Local Coverage Determination (LCD): Vitamin D Assay Testing (L34051)

Links in PDF documents are not guaranteed to work. To follow a web link, please use the MCD Website.

Contractor Information

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LCD Information

Document Information

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<th>LCD ID</th>
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<td>For services performed on or after 10/01/2015</td>
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Vitamin D Assay Testing

For services performed on or after 12/01/2019

**Proposed LCD in Comment Period**

N/A

**Source Proposed LCD**

DL34051

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**CMS National Coverage Policy**

Title XVIII of the Social Security Act, Section 1862(a)(1)(A) states that no Medicare payment shall be made for items or services which are not reasonable and necessary for the diagnosis or treatment of illness or injury.

Title XVIII of the Social Security Act, Section 1862(a)(7). This section excludes routine physical examinations.
Title XVIII of the Social Security Act, Section 1833(e) states that no payment shall be made to any provider for any claim that lacks the necessary information to process the claim.

42CFR410.32(a) requires a clinical diagnostic test be ordered by the physician who is treating the patient for a specific medical problem and uses the results in the management of the beneficiary’s specific problem.

MBPM Internet Only Manual(IOM 100-02), chap. 6, §20.4.3 applies 42CFR410.32 to hospitals.

**Coverage Guidance**

**Coverage Indications, Limitations, and/or Medical Necessity**

Vitamin D is called a "vitamin" because of its exogenous source, predominately from oily fish in the form of vitamin D2 and vitamin D3. It is more accurate to consider fat-soluble Vitamin D as a steroid hormone, synthesized by the skin and metabolized by the kidney to an active hormone, calcitriol. Clinical disorders related to vitamin D may arise because of altered availability of the parent vitamin D, altered conversion of vitamin D to its predominant metabolites, altered organ responsiveness to dihydroxylated metabolites and disturbances in the interactions of the vitamin D metabolites with PTH and calcitonin. Normal levels of Vitamin D range from 20 – 50 ng/dl. This LCD identifies the indications and limitations of Medicare coverage and reimbursement for the lab assay.

**Indications:**

Measurement of 25-OH Vitamin D 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
  i. T score on DEXA scan
  ii. History of fragility fractures or
  iii. FRAX > 3% 10-year probability of hip fracture or 20% 10-year probability of other major osteoporotic fracture or
  iv. FRAX > 3% (any fracture) with T-score
  v. Initiating bisphosphonate therapy (Vit 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 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:

Testing may not be used for routine or other screening.

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. Although it is not the active form of the hormone, 25-OH vitamin D is much more commonly measured because it better reflects the sum total of vitamin D produced endogenously and absorbed from the diet than does the level of the active hormone 1, 25-dihydroxy vitamin D. Deficiency of 1, 25-dihydroxy vitamin D, which is present at much lower concentrations, does not necessarily reflect deficiency of 25-OH vitamin D and its measurement should be limited to the indications listed. Documentation must justify the test(s) chosen for a particular disease entity. Various component sources of 25-OH vitamin D, such as stored D or diet-derived D, should not be billed separately.

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 most clearly indicate the necessity of the test. If level 60 ng/dl, a subsequent level(s) may be reimbursed until the level is within the normal range.

Summary of Evidence

N/A

Analysis of Evidence
(Rationale for Determination)

N/A

General Information

Associated Information
Documentation must clearly indicate the necessity for the test(s), any and all repeat testing and frequency of testing.

The medical record must be made available to Medicare upon request.

**Sources of Information**


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48. Other Contractor(s)' Policies.

Bibliography

N/A
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<td>12/01/2019</td>
<td>R10</td>
<td>The LCD is revised to remove CPT/HCPCS codes in the Keyword Section of the LCD.</td>
<td>Other (The LCD is revised to remove CPT/HCPCS codes in the Keyword Section of the LCD. )</td>
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<td>At this time 21st Century Cures Act will apply to new and revised LCDs that restrict coverage which requires comment and notice. This revision is not a restriction to the coverage determination; and, therefore not all the fields included on the LCD are applicable as noted in this policy.</td>
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| 12/01/2019            | R9                      | 12/01/2019: At this time 21st Century Cures Act will apply to new and revised LCDs that restrict coverage which requires comment and notice. This revision is not a restriction to the coverage determination; and, therefore not all the fields included on the LCD are applicable as noted in this policy. | Provider Education/Guidance  
Revisions Due To Code Removal |
<p>|                       |                         | As required by CR 10901, all billing and coding information has been moved to the companion article, this article is linked to the LCD. | |
| 10/01/2018            | R8                      | At this time 21st Century Cures Act will apply to new and revised Articles that restrict coverage which requires comment and notice. This revision is not a restriction to the coverage determination; and, therefore not all the fields included on the Article are applicable as noted in this policy. | Revisions Due To ICD-10-CM Code Changes |
|                       |                         | 08/09/2018 - For the following ICD-10 code descriptions were changed in the ICD-10 Codes that Support Medical Necessity field: | |</p>
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<td>10/01/2015</td>
<td>R3</td>
<td>The following ICD-10 Codes were added from the ICD-10 2016-2017 update: E89820, E89821, E89822, E89823, K9041, K9049. Code K90.4 was deleted.</td>
<td>• Revisions Due To ICD-10-CM Code Changes</td>
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<td>The LCD is revised to add M85.80 and M85.88 to the ICD-10 Codes that Support Medical Necessity section; CPT 82306 only.</td>
<td>• Reconsideration Request</td>
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<td>R1</td>
<td>This LCD is revised to remove the paragraph, &quot;When requesting an individual consideration through the written redetermination (formerly appeal) process, providers must include all relevant medical records and any pertinent peer-reviewed literature that supports the request. At a minimum two (2) Phase II studies (human studies of efficacy, pivotal) or one (1) Phase III study (evidence of safety and efficacy, pivotal) must be submitted for the Medical Director’s review.” from the Associated Information field.</td>
<td>• Other (Removed the paragraph, “When requesting an individual consideration through the written redetermination (formerly appeal) process, providers must include all relevant medical records and any pertinent peer-reviewed literature that supports the request. At a minimum two (2) Phase II studies (human studies of efficacy, pivotal) or one (1) Phase III study (evidence of safety and efficacy, pivotal) must be submitted for the Medical Director’s review.”)</td>
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<td>02/03/2017</td>
<td>R7</td>
<td>Added ICD-10 Codes A15.0, A15.4, A15.5, A15.6, A15.7, A15.8, Z79.3, Z79.4, Z79.51, Z79.52, Z79.810, Z79.811, Z79.818, Z79.82, Z79.83, Z79.84, Z79.890, Z79.891, Z79.899</td>
<td>• Creation of Uniform LCDs Within a MAC Jurisdiction</td>
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<td>Addition of codes from 2016 ICD-10 Coding updates added to Final E89.820; E89.821; E89.822; E89.823</td>
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Z68.43 descriptor was changed in Group 1 Effective 10/01/2018
Associated Documents

Attachments
N/A

Related Local Coverage Documents

Article(s)
A57719 - Billing and Coding: Vitamin D Assay Testing
A55373 - Response to Comments: Vitamin D Assay Testing

LCD(s)
DL34051
- (MCD Archive Site)

Related National Coverage Documents
N/A

Public Version(s)
Updated on 01/29/2020 with effective dates 12/01/2019 - N/A
Updated on 11/08/2019 with effective dates 12/01/2019 - N/A
Updated on 09/10/2018 with effective dates 10/01/2018 - 11/30/2019
Some older versions have been archived. Please visit the MCD Archive Site to retrieve them.

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