PAYMENT POLICY: Vitamin D Testing

Owner	Current Effective Date	Next Review Date
Operations	11/04/2026	11/04/2027

OVERVIEW

The purpose of this policy and procedure is to explain Community Health Choice reimbursement guidelines for vitamin D testing services submitted by participating and non-participating providers. The policy is intended to support accurate claim submission, appropriate documentation, and consistent reimbursement review.

This policy applies to claims submitted for Community Health Choice members enrolled in STAR, CHIP/CHIP P, STAR+PLUS, Health Insurance Marketplace, and Medicare Advantage products, unless otherwise required by applicable law, regulation, member benefit plan, or provider contract.

This policy is intended as general reimbursement guidance. It does not determine member eligibility, authorize services, guarantee coverage or payment, replace medical necessity review, or supersede applicable federal or Texas requirements, the member's benefit plan document, Community Health Choice coverage criteria, or the terms of the applicable provider agreement.

Covered Codes

The following procedure codes are subject to this payment policy when submitted for vitamin D testing services:

CPT Code	Description
82306	25-Hydroxyvitamin D Test
82652	1,25-Dihydroxyvitamin D Test
0038U	Sensieva™ Droplet 25-OH Vitamin D2/D3 Microvolume LC/MS Assay; InSource Diagnostics

Reimbursement Criteria

Vitamin D testing is eligible for reimbursement when the claim includes a diagnosis code that supports medical necessity and the service is consistent with the member's clinical condition. Claims submitted without a qualifying diagnosis code or required supporting documentation may be denied as not medically necessary.

Medicaid products: Reimbursement is limited to one vitamin D test per member per day.

EPSDT exception: For Medicaid members from birth through 20 years of age, additional testing beyond the stated frequency limit may be covered when medically necessary to evaluate or treat an identified illness or condition and supported by documentation in the medical record.

Non-Medicaid products: Reimbursement is limited to one vitamin D test per member per calendar year when medically necessary. For rickets, vitamin D deficiency, osteomalacia, or aluminum bone disease, reimbursement is limited to four tests per member per calendar year for the previously identified deficient form of vitamin D.

Provider Documentation Requirements

Providers are responsible for submitting the appropriate ICD-10-CM diagnosis code or codes that support the medical necessity of vitamin D testing. The medical record should support the member's clinical condition, the need for testing, and the services billed.

Documentation may be requested to validate that the service billed was medically necessary, appropriately coded, and consistent with applicable benefit coverage and reimbursement requirements.

Claim Review and Payment

Community Health Choice may use nationally recognized coverage criteria, including applicable Centers for Medicare & Medicaid Services guidance and Local Coverage Determinations, to identify diagnosis codes that support medical necessity.

Community Health Choice may audit, review, deny, or recoup payment for services based on medical necessity, benefit coverage, applicable state and federal requirements, the Texas Medicaid Provider Procedures Manual, MCG Health criteria, InterQual® criteria, plan-specific coverage determinations, and the terms of the applicable provider agreement.

References

Community Health Choice may consider the following sources when applying this payment policy:

American Medical Association, Current Procedural Terminology (CPT®) and related publications and services

Centers for Medicare & Medicaid Services manuals and applicable CMS publications

Texas Medicaid Provider Procedures Manual

Applicable state and federal regulatory requirements

Community Health Choice medical coverage criteria and provider contract requirements

Provider Disclaimer

Codes listed in this policy are provided for reference and may not be all-inclusive. Deleted codes, inactive codes, or codes that are not valid on the date of service may not be eligible for reimbursement. Inclusion of a code or service in this policy does not guarantee coverage, authorization, payment, or reimbursement.

Payment decisions are based on member eligibility, covered benefits, medical necessity, prior authorization requirements when applicable, correct coding, complete claim submission, provider contract terms, Community Health Choice reimbursement policies and system configuration, and applicable federal and Texas requirements. Providers and facilities are responsible for following current coding, billing, documentation, and claim submission requirements. Failure to meet these requirements may result in claim denial, adjustment, recoupment, or recovery of payments. Community Health Choice reserves the right to revise this policy at any time based on regulatory updates, coding changes, contract requirements, benefit changes, or updates to Community Health Choice coverage criteria.

RELATED POLICIES

- All Payment Policies