Intracellular Micronutrient Analysis

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Line(s) of Business: HMO; PPO; QUEST Integration
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Section: Medicine
Place(s) of Service: Outpatient

I. Description

Commercial laboratories offer panels of tests evaluating intracellular levels of micronutrients (essential vitamins and minerals). Potential uses of this test include screening for nutritional deficiencies in healthy people or those with chronic disease and aiding in the diagnosis of disease in patients with generalized symptoms.

Background

“Micronutrients” is a collective term used to describe essential vitamins and minerals. Adequate intake of micronutrients is important to the maintenance of health. Clinical deficiency states (states occurring after prolonged consumption of a diet lacking the nutrient that is treated by adding the nutrient to the diet) have been reported for vitamins A, B₁, B₁₂, C and D, selenium, and other micronutrients. Classic nutritional deficiency diseases are uncommon in the United States; most people derive sufficient nutrition from their diets alone or in combination with over-the-counter multivitamins.

Laboratory tests are available for individual micronutrients and are generally used to confirm suspected micronutrient deficiencies. Testing is performed by serum analysis using standardized values for defining normal and deficient states. In addition, some commercial laboratories offer panels of vitamin and mineral testing that also use serum analysis.

This policy addresses a novel laboratory test that measures the intracellular levels of micronutrients. This testing is known as intracellular micronutrient analysis and is also called micronutrient testing and functional intracellular analysis. Advocates claim that intracellular nutrient status is superior to serum testing. This is because intracellular levels may reflect more stable micronutrient levels over longer time periods compared with serum levels, because intracellular levels are not influenced by recent nutrition intake. However, this is not a widely accepted view, as the relationship between serum and intracellular levels of micronutrients is complex. The balance of intra- and extracellular levels depend on a number of factors, including the physiology of cellular transport mechanisms and the individual cell type.

At least two commercial laboratories offer intracellular testing for micronutrients. Laboratories perform a panel of tests evaluating the intracellular level of a variety of micronutrients (e.g.,
minerals, vitamins, amino acids, fatty acids, etc.). The test offered by IntraCellular Diagnostics evaluates epithelial cells from buccal swabs and assesses levels of magnesium, calcium, potassium, phosphorous, sodium, and chloride, as well as ratios between various combinations of these minerals. SpectraCell Laboratories offers a panel of tests that evaluates the intracellular status of micronutrients within lymphocytes in blood samples. The micronutrients measured by the test are as follows:

- Vitamins: A, B_1, B_2, B_3, B_6, B_12, C, D, K; biotin, folate, pantothenic acid
- Minerals: calcium, magnesium, zinc, copper
- Antioxidants: α-lipoic acid, coenzyme Q10, cysteine, glutathione, selenium, vitamin E
- Amino acids: asparagine, glutamine, serine
- Carbohydrate metabolism: chromium, fructose sensitivity, glucose-insulin metabolism
- Fatty acids: oleic acid
- Metabolites: choline, inositol, carnitine

The SpectraCell micronutrient panel also includes an evaluation of total antioxidant function.

**Regulatory Status**

Intracellular micronutrient testing is offered by companies SpectraCell and IntraCellular Diagnostics, which have Clinical Laboratories Improvement Amendments and accredited laboratories. SpectraCell’s micronutrient panel test and the IntraCellular Diagnostics ExaTest have not been through the Food and Drug Administration approval process.

**II. Criteria / Guidelines**

Intracellular micronutrient panel testing is not covered because it is not known to be effective in improving health outcomes.

**III. Administrative Guidelines**

A. There is no specific CPT code for this test. The specific CPT codes for each of the elements of the panel along with multiple units of not otherwise specified or unlisted codes for elements of the panel which don’t have specific codes would most likely be reported.

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<th>Description</th>
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<tr>
<td>84590</td>
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<tr>
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B. According to SpectraCell Laboratories, their total antioxidant function testing (which they call SPECTROX®) is reported using CPT code 86353.

C. IntraCellular Diagnostics uses electron microscopy for which CPT code 88348 might be reported.

IV. Scientific Background

This policy was created with a search of the MEDLINE database through May 2011. The policy was updated regularly with literature reviews. Most recently, the literature was reviewed through June 15, 2015. Following is a summary of the key literature to date.

One proposed use of intracellular micronutrient testing is as a screening test in people who do not have signs or symptoms of nutritional deficiency. The appropriate study design to evaluate the clinical benefit of a screening test is a randomized controlled trial comparing health outcomes in a screened and unscreened population. No such studies were identified in the literature search. In addition, no controlled observational (nonrandomized) studies were identified.

In 2010, Houston published an article on screening asymptomatic patients using micronutrient testing. The article was primarily a review but presented data on one center’s experience with micronutrient testing in the management of hypertensive patients. A total of 3,338 patients treated over five years received micronutrient testing. Among the 3,338 patients, 671 (20%) were considered to have hypertension (defined as blood pressure above 140/90 mm Hg). The author stated that there were differences in levels of many micronutrients in the hypertensive versus non-hypertensive populations but did not report the specific micronutrients for which levels differed. Hypertensive patients identified as having micronutrient deficiencies were treated with high-dose therapy of appropriate supplements, as well as with recommendations on optimal diet, exercise, and weight management. The author reported that, after six months, 62% of the hypertensive population had succeeded in reaching their blood pressure goals and had tapered and discontinued hypertensive medication. The article did not report micronutrient levels before or after treatment and did not report 6-month blood pressure data for a comparison group of hypertensive patients who did not undergo micronutrient testing.

Intracellular micronutrient testing is also proposed to aid in the diagnosis of patients with generalized symptoms with no identified disease source. No studies were identified evaluating this potential application of intracellular micronutrient testing.

Another possible application of intracellular micronutrient testing is as an alternative to serum testing for the diagnosis of specific nutritional deficiencies in patients with signs or symptoms of a nutritional disorder. A related application would be using intracellular micronutrient testing instead of serum testing for asymptomatic patients who have been diagnosed with a disease associated with a specific nutritional deficiency. No studies comparing the diagnostic accuracy or clinical utility of intracellular versus serum testing were identified for any particular micronutrient in either of these patient populations.

There are, however, some published data from the 1990s by Haigney and colleagues examining intracellular and serum magnesium levels in patients with heart disease. (Magnesium sulfate is an accepted treatment in selected patients with ventricular arrhythmias.) In a study with 40 patients referred for arrhythmia evaluation, there was a statistically significant correlation between
intracellular magnesium levels and increased QT interval dispersion (dQT), defined as the difference between the longest and shortest QT interval. The Pearson product-moment correlation was \( r=0.22, p<0.22 \). There was not a significant correlation between serum magnesium and the dQT \( r=0.03, p>0.05 \). Another study by this research team included 18 patients admitted to the hospital for cardiac surgery, 21 control patients admitted with acute medical illnesses, and 15 healthy controls. The mean serum magnesium levels were within the normal range for the cardiac surgery patients \( (1.87 \pm 0.06 \text{ milliequivalents per liter [mEq/L]}) \). However, the mean intracellular magnesium level was significantly lower in cardiac surgery patients than healthy volunteers \( (32.1 \pm 0.2 \text{ vs. } 33.7 \pm 0.5 \text{ mEq/L, respectively, } p<0.01) \). The Haigney and colleagues studies did not assess the accuracy of intracellular versus serum testing of magnesium levels and did not evaluate the impact of testing on health outcomes.

**Summary of Evidence**

There is a very limited evidence base, and conclusions cannot be drawn about the effect of intracellular micronutrient analysis on health outcomes. No studies were identified that evaluated the accuracy or clinical utility of intracellular micronutrient testing compared with standard testing for vitamin or mineral levels. In addition, no randomized controlled trials were identified that evaluated the health impact of any potential clinical application of intracellular micronutrient testing including diagnosing patients with generalized symptoms or screening people for nutrient deficiencies. Limited data are available on correlations between serum and intracellular micronutrient levels.

**Practice Guidelines and Position Statements**

No practice guidelines or position statements on intracellular micronutrient testing were identified.

**Medicare National Coverage**

There is no national coverage determination (NCD). In the absence of an NCD, coverage decisions are left to the discretion of local Medicare carriers.
V. Important Reminder

The purpose of this Medical Policy is to provide a guide to coverage. This Medical Policy is not intended to dictate to providers how to practice medicine. Nothing in this Medical Policy is intended to discourage or prohibit providing other medical advice or treatment deemed appropriate by the treating physician.

Benefit determinations are subject to applicable member contract language. To the extent there are any conflicts between these guidelines and the contract language, the contract language will control.

This Medical Policy has been developed through consideration of the medical necessity criteria under Hawaii’s Patients’ Bill of Rights and Responsibilities Act (Hawaii Revised Statutes §432E-1.4), generally accepted standards of medical practice and review of medical literature and government approval status. HMSA has determined that services not covered under this Medical Policy will not be medically necessary under Hawaii law in most cases. If a treating physician disagrees with HMSA’s determination as to medical necessity in a given case, the physician may request that HMSA reconsider the application of the medical necessity criteria to the case at issue in light of any supporting documentation.

VI. References


