

Clinical Policy: Thyroid Hormones and Insulin Testing in Pediatrics

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[Coding Implications](#)

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Description

Numerous essential metabolic functions are mitigated by hormones produced by, and affecting the thyroid, e.g., thyroid stimulating hormone (TSH) and thyroxine (T4), as well as by insulin. This policy discusses the medical necessity requirements for the testing of these hormones.

Policy/Criteria

- I. It is the policy of health plans affiliated with Centene Corporation® that routine thyroid hormone testing in healthy, including obese but otherwise healthy, children (age ≥ 1 and ≤ 18) is **not medically necessary** because these tests have not been demonstrated to have a clear clinical benefit.
- II. It is the policy of health plans affiliated with Centene Corporation that routine insulin testing in healthy, including obese but otherwise healthy, children (age ≥ 1 and ≤ 18) is **not medically necessary** because these tests have not been demonstrated to have a clear clinical benefit.

Background

The thyroid is an endocrine gland that regulates numerous metabolic processes through hormone secretion. Thyroid homeostasis is controlled through a complex feedback loop through the hypothalamus-pituitary-thyroid axis. Thyroxine (otherwise known as T4 due to the presence of four iodine molecules), is the major secretory hormone of the thyroid and is converted into triiodothyronine (T3). Secretion of thyroxine by the thyroid is regulated by the concentration of thyroid stimulating hormone (TSH). TSH is generated by the pituitary gland and secreted in the bloodstream to generate a feedback loop with T4. Loss of the regulatory feedback cycle of the thyroid hormones could lead to hyperthyroidism and primary or secondary hypothyroidism.¹

Assessment of thyroid function can be achieved through the quantification of thyroid hormone levels. However, the appropriate clinical utilization of these tests has been a subject of concern in the recent literature.^{2,3} For example, in pediatric patients, TSH and total T4 levels may be elevated in children who are overweight or obese, but it remains unclear if this is a cause or consequence of obesity.^{4,5,6} Therefore general screening may not provide actionable clinical information.^{4,5,6,7,8}

The Endocrine Society Clinical Practice Guideline on pediatric obesity and the American Academy of Pediatrics recommend against routine laboratory evaluations for endocrine etiologies of pediatric obesity unless the patient's stature and/or height velocity are attenuated (assessed in relationship to genetic/familial potential and pubertal stage). They also recommend against measuring insulin concentrations when evaluating children or adolescents for obesity. They note that although obesity is associated with insulin resistance/hyperinsulinemia, attempts

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to diagnose insulin resistance by measuring plasma insulin concentration or any other surrogate in the clinical setting has no merit because it has no diagnostic value. Fasting insulin concentrations show considerable overlap between insulin-resistant and insulin-sensitive youths. Therefore, there is no clearly established threshold distinguishing normal from abnormal insulin sensitivity, nor is there a universally accepted and clinically useful numeric measure to define insulin resistance, unlike what exists for glucose or lipid levels. Moreover, measuring insulin is hampered by the lack of standardized insulin assays and poor reproducibility of even the same assay. Further limitations include race/ethnicity-related differences in insulin concentrations due to differences in the metabolic clearance rate of insulin and the cross reactivity between insulin and proinsulin. In youths with Type 2 diabetes mellitus, despite severe deficiency in insulin secretion, fasting insulin concentrations are higher than in youths without diabetes. Notably, fasting insulin concentrations are similar in obese youth with normal glucose tolerance and those with impaired glucose tolerance, highlighting the risk of missing a diagnosis if fasting insulin is used as a screening tool. Because of these limitations, measuring plasma insulin concentrations remains a research tool with no clinical value for evaluation of obesity.^{8,9}

United States Preventive Services Task Force

Body mass index (BMI) measurement is the recommended screening test for obesity. BMI percentile is plotted on growth charts, such as those developed by the Centers for Disease Control and Prevention (CDC), and obesity is defined as an age- and sex-specific BMI in the 95th percentile or greater.¹⁰

Coding Implications

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Table 1: CPT codes not medically necessary when billed with a corresponding ICD-10CM in Table 2

CPT® Codes	Description
83525	Insulin; total
83527	Insulin; free
84436	Thyroxine; total
84439	Thyroxine; free
84443	Thyroid stimulating hormone (TSH)
84479	Thyroid hormone (T3 or T4) uptake or thyroid hormone binding ratio (THBR)
84480	Triiodothyronine T3; total (TT-3)
84481	Triiodothyronine T3; free
84482	Triiodothyronine T3; reverse

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Table 2: ICD-10-CM diagnosis codes not medically necessary when billed with a corresponding CPT code in Table 1.

ICD-10-CM Code	Description
E66.01	Morbid (severe) obesity due to excess calories
E66.09	Other obesity due to excess calories
E66.1	Drug-induced obesity
E66.3	Overweight
E66.8	Other obesity
E66.9	Obesity, unspecified
Z00.00	Encounter for general adult medical examination without abnormal findings
Z00.129	Encounter for routine child health examination without abnormal findings
Z00.8	Encounter for other general examination
Z68.52	Body mass index [BMI] pediatric, 5 th percentile to less than 85 th percentile for age
Z68.53	Body mass index [BMI] pediatric, 85 th percentile to less than 95 th percentile for age
Z68.54	Body mass index [BMI] pediatric, 95 th percentile for age to less than 120% of the 95 th percentile for age

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Policy developed	12/17	12/17
Annual review. References reviewed and updated. Specialist review. Changed "Last Review Date" in the header to "Date of Last Review" and "Date" in revision log to "Revision Date."	10/21	10/21
Annual review completed. Changed "Date of Last Review" to "Date of Last Revision" in the header. Background updated and minor rewording with no clinical significance. References reviewed and updated.	09/22	09/22
Annual review. Edits to title in header. References reviewed and updated. Reviewed by external specialist.	09/23	09/23
Annual review. Added "routine" verbiage to Criteria I. and to Criteria II. for clarification on testing. Background updated with no impact on criteria. References reviewed and updated.	09/24	09/24
Annual review. Background updated with no impact on criteria. Coding and descriptions reviewed. References reviewed and updated. Reviewed by external specialist.	09/25	09/25

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Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

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The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

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Note: For Medicaid members/enrollees, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members/enrollees, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at <http://www.cms.gov> for additional information.

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