Harvard Pilgrim Health Care | TUFTS Health Plan

Point32Health companies

Medical Necessity Guidelines:

Vitamin D Screening and Testing

Effective: August 1, 2026

Prior Authorization Required If REQUIRED, submit supporting clinical documentation (electronically recommended or by fax)	Yes ☐ No ☒
Notification Required	Yes ☐ No ☒

Applies to:

- Harvard Pilgrim Health Care Commercial products
- Tufts Health Plan Commercial products
- Tufts Health Direct
- Tufts Health Together
- Tufts Health RITogether
- Tufts Health One Care

We recommend submitting prior authorization electronically. If you opt to submit prior authorization requests via fax, please refer to this reference chart for the appropriate fax number (varies by product).
For details on all our products, please visit the Our Plans page on our provider website. For additional Prior Authorization and Notification details on other lines of business not listed on our Medical Necessity Guidelines page, please also reference our Prior Authorization Resources page.

Note: While you may not be the provider responsible for obtaining prior authorization or notifying Point32Health, as a condition of payment you will need to ensure that any necessary prior authorization has been obtained and/or Point32Health has received proper notification. If notification is required, providers may additionally be required to provide updated clinical information to qualify for continued service.

Overview

Vitamin D is a hormone, synthesized by the skin and metabolized by the kidney to an active hormone, calcitriol. An excess of vitamin D may lead to hypercalcemia while deficiency may lead to various disorders, such as rickets. Evaluation of vitamin D levels is accomplished by measuring levels of 25-hydroxyvitamin D.

The Institute of Medicine lists the following vitamin D levels as guidelines:

- Deficiency—serum 25-hydroxyvitamin D values <12 ng/mL (<30 nmol/L)
- Sufficiency—serum 25-hydroxyvitamin D values of ≥ 20 ng/mL (≥50 nmol/L)

Clinical Guideline Coverage Criteria

The Plan considers vitamin D screening and testing as reasonable and medically necessary for members who are symptomatic or at risk for vitamin D deficiency when documentation confirms diagnosis of **ONE of th**e following:

- Members under age 18; **OR**
- Symptomatic or “high risk” members aged 18 to 65 years. Members are considered “high risk” due to certain medical conditions, including:
  - Biliary Cirrhosis
  - Biliary Tract Disorders
  - Blind Loop Syndrome
  - Calcium Metabolism Disorders (e.g., hyper/hypocalcemia)
  - Celiac Disease
  - Chronic Kidney Disease Stage III or greater

- Crohn's Disease
- Cystic Fibrosis
- Dermatomyositis
- Gastric Bypass
- Granuloma forming diseases
- Hyperparathyroidism or Hypoparathyroidism
- Hypervitaminosis of Vitamin D
- Individuals receiving hyperalimentation
- Intestinal Malabsorption
- Liver Cirrhosis
- Long term use of medications known to lower vitamin D levels (e.g., anticonvulsants, glucocorticoids)
- Lupus Erythematosus (any form)
- Lymphoma
- Malnutrition
- Myalgia
- Myopathy related to endocrine diseases
- Myositis
- Obesity
- Obstructive jaundice
- Osteogenesis imperfecta
- Osteomalacia
- Osteoporosis
    - T score on DEXA scan < -2.5
    - History of fragility fractures
    - FRAX > 3% 10-year probability of hip fracture or 20% 10-year probability of other major
    - osteoporotic fracture
    - FRAX> 3% (any fracture) with T-score < -1.5
    - Initiating bisphosphonate therapy (Vitamin D level and serum calcium levels should be assessed and managed as necessary before bisphosphonate is initiated.)
- Paget's disease of bone
- Phosphorus metabolism disorders
- Post-Bariatric Surgery
- Premature osteopenia
- Pancreatic steatorrhea
- Primary or miliary tuberculosis
- Psoriasis
- Rheumatoid Arthritis
- Regional enteritis
- Renal, ureteral or urinary calculus (includes nephrolithiasis)
- Rickets
- Sarcoidosis
- Ulcerative Colitis

Vitamin D deficiency on replacement therapy related to a condition listed above; to monitor the efficacy of treatment – If Vitamin D level is between 20 and 50ng/dl and the member is clinically stable, repeat testing is often unnecessary; if performed, documentation must clearly indicate the necessity of the test.

Note: Once testing demonstrates the member is vitamin D deficient, further testing is medically necessary to ensure adequate replacement has been accomplished. If the level is < 20ng/dl or > 50ng/dl, a subsequent level(s) may be medically necessary until the level is within normal range. Thereafter, annual testing may be appropriate depending upon the indication and other mitigating factors.

Limitations

The Plan considers vitamin D screening and testing as not medically necessary for all other indications including but not limited to depression, fatigue, osteoarthritis, or chronic pain. In addition, The Plan does not cover Vitamin D testing for routine screening in healthy individuals.

Codes

The following code(s) are associated with this service:

Table 1: CPT/HCPCS Codes

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

List of Medically Necessary ICD-10 Codes

References:

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2. Barake, M, Daher, RT, Salti, I, Cortas, NK, Al-Shaar, L, Habib, RH, and Fuleihan, G. 25-hydroxyvitamin D assay variations and impact on clinical decision making. J Clin Endocrinol Metab. 2012; 97(3):835-843
3. Center for Medicaid and Medicare Services. Local Coverage Determination (LCD): Vitamin D Assay Testing (L37535). Centers for Medicare and Medicaid Services; 2018. Revised 10/01/2021. Accessed September 30, 2023
4. Chung M, et al. Vitamin D and calcium: a systematic review of health outcomes. Evidence Reports/Technology Assessments. No. 183. Rockville, MD: Agency for Healthcare Research and Quality; 2009 Aug.
5. Elamin MB, et al. Vitamin D and cardiovascular outcomes: a systematic review and meta-analysis. J Clin Endocrinol Metab 2011 Jul; 96(7):1931–42.
6. Enko, D, Fridrich, L, Rezanka, E, Stolba, R, Ernst, J, Wendler, I, Fabian, D, Hauptlorenz, S, and Halwachs-Baumann, G. 25- hydroxy-Vitamin D status: limitations in comparison and clinical interpretation of serum-levels across different assay methods. Clin Lab. 2014;60(9):1541-1550.
7. Granado-Lorencio, F, Blanco-Navarro, I, and Perez-Sacristan, B. Criteria of adequacy for vitamin D testing and prevalence of deficiency in clinical practice. Clin Chem Lab Med. 2015.
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9. Holnick, MF., Binkley, NC., Binkley, HA., et al. Evaluation, Treatment, and Prevention of Vitamin D Deficiency: An Endocrine Society Clinical Practice Guideline. J Clin Endocrine Metab. 2011; 96(7): 1911-30.
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12. LeBlanc, ES, Zakher, B, Daeges, M, Pappas, M, and Chou, R. Screening for vitamin D deficiency: a systematic review for the U.S. Preventive Services Task Force. Ann Intern Med. 2015; c162(2): 109-122.
13. Lee, J, So, T, Thackray, J. A Review on Vitamin D Deficiency Treatment in Pediatric Patients. J Pediatr Pharmacol Ther. 2013 Oct-Dec; 18(4): 277–291.
14. Lee, RH, Weber, T, and Colon-Emeric, C. Comparison of cost-effectiveness of vitamin D screening with that of universal supplementation in preventing falls in community-dwelling older adults. J Am Geriatr Soc. 2013;61(5):707-714.
15. Medical Advisory Secretariat, OMoHaL-TC. Clinical utility of vitamin d testing: an evidence-based analysis. Ont Health Technol Assess Ser. 2010; c10(2):1-93.

Approval And Revision History

September 2020: Reviewed by the Medical Policy Approval Committee (MPAC), coding updated

Subsequent endorsement date(s) and changes made:

- November 17, 2021: Reviewed by Integrated Medical Policy Advisory Committee (IMPAC) for integration purposes between Harvard Pilgrim Health Care for an effective date of April 1, 2022.
- December 1, 2022: Reviewed by MPAC, renewed without changes effective March 1, 2023
- September 20, 2023: Reviewed by MPAC, renewed without changes
- November 2023: Rebranded Unify to One Care effective January 1, 2024
- September 19, 2024: Reviewed by MPAC, minor updates to definition of Vitamin D deficiency; effective November 1, 2024
- August 20, 2025: Reviewed by MPAC for annual review, renewed without changes effective October 1, 2025
- June 17, 2026: Reviewed by MPAC for annual review, renewed without changes effective August 1, 2026

Background, Product and Disclaimer Information

Medical Necessity Guidelines are developed to determine coverage for benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. We make coverage decisions using these guidelines, along with the Member's benefit document, and in coordination with the Member's physician(s) on a case-by-case basis considering the individual Member's health care needs.

Medical Necessity Guidelines are developed for selected therapeutic or diagnostic services found to be safe and proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in our service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. We revise and update Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern. For Tufts Health Together (Medicaid), coverage may be available beyond these guidelines for pediatric members under age 21 under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits of the plan in accordance with 130 CMR 450.140 and 130 CMR 447.000, and with prior authorization.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this guideline is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to eligibility and benefits on the date of service, coordination of benefits, referral/authorization, utilization management guidelines when applicable, and adherence to plan policies, plan procedures, and claims editing logic.