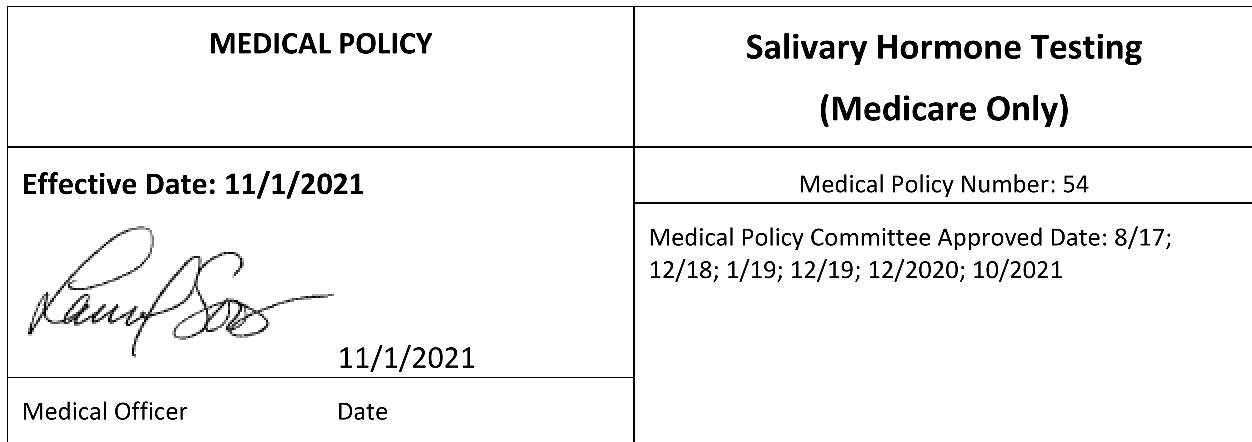

MEDICAL POLICY	Salivary Hormone Testing (Medicare Only)
Effective Date: 11/1/2021	Medical Policy Number: 54
11/1/2021	Medical Policy Committee Approved Date: 8/17; 12/18; 1/19; 12/19; 12/2020; 10/2021
Medical Officer Date	

See Policy CPT/HCPCS CODE section below for any prior authorization requirements

SCOPE:

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

APPLIES TO:

Medicare Only

BENEFIT APPLICATION

MEDICARE POLICY CRITERIA

The following Centers for Medicare & Medicaid Service (CMS) guidelines should be utilized for medical necessity coverage determinations. Click the link provided in the table below to access applicable medical necessity criteria. All listed guidelines apply.

Service	Medicare Guidelines
Salivary Hormone Testing	Local Coverage Determination (LCD): Measurement of Salivary Hormones (L36857)

BILLING GUIDELINES

See the associated local coverage article (LCA) for related billing and coding guidance:

- LCA: Billing and Coding: Measurement of Salivary Hormones (A57613)

CPT/HCPCS CODES

Medicare Only	
No Prior Authorization Required **Note: The following codes are considered medically necessary and covered when used for salivary hormone testing to diagnose Cushing's disease.**	
82530	Cortisol; free
82533	Cortisol; total
Not Covered	
S3650	Saliva test, hormone level; during menopause
S3652	Saliva test, hormone level; to assess preterm labor risk
No Prior Authorization Required **Note: The following codes are considered investigational and not covered when used for salivary hormone testing.**	
82626	Dehydroepiandrosterone (DHEA)
82627	Dehydroepiandrosterone-sulfate (DHEA-S)
82670	Estradiol
82671	Estrogens; fractionated
82672	Estrogens; total
82677	Estriol
82679	Estrone
82681	Estradiol; free, direct measurement (eg, equilibrium dialysis)
83516	Immunoassay for analyte other than infectious agent antibody or infectious agent antigen; qualitative or semiquantitative, multiple step method
83520	Immunoassay for analyte other than infectious agent antibody or infectious agent antigen; quantitative, not otherwise specified
84144	Progesterone
84402	Testosterone; free
84403	Testosterone; total
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)
86316	Immunoassay for tumor antigen, other antigen, quantitative (eg, CA 50, 72-4, 549), each
88341	Immunohistochemistry or immunocytochemistry, per specimen; each additional single antibody stain procedure (List separately in addition to code for primary procedure)
88342	Immunohistochemistry or immunocytochemistry, per specimen; initial single antibody stain procedure

88344	Immunohistochemistry or immunocytochemistry, per specimen; each multiplex antibody stain procedure
Unlisted Codes All unlisted codes will be reviewed for medical necessity, correct coding, and pricing at the claim level. If an unlisted code is billed related to services addressed in this policy then it may be denied as **Not Covered.**	
84999	Unlisted chemistry procedure

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 Companies reserve the right to determine the application of Medical Policies and make revisions to Medical Policies at any time. Providers will be given at least 60-days notice of policy changes that are restrictive in nature.

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.

REGULATORY STATUS

Mental Health Parity Statement

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.

REFERENCES

None