

Clinical Policy: 25-hydroxyvitamin D Testing in Children and Adolescents

Reference Number: CP.MP.157

Date of Last Review: 11/21

[Coding Implications](#)

[Revision Log](#)

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

Description

A global consensus statement recommends against universal screening for vitamin D deficiency in healthy children as there is insufficient evidence that the potential benefits of testing outweigh the potential harms.²

Policy/Criteria

- I. It is the policy of health plans affiliated with Centene Corporation[®] that 25-hydroxyvitamin D 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

Measurement of 25-OH-D (25-hydroxyvitamin D) concentration is the appropriate screening test for vitamin D deficiency. The 1,25-OH₂-D test has little to no predictive value related to bone health.⁶ However, there is lack of agreement concerning the best type of assay to conduct when measuring 25-hydroxyvitamin D.⁴ Furthermore, there is substantial controversy concerning cutoff levels to define vitamin D deficiency, as the evidence is inconsistent regarding optimal levels of vitamin D.

Prevalence of vitamin D deficiency in children (defined in the study as levels < 20 ng/mL) is approximately 15%, with estimates ranging from 14% to 37%.^{3,6} Rates of deficiency vary among certain populations, with increased risk among black and Hispanic teenagers, as well as overweight and obese children and adolescents.⁶ Reduced serum vitamin D in overweight and obese children and adolescents reflects sequestration in adipose tissue, but little is known about the significance of low serum vitamin D in this population.⁴

A global consensus of 33 experts, convened at the request of the European Society for Pediatric Endocrinology, reviewed the available literature on prevention and management of nutritional rickets, and determined that routine vitamin D screening is not recommended for healthy children.² They note the frequent coexistence of dietary calcium and vitamin D deficiency, which alters the threshold for development of rickets, and makes a single screening value impractical.² The global consensus panel advocates for identification and screening of groups at high risk for vitamin D deficiency based on clinical factors, as opposed to universal screening as public health policy.

The American Academy of Pediatrics (AAP) – Section on Endocrinology advises against ordering vitamin D concentrations routinely in otherwise healthy children, including children who are overweight or obese.⁵ The AAP's report on optimizing bone health recommends screening for vitamin D deficiency only in children and adolescents with conditions associated with reduced bone mass and/or recurrent low-impact fractures.⁶

CLINICAL POLICY

Hydroxyvitamin D Testing in Children

For healthy children and adolescents who are not ingesting enough foods with vitamin D, the AAP recommends supplementation with vitamin D, as does the global consensus panel convened by the European Society for Pediatric Endocrinology.

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
82306	Vitamin D; 25 hydroxy, includes fraction(s), if performed

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	BMI pediatric, 85 th percentile to less than 95 th percentile for age
Z68.54	BMI pediatric, greater than or equal to 95 th percentile for age

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Policy created	12/17	12/17
References reviewed and updated	12/18	12/18

CLINICAL POLICY

Hydroxyvitamin D Testing in Children

Reviews, Revisions, and Approvals	Revision Date	Approval Date
References reviewed and updated	02/20	02/20
References reviewed and updated. Replaced “member” with “member/enrollee” in all instances.	12/20	01/21
Annual review. References reviewed and updated. Reviewed by specialist. Changed "Last Review Date" in the header to "Date of Last Review" and "Date" in revision log to "Revision Date". Updated background with no impact to criteria.	11/21	11/21

References

1. Munns CF, Shaw N, Kiely M, et al. Global Consensus Recommendations on Prevention and Management of Nutritional Rickets. *J Clin Endocrinol Metab.* 2016;101(2):394-415. doi:10.1210/jc.2015-2175
2. Saintonge S, Bang H, Gerber LM. Implications of a new definition of vitamin D deficiency in a multiracial us adolescent population: the National Health and Nutrition Examination Survey III. *Pediatrics.* 2009;123(3):797-803. doi:10.1542/peds.2008-1195
3. Misra M. Vitamin D insufficiency and deficiency in children and adolescents. UpToDate. www.uptodate.com. Published June 22, 2020. Accessed October 7, 2021
4. Golden NH, Abrams SA; Committee on Nutrition. Optimizing bone health in children and adolescents. *Pediatrics.* 2014;134(4):e1229-e1243. doi:10.1542/peds.2014-2173
5. Turer CB, Lin H, Flores G. Prevalence of vitamin D deficiency among overweight and obese US children. *Pediatrics.* 2013;131(1):e152-e161. doi:10.1542/peds.2012-1711
6. Jin J. Screening for Vitamin D Deficiency in Adults. *JAMA.* 2021;325(14):1480. doi:10.1001/jama.2021.4606

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,

CLINICAL POLICY

Hydroxyvitamin D Testing in Children

contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

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Note: For Medicaid member/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 member/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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Hydroxyvitamin D Testing in Children

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