

Thyroid Testing

MEDICAL POLICY NUMBER: 206

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INSTRUCTIONS FOR USE: Company Medical Policies serve as guidance for the administration of plan benefits. Medical policies do not constitute medical advice nor a guarantee of coverage. Company Medical Policies are reviewed annually and are based upon published, peer-reviewed scientific evidence and evidence-based clinical practice guidelines that are available as of the last policy update. The Company reserves the right to determine the application of medical policies and make revisions to medical policies at any time. The scope and availability of all plan benefits are determined in accordance with the applicable coverage agreement. Any conflict or variance between the terms of the coverage agreement and Company Medical Policy will be resolved in favor of the coverage agreement. Coverage decisions are made on the basis of individualized determinations of medical necessity and the experimental or investigational character of the treatment in the individual case. In cases where medical necessity is not established by policy for specific treatment modalities, evidence not previously considered regarding the efficacy of the modality that is presented shall be given consideration to determine if the policy represents current standards of care.

SCOPE: Providence Health Plan, Providence Health Assurance and Providence Plan Partners as applicable (referred to individually as “Company” and collectively as “Companies”).

PLAN PRODUCT AND BENEFIT APPLICATION

Commercial

Medicaid/OHP*

Medicare**

*Medicaid/OHP Members

Oregon: Services requested for Oregon Health Plan (OHP) members follow the OHP Prioritized List and Oregon Administrative Rules (OARs) as the primary resource for coverage determinations. Medical policy criteria below may be applied when there are no criteria available in the OARs and the OHP Prioritized List.

**Medicare Members

This *Company* policy may be applied to Medicare Plan members only when directed by a separate *Medicare* policy. Note that investigational services are considered “**not medically necessary**” for Medicare members.

COVERAGE CRITERIA

Diagnostic Testing Based on Symptoms

Suspected hypothyroidism

- I. Thyroid testing may be considered **medically necessary** for individuals with signs and symptoms consistent with hypothyroidism (see [Policy Guidelines](#)) in the following scenarios:
 - A. Thyroid stimulating hormone (TSH) testing to confirm or rule out primary hypothyroidism; or
 - B. Free T4 (fT4) testing as a follow up to abnormal TSH (reflex testing is permissible);
 - C. TSH and fT4 testing for suspected secondary hypothyroidism
- II. Thyroid testing for suspected hypothyroidism is considered **not medically necessary** when TSH and fT4 are ordered together as first line testing.

Suspected hyperthyroidism

- III. Thyroid testing may be considered **medically necessary** for individuals with signs and symptoms consistent with hyperthyroidism (see [Policy Guidelines](#)) in the following scenarios:
 - A. TSH testing to confirm or rule out overt hyperthyroidism.
 - B. fT4 testing as follow-up to abnormal TSH.
 - C. Total T3 (TT3) testing to confirm diagnosis.

- D. fT4 testing to distinguish overt vs. subclinical hyperthyroidism.
- IV. Thyroid testing for suspected hyperthyroidism is considered **not medically necessary** when TSH and fT4 are ordered together as first line testing.

Monitoring During Treatment

Hypothyroidism Treatment

- V. Thyroid testing for members being treated for hypothyroidism may be considered **medically necessary** in the following scenarios:
 - A. For primary hypothyroidism, TSH testing every 6 weeks after dosage change, then annually.
 - B. For secondary hypothyroidism, fT4 testing every 6 weeks after dosage change, then annually.

Hyperthyroidism Treatment

- VI. Thyroid testing for members treated for hyperthyroidism may be considered **medically necessary** in the following scenarios:
 - A. TSH and fT4 testing every 8 weeks.
 - B. For members with persistent symptoms of hyperthyroidism despite treatment (such as radio ablation, ongoing methimazole, etc.), monitoring for 3-4 years for fT4 to make medication adjustments.
 - C. Annual monitoring after the first year, even if asymptomatic for risk of relapse or late-onset hypothyroidism.

Drug-Induced Thyroid Dysfunction

- VII. Thyroid testing for asymptomatic individuals on thyroid-interfering drugs may be considered **medically necessary** in any of the following situations:
 - A. TSH testing annually.
 - B. TSH testing when dosage or medication changes.
 - C. TSH testing if symptoms consistent with thyroid dysfunction develop.
 - D. TSH and fT4 for immunotherapy treatment when there is a risk of hypophysitis.

Reproductive Health-Related Testing

- VIII. TSH testing may be considered **medically necessary** for individuals undergoing infertility evaluation with 2 or more pregnancy losses.

- IX. Thyroid testing may be considered **medically necessary** for pregnant and postpartum members in any of the following situations:
- A. TSH and fT4 every 4 weeks if member has symptoms of thyroid dysfunction (see Policy Guidelines for signs and symptoms of [hypothyroidism](#) and [hyperthyroidism](#)).
 - B. TSH and fT4 every 2-4 weeks for pregnant members diagnosed with hyperthyroidism if being treated with medication.
 - C. Total T4 (TT4), antithyroglobulin antibody (Tg-Ab), thyrotropin receptor antibodies (TRAb), and anti-thyroid peroxidase antibody (TPOAb) who have been diagnosed with hyperthyroidism.

Screening in High-Risk or Special Populations

- X. One-Time TSH Screening may be considered **medically necessary** for any of the following situations:
- A. Personal/family history of thyroid dysfunction or autoimmune disease.
 - B. Disease/neoplasm of thyroid or endocrine glands.
 - C. Chronic/acute urticaria.
 - D. Pediatric members with short stature or a clinical finding of failure-to-thrive.
 - E. A diagnosis of behavioral health disorder (e.g., depression, anxiety, bipolar disorder)
 - F. Cognitive impairment evaluation
 - G. Anemia not explained by other common causes
 - H. Hyperlipidemia
 - I. Abnormal uterine bleeding
 - J. Hypertensive kidney disease
- XI. Thyroid testing may be considered **medically necessary** for individuals undergoing immune reconstitution therapy (IRT) using TSH testing every 3 months, with reflex fT4 and TT3 if TSH is abnormal for any of the following situations:
- A. Individuals with active relapsing remitting multiple sclerosis (MS) undergoing therapy with alemtuzumab (Lemtrada).
 - B. Individuals with HIV undergoing highly active antiretroviral therapy (HAART).
 - C. Individuals following allogeneic bone marrow transplantation (BMT) or hematopoietic stem cell transplantation (HSCT).
- XII. Thyroid testing with TSH may be considered **medically necessary** for members taking oral amiodarone for arrhythmia at baseline, 3-6 month follow up, and every 6 months after that.
- XIII. TSH and fT4 monitoring may be considered **medically necessary** for hypothalamic-pituitary disease in either of the following situations:
- A. Biannually for members under 18 years of age.

B. Annually for members 18 years of age or older.

XIV. Annual TSH and fT4 testing may be considered **medically necessary** for members diagnosed with primary mitochondrial disease.

Antibody and Cancer-Related Testing

XV. Thyroid Antibody testing (TPOAb, Tg-Ab, TRAb) may be considered **medically necessary** for Graves' Disease or thyroiditis.

XVI. Testing serum thyroglobulin and/or Tg-Ab may be considered **medically necessary** for tumor recurrence detection, post-surgical evaluation, surveillance, and maintenance for differentiated thyroid carcinoma.

Non-Covered Thyroid Testing

XVII. Thyroid testing is considered **not medically necessary** when criteria I-XV above are not met, including but not limited to the following situations:

- A. Testing for thyroid dysfunction as part of normal routine screening during a general exam without abnormal findings
- B. Testing of reverse T3, T3 uptake in all situations
- C. Testing of TT3 and/or fT3 in the assessment of hypothyroidism
- D. Testing of total or fT3 level when assessing levothyroxine (T4) dose in hypothyroid patients
- E. Testing for thyrotropin-releasing hormone (TRH) or thyroxine-binding globulin (TBG) for the evaluation of the cause of hyperthyroidism or hypothyroidism
- F. Diabetes, other than Type I
- G. Essential hypertension
- H. Routine anemia
- I. Cancer, non-thyroid
- J. Routine pregnancy and fertility testing outside of criteria VIII and IX
- K. Vitamin deficiency
- L. Age-based testing in the absence of symptoms

Link to [Evidence Summary](#)

POLICY CROSS REFERENCES

None

The full Company portfolio of current Medical Policies is available online and can be [accessed here](#).

POLICY GUIDELINES

DOCUMENTATION REQUIREMENTS

In order to determine the medical necessity of the request, the following documentation must be provided at the time of the request. Medical records to include documentation of all of the following:

- All medical records and chart notes pertinent to the request. This includes:
 - History
 - Physical examination
 - Treatment plan

DEFINITIONS

Signs and symptoms of hypothyroidism:

Fatigue	Increased sensitivity to cold
Constipation	Dry skin
Unexplained weight gain	Puffy face
Hoarseness	Muscle weakness
Elevated blood cholesterol level	Muscle aches, tenderness, and stiffness
Pain, stiffness or swelling in your joints	Heavier than normal or irregular menstrual periods
Thinning hair	Slowed heart rate
Depression	Impaired memory

Signs and symptoms of hyperthyroidism:

Sudden weight loss, even when your appetite and the amount and type of food you eat remain the same or even increase	Rapid heartbeat (tachycardia)— commonly more than 100 beats a minute — irregular heartbeat (arrhythmia) or pounding of your heart (palpitations)
Increased appetite	Nervousness, anxiety, and irritability
Tremor — usually a fine trembling in hands and fingers	Sweating
Changes in menstrual patterns	Increased sensitivity to heat
Changes in bowel patterns, especially more frequent bowel movements	An enlarged thyroid gland (goiter), which may appear as a swelling at the base of neck
Difficulty sleeping	Fatigue, muscle weakness
Fine, brittle hair	Skin thinning

BACKGROUND

Thyroid function studies are used to delineate the presence or absence of hormonal abnormalities of the thyroid and pituitary glands. These abnormalities may be either primary or secondary and often but not always accompany clinically defined signs and symptoms indicative of thyroid dysfunction.

Laboratory evaluation of thyroid function has become more scientifically defined. Tests can be done with increased specificity, thereby reducing the number of tests needed to diagnose and follow treatment of most thyroid disease. Measurements of serum sensitive thyroid-stimulating hormone (TSH) levels, complemented by determination of thyroid hormone levels [free thyroxine (fT-4) or total thyroxine (T4) with Triiodothyronine (T3) uptake] are used for diagnosis and follow-up of patients with thyroid disorders.

Additional tests may be necessary to evaluate certain complex diagnostic problems or on hospitalized patients, where many circumstances can skew tests results. When a test for total thyroxine (total T4 or T4 radioimmunoassay) or T3 uptake is performed, calculation of the free thyroxine index (FTI) is useful to correct for abnormal results for either total T4 or T3 uptake due to protein binding effects.

REGULATORY STATUS

U.S. FOOD AND DRUG ADMINISTRATION (FDA)

Approval or clearance by the Food and Drug Administration (FDA) does not in itself establish medical necessity or serve as a basis for coverage. Therefore, this section is provided for informational purposes only.

CLINICAL EVIDENCE AND LITERATURE REVIEW

CLINICAL PRACTICE GUIDELINES

American Thyroid Association

The 2017 Guidelines of the American Thyroid Association for the Diagnosis and Management of Thyroid Disease During pregnancy and the Postpartum¹ recommend the following:

“Should women be universally tested for thyroid function before or during pregnancy?”

- There is insufficient evidence to recommend for or against universal screening for abnormal TSH concentrations in early pregnancy.
No recommendation, insufficient evidence.
- There is insufficient evidence to recommend for or against universal screening for abnormal TSH concentrations preconception, with the exception of women planning assisted reproduction or those known to have TPOAb positivity.
No recommendation, insufficient evidence.
- Universal screening to detect low FT4 concentrations in pregnant women is not recommended.
Weak recommendation, moderate-quality evidence.
- All pregnant women should be verbally screened at the initial prenatal visit for any history of thyroid dysfunction, and prior or current use of either thyroid hormone (LT4) or antithyroid medications (MMI, CM, or PTU).
Strong recommendation, high-quality evidence.

- All patients seeking pregnancy, or newly pregnant, should undergo clinical evaluation. If any of the following risk factors are identified, testing for serum TSH is recommended:
 - A history of hypothyroidism/hyperthyroidism or current symptoms/signs of thyroid dysfunction
 - Known thyroid antibody positivity or presence of a goiter
 - History of head or neck radiation or prior thyroid surgery
 - Age >30 years
 - Type 1 diabetes or other autoimmune disorders
 - History of pregnancy loss, preterm delivery, or infertility
 - Multiple prior pregnancies (≥2)
 - Family history of autoimmune thyroid disease or thyroid dysfunction
 - Morbid obesity (BMI ≥40 kg/m²)
 - Use of amiodarone or lithium, or recent administration of iodinated radiologic contrast
 - Residing in an area of known moderate to severe iodine insufficiency

Strong recommendation, moderate-quality evidence.”

US Preventive Services Task Force

In 2015, USPSTF published guidelines on Thyroid Dysfunction Screening. They recommend against screening nonpregnant, asymptomatic adults, stating: “The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for thyroid dysfunction in nonpregnant, asymptomatic adults.”²

EVIDENCE SUMMARY

National clinical practice guidelines support thyroid testing as a tool for diagnosis and monitoring of certain symptoms, indications, and situations. Certain thyroid tests are more appropriate for certain situations, which are detailed in guidelines and supported by evidence. There is not enough evidence in peer reviewed literature or support from clinical guidelines to recommend thyroid testing as a screening tool in the general population, and is not considered medically necessary.

HEALTH EQUITY CONSIDERATIONS

The Centers for Disease Control and Prevention (CDC) defines health equity as the state in which everyone has a fair and just opportunity to attain their highest level of health. Achieving health equity requires addressing health disparities and social determinants of health. A health disparity is the occurrence of diseases at greater levels among certain population groups more than among others. Health disparities are linked to social determinants of health which are non-medical factors that influence health outcomes such as the conditions in which people are born, grow, work, live, age, and the wider set of forces and systems shaping the conditions of daily life. Social determinants of health include unequal access to health care, lack of education, poverty, stigma, and racism.

The U.S. Department of Health and Human Services Office of Minority Health calls out unique areas where health disparities are noted based on race and ethnicity. Providence Health Plan (PHP) regularly reviews these areas of opportunity to see if any changes can be made to our medical or pharmacy policies to support our members obtaining their highest level of health. Upon review, PHP creates a Coverage Recommendation (CORE) form detailing which groups are impacted by the disparity, the research surrounding the disparity, and recommendations from professional organizations. PHP Health Equity COREs are updated regularly and can be found online [here](#).

BILLING GUIDELINES AND CODING

See Appendices I-IV below for medically necessary diagnosis codes for thyroid testing. Additional ICD codes may apply.

See Appendix II for diagnosis codes that may be billed *once per lifetime*. Additional ICD codes may apply.

CODES*		
CPT	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
	86376	Microsomal antibodies (eg, thyroid or liver-kidney), each
	86800	Thyroglobulin antibody

*Coding Notes:

- The above code list is provided as a courtesy and may not be all-inclusive. Inclusion or omission of a code from this policy neither implies nor guarantees reimbursement or coverage. Some codes may not require routine review for medical necessity, but they are subject to provider contracts, as well as member benefits, eligibility and potential utilization audit.
- All unlisted codes are reviewed for medical necessity, correct coding, and pricing at the claim level. If an unlisted code is submitted for non-covered services addressed in this policy then it will be **denied as not covered**. If an unlisted code is submitted for potentially covered services addressed in this policy, to avoid post-service denial, **prior authorization is recommended**.
- **See the non-covered and prior authorization lists on the Company [Medical Policy](#), [Reimbursement Policy](#), [Pharmacy Policy and Provider Information website](#) for additional information.**
- HCPCS/CPT code(s) may be subject to National Correct Coding Initiative (NCCI) procedure-to-procedure (PTP) bundling edits and daily maximum edits known as “medically unlikely edits” (MUEs) published by the Centers for Medicare and Medicaid Services (CMS). This policy does not take precedence over NCCI edits or MUEs. Please refer to the CMS website for coding guidelines and applicable code combinations.

REFERENCES

1. Alexander EK, Pearce EN, Brent GA, et al. 2017 Guidelines of the American Thyroid Association for the Diagnosis and Management of Thyroid Disease During Pregnancy and the Postpartum. *Thyroid*®. 2017;27(3):315-389.

2. LeFevre ML. Screening for thyroid dysfunction: U.S. Preventive Services Task Force recommendation statement. *Ann Intern Med.* 2015;162(9):641-650.

POLICY REVISION HISTORY

DATE	REVISION SUMMARY
2/2023	Converted to new policy template.
5/2023	Annual review, updating list of diagnosis codes that may be medically necessary when billed with the CPT codes on the policy, based on NCD Coding Policy Manual.
6/2024	Annual review, updating list of diagnosis codes that may be medically necessary when billed with the CPT codes on the policy, based on NCD Coding Policy Manual.
6/2025	Annual review, updating list of diagnosis codes that may be medically necessary when billed with the CPT codes on the policy, based on NCD Coding Policy Manual.
2/2026	Interim update. Multiple criteria changes. Added clinical guideline section. Four codes added to policy. Code configuration updated.
5/2026	Annual review. No changes to codes or criteria.

APPENDICES

APPENDIX I

Diagnosis codes for medically necessary indications for CPT codes **84436, 84439, 84443, and 84479** include but are not limited to any of the ICD-10 codes listed below. Additional ICD codes may apply.

C73	E1010	E2740	G4700	I4891	M320	Q382	R4182
D34	E1021	E2749	G4701	I498	M3214	Q892	R419
D352	E1022	E28310	G4709	I499	M3219	R000	R450
D440	E1029	E28319	G4730	I5020	M328	R001	R451
D497	E10319	E2839	G4739	I5021	M329	R002	R454
D8989	E103211	E3121	G4762	I5022	M3310	R0600	R4582
E002	E103213	E3122	G478	I5023	M3320	R0609	R4586
E010	E103219	E319	G479	I5030	M341	R0683	R4589
E018	E103293	E43	G5601	I5031	M3481	R0689	R471
E02	E103299	E440	G5602	I5032	M349	R070	R4781
E030	E103393	E441	G5603	I5033	M3500	R0989	R4789
E031	E103399	E46	G5693	I5040	M3501	R1310	R479
E032	E103513	E530	G5793	I5041	M351	R1312	R490
E033	E103553	E7841	G609	I5042	M3581	R1313	R509
E034	E103593	E8351	G6182	I5043	M3589	R1314	R52
E035	E103599	E8352	G9331	I50812	M359	R1319	R530
E038	E1039	E8359	G9332	I50813	M609	R188	R531
E039	E1040	E870	G9339	I509	M6250	R194	R532
E040	E1042	E871	H02535	I517	M62559	R197	R5381

E041	E1049	E890	H02539	J9601	M6281	R198	R5382
E042	E1051	E892	H02842	K5289	M7910	R200	R5383
E049	E1059	E893	H0520	K581	M7918	R202	R600
E0500	E10649	F05	H05229	K582	M797	R208	R601
E0501	E1065	F061	H05243	K588	M810	R209	R609
E0510	E1069	F0670	H4912	K5900	M816	R234	R61
E0520	E108	F070	H4922	K5901	M818	R238	R630
E0540	E109	F22	H532	K5904	M869	R239	R632
E0580	E200	F23	I160	K5909	N910	R251	R634
E0581	E201	F3010	I161	L299	N911	R252	R635
E0590	E2089	F308	I3139	L603	N912	R253	R6881
E0591	E209	F309	I319	L604	N913	R258	R6883
E060	E213	F3481	I4710	L608	N914	R259	R9089
E061	E221	F349	I4711	L638	N915	R270	R9389
E063	E229	F39	I4719	L639	N944	R278	R946
E064	E230	F5082	I479	L648	N945	R279	U071
E065	E236	F633	I480	L649	N946	R400	U099
E069	E259	G250	I4811	L650	O1495	R4020	Z1329
E071	E271	G252	I4819	L658	O368390	R404	Z85850
E0789	E272	G3109	I4820	L659	O368399	R410	
E079	E273	G3184	I4821	L80	O905	R412	

APPENDIX II

Diagnosis codes for indications that may be billed *once per lifetime* for CPT codes **84436, 84439, 84443, and 84479** include but are not limited to the ICD-10 codes listed below. Additional ICD codes may apply.

E291	F3110	F3160	F3178	F325	F3340	F419	I1310
E7800	F3111	F3162	F3181	F3281	F3341	F530	N920
E7801	F3112	F3164	F3189	F3289	F3342	G300	N925
E782	F3113	F3170	F319	F329	F338	G301	N926
E7849	F312	F3172	F320	F32A	F339	G308	R413
E785	F3131	F3174	F321	F330	F410	G309	
F0390	F3132	F3175	F322	F331	F411	I120	
F064	F314	F3176	F323	F332	F413	I129	
F310	F315	F3177	F324	F333	F418	I130	

APPENDIX III

Diagnosis codes for medically necessary indications for CPT code **84480** include but are not limited to the ICD-10 codes listed below. Additional ICD codes may apply.

B20	C859	C9021	C951	D472	D611	E058	G35B0
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C470	C8590	C9022	C9510	D472	D612	E059	G35B1
C499	C8591	C9030	C9511	D477	D613	E71520	G35B2
C820	C8592	C910	D46	D561	D618	E71521	G35C
C830	C8593	C911	D460	D562	D6181	E71522	G35C0
C831	C8594	C920	D461	D563	D6182	E71528	G35C1
C841	C8595	C921	D462	D565	D6189	E71529	G35C2
C850	C900	C924	D463	D573	D619	E854	G35D
C851	C9000	C925	D464	D574	D72822	E8581	G909
			D465	D582	D80-D84	E8589	O98711-73
C852	C9001	C926					Z856
C853	C9002	C92A	D466	D60xx	E050	E8809	
C854	C9010	C931	D467	D61	E051	G35	
C855	C9011	C940	D468	D610	E052	G35A	
C858	C9020	C950	D469	D610	E053	G35B	

APPENDIX IV

Diagnosis codes for medically necessary indications for CPT codes **86376** and **86800** include but are not limited to the ICD-10 codes listed below. Additional ICD codes may apply.

O368390	O905	E0501	E061	E064	E069	C73
O368399	E0500	E060	E063	E065	E062	