

# Vitamin D Testing

**Guideline Number:** MPG377.09  
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[↪ Terms and Conditions](#)

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Related Medicare Advantage Policy Guideline
<ul style="list-style-type: none"> <li><a href="#">Clinical Diagnostic Laboratory Services</a></li> </ul>
Related Medicare Advantage Coverage Summary
<ul style="list-style-type: none"> <li><a href="#">Laboratory Tests and Services</a></li> </ul>

## Policy Summary

[↪ See Purpose](#)

### Overview

Vitamin D deficiencies are the result of dietary inadequacy, impaired absorption and use, increased requirement, or increased excretion. Vitamin D deficiency can occur when usual intake is lower than recommended levels over a period of time, or when exposure to sunlight is limited. Vitamin D deficiency can also result from the inability of the kidneys to convert the Vitamin D to its active form.

### Guidelines

#### Indications

Documentation must justify the test(s) chosen for a particular disease entity. These are some, not all of the medical conditions that may result in Vitamin D deficiency.

#### Measurement of 25-OH Vitamin D, CPT code 82306, level is indicated for patients with:

- Chronic kidney disease stage III or greater
- Cirrhosis
- Hypocalcemia
- Hypercalcemia
- Hypercalciuria
- Hypervitaminosis D
- Parathyroid disorders
- Malabsorption states
- Obstructive jaundice
- Osteomalacia
- Osteoporosis if:
  - T score on DEXA scan < -2.5; or
  - History of fragility fractures; or
  - FRAX > 3% 10-year probability of hip fracture or 20% 10-year probability of other major osteoporotic fracture; or
  - FRAX > 3% (any fracture) with T-score.

- Initiating bisphosphonate therapy (Vitamin D level should be determined and managed as necessary before bisphosphonate is initiated)
- Osteosclerosis/petrosis
- Rickets
- Vitamin D deficiency on replacement therapy related to a condition listed above; to monitor the efficacy of treatment

**Measurement of 1, 25-OH Vitamin D, CPT code 82652, level is indicated for patients with:**

- Unexplained hypercalcemia (suspected granulomatous disease or lymphoma)
- Unexplained hypercalciuria (suspected granulomatous disease or lymphoma)
- Suspected genetic childhood rickets
- Suspected tumor-induced osteomalacia
- Nephrolithiasis or hypercalciuria

**Limitations**

- Both assays of vitamin D need not be performed for each of the above conditions. Often, one type is more appropriate for a certain disease state than another. The most common type of vitamin D deficiency is 25-OH vitamin D. A much smaller percentage of 1, 25-dihydroxy vitamin D deficiency exists; mostly, in those with renal disease.
- Once a beneficiary has been shown to be vitamin D deficient, further testing may be medically necessary only to ensure adequate replacement has been accomplished.
- If Vitamin D level is between 20 and 50 ng/dl and patient is clinically stable, repeat testing is often unnecessary; if performed, documentation must clearly indicate the necessity of the test.
- If level < 20 ng/dl or > 60 ng/dl are noted, a subsequent level(s) may be reimbursed until the level is within the normal range.
- Testing may not be used for routine or other screening.

**Applicable Codes**

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this guideline does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

CPT Code	Description
82306	Vitamin D; 25 hydroxy, includes fraction(s), if performed
82652	Vitamin D; 1, 25 dihydroxy, includes fraction(s), if performed

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**Diagnosis Code**

[Vitamin D Testing: Diagnosis Code List](#)



**Questions and Answers**

1	<b>Q:</b>	What is the guideline for how many times a year I can get this test completed?
	<b>A:</b>	If needed/required, up to 4 times a year.

## References

### CMS Local Coverage Determinations (LCDs) and Articles

LCD	Article	Contractor	Medicare Part A	Medicare Part B
<a href="#">L33996 Vitamin D Assay Testing</a>	<a href="#">A56798 Billing and Coding: Vitamin D Assay Testing</a>	CGS	KY, OH	KY, OH
<a href="#">L37535 Vitamin D Assay Testing</a>	<a href="#">A57736 Billing and Coding: Vitamin D Assay Testing</a>	NGS	CT, IL, MA, ME, MN, NH, NY (Upstate, Down State, Queens), RI, VT, WI	CT, IL, MA, ME, MN, NH, NY (Entire State), RI, VT, WI
<a href="#">L36692 Vitamin D Assay Testing</a>	<a href="#">A57718 Billing and Coding: Vitamin D Assay Testing</a>	Noridian	AS, CA (Northern, Southern), GU, HI, MP, NV	AS, CA (Entire State), GU, HI, MP, NV
<a href="#">L34051 Vitamin D Assay Testing</a>	<a href="#">A57719 Billing and Coding: Vitamin D Assay Testing</a>	Noridian	AK, AZ, ID, MT, ND, OR, SD, UT, WA, WY	AK, AZ, ID, MT, ND, OR, SD, UT, WA, WY
<a href="#">L34658 Vitamin D Assay Testing</a>	<a href="#">A57484 Billing and Coding: Vitamin D Assay Testing</a>	WPS	IA, IN, KS, MI, MO, NE	IA, IN, KS, MI, MO, NE
<a href="#">L33771 Vitamin D; 25 hydroxy, includes fraction(s), if performed</a>	<a href="#">A56841 Billing and Coding: Vitamin D; 25 hydroxy, includes fraction(s), if performed</a>	First Coast	FL, PR, VI	FL, PR, VI
<a href="#">L34914 Assays for Vitamins and Metabolic Function</a>	<a href="#">A56416 Billing and Coding: Assays for Vitamins and Metabolic Function</a>	Novitas	AR, CO, DC, DE, LA, MD, MS, NJ, NM, OK, PA, TX	AR, CO, DC, DE, LA, MD, MS, NJ, NM, OK, PA, TX
<a href="#">L39391 Vitamin D Assay Testing</a>	<a href="#">A59170 Billing and Coding: Vitamin D Assay Testing</a>	Palmetto	AL, GA, NC, SC, TN, VA, WV	AL, GA, NC, SC, TN, VA, WV
L33418 Assays for Vitamins and Metabolic Function Retired 01/29/2023	A56485 Billing and Coding: Assays for Vitamins and Metabolic Function Retired 01/29/2023	Palmetto		AL, GA, NC, SC, TN, VA, WV

## Guideline History/Revision Information

Revisions to this summary document do not in any way modify the requirement that services be provided and documented in accordance with the Medicare guidelines in effect on the date of service in question.

Date	Summary of Changes
02/23/2024	<b>Supporting Information</b> <ul style="list-style-type: none"> <li>Updated <i>References</i> section to reflect the most current information</li> <li>Archived previous policy version MPG377.08</li> </ul>

## Purpose

The Medicare Advantage Policy Guideline documents are generally used to support UnitedHealthcare Medicare Advantage claims processing activities and facilitate providers' submission of accurate claims for the specified services. The document can be used as a guide to help determine applicable:

- Medicare coding or billing requirements, and/or
- Medical necessity coverage guidelines; including documentation requirements.

UnitedHealthcare follows Medicare guidelines such as NCDs, LCDs, LCAs, and other Medicare manuals for the purposes of determining coverage. It is expected providers retain or have access to appropriate documentation when requested to support coverage. Please utilize the links in the [References](#) section above to view the Medicare source materials used to develop this resource document. This document is not a replacement for the Medicare source materials that outline Medicare coverage requirements. Where there is a conflict between this document and Medicare source materials, the Medicare source materials will apply.

## Terms and Conditions

The Medicare Advantage Policy Guidelines are applicable to UnitedHealthcare Medicare Advantage Plans offered by UnitedHealthcare and its affiliates.

These Policy Guidelines are provided for informational purposes, and do not constitute medical advice. Treating physicians and healthcare providers are solely responsible for determining what care to provide to their patients. Members should always consult their physician before making any decisions about medical care.

Benefit coverage for health services is determined by the member specific benefit plan document\* and applicable laws that may require coverage for a specific service. The member specific benefit plan document identifies which services are covered, which are excluded, and which are subject to limitations. In the event of a conflict, the member specific benefit plan document supersedes the Medicare Advantage Policy Guidelines.

Medicare Advantage Policy Guidelines are developed as needed, are regularly reviewed and updated, and are subject to change. They represent a portion of the resources used to support UnitedHealthcare coverage decision making. UnitedHealthcare may modify these Policy Guidelines at any time by publishing a new version of the policy on this website. Medicare source materials used to develop these guidelines include, but are not limited to, CMS National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Medicare Benefit Policy Manual, Medicare Claims Processing Manual, Medicare Program Integrity Manual, Medicare Managed Care Manual, etc. The information presented in the Medicare Advantage Policy Guidelines is believed to be accurate and current as of the date of publication and is provided on an "AS IS" basis. Where there is a conflict between this document and Medicare source materials, the Medicare source materials will apply.

You are responsible for submission of accurate claims. Medicare Advantage Policy Guidelines are intended to ensure that coverage decisions are made accurately based on the code or codes that correctly describe the health care services provided. UnitedHealthcare Medicare Advantage Policy Guidelines use Current Procedural Terminology (CPT®), Centers for Medicare and Medicaid Services (CMS), or other coding guidelines. References to CPT® or other sources are for definitional purposes only and do not imply any right to reimbursement or guarantee claims payment.

Medicare Advantage Policy Guidelines are the property of UnitedHealthcare. Unauthorized copying, use, and distribution of this information are strictly prohibited.

\*For more information on a specific member's benefit coverage, please call the customer service number on the back of the member ID card or refer to the [Administrative Guide](#).