



## Kaiser Foundation Health Plan of Washington

### *Clinical Review Criteria* **Micronutrient Panel Testing** **Intracellular micronutrient analysis**

**NOTICE:** Kaiser Foundation Health Plan of Washington and Kaiser Foundation Health Plan of Washington Options, Inc. (Kaiser Permanente) provide these Clinical Review Criteria for internal use by their members and health care providers. The Clinical Review Criteria only apply to Kaiser Foundation Health Plan of Washington and Kaiser Foundation Health Plan of Washington Options, Inc. Use of the Clinical Review Criteria or any Kaiser Permanente entity name, logo, trade name, trademark, or service mark for marketing or publicity purposes, including on any website, or in any press release or promotional material, is strictly prohibited.

Kaiser Permanente Clinical Review Criteria are developed to assist in administering plan benefits. These criteria neither offer medical advice nor guarantee coverage. Kaiser Permanente reserves the exclusive right to modify, revoke, suspend or change any or all of these Clinical Review Criteria, at Kaiser Permanente's sole discretion, at any time, with or without notice. **Member contracts differ in health plan benefits. Always consult the patient's Evidence of Coverage or call Kaiser Permanente Member Services at 1-888-901-4636 (TTY 711), Monday through Friday, 8 a.m. to 5 p.m. to determine coverage for a specific medical service.**

### **Criteria** **For Medicare Members**

Source	Policy
CMS Coverage Manuals	None
National Coverage Determinations (NCD)	None
Local Coverage Determinations (LCD)	None
Local Coverage Article	None
Kaiser Permanente Medical Policy	Due to the absence of an active NCD, LCD, or other coverage guidance, Kaiser Permanente has chosen to use their own Clinical Review Criteria, " <b><i>Micronutrient Panel Testing</i></b> " for medical necessity determinations. Refer to the Non-Medicare criteria below.

### **For Non-Medicare Members**

There is insufficient evidence in the published medical literature to show that micronutrient testing provides better long-term outcomes than current standard services/therapies.

Micronutrient testing, also known as functional intracellular analysis, essential metabolic analysis, intracellular micronutrient analysis, or leukocyte nutrient analysis, is a blood test consisting of multiple micronutrient levels intended to assess nutritional deficiencies and offer supplementation suggestions. Micronutrient tests are considered **not medically necessary**.

Some examples of commercially available micronutrient tests include but are not limited to the following:

- Genova Diagnostics ION Profile®
- IntraCellular Diagnostics EXA Test®
- SpectraCell Laboratories Micronutrient Test
- VibrantAmerica Micronutrients

### **If requesting review for this service, please send the following documentation:**

- Last 6 months of clinical notes from requesting provider &/or specialist

The following information was used in the development of this document and is provided as background only. It is provided for historical purposes and does not necessarily reflect the most current published literature. When significant new articles are published that impact treatment option, Kaiser Permanente will review as needed. This information is not to be used as coverage criteria. Please only refer to the criteria listed above for coverage determinations.

## Background

Micronutrient testing assesses the level of multiple nutrients in the body. These panels may include measurement of numerous vitamins, minerals, amino acids, fatty acids, oxidation products, organic acids, toxins and antioxidants. The test results are proposed to help determine the cause of various symptoms, such as hair loss and fatigue, and various disease processes. Antioxidant function testing (e.g., Spectrox™) has been proposed as a method to evaluate the ability of cells to resist damage caused by free radicals and other forms of oxidative stress. SpectraCell Laboratories, Inc., (Houston, TX) offers a micronutrient testing panel proposed to measure how micronutrients function within the white blood cell. The Individual Optimal Nutrition (ION) (Genova Diagnostics, Asheville, NC) is a blood test that measures levels of vitamins, minerals, antioxidants, and organic, fatty, and amino acids. ExaTest®, offered by IntraCellular Diagnostics, Inc® (Medford, OR) is an intracellular tissue analysis of mineral electrolytes. The test is proposed to provide information on mineral electrolyte deficiencies or imbalances not available by blood testing. The analysis is made from an epithelial cell scraping from the sublingual area. The sample is analyzed using high energy photos (x-rays).

Currently, there is insufficient evidence in the published, peer-reviewed, scientific literature to establish the clinical utility of nutrient panel testing or antioxidant function testing or to demonstrate that the use of such testing results in improved health outcomes.

## Applicable Codes

Micronutrient Test (identified by the volume of lab tests for vitamins, minerals, amino acids, antioxidants, and metabolites for diagnoses such as fatigue)

**The following is a list of codes that will not be covered when billed for a Micronutrient Test. This is not an all-inclusive list.**

CPT® Codes	Description
82136	Amino acids, 2 to 5 amino acids, quantitative, each specimen
82180	Ascorbic acid (Vitamin C), blood
82306	Vitamin D; 25 hydroxy, includes fraction(s), if performed
82310	Calcium; total
82379	Carnitine (total and free), quantitative, each specimen
82495	Chromium
82525	Copper
82607	Cyanocobalamin (Vitamin B-12)
82652	Vitamin D; 1, 25 dihydroxy, includes fraction(s), if performed
82725	Fatty acids, nonesterified
82746	Folic acid; serum
82978	Glutathione
83735	Magnesium
83785	Manganese
84207	Pyridoxal phosphate (Vitamin B-6)
84252	Riboflavin (Vitamin B-2)
84255	Selenium
84425	Thiamine (Vitamin B-1)
84446	Tocopherol alpha (Vitamin E)
84590	Vitamin A
84591	Vitamin, not otherwise specified
84597	Vitamin K
84630	Zinc
86353	Lymphocyte transformation, mitogen (phytomitogen) or antigen induced blastogenesis

**\*Note:** Codes may not be all-inclusive. Deleted codes and codes not in effect at the time of service may not be covered.

\*\*To verify authorization requirements for a specific code by plan type, please use the [Pre-authorization Code Check](#).

CPT codes, descriptions and materials are copyrighted by the American Medical Association (AMA). HCPCS codes, descriptions and materials are copyrighted by Centers for Medicare Services (CMS).

Date Created	Date Reviewed	Date Last Revised
05/05/2020	05/05/2020 <sup>MPC</sup> , 05/04/2021 <sup>MPC</sup> , 05/03/2022 <sup>MPC</sup> , 05/02/2023 <sup>MPC</sup> , 10/01/2024 <sup>MPC</sup>	05/05/2020

<sup>MPC</sup> Medical Policy Committee

Revision History	Description
05/05/2020	MPC approved to adopt new non-coverage policy. Requires 60-day notice, effective date 9/1/2020.