

## Clinical Policy: Vitamin D Testing

Reference Number: WA.CP.MP.527

Last Review Date: 9/25

Effective Date: 11/01/25

[Coding Implications](#)

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

### Description

Vitamin D is metabolized in the liver to 25-hydroxyvitamin D [25(OH)D], (also known as calcidiol, CPT 82306), and then in the kidney to 1,25-dihydroxyvitamin D [1,25(OH)2D], (also known as calcitriol, CPT 82652). 25(OH)D is the major circulating form of vitamin D and the best method for determining vitamin D status while 1,25(OH)2D is the active form of vitamin D. This policy addresses when vitamin D assay testing is appropriate and medically necessary.

### Policy/Criteria

- I. It is the policy of Coordinated Care of Washington, Inc., and Coordinated Care Corporation, that vitamin D assay testing may be **medically necessary** when the clinical criteria defined in the Center for Medicare and Medicaid Services (CMS) Local Coverage Determination (LCD)L36692 are met. Specifically, testing may not be used for routine or other screening. Medical necessity is established only for diagnosis codes outlined in CMS Billing and Coding guidelines A57718.
- II. It is the policy of Coordinated Care that when Sensieva™ Droplet 25OH Vitamin D2/D3 Microvolume LC/MS Assay (0038U) is a covered service, medical necessity criteria will be as defined in LCD L34051 for Vitamin D, 25 hydroxy (82306).

### Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2020, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

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

HCPCS Codes	Description
0038U	Vitamin D, 25 hydroxy D2 and D3, by LC-MS/MS, serum microsample, quantitative

Reviews, Revisions, and Approvals	Date	Approval Date
New Policy	03/21	04/21
Clarified medical necessity criteria for 0038U.	05/21	06/21
Annual review. Added reference to coding guidelines. References updated.	04/22	05/22
Annual review. Updated references. Removed references to 0038U; code has been deleted.	10/22	11/22
Returned 0038U to policy. Deleted in error.	11/22	11/22
Annual review. Updated references.	11/23	11/23
Annual review. References verified	10/24	10/24
Annual review. Updated logo and LCD reference numbers. Stated that testing is not covered for routine screening. References update.	8/25	9/25

## References

- Centers for Medicare and Medicaid Services. Local Coverage Determination L36692 – Vitamin D Assay Testing [LCD - Vitamin D Assay Testing \(L36692\)](#) Accessed 8/28/25.
- Centers for Medicare and Medicaid Services. Billing and Coding: Vitamin D Assay Testing. A57718. [Article - Billing and Coding: Vitamin D Assay Testing \(A57718\)](#) Accessed 8/28/25.

## 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.

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.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

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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.

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