

## Corporate Medical Policy

### Helicobacter Pylori Testing AHS – G2044

**File Name:** helicobacter\_pylori\_testing  
**Origination:** 01/2019  
**Last Review:** 04/2024

#### Description

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Helicobacter pylori (*H. pylori*) is a spiral-shaped, gram-negative bacteria that thrives while living in acidic environments, growing in close association with the stomach lining. *H. pylori* infection causes chronic inflammation (infection) in the stomach and is associated with conditions such as peptic ulcer disease, chronic gastritis, gastric adenocarcinoma, and gastric mucosa associated lymphoid tissue (MALT) lymphoma (Lamont, 2023).

**\*\*\*Note: This Medical Policy is complex and technical. For questions concerning the technical language and/or specific clinical indications for its use, please consult your physician.**

#### Policy

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**BCBSNC will provide coverage for helicobacter pylori testing when it is determined the medical criteria or reimbursement guidelines below are met.**

#### Benefits Application

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This medical policy relates only to the services or supplies described herein. Please refer to the Member's Benefit Booklet for availability of benefits. Member's benefits may vary according to benefit design; therefore, member benefit language should be reviewed before applying the terms of this medical policy.

#### When Helicobacter Pylori Testing is covered

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1. Reimbursement for urea breath testing **or** stool antigen testing to diagnose an *H. pylori* infection is allowed for individuals 18 years of age and older in **any** of the following situations:
  - a. For individuals with dyspeptic symptoms.
  - b. For individuals with active peptic ulcer disease (PUD).
  - c. For individuals with past PUD without *H. pylori* history.
  - d. For individuals with low-grade gastric mucosa-associated lymphoid tissue (MALT) lymphoma.
  - e. For individuals with a history of endoscopic resection of early gastric cancer (EGC).
  - f. For individuals with gastric intestinal metaplasia (GIM).
  - g. For individuals with uninvestigated dyspepsia who are under the age of 60 years and without alarm features.
  - h. For individuals initiating chronic treatment with a non-steroidal anti-inflammatory drug (NSAID).
  - i. For individuals with unexplained iron deficiency anemia.
  - j. For the evaluation of individuals with chronic immune thrombocytopenic purpura (ITP) and suspected *H. pylori* infection.
  - k. For individuals with a family history of gastric cancer.
  - l. For individuals who are first-generation immigrants from a high prevalence area.

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2. Reimbursement for urea breath testing **or** stool antigen testing to measure the success of eradication of *H. pylori* infection (follow-up measurement at least 4 weeks post-treatment) is allowed for individuals 18 years of age and older in **any** of the following situations:
  - a. For individuals with an *H. pylori*-associated ulcer.
  - b. As part of the follow-up for individuals with persistent symptoms of dyspepsia following appropriate antibiotic treatment for *H. pylori*.
  - c. For individuals with Gastric MALT Lymphoma.
  - d. For individuals who have undergone resection of early gastric cancer.
3. Reimbursement is allowed for individuals 18 years of age and older undergoing endoscopic examination or who have alarm symptoms, a biopsy-based endoscopic histology test and **either** a rapid urease test **or** a culture with susceptibility testing to diagnose an *H. pylori* infection.
4. Reimbursement for urea breath testing **or** stool antigen testing to diagnose an *H. pylori* infection is allowed for individuals less than 18 years of age in any of the following situations:
  - a. For individuals with chronic ITP and suspected *H. pylori* infection.
  - b. To measure the success of eradication of *H. pylori* infection, (follow-up measurement at least 4 weeks post-treatment).
5. Reimbursement for a biopsy-based endoscopic histology test and **either** a rapid urease test **or** a culture with susceptibility testing is allowed for individuals less than 18 years of age to diagnose an *H. pylori* infection in **any** of following situations:
  - a. For individuals with gastric or duodenal ulcers.
  - b. For individuals with refractory iron deficiency anemia (when other causes have been ruled out).

## **When Helicobacter Pylori Testing is not covered**

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1. Reimbursement is not allowed for urea breath testing **or** stool antigen testing to diagnose an *H. pylori* infection for **any** of the following situations:
  - a. For asymptomatic individuals of all ages.
  - b. For individuals 18 years and older with typical symptoms of gastroesophageal reflux disease (GERD) who do not have a history of peptic ulcer disease (PUD).
2. Reimbursement is not allowed for serologic testing for *H. pylori* infection for individuals of all ages.
3. Reimbursement is not allowed for a biopsy-based endoscopic histology test and rapid urease test **or** a culture with susceptibility testing to diagnose an *H. pylori* infection in individuals less than 18 years of age in any of the following situations:
  - a. For children with functional abdominal pain.
  - b. As part of an initial investigation in children with iron deficiency anemia.
  - c. When investigating causes of short stature.
4. Reimbursement is not allowed for testing with the urea breath test, stool antigen **or** biopsy-based testing to diagnose *H. pylori* in individuals with recent use of antibiotics, proton pump inhibitors (PPIs) or bismuth.

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5. Reimbursement is not allowed for concurrent testing with **any** combination of the urea breath test, stool antigen testing, **and/or** biopsy-based testing to diagnose an *H. pylori* infection.
6. Nucleic acid testing for *H. pylori* is considered investigational.

## Policy Guidelines

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### Background

Infection with *H. pylori* is common, with conservative estimates at 50% of the world's population affected. Prevalence in the United States is significant, estimated to be 30 – 40% in the general population (Siao & Somsouk, 2014). *H. pylori* is associated with many conditions, such as peptic ulcer disease, chronic gastritis, and gastric mucosa associated lymphoid tissue (MALT) lymphoma. Other conditions such as dyspepsia have been attributed to *H. pylori* as well (Lamont, 2023). Common symptoms of these conditions include gastritis, dyspepsia, heartburn, and stomach pain (Jensen, 2023; Longstreth, 2022).

Identification of *H. pylori* infection is accomplished with one or more of the several tests available. The choice of test is guided by the reason for the test, cost and availability of the test, the patient's age and clinical presentation, prevalence in a population, and the patient's use of certain medications. Testing for *H. pylori* infection is done for two main reasons; to detect an active infection that will be treated and to confirm eradication of the infection post-treatment. Invasive and non-invasive approaches have been used. Endoscopy and collection of biopsy specimens for evaluation of *H. pylori* infection and early gastric cancer detection typically is done in older individuals and those with "alarm" symptoms, including bleeding, unexplained anemia, unexplained weight loss, progressing dysphagia, recurrent vomiting, a family history of gastrointestinal cancer, or a personal history of esophagogastric malignancy. Tissue samples can be tested for *H. pylori* via methods such as a rapid urease test, culture, or staining. Molecular methods include PCR and next-generation sequencing, and serological methods include ELISA, immunoassays, and dried blood spots. Other non-invasive methods include urea breath test and stool antigen test. Testing for eradication of infection may be performed with the same tests used for diagnosis (Lamont, 2023).

### Analytical Validity

Non-invasive options for detection of active *H. pylori* infection include urea breath tests and stool antigen testing. The stool antigen test is an immunoassay that detects the presence of *H. pylori* in a stool sample. The test is reported to have greater than 90% sensitivity and specificity for detection of active *H. pylori* infection, and its use has been FDA cleared for all ages. This test may be used for initial diagnostic purposes and for post-treatment testing. Urea breath tests, which take advantage of the bacteria's urease activity, may also be used to detect active *H. pylori* infection. The patient ingests a solution containing either <sup>13</sup>C or <sup>14</sup>C labeled urea, after a set amount of time, the patient's breath is collected and analyzed for the presence of <sup>13</sup>C or <sup>14</sup>C labeled CO<sub>2</sub>. If *H. pylori* is present, it will have metabolized the labeled urea and labeled CO<sub>2</sub> will be detected, thus indicating infection with *H. pylori*. This test takes approximately 15-20 minutes (Lamont, 2023).

ELISA-based serological tests are also available for detection of *H. pylori*. However, serological tests often need validation at the local level, which may not be practical in routine practice. Furthermore, serological tests do not distinguish between past and present infections. Serological tests also have a very low positive predictive value in populations with low or average prevalence, as the antibodies will be detected even after an infection has been treated or naturally resolved. In these low-prevalence areas, a positive serological test is more likely to be a false positive (Lamont, 2023).

Other tests such as PCR-based tests are infrequently used. The PCR test, despite its high accuracy, is often too expensive for routine use. In fact, nested PCR tests have approached 100% sensitivity and 100% specificity for detection of *H. pylori* (Singh et al., 2008), but the test may not be widely available and may be of limited use due to high cost (Lamont, 2023; Patel et al., 2014). PCR tests have been used for diagnostic purposes as well as identifying genetic variants of the bacteria and pathogenic genes

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present in a patient. A variety of body fluids, such as stool and saliva, have been used in PCR tests for this bacterial species (Patel et al., 2014).

Some medications are known to inhibit the growth or urease activity of *H. pylori* and can cause a false negative *H. pylori* test result. Proton pump inhibitors, antibiotics, and bismuth-containing medications may decrease sensitivity of tests, thereby increasing rates of a false negative. Eradication testing is often done weeks after treatment is completed (Lamont, 2023).

Dechant et al. (2020) evaluated the accuracy of various rapid urease tests (RUTs) and compared it with histopathology results. No differences were detected in the sensitivity or specificity of the various RUTs and RUTs had comparable results to histology; however, in patients treated with proton pump inhibitors and antibiotics. RUTs seemed to be more sensitive compared to histology. Pohl et al. (2019) discuss the drawbacks of RUTs, including false negative test results if the bacterial load is less than 104 in the gastric biopsy and false positive test results with some urease positive bacteria, affecting the sensitivity and specificity of RUTs. Commercially available RUTs, such as HpFast, CLOTest, and HpOne, have reported specificities ranging from 95% to 100%, but their sensitivity is moderate (85% to 95%) (Pohl et al., 2019).

Hussein et al. (2021) compared the sensitivity, specificity, positive, and negative predictive values of invasive tests (RUT and gastric tissue culture) and noninvasive tests (14C-Urea breath test (14C-UBT), stool antigen test, and CagA-IgG serology) to the gold standard quantitative PCR (qPCR) tests for *H. pylori* in Iraq. One hundred and fifteen participants strongly suspected of *H. pylori* infection were tested. Overall, the prevalence rates ranged from 47.8% to 70.4% depending on the test method. “The 14C-UBT showed the highest overall performance with 97.5% sensitivity, 97% specificity, and total accuracy of 97.3% followed by SAT, RUT, Cag-IgG, and culture method.” SAT had a sensitivity of 95.0% and a specificity of 91.2%. RUT had a sensitivity of 93.8% and a specificity of 94.1%. CagA-IgG had a sensitivity of 75.3% and a specificity of 85.3%. Gastric tissue culture had a sensitivity of 67.9% and a specificity of 79.4%. The authors conclude that 14C-UBT “may be recommended as first choice due to its higher performance compared to other methods” (Hussein et al., 2021). Hassan et al. (2021) compared the accuracy, specificity, and sensitivity of the stool antigen test and the urea breath test in 45 children who underwent esophagogastroduodenoscopy between 2013 and 2019 in Sulaymaniyah City, Iraq. Histopathological findings from biopsies were used as a confirmatory diagnosis tool. The authors found that “UBT has a statistically significant correlation with result of biopsy, also it is more accurate and more sensitive than SAT, but they share same positive predictive value and same specificity.” The authors conclude that UBT is preferred over SAT in children above six years (Hassan et al., 2021).

Abdelmalek et al. (2022) evaluated the accuracy and utility assurance of *H. pylori* stool antigen lateral flow immunochromatography assay (HpSA-LFIA) in Egypt. The study used stool samples from 200 gastric patients and compared HpSA-LFIA results to the monoclonal antibody-based ELISA kit. The authors report that HpSA-LFIA achieved sensitivity of 93.75%, specificity of 59.76%, a negative predictive value of 98.00%, positive predictive value of 31.25%, and accuracy of 65.31%. The authors conclude that “HpSA-LFIA was not accurate enough to be the sole test for diagnosis and needs other confirmatory tests in case of positive conditions” (Abdelmalek et al., 2022).

## ***Clinical Utility and Validity***

The stool antigen test has been shown to have strong accuracy. A meta-analysis by Gisbert et al. (2006) focusing on 2499 patients of 22 studies found the diagnostic test to have a sensitivity of 0.94 and a specificity of 0.97. The monoclonal version of the test was shown to be more sensitive than the polyclonal one (0.95 vs 0.83). The authors also evaluated the diagnostic test after eradication of the bacteria in 957 patients of 12 studies. The authors evaluated the antigen test at 0.93 sensitivity and 0.96 specificity post-eradication (Gisbert et al., 2006).

A new automated LIAISON® Meridian *H. pylori* SA assay, a chemiluminescent immunoassay that uses novel monoclonal antibodies for capture and detection of the *H. pylori* stool antigen, was evaluated for its clinical performance. Opekun et al. (2020) studied the utility of this assay on 277 patients who tested

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positive for *H. pylori* infection from an endoscopy. Comparing histology, culture, and rapid urease test results, the assay delivered a sensitivity of 95.5% and specificity of 97.6%. The authors conclude that LIAISON® “brings reliable noninvasive testing for *H. pylori* to the laboratory that is in very good agreement with the current, more invasive biopsy-based methods such as histology, culture, or rapid urease test” (Opekun et al., 2020).

The rapid in-office, monoclonal test is widely used and provides significant benefit in terms of availability and speed. However, a study using the test as a reference to compare against a new test found the in-office test to only have a 0.50 sensitivity and 0.96 specificity out of 162 patients (Korkmaz et al., 2015).

The UBT has also been well-validated. A meta-analysis by Ferwana et al. (2015) including 3999 patients of 23 studies found the diagnostic test to have a pooled sensitivity of 0.96 and a pooled specificity of 0.93. The authors noted that their populations had significant heterogeneity but concluded that the UBT had high diagnostic accuracy for detecting an *H. pylori* infection (Ferwana et al., 2015). This test is often considered the gold standard for diagnosing an *H. pylori* infection (Patel et al., 2014).

Serological tests to assess infection have also been used. A meta-analysis by Loy et al. (1996) focused on commercial serological kits assessing *H. pylori*. Loy et al. (1996) found these kits to have a pooled sensitivity of 0.85 and specificity of 0.79. The authors concluded that there was no major difference in accuracy between any of the kits tested (Loy et al., 1996).

As costs of sequencing decreases, use of Next Generation Sequencing (NGS) to detect *H. pylori* infection and its antibiotic resistance has increased. In a study by Nezami et al. (2019), 133 *H. pylori* positive specimens from histological evaluation were analyzed by NGS to detect mutations in *gyrA*, 23S rRNA, and 16S rRNA genes. NGS detected *H. pylori* in 126/133 cases (95% sensitivity). NGS also detected multiple mutations associated with resistance in 92 cases (73%), one mutation in 63 cases (50%), and mutations in several genes in 29 cases (23%). In the 58 cases where treatment history was available, therapy failure was observed in cases where the number of mutated genes was high. Therapy failed in 11/16 cases with multiple gene mutations and 5/27 cases with one gene mutation (Nezami et al., 2019).

Yang et al. (2019) performed a meta-analysis investigating the association between *H. pylori* and colorectal cancer. Twenty-seven studies encompassing 14357 cases were included. The authors found an increased rate of colorectal cancer with *H. pylori* infection (odds ratio [OR] = 1.27). The authors also identified odds ratios for certain subgroups, such as Western countries (OR = 1.34), serological testing (OR = 1.20), multiple methods of testing (OR = 2.63), and cross-sectional studies (OR = 1.92) (Yang et al., 2019).

Wang et al. (2019) performed a meta-analysis assessing the association between *H. pylori* and osteoporosis. Twenty-one studies totaling 9655 patients were analyzed. The authors found that *H. pylori* infection was associated with an increased risk of osteoporosis with an odds ratio of 1.39. However, the decrease of bone mineral density in *H. pylori* positive patients was not found to be significant compared to *H. pylori* negative patients (Wang et al., 2019).

Zhou et al. (2019) investigated the association between *H. pylori* infection and non-alcoholic fatty liver disease (NAFLD). Fifteen studies including 97228 patients were evaluated. The authors identified an increased risk of NAFLD in *H. pylori* positive patients compared to *H. pylori* negative patients by an odds ratio of 1.19. Similar results were found despite differing subgroups, such as geographical locations. Testing method did not significantly change the results, and there was no significant difference when using multiple detection methods (Zhou et al., 2019).

Halland et al. (2021) assessed two novel enzyme assays (EIA), H. PYLORI QUIK CHEK™ and H. PYLORI CHEK™, for the detection of *H. pylori* antigen in stool from 271 patients in America, Germany, and Bangladesh. The EIA results were compared to clinical diagnosis, which included histological analysis and rapid urease test. H. PYLORI QUIK CHEK™ had a sensitivity of 92% and a specificity of 91%. H. PYLORI CHEK™ had a sensitivity of 91% and a specificity of 100%. The

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authors concluded that “the H. PYLORI QUIK CHEK™ and H. PYLORI CHEK™ assays demonstrate excellent clinical performance compared the composite reference method” (Halland et al., 2021). Marrero Rolon et al. (2022) have developed and tested a real-time PCR assay to simultaneously detect H. pylori infection and genotypic markers of clarithromycin resistance. H. pylori infection can be treated with clarithromycin-based therapy; The American College of Gastroenterology (ACG) recommends clarithromycin-based triple therapy as first-line treatment in regions where clarithromycin resistance is known to be below 15% in patients with no history of macrolide exposure. “Clarithromycin resistance is most commonly caused by point mutations in the 23S rRNA (rRNA) gene, including A2143G, A2142G, and A2142C, which result in decreased macrolide binding to the 23S rRNA ribosomal subunit; clarithromycin resistance is considered the main cause of clarithromycin therapy failure.” The authors tested 524 stool samples. H. pylori stool antigen tests were used as a control test for H. pylori detection. Sanger sequencing was used as control tests for genetic susceptibility. PCR results were positive for 98% of positive antigen stool tests. “The clarithromycin-based triple therapy success was lower when resistance was predicted by PCR (41%) than when no resistance was predicted (70%; P = 0.03).” The authors conclude that the PCR assay can diagnose H. pylori infection and provide genetic susceptibility information. The authors suggest the need for susceptibility-guided therapy when clarithromycin-based therapy is considered (Marrero Rolon et al., 2022).

Nguyen Wenker et al. (2023) studied the predictive performance of current guidelines about *H. pylori* testing in the United States. The authors investigated the association between *H. pylori* presence and *H. pylori* risk factors. *H. pylori* presence was determined based on histopathology, stool antigen, urea breath test, immunoglobulin G serology, or prior treatment. The risk factors were selected based on the Houston Consensus Conference and American College of Gastroenterology guidelines. The study included 942 patients undergoing upper endoscopy with gastric biopsies for any indication from one hospital in Houston, Texas. Overall, the risk factors with the highest predictive performance were “first-generation immigrant” and “Hispanic or black race/ethnicity.” The other seven risk factors included had low predictive values. The authors concluded that “the performance of individual risk factors identified by the Houston Consensus Conference and ACG was generally low for predicting H pylori infection except for black or Hispanic race/ethnicity and first-generation immigrant status” (Nguyen Wenker et al., 2023).

## Guidelines and Recommendations

### American Gastroenterological Association (AGA)

The AGA recommends that “patients 55 years or younger without alarm features should receive H. pylori test and treat followed by acid suppression if symptoms remain” and note that “H. pylori testing is optimally performed by a 13C-urea breath test or stool antigen test.” Alarm features include symptoms such as recurrent vomiting and weight loss. Additionally, the AGA indicates that “although the yield of endoscopy is low, it is recommended for patients older than 55 years of age and for younger patients...presenting with new-onset dyspepsia.” They reason that endoscopy with biopsy is the preferred test for this age group because upper gastrointestinal malignancy becomes more common after age 55 years (Talley, 2005).

In 2015 the AGA published a technical review on Upper Gastrointestinal biopsy to evaluate dyspepsia in the absence of visible mucosal lesions and found that:

- In the defined population, biopsy of normal-appearing gastric mucosa can detect HP [H. pylori] infection that would be missed on the exam without biopsies. The quality of evidence is very low, and there are noninvasive methods to detect HP infection.
- “Detection of HP infection with tissue biopsy and its eradication in patients with dyspepsia is associated with symptom improvement and reduction of risk for HP-related comorbidities, including gastric cancer compared with no biopsy (or no eradication). The quality of evidence is moderate. The effect on

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symptom resolution is not universal and it does not appear to improve well-being. Quality of evidence for this statement is low” (Allen et al., 2015).

The AGA also released guidelines focusing on gastric intestinal metaplasia. In it, they recommend testing for *H. pylori* (followed by eradication) over no testing and eradication (Gupta et al., 2020).

The AGA released guidelines on gastrointestinal evaluation of iron deficiency anemia. AGA recommends that patients with iron deficiency anemia, without other identifiable etiology after bidirectional endoscopy, should undergo noninvasive testing for *H. pylori* over no testing at all to reduce the incidence of gastric cancer (Ko et al., 2020).

### **American College of Gastroenterology/Canadian Association of Gastroenterology**

The ACG and CAG have released guidelines on testing for *H. pylori*:

- All patients with active peptic ulcer disease (PUD), a past history of PUD (unless previous cure of *H. pylori* infection has been documented), low-grade gastric mucosa-associated lymphoid tissue (MALT) lymphoma, or a history of endoscopic resection of early gastric cancer (EGC) should be tested for *H. pylori* infection. Those who test positive should be offered treatment for the infection.
- In patients with uninvestigated dyspepsia who are under the age of 60 years and without alarm features, non-endoscopic testing for *H. pylori* infection is a consideration. Those who test positive should be offered eradication therapy.
- When upper endoscopy is undertaken in patients with dyspepsia, gastric biopsies should be taken to evaluate for *H. pylori* infection. Infected patients should be offered eradication therapy.
- Patients with typical symptoms of gastroesophageal reflux disease (GERD) without history of PUD need not be tested for *H. pylori* infection. For those who are found to be infected, treatment should be offered, acknowledging that effects on GERD symptoms are unpredictable.
- In patients taking long-term low-dose aspirin, testing for *H. pylori* infection could be considered.
- Patients initiating chronic treatment with a non-steroidal anti-inflammatory drug (NSAID) should be tested for *H. pylori* infection. Those who test positive should be offered eradication therapy.
- Patients with unexplained iron deficiency (ID) anemia despite an appropriate evaluation or idiopathic thrombocytopenic purpura should be tested for *H. pylori* infection.
- There is insufficient evidence to support routine testing and treating of *H. pylori* in asymptomatic individuals with a family history of “gastric cancer or patients with lymphocytic gastritis, hyperplastic gastric polyps and hyperemesis gravidarum”.
- The ACG recommends the breath test and fecal stool antigen test as eradication tests, supported by moderate evidence (Chey et al., 2017).

Another set of joint guidelines from the ACG and Canadian Association of Gastroenterology (CAG) noted that dyspepsia patients under 60 should be tested for *H. pylori* (Moayyedi et al., 2017).

### **National Institute for Health and Care Excellence (NICE)**

NICE recommends testing for *H. pylori* with a carbon-13 urea breath test or a stool antigen test. A re-test should be with a breath test. Office-based serological tests are not recommended. NICE recommends a “2-week washout period after proton pump inhibitor (PPI) use before testing for *Helicobacter pylori*.” NICE recommends that individuals with positive *H. pylori* tests be offered therapy to eradicate the bacteria; however, they note that re-testing to confirm eradication should not be

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routinely offered. NICE limits the recommendation for post-treatment testing to “people with peptic ulcer (gastric or duodenal)...6 to 8 weeks after beginning treatment, depending on the size of the lesion” (NICE, 2019).

NICE released further guidelines in 2015 reaffirming the carbon-13 urea breath test and the stool antigen test to test for *H. pylori*. A locally validated lab-based serology test may also be used to assess *H. pylori*. NICE reaffirms the two week washout period before testing for *H. pylori* if the patient is on PPIs as well as the four week washout period if the patient is on antibiotics (NICE, 2015).

## **American College of Cardiology**

The American College of Cardiology recommends testing for and eradicating *H. pylori* in patients with a history of ulcer disease before starting chronic antiplatelet therapy (Bhatt et al., 2008).

## **World Gastroenterology Organization**

The World Gastroenterology Organization Global Guidelines on Helicobacter pylori recommends testing for *H. pylori* based on evidence-based indications, noting that these indications may differ in different regions of the world based on prevalence, resources, competing needs, and individual patient factors. The guidelines state that “peptic ulcer disease is the prime indication in most of the world.” The guidelines list other indications for the treatment of *H. pylori* as: past or present duodenal and/or gastric ulcer (with or without complications), gastric MALT lymphoma, gastric mucosal atrophy and/or intestinal metaplasia, resection of gastric cancer, first-degree relatives with gastric cancer, functional dyspepsia, NSAID use, before long-term aspirin therapy in patients at high risk of ulcers and ulcer-related complications, during long-term low-dose aspirin therapy in patients with a history of upper gastrointestinal bleeding and perforation, patients with gastroesophageal reflux disease who require long-term proton-pump inhibitors, as a strategy for gastric cancer prevention in communities with a high incidence, and unexplained iron-deficiency anemia or idiopathic thrombocytopenic purpura, (Katelaris et al., 2023).

## **European Association for Gastroenterology, Endoscopy and Nutrition (EAGEN), European Society of Neurogastroenterology and Motility (ESNM), and European Society for Paediatric Gastroenterology Hepatology and Nutrition (ESPGHAN)**

The pan-European guideline recommends the use of <sup>13</sup>C -urea breath tests as a noninvasive alternative for testing for “all indications of *Helicobacter pylori* testing if endoscopy is not required or if biopsies are contraindicated” and as “a preferred option for conformation of *Helicobacter pylori* eradication in adults and children.” Alternatively, when there is indication for endoscopy and no contraindication for biopsy, the guidelines recommend RUT as the first-line diagnostic tests (Keller et al., 2021).

## **ESPGHAN and The North American Society for Pediatric Gastroenterology, Hepatology and Nutrition (NASPGHAN)**

The ESPGHAN and NASPGHAN have issued updated guidelines for management of *H. pylori* in children and adolescents. They have proposed recommendations for diagnosis and management of *H. pylori* infection in pediatric patients. They have defined pediatric patients as children and adolescents below 18 years of age. The following recommendations were stated:

The guidelines recommend biopsies for rapid urease test and other cultures should only be taken if treatment is likely to be offered in the case of a confirmed infection. Treatment may be considered if *H. pylori* is an incidental finding at endoscopy.

The guidelines recommend against a “test and treat” strategy for *H. pylori* infection in children. The panelists explained that performing a noninvasive test to detect infection and treat is not needed because *H. pylori* infection usually does not cause any symptoms in the absence of peptic ulcer disease (PUD).



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The guidelines recommend that “testing for *H. pylori* be performed in children with gastric or duodenal PUD.”

The guidelines recommend against diagnostic testing for *H. pylori* infection in children with functional abdominal pain, iron deficiency anemia, and when investigating causes of short stature. Serology-based testing was also not recommended.

Proton pump inhibitors (PPIs) should be stopped two weeks before *H. pylori* testing, and antibiotics should be stopped four weeks before *H. pylori* testing. Diagnosis should be based on either: “positive culture or *H. pylori* gastritis on histopathology with at least 1 other positive biopsy-based test.”

The non-invasive diagnostic testing was indicated in children when investigating causes of chronic immune thrombocytopenic purpura or for the assessment of anti-*H. pylori* therapy at least after four weeks of therapy (L. Jones et al., 2017).

## **Japanese Society for Pediatric Gastroenterology, Hepatology and Nutrition (JSPGHAN)**

The JSPGHAN have updated their guidelines for *H. pylori* testing in pediatrics, including recommendations for diagnostic methods in children.

For diagnosis using endoscopic biopsy specimens, the guidelines recommend considering the performance and accuracy of the rapid urease test, recommending an additional urea breath test or stool antigen test when there is inconsistency between histopathology and the rapid urease test. The guidelines further recommend histological examination of gastric biopsies, and culture diagnostic tests to diagnose active *H. pylori* infection (Kato et al., 2020).

For diagnosis without endoscopic biopsy specimens, the guidelines recommend <sup>13</sup>C-urea breath test and stool antigen tests. To increase the diagnosis accuracy, the guidelines recommend more than two tests (two noninvasive tests or a biopsy-based and a noninvasive test) be completed. The guidelines recommend urea breath test or stool antigen test four or more weeks after treatment to confirm eradication of *H. pylori*, and recommend against using endoscopic biopsy methods and single serological tests to confirm eradication. The guidelines also recommend against anti-*H. pylori* antibody tests as a single test to diagnose *H. pylori* in a clinical setting (Kato et al., 2020).

## **Maastricht V/Florence Consensus Report**

The Maastricht V/Florence Consensus report was published in 2017 on behalf of the European Helicobacter and Microbiota Study Group and Consensus panel. The panel reports that UBT is “the most investigated and best recommended non-invasive test in the context of a ‘test-and-treat strategy’”. The panel also notes that monoclonal tests can be used and that serological tests can be used only after validation. However, rapid “office” serology tests are not recommended and “should be avoided”. The guidelines recommend the rapid urease test (RUT) as a first line diagnostic test if there is an indication for endoscopy and no contraindication for biopsy. The guideline state that *H. pylori* is linked to “unexplained iron deficiency anaemia (IDA), idiopathic thrombocytopenic purpura, and vitamin B12 deficiency”, and in these disorders, an *H. pylori* infection should be “sought and eradicated.” The guidelines state that PPIs should be stopped two weeks and antibiotics and other bismuth compounds should be stopped four weeks before testing for *H. pylori*. In cases of chronic (active) gastritis in which *H. pylori* is not detected by histochemistry, immunohistochemical testing of *H. pylori* can be used as an ancillary test. If histology is normal, no immunohistochemical staining should be performed. It is recommended to perform clarithromycin susceptibility testing when a standard clarithromycin-based treatment is considered as the first-line therapy, except in populations or regions with well documented low clarithromycin resistance (<15%). Pepsinogen (Pg) serology is considered the most useful non-invasive test to explore gastric mucosa status (non-atrophic vs atrophic). The Pgl/PgII ratio can never be assumed as a biomarker of gastric neoplasia. UBT is the best option for confirmation of *H. pylori* eradication and monoclonal SAT is an alternative. It should be performed at least four weeks after completion of therapy (Malfertheiner et al., 2017).

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The Maastricht IV from 2012 also addressed testing for the *cagA* and *vacA* variants, stating that no specific genetic or virulence markers can be recommended at this time (Malfertheiner et al., 2012).

## American Society for Clinical Pathology (ASCP)

The ASCP recommends against using the serological tests for *H. pylori* and recommends the stool antigen and breath tests instead. The ASCP states that serological evaluation is no longer clinically useful and the stool and breath tests have superior statistical power (ASCP, 2016).

## American Society of Hematology (ASH)

American Society of Hematology (ASH) published an update to the immune thrombocytopenic purpura guidelines in 2019. In it, they “suggest” that “Screening for *H. pylori* be considered for patients with ITP in whom eradication therapy would be used if testing is positive.” However, ASH still recommends against “routine testing for *H. pylori* in children with chronic ITP” (Neunert et al., 2020).

## Houston Consensus Conference

This conference included 11 experts on “management of adult and pediatric patients with *H. pylori*, from different geographic regions of the United States” and was convened to “discuss key factors in diagnosis of *H. pylori* infection, including identification of appropriate patients for testing, effects of antibiotic susceptibility on testing and treatment, appropriate methods for confirmation of infection and eradication, and relevant health system considerations.” Two cohorts of approval were present: one of the 11 experts, and another consisting of a selected group of United States-based gastroenterologists. These recommendations were intended to provide practical advice for US practitioners, and guidelines to be adopted by US health care systems.

Recommendations approved by both groups are listed below:

- “Statement 1: We recommend that all patients with active *H. pylori* infection be treated (100% agree/strongly agree, Grade 1A).
- Statement 2: All patients with current or past gastric or duodenal ulcers should be tested for *H. pylori* infection (100% agree/strongly agree; Grade 1A).
- Statement 3: We recommend that all patients with uninvestigated dyspepsia be tested for *H. pylori* infection (100% agree/strongly agree, Grade 1A).
- Statement 4: We recommend routine testing for *H. pylori* infection in patients with reflux symptoms only if they are at high risk for *H. pylori*-related disease (91% agree/strongly agree, Grade 1C).
- Statement 5: We recommend that patients with gastric mucosa-associated lymphoid tissue (MALT) lymphoma be tested for *H. pylori* infection (100% agree/strongly agree, Grade 1B).
- Statement 6: We recommend that individuals with family history of gastric cancer be tested for *H. pylori* infection (100% agree/strongly agree, Grade 1B).
- Statement 7: We recommend that patients who are first-generation immigrants from high prevalence areas be tested for *H. pylori* infection (82% agree/strongly agree, Grade 1B).
- Statement 8: We suggest that patients of Latino and African American racial or ethnic groups may be considered for *H. pylori* testing due to their high risk of infection (91% agree/strongly agree, Grade 2C).”
- Statement 17: We recommend that validated diagnostic testing of stool or gastric mucosal biopsy by culture and susceptibility, or molecular analysis be universally available (100% agree/strongly agree, Grade 1)

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- Statement 18: We suggest that antibiotics that may be routinely evaluated for susceptibility include amoxicillin, clarithromycin, levofloxacin, metronidazole, and tetracycline (100% agree/strongly agree, Grade 2C).
- Statement 20: We recommend the use of tests for active H pylori infection (ie, UBT, HpSAg testing) for the initial diagnosis (100% agree/strongly agree, Grade 1A).
- Statement 22: We recommend that serology not be utilized for detection of active H pylori infection (100% agree/strongly agree, Grade 1A).
- Statement 23: We recommend that bismuth and antibiotics be stopped at least 4 weeks before H pylori testing with tests for active infection (ie, UBT, and HpSAg testing and histology; 100% agree/strongly agree, Grade 1C).
- Statement 27: We recommend that all patients receiving treatment for H pylori receive posttreatment confirmation of eradication. We recommend that only tests that evaluate for active infection, such as UBT, HpSAg test, or histology (if endoscopy is required for other reasons), are utilized for this purpose (100% agree/strongly agree, Grade 1A).
- Statement 28: Once appropriate testing has confirmed eradication, we recommend against further H pylori testing, (100% agree/strongly agree, Grade 1C)”

The following recommendations reached a consensus by the expert panel, but not the external group:

- “Statement 9: We recommend that patients with idiopathic thrombocytopenia be tested for H pylori infection (experts vs survey: 100% vs 68% agree/strongly agree, Expert Grade 1B)
- Statement 10: We suggest that patients receiving long-term PPIs (>1 month) be tested for H pylori infection (experts vs survey: 82% vs 68% agree/strongly agree, Expert Grade 2C)
- Statement 11: We recommend that family members residing in the same household of patients with proven active H pylori infections undergo H pylori testing (experts vs survey: 91% vs 78% agree/strongly agree, Expert Grade 1B)
- Statement 12: We recommend that individuals with a family history of peptic ulcer disease be tested for H pylori infection (experts vs survey: 91% vs (73% agree/strongly agree, Expert Grade 1B)” (El-Serag et al., 2018).

## **State and Federal Regulations, as applicable**

### **Food and Drug Administration (FDA)**

On Feb 22, 2012, the FDA approved the BreathTek UBT for H. pylori Kit created by Otsuka America Pharmaceutical, Inc. The BreathTek UBT for H. pylori Kit (BreathTek UBT Kit) is intended for use in the qualitative detection of urease associated with H. pylori in the human stomach and is indicated as an aid in the initial diagnosis and post-treatment monitoring of H. pylori infection in adults, and pediatric patients three to 17 years old. The test may be used for monitoring treatment if used at four weeks following completion of therapy. The FDA notes its sensitivity and specificity to be 0.958 and 0.992 respectively (FDA, 2012).

On Jan 17, 2002, the FDA approved the BreathTek UBiT for H. pylori created by Meretek Diagnostics Inc. The scientific basis underlying the BreathTek UBT and the BreathTek UBiT UBT kit is identical. The urea breath test is FDA cleared for use in individuals 18 years of age and older (FDA, 2002).

On February 18, 2020, the FDA approved the PyloPlus UBT System created by ARJ Medical Inc. PyloPlus detects urease associated with H. pylori in the stomach and is indicated as an aid in the initial diagnosis of H. pylori infection in adults 18 years and older (FDA, 2023).

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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.

## Billing/Coding/Physician Documentation Information

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This policy may apply to the following codes. Inclusion of a code in this section does not guarantee that it will be reimbursed. For further information on reimbursement guidelines, please see Administrative Policies on the Blue Cross Blue Shield of North Carolina web site at [www.bcbsnc.com](http://www.bcbsnc.com). They are listed in the Category Search on the Medical Policy search page.

*Applicable service codes: 83009, 83013, 83014, 86318, 86677, 87070, 87077, 87081, 87149, 87150, 87153, 87181, 87186, 87205, 87338, 87339, 87513, 88305, 0008U*

BCBSNC may request medical records for determination of medical necessity. When medical records are requested, letters of support and/or explanation are often useful but are not sufficient documentation unless all specific information needed to make a medical necessity determination is included.

## Scientific Background and Reference Sources

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Specialty Matched Consultant Advisory Panel review 5/2020

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Specialty Matched Consultant Advisory Panel review 5/2021

Medical Director review 5/2021

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Medical Director review 4/2023

Medical Director review 4/2024

## **Policy Implementation/Update Information**

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- 1/1/2019 New policy developed. BCBSNC will provide coverage for helicobacter pylori testing when it is determined to be medically necessary because criteria and guidelines are met. Medical Director review 1/1/2019. Policy noticed 1/1/2019 for effective date 4/1/2019. (jd)
- 6/11/2019 Reviewed by Avalon 2<sup>nd</sup> Quarter 2019 CAB. Under the When Covered section, added “either” to item #3. Under the When Not Covered section, added the following statement to item #6: **“The use of nucleic acid testing for *H. pylori*, including polymerase chain reaction (PCR), 16S rRNA, 23S rRNA, and next-generation sequencing (NGS) of” *H. Pylori*, is considered not medically necessary as it is not practical for routine diagnosis. Policy guidelines and references extensively revised. Under the Coding/Billing section, the following changes were made: 86677 – changed to Not Covered, and added code 87149, 87150, 87153, 0008U to the policy as Not Covered. References updated. Policy noticed 6/11/19 for effective date of 8/13/19. Medical Director reviewed 5/2019. (jd)**
- 10/29/19 Wording in the Policy, When Covered, and/or Not Covered section(s) changed from Medical Necessity to Reimbursement language, where needed. (gm)
- 5/12/20 Reviewed by Avalon 1<sup>st</sup> Quarter 2020 CAB. Minor updates to Description, Background, and Policy guideline sections. Under the When Covered section: added item vi. “in patients with gastric intestinal metaplasia (GIM); minor revision to item number 2, incorporating items a. and b. with no change to policy intent; added “with susceptibility testing” to items 3 and 4. Under the When Not Covered section: added “with susceptibility testing” to item 3. Added the following codes to the Billing/Coding section: 86318, 87070. Minor update to reference section. Medical Director review 4/2020. (jd)
- 6/9/20 Specialty Matched Consultant Advisory Panel review 5/2020. Medical Director review 5/2020. (jd)
- 5/4/21 Reviewed by Avalon 1<sup>st</sup> Quarter 2021 CAB. Added the following statements to the When Covered sections: “xi. In patients with family history of gastric cancer xii. In patients who are first-generation immigrants from high prevalence areas”. Minor updates to policy guidelines and references. Medical Director review 4/2021. (jd)
- 6/1/21 Specialty Matched Consultant Advisory Panel review 5/2021. Medical Director review 5/2021. (jd)
- 5/17/22 Reviewed by Avalon 1<sup>st</sup> Quarter 2022 CAB. Updated background, policy guidelines (added Table of Terminology) and references. Added “or” to several coverage criteria for clarity; no change to policy intent. Medical Director review 4/2022. (jd)
- 5/16/23 Reviewed by Avalon 1<sup>st</sup> Quarter 2023 CAB. Description, Policy Guidelines, and References updated. Coverage criteria edited for clarity, no change in policy statement. Medical Director review 4/2023. (tm)
- 5/15/24 Reviewed by Avalon 1<sup>st</sup> Quarter 2024 CAB. Description, Policy Guidelines, and References updated. Table of Terminology removed. No change to policy statement. Medical Director review 4/2024. (tm)



# Helicobacter Pylori Testing AHS – G2044

12/31/24 Code 87513 added to Billing/Coding section, effective 1/1/2025. (tm)

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