Identification of Microorganisms using Nucleic Acid Probes

Origination Date: 06/16/2026
Last Review: 09/28/2026
Update Notification: 10/01/2026
Effective Date: 01/01/2027

Important Note About This Policy

Oscar's reimbursement policies serve as a guide to assist providers with accurate claims submission and outline the basis for reimbursement if the service is a covered benefit. Coverage does not guarantee reimbursement; services must meet authorization and medical necessity guidelines for the procedure, diagnosis, and member's state of residence.

Our policies provide general reference for described services and do not cover every aspect of reimbursement. Other factors may supplement, modify, or supersede this policy, including legislative mandates, provider contracts, member benefit documents, and/or other reimbursement, medical, or drug policies. Unless otherwise noted within the policy, our reimbursement policies apply to both participating and non-participating professional providers and facilities.

Providers are responsible for submission of accurate documentation of services performed. Claims should be coded appropriately according to industry standard coding guidelines including, but not limited to: Uniform Billing Editor, American Medical Association, Current Procedural Terminology, CPT® Assistant, Healthcare Common Procedure Coding System, ICD-10 CM and PCS, National Drug Codes, Diagnosis Related Group guidelines, Centers for Medicare and Medicaid Services National Correct Coding Initiative Policy Manual, CCI table edits and other CMS guidelines. If appropriate coding/billing guidelines or current reimbursement policies are not followed, we may deny the claim and/or recoup claim payment.

Oscar routinely updates reimbursement policies, and new versions are published on this website. If you print a copy of this policy, please be aware that the policy may be updated later. Oscar communicates policy updates to providers via update notifications.

Policy Description | Related Policies | Indications and/or Limitations of Coverage | Table of Terminology | Scientific Background | Guidelines and Recommendations | Applicable State and Federal Regulations | Applicable CPT/HCPCS Procedure Codes | Evidence-based Scientific References

I. Policy Description

Nucleic acid hybridization technologies utilize complementary properties of the DNA double-helix structures to anneal together DNA fragments from different sources. These techniques are utilized in polymerase chain reaction (PCR) and fluorescent resonance energy transfer (FRET) techniques to identify microorganisms.[1]

A discussion of every infectious agent that might be detected with a probe technique is beyond the scope of this policy. Many probes have been combined into panels of tests. For the purposes of this policy, only individual probes are reviewed.

II. Related Policies

Policy Number	Policy Title
AHS-G2036	Hepatitis Testing
AHS-G2143	Lyme Disease
AHS-G2149	Pathogen Panel Testing
AHS-G2157	Diagnostic Testing of Common Sexually Transmitted Infections

AHS-G2158	Testing for Vector-Borne Infections
AHS-M2057	Diagnosis of Vaginitis

III. Indications and/or Limitations of Coverage

Application of criteria is dependent upon an individual's benefit coverage at the time of the request. Specifications pertaining to Medicare and Medicaid can be found in the "Applicable State and Federal Regulations" section of this policy document.

1) Table 1 summarizes whether nucleic acid identification testing using direct probe, amplified probe, or quantification procedure codes meets criteria. "MC" indicates that the test meets criteria, and "DNMC" indicates that the test does not meet criteria.

Microorganism	Direct Probe	Amplified Probe	Quantification
Bartonella henselae* or *quintana		87471 (MC)	87472 (DNMC)
Chlamydia pneumoniae	87485 (DNMC)	87486 (MC)	87487 (DNMC)
Clostridium difficile		87493 (MC)	
Cytomegalovirus	87495 (DNMC)	87496 (MC)	87497 (MC)
***Enterococcus*, Vancomycin-resistant (e.g., enterococcus vanA, vanB)**		87500 (MC)	
Enterovirus		87498 (MC)	
Hepatitis G	87525 (DNMC)	87526 (DNMC)	87527 (DNMC)
Herpes virus-6	87531 (DNMC)	87532 (DNMC)	87533 (MC)
Legionella pneumophila	87540 (DNMC)	87541 (MC)	87542 (DNMC)
Orthopoxvirus		87593 (MC)	
Pneumocystis jirovecii		87594 (MC)	
Mycoplasma pneumoniae	87580 (DNMC)	87581 (MC)	87582 (DNMC)
Respiratory syncytial virus		87634 (MC)	
Rubeola virus		87638 (MC)	
Staphylococcus aureus		87640 (MC)	
***Staphylococcus aureus*, methicillin resistant**		87641 (MC)	

2) Simultaneous ordering of amplified probe and quantification for the same organism in a single encounter **DOES NOT MEET CRITERIA.**

IV. Table of Terminology

Term	Definition
ASM	American Society of Microbiology
CDC	Centers for Disease Control and Prevention
CDI	*Clostridioides difficile* infection
CIDT	Culture-independent diagnostic test
CMV	Cytomegalovirus
CPT	Current procedural terminology
DFA	Direct fluorescent antibody testing
DNA	Deoxyribonucleic acid

DNMC	Does not meet criteria
EVD	Ebola virus disease
FDA	Food and Drug Administration
FRET	Fluorescent resonance energy transfer
HHV-6	Human herpesvirus 6
HIV	Human immunodeficiency virus
HIVMA	Human Immunodeficiency Virus Medicine Association
IDSA	Infectious Diseases Society of America
ITS	Internal transcribed region
MC	Meets Criteria
Mpox	Monkeypox
MRSA	Methicillin-Resistant Staphylococcus Aureus
NAAT	Nucleic acid amplification test
NGU	Nongonococcal urethritis
NIH	National Institutes of Health
PCR	Polymerase chain reaction
PID	Pelvic inflammatory disease
qPCR	Quantitative polymerase chain reaction
rDNA	Recombinant deoxyribonucleic acid
RNA	Ribonucleic acid
rRT-PCR	Real-time reverse transcriptase-polymerase chain reaction
RSV	Respiratory syncytial virus infection
RT-PCR	Reverse transcriptase-polymerase chain reaction
SARS	Severe acute respiratory syndrome

V. Scientific Background

Nucleic acid hybridization technologies, including polymerase chain reaction (PCR), ligase- or helicase-dependent amplification, and transcription-mediated amplification, are beneficial tools for pathogen detection in blood culture and other clinical specimens due to high specificity and sensitivity.[1] The use of nucleic acid-based methods to detect bacterial pathogens in a clinical laboratory setting offers "increased sensitivity and specificity over traditional microbiological techniques" due to its specificity, sensitivity, reduction in time, and high-throughput capability; however, "contamination potential, lack of standardization or validation for some assays, complex interpretation of results, and increased cost are possible limitations of these tests."[2]

VI. Guidelines and Recommendations

World Health Organization (WHO)

For detection of mpox, the WHO recommends "detection of viral DNA by polymerase chain reaction (PCR)" as the preferred laboratory test and recommends that any individual with a suspected case should be offered testing. They note that the best specimens for diagnosis are taken directly from the rash. Antigen and antibody detection may not be able to distinguish between orthopoxviruses.[3]

Infectious Diseases Society of America (IDSA)

Specific guidelines for testing of many organisms listed within the policy criteria is found in the updated 2018 Infectious Diseases Society of America (IDSA) guidelines and recommendations titled, "A Guide to Utilization of the Microbiology Laboratory for Diagnosis of Infectious Diseases: 2018 Update by the Infectious Diseases Society of America and the American Society for Microbiology."[4] "This document is organized by body system, although many organisms are capable of causing disease in >1 body system. There may be a redundant mention of some organisms because of their propensity to infect multiple sites. One of the unique features of this document is its ability to assist clinicians who have specific suspicions regarding possible etiologic agents causing a specific type of disease. When the term "clinician" is used throughout the document, it also includes other licensed, advanced practice providers. Another unique feature is that in most chapters, there are targeted recommendations and precautions regarding selecting and collecting specimens for analysis for a disease process. It is very easy to access critical information about a specific body site just by consulting the table of contents. Within each chapter, there is a table describing the specimen needs regarding a variety of etiologic agents that one may suspect as causing the illness. The test methods in the tables are listed in priority order according to the recommendations of the authors and reviewers."[4]

The IDSA, in conjunction with the American Society for Microbiology (ASM,) released a 2024 update to their Guide to Utilization of the Microbiology Laboratory for Diagnosis of Infectious Diseases. "The current 2024 version provides new knowledge, discusses new infections, and suggests new laboratory procedures to assist in confirming the causes of infectious diseases."[5] Like the 2018 version, this guide covers key point for the laboratory diagnosis for various infections and symptoms broken down by body system. Overall, this guide highlights NAATs and PCR tests as important testing tools for modern infectious disease diagnostics due to rapid direction of pathogens with a high level of sensitivity and specificity in the clinical setting.

Centers of Disease Control and Prevention (CDC)

Chlamydia Pneumoniae (C. pneumoniae)

The CDC writes that "Nucleic acid amplification tests (NAAT), including real-time polymerase chain reaction (PCR), are the preferred method of diagnostic testing for acute *C. pneumoniae* infection. . . Molecular tests, including NAATs, offer high sensitivity and specificity and provide timely results for treatment decisions. These tests can also determine antibiotic susceptibilities."[6]

Clostridioides difficile (C. diff)

The CDC states that there are four laboratory tests that can be used to diagnose *Clostridioides difficile* infection (CDI). "FDA-approved PCR assays are same-day tests that are highly sensitive and specific for the presence of a toxin-producing *C. diff* organism." The CDC does note that "molecular assays can be positive for C. diff in asymptomatic individuals and those who do not have an infection" and "when using multi-pathogen (multiplex) molecular methods, read the results with caution as the pre-test probability of *C. diff* infection might be less."[7]

Cytomegalovirus (CMV)

The CDC states that "the standard laboratory test for diagnosing congenital CMV infection is a PCR on saliva, with a confirmatory test on urine. . . The reason for the confirmatory test on urine is that most CMV seropositive mothers shed CMV in their breast milk. This can cause a false-positive CMV result on saliva collected shortly after the baby has breast fed."[8]

Measles (Rubeola Virus)

The CDC states that "detection of measles RNA is most successful when specimens are collected on the first day of rash through the 3 days following onset of rash," and further notes that detection by rRT-PCR "may be successful as late as 10–14 days after rash onset." The CDC recommends that "throat or nasopharyngeal swab specimens [be collected] as soon as measles disease is suspected," emphasizing that "rRT-PCR has the greatest diagnostic sensitivity when specimens are collected at first contact with a suspected case."[9] Acceptable specimen types include nasopharyngeal swabs, throat swabs, and urine.

The CDC cautions that "a negative result should not be used to rule out measles infection as many variables can affect specimen quality." A vaccine-specific assay is available, as the CDC notes that this test "specifically detects measles vaccine strains and must be performed in parallel with the existing Measles Detection" assay in individuals with recent vaccination. CDC clinician guidance further identifies RT-PCR as the "preferred test" for acute measles and recommends that it "be performed for all suspect measles cases identified within 10 days of rash onset," ideally in combination with serologic testing.[10]

Mpox Virus

The CDC defines a suspect case of Mpox as a "new characteristic rash or meets one of the epidemiologic criteria and has a high clinical suspicion for mpox." A probable case is defined as "no suspicion of other recent *Orthopoxvirus* exposure (e.g., Vaccinia virus in ACAM2000 vaccination) AND demonstration of the presence of *Orthopoxvirus* DNA by polymerase chain reaction of a clinical specimen OR *Orthopoxvirus* using immunohistochemical or electron microscopy testing methods OR Demonstration of detectable levels of anti-orthopoxvirus IgM antibody during the period of 4 to 56 days after rash onset." A confirmed case of Mpox is defined as "demonstration of the presence of Mpox virus DNA by polymerase chain reaction testing or Next-Generation sequencing of a clinical specimen OR isolation of Mpox virus in culture from a clinical specimen."[11]

The CDC states that "Mpox is diagnosed using real time PCR tests" and further notes "clinicians should collect two swabs from each lesion (generally from 2-3 lesions) in case additional testing, such as clade-specific testing, is needed for these patients."[12]

MRSA

The CDC further states "There are many methods laboratorians can use to test for MRSA" and lists that "Four phenotypic methods are recommended for the detection of MRSA.." The CDC includes additional methods including "Nucleic acid amplification tests, such as the polymerase chain reaction (PCR), to detect the *mecA* gene, which mediates oxacillin resistance in staphylococci" but notes "*mecA* PCR tests will not detect novel resistance mechanisms or uncommon phenotypes (e.g., *mecC* or borderline-resistant oxacillin resistance)."[13]

Mycoplasma pneumoniae

The states that "(NAATs) are the preferred method of diagnostic testing for *M. pneumoniae* infections. . . Molecular tests such as nucleic acid amplification tests (NAATs) offer high sensitivity and specificity and provide timely results for treatment decisions. These tests can also predict antibiotic susceptibilities."[14]

Non-Polio Enterovirus

The CDC remarks that their laboratories "routinely" perform qualitative testing for enteroviruses, parechoviruses, and uncommon picornaviruses and states that "CDC and some health departments test with molecular sequencing methods, or a real-time reverse transcription polymerase chain reaction (rRT-PCR) lab test."[15]

Respiratory Syncytial Virus (RSV)

The CDC writes that "Nucleic acid amplification tests (NAATs), such as PCR tests, are highly sensitive and can be used to diagnose anyone with RSV. Antigen tests are also available."[16]

Miscellaneous

The CDC does not mention the need to quantify [through PCR] *Bartonella*, *Legionella pneumophila,* or *Mycoplasma pneumoniae.* However, PCR can be performed for both *Bartonella* and *Legionella pneumophila* specimen.[17,18] No guidance was found on Hepatitis G.

European Centre for Disease Prevention and Control (ECDC)

On May 23, 2022, the ECDC released a rapid risk assessment of the Mpoxmulti-country outbreak. They recommend that patients with probable cases should be tested with a "Mpox virus specific PCR or an orthopoxvirus specific PCR assay which is then confirmed through sequencing."[19]

On June 2, 2022, ECDC released interim advice on risk communication and community engagement during the 2022 Mpox outbreak in Europe. This is a joint report with the WHO regional office for Europe. They recommend speaking to your doctor about getting tested for Mpox if you develop a rash with a fever or feeling of discomfort or illness.[20]

United Kingdom Heath Security Agency (UKHSA)

The UKHSA states that "Mpox is diagnosed by PCR test for the Mpox virus (MPXV) on a viral swab taken from one or more vesicles or ulcers." Specifically, it is recommended that healthcare workers "Take a viral swab in viral culture medium or viral transport medium (for example Virocult®) from an open sore or from the surface of a vesicle. If other wounds are present, ensure that the sample is definitely taken from a vesicle, an ulcer or a crusted vesicle. Rub the swab over the lesion and place the swab in the collection tube. If there are pharyngeal lesions, a throat swab should also be taken."[21] UKHSA also suggests that "A viral throat swab can be taken for high-risk contacts of a confirmed or highly probable case who have developed systemic symptoms but do not have a rash or lesions that can be sampled. Please note that even if the throat swab is negative, the individual must continue with monitoring and isolation as instructed by their local health protection team and should be reassessed and sampled if further symptoms develop." Lastly, "If follow-up testing is required from a confirmed or highly probable case, either because of clinical deterioration or to inform discharge from isolation to an inpatient setting, additional samples should be taken and should include the following:

- a lesion swab and throat swab in viral transport medium
- a blood sample in an EDTA tube
- a urine sample in a universal sterile container."[21]

The UKHSA states that "Following the identification of a cluster of sexually transmitted HCID Clade I mpox in 2023, there is an increased risk of mpox HCID infection circulating unrecognized on the background of Clade II infections." They therefore recommend "All diagnostic samples from all individuals testing positive for mpox should now be subject to clade confirmation. Positive mpox samples should be sent to RIPL for clade specific testing if clade differentiation is not available through local mpox testing services."[21]

The UKHSA states that mpox DNA viruses can be detected in semen up to 11 days after acute infection, and recommends that: "Following the initial 12 weeks and up to 6 months after recovery from infection, UKHSA recommends performing MPXV PCR on semen samples (and where necessary, oropharyngeal and/or rectal swabs) if the patient:

- is undergoing fertility treatment or planning pregnancy
- is undergoing planned semen storage (for example prior to chemotherapy)

- has an immunocompromised sexual partner (including a pregnant partner)
- is concerned about transmission to sexual partner or partners for any other reason and requests a test from their clinician."[21]

HHV-6 Foundation

The human herpesvirus 6 (HHV-6) foundation also states that "a negative finding in the plasma does not rule out a localized active infection in an organ (e.g. uterus, brain, thyroid, liver). Persistent HHV-6 infections have been found in the liver, brain, lungs, heart tissue and uterus, with no trace of HHV-6 DNA in the plasma. Quantitative testing on blood and tissues is preferred because it can differentiate between the very low levels occasionally found in healthy controls and high levels found in diseased tissues."[22]

The HHV-6 foundation states that *qualitative* PCR DNA tests on whole blood are "useless for differentiating active from latent infection" but notes that the test may be useful for differentiating between herpes virus-6A and herpes virus-6B. The HHV-6 foundation states that *quantitative* PCR DNA tests on whole blood can differentiate active from latent infection "If the viral load is >200 copies per ml or 20 copies per microgram of DNA then this is an active infection."[22]

Public Health Ontario

Public Health Ontario lists testing indications for patients suspected of having *Pneumocystis jirovecii* pneumonia. The "Acceptance/Rejection Criteria" is:

- "Requests for testing will be accepted for patients who are immunocompromised with risk factors and clinical symptoms suggestive of PJP infection; this information must be indicated on the requisition. Absence of such information in the requisition will lead to rejection of the specimen for this testing.
- Only one specimen per patient per week will be tested. Pooled specimens will be accepted.
- Specimens collected using swab are not acceptable for testing.
- Expectorated sputum specimens are not acceptable for testing."[23]

National Institutes of Health (NIH)/HIV Medicine Association (HIVMA)/ Infectious Diseases Society of America (IDSA)

The "NIH/HIVMA/IDSA Guidelines for the Prevention and Treatment of Opportunistic Infections in Adults and Adolescents with HIV" have a section for *Pneumocystis* pneumonia (PCP), which is caused by *Pneumocystis jirovecii*. The guidelines state that "Because clinical presentation, blood tests, and chest radiographs are not pathognomonic for PCP (and because the organism cannot be cultivated routinely), histopathologic or cytopathologic demonstration of organisms in tissue, bronchoalveolar lavage (BAL) fluid, or induced sputum samples is required for a definitive diagnosis of PCP."[24]

British HIV Association

The "British HIV Association guidelines on the management of opportunistic infection in people living with HIV" state "We recommend that PCP should be diagnosed by detection of *Pneumocystis* by immunofluorescence, histochemistry or PCR of induced sputum or BAL." The guidelines do note "We recommend that the detection of *P. jirovecii* by PCR in respiratory samples, in the absence of symptoms or signs of respiratory disease, should not per se trigger initiation of treatment for PCP."[25]

VII. Applicable State and Federal Regulations

DISCLAIMER: If there is a conflict between this Policy and any relevant, applicable government policy for a particular member [e.g., Local Coverage Determinations (LCDs) or National Coverage Determinations (NCDs) for Medicare and/or state coverage for Medicaid], then the government policy will be used to make the determination. For the most up-to-date Medicare policies and coverage, please visit the Medicare search website:

https://www.cms.gov/medicare-coverage-database/search.aspx. For the most up-to-date Medicaid policies and coverage, visit the applicable state Medicaid website.

Food and Drug Administration (FDA)

Many labs have developed specific tests that they must validate and perform in house. These laboratory-developed tests (LDTs) are regulated by the Centers for Medicare and Medicaid (CMS) as high-complexity tests under the Clinical Laboratory Improvement Amendments of 1988 (CLIA '88). LDTs are not approved or cleared by the U. S. Food and Drug Administration; however, FDA clearance or approval is not currently required for clinical use.

A list of current U.S. Food and Drug Administration (FDA) approved or cleared nucleic acid-based microbial tests is available at: https://www.fda.gov/medical-devices/vitro-diagnostics/nucleic-acid-based-tests.

VIII. Applicable CPT/HCPCS Procedure Codes

CPT	Code Description
87471	Infectious agent detection by nucleic acid (DNA or RNA); Bartonella henselae and Bartonella quintana, amplified probe technique
87472	Infectious agent detection by nucleic acid (DNA or RNA); Bartonella henselae and Bartonella quintana, quantification
87485	Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia pneumoniae, direct probe technique
87486	Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia pneumoniae, amplified probe technique
87487	Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia pneumoniae, quantification
87493	Infectious agent detection by nucleic acid (DNA or RNA); Clostridium difficile, toxin gene(s), amplified probe technique
87495	Infectious agent detection by nucleic acid (DNA or RNA); cytomegalovirus, direct probe technique
87496	Infectious agent detection by nucleic acid (DNA or RNA); cytomegalovirus, amplified probe technique
87497	Infectious agent detection by nucleic acid (DNA or RNA); cytomegalovirus, quantification
87498	Infectious agent detection by nucleic acid (DNA or RNA); enterovirus, amplified probe technique, includes reverse transcription when performed
87500	Infectious agent detection by nucleic acid (DNA or RNA); vancomycin resistance (eg, enterococcus species van A, van B), amplified probe technique
87525	Infectious agent detection by nucleic acid (DNA or RNA); hepatitis G, direct probe technique
87526	Infectious agent detection by nucleic acid (DNA or RNA); hepatitis G, amplified probe technique
87527	Infectious agent detection by nucleic acid (DNA or RNA); hepatitis G, quantification
87531	Infectious agent detection by nucleic acid (DNA or RNA); Herpes virus-6, direct probe technique
87532	Infectious agent detection by nucleic acid (DNA or RNA); Herpes virus-6, amplified probe technique
87533	Infectious agent detection by nucleic acid (DNA or RNA); Herpes virus-6, quantification
87540	Infectious agent detection by nucleic acid (DNA or RNA); Legionella pneumophila, direct probe technique

87541	Infectious agent detection by nucleic acid (DNA or RNA); Legionella pneumophila, amplified probe technique
87542	Infectious agent detection by nucleic acid (DNA or RNA); Legionella pneumophila, quantification
87580	Infectious agent detection by nucleic acid (DNA or RNA); Mycoplasma pneumoniae, direct probe technique
87581	Infectious agent detection by nucleic acid (DNA or RNA); Mycoplasma pneumoniae, amplified probe technique
87582	Infectious agent detection by nucleic acid (DNA or RNA); Mycoplasma pneumoniae, quantification
87593	Infectious agent detection by nucleic acid (DNA or RNA); orthopoxvirus (eg, monkeypox virus, cowpox virus, vaccinia virus), amplified probe technique, each
87594	Infectious agent detection by nucleic acid (DNA or RNA); Pneumocystis jirovecii, amplified probe technique
87634	Infectious agent detection by nucleic acid (DNA or RNA); respiratory syncytial virus, amplified probe technique
87638	Infectious agent detection by nucleic acid (DNA or RNA); rubeola (measles) virus
87640	Infectious agent detection by nucleic acid (DNA or RNA); Staphylococcus aureus, amplified probe technique
87641	Infectious agent detection by nucleic acid (DNA or RNA); Staphylococcus aureus, methicillin resistant, amplified probe technique

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Procedure codes appearing in Medical Policy documents are included only as a general reference tool for each policy. They may not be all-inclusive.

IX. Evidence-based Scientific References

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Publication History

Date	Action/Description
06/16/2026	Original Documentation; Governance Approved
09/28/2026	Policy Update; Updated policy background, guidelines, and evidence-based scientific references; Added CPT codes 87594 and 87638 to Applicable CPT/HCPCS Procedure Codes section