for high-complexity testing. More information is available at: Clinical Laboratory Improvement Amendments (CLIA) | FDA [accessed 2026 Sept 18]

CODE(S)

- Codes may not be covered under all circumstances.
- Code list may not be all inclusive (AMA and CMS code updates may occur more frequently than policy updates).
- (E/I)=Experimental/Investigational
- (NMN)=Not medically necessary/appropriate

CPT Codes

Code	Description
81513	Infectious disease, bacterial vaginosis, quantitative real-time amplification of RNA markers for Atopobium vaginae, Gardnerella vaginalis, and Lactobacillus species, utilizing vaginal-fluid specimens, algorithm reported as a positive or negative result for bacterial vaginosis
81514	Infectious disease, bacterial vaginosis and vaginitis, quantitative real-time amplification of DNA markers for Gardnerella vaginalis, Atopobium vaginae, Megasphaera type 1, Bacterial Vaginosis Associated Bacteria-2 (BVAB-2), and Lactobacillus species (L. crispatus and L. jensenii), utilizing vaginal-fluid specimens, algorithm reported as a positive or negative for high likelihood of bacterial vaginosis, includes separate detection of Trichomonas vaginalis and/or Candida species (C. albicans, C. tropicalis, C. parapsilosis, C. dubliniensis), Candida glabrata, Candida krusei, when reported
81515	Infectious disease, bacterial vaginosis and vaginitis, real-time PCR amplification of DNA markers for Atopobium vaginae, Atopobium species, Megasphaera type 1, and Bacterial Vaginosis Associated Bacteria-2 (BVAB-2), utilizing vaginal-fluid specimens, algorithm reported as positive or negative for high likelihood of bacterial vaginosis, includes separate detection of Trichomonas vaginalis and Candida species (C. albicans, C. tropicalis, C. parapsilosis, C. dubliniensis), Candida glabrata/Candida krusei, when reported

Code	Description
87505	Infectious agent detection by nucleic acid (DNA or RNA); gastrointestinal pathogen (eg, Clostridium difficile, E. coli, Salmonella, Shigella, norovirus, Giardia), includes multiplex reverse transcription, when performed, and multiplex amplified probe technique, multiple types or subtypes, 3-5 targets
87506	Infectious agent detection by nucleic acid (DNA or RNA); gastrointestinal pathogen (eg, Clostridium difficile, E. coli, Salmonella, Shigella, norovirus, Giardia), includes multiplex reverse transcription, when performed, and multiplex amplified probe technique, multiple types or subtypes, 6-11 targets
87507	Infectious agent detection by nucleic acid (DNA or RNA); gastrointestinal pathogen (eg, Clostridium difficile, E. coli, Salmonella, Shigella, norovirus, Giardia), includes multiplex reverse transcription, when performed, and multiplex amplified probe technique, multiple types or subtypes, 12-25 targets
87631	Infectious agent detection by nucleic acid (DNA or RNA); respiratory virus (eg, adenovirus, influenza virus, coronavirus, metapneumovirus, parainfluenza virus, respiratory syncytial virus, rhinovirus), includes multiplex reverse transcription, when performed, and multiplex amplified probe technique, multiple types or subtypes, 3-5 targets
87632	Infectious agent detection by nucleic acid (DNA or RNA); respiratory virus (eg, adenovirus, influenza virus, coronavirus, metapneumovirus, parainfluenza virus, respiratory syncytial virus, rhinovirus), includes multiplex reverse transcription, when performed, and multiplex amplified probe technique, multiple types or subtypes, 6-11 targets
87633	Infectious agent detection by nucleic acid (DNA or RNA); respiratory virus (eg, adenovirus, influenza virus, coronavirus, metapneumovirus, parainfluenza virus, respiratory syncytial virus, rhinovirus), includes multiplex reverse transcription, when performed, and multiplex amplified probe technique, multiple types or subtypes, 12-25 targets
87800	Infectious agent detection by nucleic acid (DNA or RNA), multiple organisms; direct probe(s) technique
87801	Infectious agent detection by nucleic acid (DNA or RNA), multiple organisms; amplified probe(s) technique
0068U	Candida species panel (C. albicans, C. glabrata, C. parapsilosis, C. kruseii, C tropicalis, and C. auris), amplified probe technique with qualitative report of the presence or absence of each species
0112U	Infectious agent detection and identification, targeted sequence analysis (16S and 18S rRNA genes) with drug-resistance gene

Code	Description
0115U	Respiratory infectious agent detection by nucleic acid (DNA and RNA), 18 viral types and subtypes and 2 bacterial targets, amplified probe technique, including multiplex reverse transcription for RNA targets, each analyte reported as detected or not detected
0202U	Infectious disease (bacterial or viral respiratory tract infection), pathogen-specific nucleic acid (DNA or RNA), 22 targets including severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), qualitative RT-PCR, nasopharyngeal swab, each pathogen reported as detected or not detected
0223U	Infectious disease (bacterial or viral respiratory tract infection), pathogen-specific nucleic acid (DNA or RNA), 22 targets including severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), qualitative RT-PCR, nasopharyngeal swab, each pathogen reported as detected or not detected
0225U	Infectious disease (bacterial or viral respiratory tract infection) pathogen-specific DNA and RNA, 21 targets, including severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), amplified probe technique, including multiplex reverse transcription for RNA targets, each analyte reported as detected or not detected
0321U	Infectious agent detection by nucleic acid (DNA or RNA), genitourinary pathogens, identification of 20 bacterial and fungal organisms and identification of 16 associated antibiotic-resistance genes, multiplex amplified probe technique
0371U	Infectious agent detection by nucleic acid (DNA or RNA), genitourinary pathogen, semiquantitative identification, DNA from 16 bacterial organisms and 1 fungal organism, multiplex amplified probe technique via quantitative polymerase chain reaction (qPCR), urine
0373U	Infectious agent detection by nucleic acid (DNA and RNA), respiratory tract infection, 17 bacteria, 8 fungus, 13 virus, and 16 antibiotic-resistance genes, multiplex amplified probe technique, upper or lower respiratory specimen
0374U	Infectious agent detection by nucleic acid (DNA or RNA), genitourinary pathogens, identification of 21 bacterial and fungal organisms and identification of 21 associated antibiotic-resistance genes, multiplex amplified probe technique, urine
0416U	Infectious agent detection by nucleic acid (DNA), genitourinary pathogens, identification of 20 bacterial and fungal organisms, including identification of 20 associated antibiotic-resistance genes, if performed, multiplex amplified probe technique, urine
0504U	Infectious disease (urinary tract infection), identification of 17 pathologic organisms, urine, real-time PCR, reported as positive or negative for each organism

Code	Description
0703U	Infectious disease (urinary tract infection), identification of 21 pathogens, urine, real-time PCR with reflex to 22 antimicrobial-resistance genes when indicated, qualitative reporting for each organism (effective 1/1/27)
0704U	Infectious disease (urinary tract infection and sexually transmitted infection), identification of 25 pathogens, urine, real-time PCR with reflex to 22 antimicrobial-resistance genes when indicated, qualitative reporting for each organism (effective 1/1/27)
0707U	Infectious disease (urinary tract infection), identification of 27 bacterial and fungal pathogens, urine, real-time PCR, qualitative reporting for each organism (effective 1/1/27)

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HCPCS Codes

Code	Description
Not Applicable	

ICD10 Codes

Code	Description
Not Applicable	

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SEARCH TERMS

Not Applicable

CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)

Respiratory Pathogen Panel Testing (LCD L39027) [accessed 2026 Sept 29]

Multiplex Gastrointestinal Pathogen Panel (GPP) Tests for Acute Gastroenteritis (AGE) (LCD L9226) [accessed 2026 Sept 29]

PRODUCT DISCLAIMER

- Services are contract dependent; if a product does not cover a service, medical policy criteria do not apply.

- If a commercial product (including an Essential Plan or Child Health Plus product) covers a specific service, medical policy criteria apply to the benefit.
- If a Medicaid product covers a specific service, and there are no New York State Medicaid guidelines (eMedNY) criteria, medical policy criteria apply to the benefit.
- If a Medicare product (including Medicare HMO-Dual Special Needs Program (DSNP) product) covers a specific service, and there is no national or local Medicare coverage decision for the service, medical policy criteria apply to the benefit.
- If a Medicare HMO-Dual Special Needs Program (DSNP) product DOES NOT cover a specific service, please refer to the Medicaid Product coverage line.

POLICY HISTORY/REVISION	
Committee Approval Dates	
10/22/26	
Date	**Summary of Changes**
02/15/27	• Original effective date
10/22/26	• New policy