



BlueCross BlueShield
of Vermont

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Fecal Analysis in Diagnosis of Intestinal Disorders Corporate Medical Policy

File Name: Fecal Analysis in Diagnosis of Intestinal Disorders

File Code: 2.04.VT26

Origination: 01/2016

Last Review: 02/2026

Next Review: 02/2027

Effective Date: 06/01/2026

Description/Summary

Intestinal dysbiosis may be defined as a state of disordered microbial ecology that is believed to cause disease. Laboratory analysis of fecal samples is proposed as a method of identifying individuals with intestinal dysbiosis and other gastrointestinal disorders.

For individuals who have suspected intestinal dysbiosis, irritable bowel syndrome, malabsorption, or small intestinal bacterial overgrowth who receive fecal analysis testing, the evidence includes several cohort and case-control studies comparing fecal microbiota in patients who had a known disease with healthy controls. Relevant outcomes are test accuracy and validity, symptoms, and functional outcomes. The available retrospective cohort studies on fecal analysis have suggested that some components of the fecal microbiome and inflammatory markers may differ across patients with irritable bowel syndrome subtypes. No studies were identified on the diagnostic accuracy of fecal analysis vs another diagnostic approach or compared health outcomes in patients managed with and without fecal analysis tests. No studies were identified that directly informed on the use of fecal analysis in the evaluation of intestinal dysbiosis, malabsorption, or small intestinal bacterial overgrowth. The evidence is insufficient to determine the effects of the technology on net health outcomes.

Policy

Coding Information

Click the links below for attachments, coding tables & instructions.

[Attachment I - CPT® Coding Table](#)

When a service is considered medically necessary

Stool testing in the setting of acute illness with diarrhea (not due to diagnoses listed in Investigational section below) may be considered **medically necessary** when such testing is expected to change the management of the member. Indications for such testing include, but are not limited to, extremes of age, signs of hypovolemia, need for hospitalization, bloody stools, fever, comorbidities that would affect treatment, immunocompromised state, inflammatory bowel disease or pregnancy.

When a service is considered investigational

All diagnoses are considered **investigational** for fecal analysis and testing for the evaluation of intestinal dysbiosis, irritable bowel syndrome, malabsorption or small intestinal overgrowth of bacteria.

Fecal analysis of the following components is considered **investigational** as a diagnostic test for the evaluation of intestinal dysbiosis, irritable bowel syndrome, malabsorption or small intestinal overgrowth of bacteria:

- Triglycerides
- Chymotrypsin
- Iso-butyrate, iso-valerate, and *n*-valerate
- Meat and vegetable fibers
- Long-chain fatty acids
- Cholesterol
- Total short-chain fatty acids
- Levels of Lactobacilli, bifidobacteria, and *Escherichia coli* and other “potential pathogens,” including: *Aeromonas*, *Bacillus cereus*, *Campylobacter*, *Citrobacter*, *Klebsiella*, *Proteus*, *Pseudomonas*, *Salmonella*, *Shigella*, *Staphylococcus aureus* and *Vibrio*
- Identification and quantitation of fecal yeast (including *Candida albicans*, *Candida tropicalis*, *Rhodotorula*, and *Geotrichum*)
- *N*-butyrate
- β -glucuronidase
- pH
- Short-chain fatty acid distribution (adequate amount and proportions of the different short-chain fatty acids reflect the basic status of intestinal metabolism)
- Fecal secretory immunoglobulin A (IgA)

Reference Resources

1. Blue Cross and Blue Shield Association Medical Policy MPRM 02.04.26 - Fecal Analysis in the Diagnosis of Intestinal Dysbiosis. Last updated 1/2026. Accessed 1/2026.
2. UpToDate - Approach to the adult with acute diarrhea in resource-abundant settings. Literature review current through 12/2025. Accessed 1/2026.

Document Precedence

Blue Cross and Blue Shield of Vermont (Blue Cross VT) Medical Policies are developed to provide clinical guidance and are based on research of current medical literature and review of common medical practices in the treatment and diagnosis of disease. The applicable group/individual contract and member certificate language, or employer's benefit plan if an ASO group, determines benefits that are in effect at the time of service. Since medical practices and knowledge are constantly evolving, Blue Cross VT reserves the right to review and revise its medical policies periodically. To the extent that there may be any conflict between medical policy and contract/employer benefit plan language, the member's contract/employer benefit plan language takes precedence.

Audit Information

Blue Cross VT reserves the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in the medical policy. If an audit identifies instances of non-compliance with this medical policy, Blue Cross VT reserves the right to recoup all non-compliant payments.

Administrative and Contractual Guidance

Benefit Determination Guidance

Prior approval may be required, and benefits are subject to all terms, limitations and conditions of the subscriber contract.

Incomplete authorization requests may result in a delay of decision pending submission of missing information. To be considered complete, see policy guidelines above.

NEHP/ABNE members may have different benefits for services listed in this policy. To confirm benefits, please contact the customer service department at the member's health plan.

Federal Employee Program (FEP) members may have different benefits that apply. For further information please contact FEP customer service or refer to the FEP Service Benefit Plan Brochure.

Coverage varies according to the member's group or individual contract. Not all groups are required to follow the Vermont legislative mandates. Member Contract language takes precedence over medical policy when there is a conflict.

If the member receives benefits through an Administrative Services (ASO) only group, benefits may vary or not apply. To verify benefit information, please refer to the member's employer benefit plan documents or contact the customer service department. Language in the employer benefit plan documents takes precedence over medical policy when there is a conflict.

Policy Implementation/Update information

01/2016	New Policy
02/2017	Policy updated with literature review through November 09, 2016; reference 2. Policy statement unchanged.
01/2019	Updated to reflect BCBS Association MPRM 02.04.26 language. Updated references. No changes to policy statement.
03/2020	Reference Reviewed and updated. No change to policy statement. Coding Table Added.
01/2021	Adaptive Maintenance: Code 83993 removed from table considered medically necessary.
02/2021	Reference Reviewed and updated. No change to policy statement.
02/2022	Policy Reviewed. Minor formatting changes. No change to policy statement. Changed codes 82656 & 83630 from investigational to medically necessary. Removed coding diagnosis table. The following codes changed from investigational with certain diagnoses to requiring prior approval: 0097U, 0107U, 82239, 82272, 82274, 82542, 82710, 82715, 82725, 83520, 83986, 84311, 87045, 87046, 87075, 87102, 87177, 87209, 87328, 87329, 87336, 89160, 89240.
06/2022	Policy reviewed. Codes 82270 & 82274 removed from requiring prior approval to medically necessary.
09/2022	Adaptive Maintenance: Codes 87045, 87046, 87075, 87102, 87177, 87209 removed from table considered medically necessary.
02/2023	Policy reviewed. Added general medical necessity criteria of testing in acute diarrheal illness. Minor formatting changes. References added and updated. Deleted code 0097U from coding table.
02/2024	Policy reviewed. No changes to policy statement. Minor formatting changes for clarity and consistency. References updated.
01/2025	Removed codes from coding table 82239, 82542, 82710, 82715, 82725, 83986, 84311, 87328, 87329, 89160, 89240 as requiring prior approval.
02/2026	Policy reviewed. No change to policy statement. References updated.

Eligible providers

Qualified healthcare professionals practicing within the scope of their license(s).

Approved by Blue Cross VT Medical Directors

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Tammaji P. Kulkarni, MD
Senior Medical Director

Attachment I
CPT® Coding Table

Code Type	Number	Description	Policy Instructions
The following codes will be considered as noted in the coding table below when applicable criteria have been met.			
CPT®	0107U	Clostridium difficile toxin(s) antigen detection by immunoassay technique, stool, qualitative, multiple-step method	Requires Prior Approval
CPT®	82239	Bile acids; total	No Prior Approval Required
CPT®	82272	Blood, occult, by peroxidase activity (eg, guaiac), qualitative, feces, 1-3 simultaneous determinations, performed for other than colorectal neoplasm screening	Medically Necessary
CPT®	82274	Blood, occult, by fecal hemoglobin determination by immunoassay, qualitative, feces, 1-3 simultaneous determinations	Medically Necessary
CPT®	82542	Column chromatography, includes mass spectrometry, if performed (eg, HPLC, LC, LC/MS, LC/MS-MS, GC, GC/MS-MS, GC/MS, HPLC/MS), non-drug analyte(s) not elsewhere specified, qualitative or quantitative, each specimen	No Prior Approval Required
CPT®	82656	Elastase, pancreatic (EL-1), fecal, qualitative or semi-quantitative	Medically Necessary
CPT®	82710	Fat or lipids, feces; quantitative	No Prior Approval Required
CPT®	82715	Fat differential, feces, quantitative	No Prior Approval Required
CPT®	82725	Fatty acids, nonesterified	No Prior Approval Required
CPT®	83520	Immunoassay for analyte other than infectious agent antibody or infectious agent antigen; quantitative, not otherwise specified	Requires Prior Approval
CPT®	83630	Lactoferrin, fecal; qualitative	Medically Necessary
CPT®	83986	pH; body fluid, not otherwise specified	No Prior Approval Required
CPT®	84311	Spectrophotometry, analyte not elsewhere specified	No Prior Approval Required

CPT®	87328	Infectious agent antigen detection by immunoassay technique, (eg, enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative, multiple-step method; cryptosporidium	No Prior Approval Required
CPT®	87329	Infectious agent antigen detection by immunoassay technique, (eg, enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative, multiple-step method; giardia	No Prior Approval Required
CPT®	87336	Infectious agent antigen detection by immunoassay technique, (eg, enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative, multiple-step method; Entamoeba histolytica dispar group	Requires Prior Approval
CPT®	89160	Meat fibers, feces	No Prior Approval Required
CPT®	89240	Unlisted miscellaneous pathology test	No Prior Approval Required