

Syphilis TrepSure EIA with Reflex – Test #8200

Syphilis Serologic Screening Algorithm (Effective February 1, 2013)

PERFORMED: MONDAY-FRIDAY

PERFORMING LAB: PLS LINCOLN

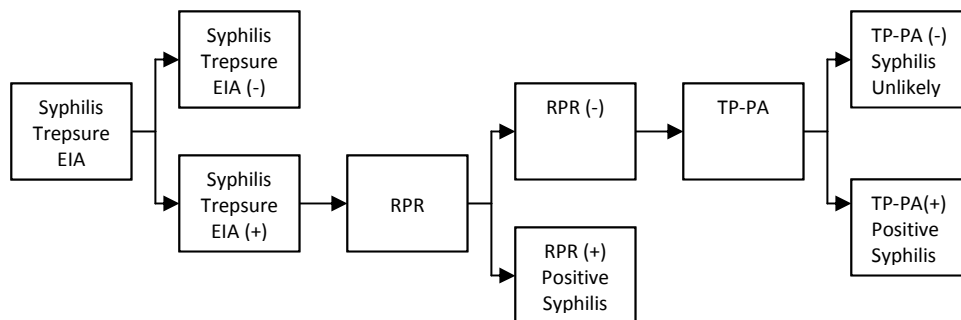
CPT: 86780

if EIA+ add 86592 RPR

if RPR- add 86780 TP-PA

Physicians Laboratory is implementing a revised algorithm for syphilis testing. There are two types of syphilis serology tests: non-treponemal (RPR, VDRL) and treponemal (FTA, TP-PA, or EIA). Non-treponemal tests detect antibodies to nonspecific antigens causing low sensitivity. Treponemal tests detect antibodies against specific antigens from *Treponema pallidum*. The traditional algorithm had the tendency to miss early primary and treated infections. RPR was found to have a high incidence rate of false positives. Because of the limitations of the traditional algorithm and the low national rate, many labs have adopted a reverse algorithm for syphilis serologic testing. PLS will implement the reverse algorithm beginning February 1, 2013.

(<http://www.cdc.gov/std/syphilis/Syphilis-Webinar-Slides.pdf>)



Patients with a negative TrepSure EIA result will be reported as negative. Patients with a positive TrepSure EIA result will reflex to RPR. When results are reactive for both the TrepSure and RPR, patients are considered to have untreated syphilis unless it is ruled out by treatment history. Patients with a positive TrepSure and a negative RPR will reflex to the TP-PA test. When results are reactive to the TrepSure, but nonreactive to the RPR and TP-PA test, patients with a history of previous treatment will require no further management. If the result of the TP-PA test is positive, treatment of syphilis should be considered, unless previously treated.

Note: Patients that have previously been treated for syphilis may continue to test reactive by TrepSure and TP-PA due to persistent anti-treponemal antibody levels. Therefore, it is important to reflex to the RPR to determine if the patient has an active case of syphilis.

Panels at PLS with test #8200 Syphilis TrepSure EIA w/Reflex:

- #480 OB Profile VI
- #582 OB Profile I
- #583 OB Profile II
- #585 OB Profile IV
- #2554 Male Infertility Panel
- #2555 Female Infertility Panel
- #2585 OB Profile IV + Hep C

HSV (Herpes Simplex Virus) Serology Tests

Herpes Simplex Virus (HSV) is the most common sexually transmitted disease and is found in two subtypes (1 and 2). Type 1 is typically associated with oral infections and present with cold sores, but is becoming a more frequent cause of genital herpes. HSV-1 seroprevalence in the US is estimated at 67%. HSV-2 is typically associated with genital infections and 26% of females older than 12 have antibodies to HSV-2. HSV infections are chronic and the type of infection has implication in both prevention and treatment. Serology testing is useful for detecting acute and past infections of HSV. There can be a delay in development of nonspecific HSV antibodies for up to 2 weeks following an initial acute infection and type specific antibodies may be further delayed for up to 6-8 weeks. Serology is an effective way to diagnose subclinical infections and is especially useful for maternal screening. Serology was previously offered as an ELISA (enzyme linked immunosorbant assay) or Immunoblot format.

ELISA and Immunoblot assays test for the presence of a common HSV IgG antibody and if positive, is reflexed to type-specific glycoprotein G assays for Type 1 and Type 2. The ELISA assay is quantitative and has superior sensitivity and specificity to the Immunoblot. The Immunoblot is a qualitative test and is subjective to technical interpretation. **Due to the limitations of the Immunoblot, we are discontinuing test #7851 Herpes Simplex Virus Types 1 & Type 2 Glycoprotein G-Specific Antibodies, IgG by Immunoblot as of February 1, 2013.**

It is recommended that acute infections still be assessed by culture (test #1040, see below) which can provide both early detection and sub typing of antigen in early initial infections. The lesions should be at a stage where crusting has not yet occurred as viremia levels drop rapidly at this stage. If you have any questions regarding this testing, please contact Dr. Gregory Post, our clinical director at (402) 326-0617.

Test #1040 – Herpes Simplex Virus (HSV) Culture Typing 1 and 2

Specimen Requirements: Tissue swab or scraping in viral transport media. Swab vesicle fluid or base of lesion. Place swab in viral transport media. Refrigerate until transport to lab. Do not freeze.

Test #8027 – Herpes Simplex Virus (HSV) Type 1 and/or 2 IgG and IgM Antibodies with Reflex to Type 1 & 2 Glycoprotein G-specific Antibodies

Specimen Requirements: 1.0 mL (0.5 mL) Serum.

Prothrombin Time Ranges

Prothrombin Time (PT) reference ranges are listed to the right of the patient's result on the PLS report. These reference ranges are for patients who are not on any type of anticoagulation therapy. Guidelines for patients on coagulation therapy can be found directly below the PT results.

	NORMAL	ABNORMAL	REFERENCE RANGE	UNIT
PATIENT RESULT		H 13.1	9.5-12.5	SECONDS
INR		H 2.1	0.9-1.2	Ratio
*	*** THERAPEUTIC RANGES FOR COAGULATION THERAPY ***			
*			INR	
*		Routine Anticoagulation	2.0-3.0	
*		High Level Anticoagulation	2.5-3.5	
*		Mechanical Heart Valve	2.5-3.5	

PSA, Total – New Lower Sensitivity

The sensitivity for PSA Total, Diagnostic (#544) and PSA Total, Screening (#2544) will change from <0.1 ng/mL to <0.05 ng/mL beginning March 1, 2013. The lower sensitivity provides an earlier window of detection of PSA in the serum following complete prostate removal. The normal range for both tests is 0 - 4.0 ng/mL. We are discontinuing test #9340 (PSA Ultrasensitive) because our assay will match the same low end sensitivity and will be more cost effective to our patients.

HPV Add-on Testing

Test #7614 HPV (Human Papilloma Virus) High Risk Screen with Reflex to 16/18 Genotype may be added to an ASC-US or abnormal pap at the discretion of the ordering physician. It is suggested to add HPV to these samples as soon as possible because DNA will degrade over time. **For either ThinPrep® or SurePath™ pap samples, test #7614 HPV High Risk Screen should be added to samples within 2 weeks of collection.** Prolonging the addition of the test may cause inaccurate results due to the degradation of the DNA in the sample.

Respiratory Viral Panel by PCR – Test #1427

PERFORMED: DAILY PERFORMING LAB: REGIONAL PATHOLOGY CPT: 87633, 87798X2, 87581

Due to the CPT molecular codes changes, the Respiratory Viral Panel has changed its components as well as the CPT codes. It is now performed daily.

Previously included: Influenza A, Influenza A subtype H1, Influenza A subtype H3, Influenza B, RSV subtype B, Human Metapneumovirus, Rhinovirus, Adenovirus, and Parainfluenza viruses 1, 2, and 3.

NOW INCLUDES:

- Adenovirus
- Coronavirus (229E, HKU1, OC43, NL63)
- Metapneumovirus
- Rhinovirus/Enterovirus
- Influenza A (H1, H3, 2009A-H1N1)
- Influenza B
- Parainfluenza (1, 2, 3, 4)
- RSV
- *Bordetella pertussis*
- *Chlamydia pneumoniae*
- *Mycoplasma pneumoniae*

Acceptable specimens: Nasopharyngeal washes, BAL/bronchial washes, nasal swabs in viral transport media.

Stability: Refrigerated 72 Hours.

Thrombophilia Profiles – Test #1556 & 7598

In the last PLS update an error was made when listing the components of these two profiles. They both include Antithrombin III Activity (CPT Code 85300) **not** Antithrombin III Antigen (CPT Code 85301). Additionally, Plasminogen Activator Inhibitor 1, Activity (#9854) has been discontinued and will no longer be included in the Thrombophilia Panel II (#7598). The panels and CPT codes are listed below for your review.

Thrombophilia Panel I – Test #1556

Components of Thrombophilia Panel I:	CPT
2070 Factor V Leiden w/Prothrombin Factor II G20210A	81240, 81241
528 Lupus Anticoagulant Profile	85610, 85730, 85613
1601 Protein S Functional	85306
1600 Protein C Functional	85303
546 Cardiolipin IGG & IGM	86147X2
1524 Homocysteine	83090
1687 Antithrombin III Activity	85300

Thrombophilia Panel II – Test #7598

Components of Thrombophilia Panel I:	CPT
2070 Factor V Leiden w/Prothrombin Factor II G20210A	81240, 81241
528 Lupus Anticoagulant Profile	85610, 85730, 85613
1601 Protein S Functional	85306
1600 Protein C Functional	85303
546 Cardiolipin IGG & IGM	86147X2
1524 Homocysteine	83090
1687 Antithrombin III Activity	85300
8140 MTHFR	81291

BILLING INFORMATION

Urinalysis CPT Code Changes – Effective January 1, 2013

PLS has recently changed the methodology of performing Urinalysis testing. The CPT codes have been modified to reflect this change.

Test #1299	Urinalysis	Previous CPT code: 81003	New CPT code: 81002
Test #4216	Urinalysis with reflex to culture	Previous CPT code: 81003	New CPT code: 81002
Test #2299	Urinalysis with microscopic exam	Previous CPT code: 81001	New CPT code: 81000

Screening Diagnosis Code Changes for STIs

The Centers for Medicare & Medicaid Services (CMS) have determined a new national coverage determination (NCD) for screening Sexually Transmitted Infections (STIs). The tests specifically affected are Chlamydia, Gonorrhea, Syphilis, and Hepatitis B surface antigen. CMS will cover screening for Chlamydia (86631, 86632, 87110, 87270, 87320, 87490, 87491, 87810, 87800), Gonorrhea (87590, 87591, 87850, 87800), Syphilis (86592, 86593, 86780), and Hepatitis B surface antigen (87340, 87341).

The appropriate screening diagnosis codes (ICD-9-CM) listed below will be covered by Medicare & Medicaid:

- V74.5 (screening bacterial – sexually transmitted)
- V73.89 (screening, disease or disorder, viral, specified type NEC)
- V69.8 (other problems related to lifestyle)
- V22.0 (supervision of normal first pregnancy)
- V22.1 (supervision of other normal pregnancy)
- V23.9 (supervision of unspecified high-risk pregnancy)

There is also an annual frequency limitation for these tests as well. More information can be found on the Wisconsin Medicare Website at <http://www.wpsmedicare.com>.

Vitamin D Testing

Physicians Laboratory is still receiving numerous requests for Vitamin D testing with diagnosis codes that do not support medical necessity (Example: V70.0). Effective 12/15/2010 an LCD was issued for Vitamin D testing. **Insurance will no longer pay for Vitamin D testing for screening purposes.** There must be a medical condition that warrants the testing in order for insurance to pay for this test. A complete list of payable codes is provided on the Wisconsin Medicare Website at <http://www.wpsmedicare.com>.