



Reimbursement Policy

Policy Number: RPLAB047

Policy Title: Pancreatic Enzyme Testing for
Acute Pancreatitis

Approval Date: May 15, 2026

Effective Date: Sept. 4, 2026

Policy Disclaimer

If a conflict arises between a Reimbursement Policy and any Plan document under which a member is entitled to covered services, the Plan document will govern. If a conflict arises between a reimbursement policy and any provider contract pursuant to which a provider participates in and/or provides covered services to eligible member(s) and/or plans, the provider's contract will govern. "Plan documents" include, but are not limited to, Certificates of Health Care Benefits, Benefit Booklets, Summary Plan Descriptions, and other coverage documents. Blue Cross and Blue Shield of Illinois may use reasonable discretion interpreting and applying this policy to services being delivered in a particular case. BCBSIL has full and final discretionary authority for their interpretation and application to the extent provided under any applicable Plan documents.

Providers are responsible for submitting accurate documentation of services performed. Providers are expected to submit claims for services rendered using valid code combinations from Health Insurance Portability and Accountability Act approved code sets. 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 ICD-10-PCS, National Drug Codes, Diagnosis Related Group guidelines, Centers for Medicare & Medicaid Services National Correct Coding Initiative Policy Manual, CCI table edits and other CMS guidelines.

Claims are subject to the code edit protocols for services and procedures billed. Claim submissions are subject to claim review, including but not limited to, any terms of benefit coverage, provider contract language, medical policies, and reimbursement policies, as well as coding software logic. Upon request, the provider is urged to submit any additional documentation.

Description

The Plan has implemented certain lab management reimbursement criteria. Not all requirements apply to each product. Providers are urged to review Plan documents for eligible coverage for services rendered.

Reimbursement Information

1. For individuals presenting with signs and symptoms of acute pancreatitis (see **NOTE 1**), measurement of serum lipase (no more than one test per day in the outpatient setting) **may be reimbursable**.
2. When ordered for anything other than analysis of pancreatic cyst fluid, measurement of amylase **is not reimbursable**.
3. For the diagnosis, assessment, prognosis, and/or determination of severity of acute pancreatitis, measurement of serum and urine trypsin/trypsinogen/TAP (trypsinogen activation peptide) **is not reimbursable**.
4. For the diagnosis, assessment, prognosis, and/or determination of severity of acute pancreatitis, measurement of the following biomarkers **is not reimbursable**:
 - a. C-Reactive Protein (CRP)
 - b. Interleukin-6 (IL-6)
 - c. Interleukin-8 (IL-8)
 - d. Procalcitonin
5. For all other situations or conditions not described above, measurement of serum lipase **is not reimbursable**.

NOTE 1: Signs and symptoms of acute pancreatitis (3, 4):

- Mild to severe epigastric pain that begins slowly or suddenly (may spread to the back in some patients)
- Nausea
- Vomiting
- Tender to palpitation of epigastrium
- Abdominal distention
- Hypoactive bowel sounds
- Fever
- Rapid pulse
- Tachypnea
- Hypoxemia

- Hypotension
- Anorexia
- Diarrhea
- Cullen sign
- Grey Turner sign

Procedure Codes

The following is not an all-encompassing code list. The inclusion of a code does not guarantee it is a covered service or eligible for reimbursement.

Code	Description
82150	ASSAY OF AMYLASE
83519	RIA NONANTIBODY
83520	IMMUNOASSAY QUANT NOS NONAB
83529	ASAY OF INTERLEUKIN-6 (IL-6)
83690	ASSAY OF LIPASE
84145	PROCALCITONIN (PCT)
86140	C-REACTIVE PROTEIN
86141	C-REACTIVE PROTEIN HS

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Policy History

Approval Date	Description
05/15/2026	09/04/2026; Document updated with literature review. The following changes were made: Added to #1 "(no more than one test per day in the outpatient setting)." Removed #2. New #2 (formerly #3, removed "serum" as that contradicted with the intent of measuring amylase from the pancreatic cyst fluid. Removed #6 as all other types of amylase testing, now addressed in new #2, is not reimbursable. Added code 86141. References revised.
09/05/2025	01/01/2026: New policy.