Harvard Pilgrim Health Care | TUFTS Health Plan

Point32Health companies

Payment Policy:

Laboratory: Celiac Disease Testing

Effective date: Nov. 1, 2025

Applies to:

Commercial Products

☒ Harvard Pilgrim Health Care Commercial products
☐ Tufts Health Plan Commercial products

Public Plans Products

☐ Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product)
☐ Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans
☐ Tufts Health RITogether – A Rhode Island Medicaid Plan
☐ Tufts Health One Care – A dual-eligible product

Senior Products

☐ Tufts Health Plan Senior Care Options (SCO) (a dual-eligible product)
☐ Tufts Medicare Preferred HMO/PPO (Medicare Advantage products)

Policy

Celiac disease is a hereditary, chronic autoimmune disorder that affects one in 100 individuals worldwide. It is triggered by the ingestion of gluten, a protein found in wheat, rye, and barley. When an individual with celiac disease ingests gluten, the body mounts an immune response that attacks the small intestine. These attacks lead to damage on the villi within the small intestine, inhibiting nutrient absorption.

Indications and/or Limitations of Coverage

Application of coverage criteria is dependent upon an individual's benefit coverage at the time of the request.

1. For individuals who have been diagnosed with celiac disease and who are IgA sufficient, serologic testing with IgA anti-tissue transglutaminase (TTG) **MEETS COVERAGE CRITERIA** at the following intervals:
   a. At the first follow-up visit 3-6 months after diagnosis.
   b. Every 6 months until normalization of anti-TTG levels has occurred.
   c. Every 12-24 months thereafter.
2. For individuals who have been diagnosed with celiac disease and who are IgA deficient, testing for IgG endomysial antibodies, IgG deamidated gliadin peptide, or IgG TTG **MEETS COVERAGE CRITERIA** at the following intervals:
   a. At the first follow-up visit 3-6 months after diagnosis.
   b. Every 6 months until normalization of IgG levels has occurred.
   c. Every 12-24 months thereafter.
3. For individuals with signs and symptoms of celiac disease (see Note 1), serologic testing with the IgA anti-TTG and the total IgA test for the diagnosis of celiac disease **MEETS COVERAGE CRITERIA**.
4. For individuals at risk for celiac disease (see Note 1), when IgA anti-TTG is negative or weakly positive, testing for IgA endomysial antibodies **MEETS COVERAGE CRITERIA**.
5. For individuals with clinical suspicion of celiac disease (see Note 1) with an IgA deficiency, testing for IgG endomysial antibodies, IgG deamidated gliadin peptide, or IgG TTG **MEETS COVERAGE CRITERIA**.
6. Testing for IgA and IgG antibodies to deamidated gliadin peptides **MEETS COVERAGE CRITERIA** in any of the following situations:
   a. For individuals under 2 years of age with a clinical suspicion of celiac disease (see **Note 1**).
   b. For individuals over 2 years of age as a substitute for anti-TTG testing.
7. For confirmation of celiac disease in individuals at high risk for celiac disease, regardless of the result of celiac disease serology testing, pathological examination of tissue obtained from a biopsy of the small intestine **MEETS COVERAGE CRITERIA**.
8. Rapid antigen point-of-care testing for anti-TTG **DOES NOT MEET COVERAGE CRITERIA**.

9. Panel testing, multiplex testing, or multi-analyte testing (for more than two analytes) for the diagnosis or evaluation of celiac disease **DOES NOT MEET COVERAGE CRITERIA**.
10. For asymptomatic individuals not at an increased risk for developing celiac disease (see **Note 1**), testing for celiac disease **DOES NOT MEET COVERAGE CRITERIA**.

The following does not meet coverage criteria due to a lack of available published scientific literature confirming that the test(s) is/are required and beneficial for the diagnosis and treatment of an individual's illness.

11. For the diagnosis of celiac disease, testing for anti-reticulin antibodies **DOES NOT MEET COVERAGE CRITERIA**.
12. For the evaluation of celiac disease, testing of stool or saliva samples **DOES NOT MEET COVERAGE CRITERIA**.
13. Serologic testing using an HLA-DQ-gluten tetramer-based assay, including flow cytometry-based HLA-DQ-gluten tetramer assays, **DOES NOT MEET COVERAGE CRITERIA**.

NOTES:
Note 1: Signs and symptoms of celiac disease may include, but are not limited to, the following: unexplained chronic or intermittent diarrhea; unexplained weight loss; unexplained chronic or intermittent abdominal pain or bloating; recurrent nausea or vomiting; unexplained iron deficiency anemia; unexplained vitamin B12 or folate deficiency; unexplained liver transaminase elevations; autoimmune hepatitis; dermatitis herpetiformis; type 1 diabetes; intestinal blockages; unexplained subfertility or miscarriage; unexplained osteoporosis, osteomalacia, or low bone density; and/or primary biliary cirrhosis. Individuals with Down syndrome, Turner syndrome, or Williams-Beuren syndrome are also at high risk for celiac disease. Additionally, in pediatric patients, fatty stools, delayed puberty, amenorrhea, failure to thrive, stunted growth, and/or short stature may also be associated with celiac disease.

Applicable CPT/HCPCS Procedure Codes

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

Coding

Code	Description
82784	Gammaglobulin (immunoglobulin); IgA, IgD, IgG, IgM, each
83516	Immunoassay for analyte other than infectious agent antibody or infectious agent antigen; qualitative or semiquantitative, multiple step method
86231	Endomysial antibody (EMA), each immunoglobulin (Ig) class
86255	Fluorescent noninfectious agent antibody; screen, each antibody
86256	Fluorescent noninfectious agent antibody; titer, each antibody
86258	Gliadin (deamidated) (DGP) antibody, each immunoglobulin (Ig) class
86364	Tissue transglutaminase, each immunoglobulin (Ig) class
88305	Level IV - Surgical pathology, gross and microscopic examination, colon biopsy

Evidence-based Scientific References

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Publication History

03/01/2026: Annual review; administrative edits; removed codes 81376, 81377, 81382, and 81383.
09/01/2025: Policy created to support coverage guidelines, effective for dates of service beginning Nov. 1, 2025

Background and Disclaimer Information

This policy applies to the products of Harvard Pilgrim Health Care and Tufts Health Plan and their affiliates, as identified in the check boxes on the first page for services performed by contracted providers.

Payment is based on member benefits and eligibility on the date of service, medical necessity review, where applicable, and the provider's network participation agreement with the Plan. As every claim is unique, this policy is neither a guarantee of payment, nor a final indication of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization, and utilization management requirements (when applicable), adherence to Plan policies and procedures, and claims editing logic. An authorization is not a guarantee of payment.

Point32Health reserves the right to amend a payment policy at its discretion. CPT and HCPCS codes are updated as applicable; please adhere to the most recent CPT and HCPCS coding guidelines.

We reserve the right to conduct audits on any provider and/or facility to ensure accuracy and compliance with the guidelines stated in this payment policy. If such an audit determines that a provider/facility did not comply with this payment policy, Harvard Pilgrim Health Care and Tufts Health Plan will expect the provider/facility to refund all payments related to noncompliance.