BlueCross BlueShield of Illinois

If a conflict arises between a Clinical Payment and Coding Policy ("CPCP") and any plan document under which a member is entitled to Covered Services, the plan document will govern. If a conflict arises between a CPCP and any provider contract pursuant to which a provider participates in and/or provides Covered Services to eligible member(s) and/or plans, the provider contract will govern. "Plan documents" include, but are not limited to, Certificates of Health Care Benefits, benefit booklets, Summary Plan Descriptions, and other coverage documents. BCBSIL may use reasonable discretion interpreting and applying this policy to services being delivered in a particular case. BCBSIL has full and final discretionary authority for their interpretation and application to the extent provided under any applicable plan documents.

Providers are responsible for submission of accurate documentation of services performed. Providers are expected to submit claims for services rendered using valid code combinations from Health Insurance Portability and Accountability Act ("HIPAA") approved code sets. Claims should be coded appropriately according to industry standard coding guidelines including, but not limited to: Uniform Billing ("UB") Editor, American Medical Association ("AMA"), Current Procedural Terminology ("CPT®"), CPT® Assistant, Healthcare Common Procedure Coding System ("HCPCS"), ICD-10 CM and PCS, National Drug Codes ("NDC"), Diagnosis Related Group ("DRG") guidelines, Centers for Medicare and Medicaid Services ("CMS") National Correct Coding Initiative ("NCCI") Policy Manual, CCI table edits and other CMS guidelines.

Claims are subject to the code edit protocols for services/procedures billed. Claim submissions are subject to claim review including but not limited to, any terms of benefit coverage, provider contract language, medical policies, clinical payment and coding policies as well as coding software logic. Upon request, the provider is urged to submit any additional documentation.

Testosterone Testing

Policy Number: CPCPLAB009

Version 1.0

Enterprise Medical Policy Committee Approval Date: January 25, 2022

Plan Effective Date: May 1, 2022

Description

BCBSIL has implemented certain lab management reimbursement criteria. Not all requirements apply to each product. Providers are urged to review Plan documents for eligible coverage for services rendered.

Reimbursement Information:

1. Testing for serum total testosterone (See **Note 1**) **may be reimbursable** in symptomatic males being evaluated for androgen deficiency.

2. Repeat testing for serum total testosterone (See **Note 1**) **may be reimbursable** in males with low initial serum testosterone results. Sample collection should occur in early morning, after fasting, and at least one week after the initial test.

3. For males with hypogonadism, gynecomastia, and/or other forms of testicular hypofunction, measurement of serum free testosterone, sex hormone-binding globulin (SHBG), and/or albumin **may be reimbursable** if total testosterone is confirmed as borderline or low.

4. Testing for serum total testosterone (See **Note 1**) **may be reimbursable** in symptomatic males being evaluated for conditions associated with androgen excess.

5. Measurement of serum free testosterone using a medically accepted algorithm based on total serum testosterone, SBHG, and/or albumin or bioavailable testosterone **may be reimbursable** in individuals suspected of having a disorder that is accompanied by increased or decreased SHBG levels (See **Notes 2 and 3**).

6. Testing for serum total testosterone measurements (See **Note 1**) **may be reimbursable** in monitoring treatment response in men taking enzyme inhibitors for prostate cancer.

7. Testing for serum total testosterone (See **Note 1**) **may be reimbursable** in men receiving testosterone replacement therapy every 3-6 months for the first year after initiation of therapy, and annually thereafter.

8. Testing for serum total testosterone (See **Note 1**) **may be reimbursable** in gender-dysphoric/gender-incongruent persons at baseline, during the treatment and for the therapy monitoring.

9. For males with gynecomastia, serum estradiol testing **may be reimbursable ONCE** in a lifetime prior to initiating testosterone therapy.

10. Testing for serum testosterone (See **Note 1**) **may be reimbursable** in symptomatic females being evaluated for conditions associated with androgen excess (e.g., polycystic ovary syndrome and functional hypothalamic amenorrhea). The technology used for testing should be sensitive enough to detect the low concentrations normally found in females.

11. Testing for serum free testosterone and/or bioavailable testosterone as primary testing (i.e., in the absence of prior serum TOTAL testosterone testing) **is not reimbursable**.

12. Testing for serum total testosterone, free testosterone, and/or bioavailable testosterone **is not reimbursable** in asymptomatic individuals or in individuals with non-specific symptoms.

13. Testing for serum testosterone **is not reimbursable** for the identification of androgen deficiency in women.

14. Salivary testing for testosterone **is not reimbursable**.

15. Measurement of serum dihydrotestosterone in individuals **is not reimbursable** except in diagnosing 5-alpha reductase deficiency in individuals with ambiguous genitalia, hypospadias, or microphallus.

NOTE 1: Due to considerable variability in serum total testosterone testing, the Centers for Disease Control and Prevention (CDC) developed a standardization program for total testosterone assays (Hormone Standardization [HoSt]/Testosterone). An assay certified by the CDC's HoSt/Testosterone program is standardized to within ±6.4% of the CDC total testosterone reference standard. It is **STRONGLY RECOMMENDED** that serum total

testosterone testing be performed on an assay that has been certified by the CDC HoSt/Testosterone program (Bhasin et al., 2018). A list of CDC-certified assays is available on the HoSt website (CDC, 2021).

NOTE 2: Conditions associated with decreased SHBG concentrations according to the 2018 Endocrine Society Guidelines (Bhasin et al., 2018):

- Obesity
- Diabetes mellitus
- Use of glucocorticoids, progestins, and androgenic steroids
- Nephrotic syndrome
- Hypothyroidism
- Acromegaly
- Polymorphisms in the SHBG gene

NOTE 3: Conditions associated with increased SHBG concentrations according to the 2018 Endocrine Society Guidelines (Bhasin et al., 2018):

- Aging
- HIV disease
- Cirrhosis and hepatitis
- Hyperthyroidism
- Use of some anticonvulsants
- Use of estrogen
- Polymorphisms in the SHBG gene

Procedure Codes

Codes
82040, 82642, 82670, 82681, 84270, 84402, 84403, 84410

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Policy Update History:

5/1/2022	New policy