INSTRUCTIONS FOR USE

This Policy Guideline is applicable to UnitedHealthcare Medicare Advantage Plans offered by UnitedHealthcare and its affiliates for health care services submitted on CMS 1500 forms and, when specified, to those billed on UB04 forms (CMS 1450), or their electronic comparative. The information presented in this Policy Guideline is believed to be accurate and current as of the date of publication.

This Policy Guideline provides assistance in administering health benefits. All reviewers must first identify member eligibility, any federal or state regulatory requirements, Centers for Medicare and Medicaid Services (CMS) policy, the member specific benefit plan coverage, and individual provider contracts prior to use of this Policy Guideline. When deciding coverage, the member specific benefit plan document must be referenced. The terms of the member specific benefit plan document may differ greatly from the standard benefit plan upon which this Policy Guideline is based. In the event of a conflict, the member specific benefit plan document supersedes this Policy Guideline. Other Policies and Guidelines may apply. UnitedHealthcare reserves the right, in its sole discretion, to modify its Policies and Guidelines as necessary.

UnitedHealthcare follows Medicare coverage guidelines and regularly updates its Medicare Advantage Policy Guidelines to comply with changes in CMS policy. UnitedHealthcare encourages physicians and other healthcare professionals to keep current with any CMS policy changes and/or billing requirements by referring to the CMS or your local carrier website regularly. Physicians and other healthcare professionals can sign up for regular distributions for policy or regulatory changes directly from CMS and/or your local carrier. This Policy Guideline is provided for informational purposes. It does not constitute medical advice.

POLICY SUMMARY

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: Request documentation supporting the medical necessity of the test from the physician in all cases where ankylosing spondylitis is indicated as the reason for the test.

APPLICABLE CODES

The following list(s) of 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 related to Medicare Advantage Policy Guidelines.
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.

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>86812</td>
<td>HLA typing; A, B, or C (e.g., A10, B7, B27), single antigen</td>
</tr>
<tr>
<td>86813</td>
<td>HLA typing; A, B, or C, multiple antigens</td>
</tr>
<tr>
<td>86816</td>
<td>HLA typing; DR/DQ, single antigen</td>
</tr>
<tr>
<td>86817</td>
<td>HLA typing; DR/DQ, multiple antigens.</td>
</tr>
<tr>
<td>86821</td>
<td>HLA typing; lymphocyte culture, mixed (MLC)</td>
</tr>
<tr>
<td>86822</td>
<td>HLA typing; lymphocyte culture, primed (PLC)</td>
</tr>
<tr>
<td>86825</td>
<td>Human leukocyte antigen (HLA) crossmatch, non-cytotoxic (e.g., using flow cytometry); first serum sample or dilution</td>
</tr>
<tr>
<td>86826</td>
<td>Human leukocyte antigen (HLA) crossmatch, non-cytotoxic (eg, using flow cytometry); each additional serum sample or sample dilution (List separately in addition to primary procedure)</td>
</tr>
</tbody>
</table>

ICD-10 Diagnosis Codes
See NCD 190.1 Diagnosis List

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

Others
CMS Clinical Laboratory Fee Schedule

GUIDELINE HISTORY/REVISION INFORMATION

<table>
<thead>
<tr>
<th>Date</th>
<th>Action/Description</th>
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<tbody>
<tr>
<td>03/15/2017</td>
<td>• Annual review for MAPG Committee presentation and approval</td>
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