

Reimbursement Policy

Policy Number: RPLAB056

Policy Title: Gamma-glutamyl Transferase in Adults

Approval Date: Aug. 6, 2026

Effective Date: Dec. 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

NOTE: This policy is specific to individuals 18 years of age or older. Criteria below do not apply to individuals less than 18 years of age.

1. For individuals with elevated alkaline phosphatase activity, serum GGT testing no more than once every two weeks **may be reimbursable**.
2. To assess for liver injury, function, and/or disease, serum GGT testing no more than once every two weeks **may be reimbursable** for individuals with at least **one** of the following:
 - a. Chronic alcohol use;
 - b. Long-term drug therapy known to have a potential for causing liver toxicity;
 - c. Exposure to hepatotoxins;
 - d. Viral hepatitis, amoebiasis, tuberculosis, psittacosis, or similar infections that may cause hepatic injury;
 - e. Primary or secondary malignant neoplasms of the digestive system;
 - f. Diabetes mellitus;
 - g. Malnutrition;
 - h. Disorders of iron and mineral metabolism;
 - i. Sarcoidosis;
 - j. Amyloidosis;
 - k. Lupus;
 - l. Hypertension;
 - m. Gastrointestinal disease;
 - n. Pancreatic disease;
 - o. To assess liver function subsequent to liver transplantation.
3. For asymptomatic individuals, serum GGT testing during a wellness visit or a general exam without abnormal findings **is not reimbursable**.

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
82977	ASSAY OF GGT

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Centers for Medicare & Medicaid Services. (2026). Healthcare Common Procedure Coding System (HCPCS) Level II.

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Policy History

Approval Date	Description
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09/25/2026	01/01/2026; New policy.