Testosterone Policy, Professional and Facility

IMPORTANT NOTE ABOUT THIS REIMBURSEMENT POLICY

You are responsible for submission of accurate claims. This reimbursement policy is intended to ensure that you are reimbursed based on the code or codes that correctly describe the health care services provided. UnitedHealthcare Community Plan reimbursement policies uses Current Procedural Terminology (CPT®), Centers for Medicare and Medicaid Services (CMS) or other coding guidelines. References to CPT or other sources are for definitional purposes only and do not imply any right to reimbursement.*

This reimbursement policy applies to all health care services billed on CMS 1500 forms and, when specified, to those billed on UB04 forms. Coding methodology, industry-standard reimbursement logic, regulatory requirements, benefits design, and other factors are considered in developing reimbursement policy.

This information is intended to serve only as a general reference resource regarding UnitedHealthcare Community Plan's reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly, UnitedHealthcare Community Plan may use reasonable discretion in interpreting and applying this policy to health care services provided in a particular case. Further, the policy does not address all issues related to reimbursement for health care services provided to UnitedHealthcare Community Plan enrollees.

Other factors affecting reimbursement may supplement, modify or, in some cases, supersede this policy. These factors include, but are not limited to: federal &/or state regulatory requirements, the physician or other provider contracts, the enrollee's benefit coverage documents, and/or other reimbursement, medical or drug policies.

Finally, this policy may not be implemented exactly the same way on the different electronic claims processing systems used by UnitedHealthcare Community Plan due to programming or other constraints; however, UnitedHealthcare Community Plan strives to minimize these variations.

UnitedHealthcare Community Plan may modify this reimbursement policy at any time by publishing a new version of the policy on this Website. However, the information presented in this policy is accurate and current as of the date of publication.

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Application

This reimbursement policy applies to UnitedHealthcare Community Plan Medicaid products.

This reimbursement policy applies to services reported using the UB-04 Form, the 1500 Health Insurance Claim Form (a/k/a CMS-1500) or their electronic equivalents or their successor forms. This policy applies to all products, all network and non-network providers, including, but not limited to, non-network authorized and percent of charge contract hospitals, ambulatory surgical centers, physicians, and other qualified health care professionals.

Policy

Overview

This policy describes the reimbursement methodology for testosterone testing when billed with designated conditions. Certain services are also subject to specific frequency limitations.

Reimbursement Guidelines

NOTE: Procedure codes appearing in policy documents are included only as a general reference tool for each policy. They may not be all-inclusive.

Serum Total Testosterone

UnitedHealthcare will consider reimbursement for the following procedure code(s) for serum total testosterone when billed for any of the conditions listed below:

Procedure Code(s)

84403					

Condition(s)

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a. The monitoring of treatment response in men taking enzyme inhibitors for prostate cancer.
b. For gender-dysphoric/gender-incongruent persons (baseline, during treatment, and for therapy monitoring).
c. For symptomatic individuals being evaluated for conditions associated with androgen excess (e.g., polycystic ovary syndrome and functional hypothalamic amenorrhea).

Serum Total Testosterone Limitation

UnitedHealthcare will consider reimbursement, subject to the frequency limitations described below, for the following serum total testosterone procedure code(s):

Procedure Code(s)

84403					

Condition(s)

a. For the evaluation of symptoms of androgen deficiency or androgen excess in males.
    i. Initial screening, one measurement per day, not to exceed two calendar days.
    ii. If initial screening results are normal and symptoms persist, follow-up testing may be considered no sooner than 60 days after the initial screening.
b. For individuals receiving testosterone replacement therapy.
    i. No more than once every 60 days.

Testicular Hypofunction Limitation

UnitedHealthcare will consider reimbursement of the following procedure codes for serum free testosterone, sex hormone–binding globulin (SHBG), and/or albumin, once annually, for males who have hypogonadism, gynecomastia, and/or other forms of testicular hypofunction:

Procedure Code(s)

82040	84270	84402			

Bioavailable Testosterone

UnitedHealthcare will consider reimbursement of the following procedure codes used to calculate bioavailable testosterone for the condition listed below, based on free and total serum testosterone, sex hormone–binding globulin (SHBG), and/or albumin.

Procedure Code(s)

84403	84410					

Condition(s)

a. For individuals suspected of having a disorder associated with increased or decreased SHBG levels.

Serum Estradiol Limitation

UnitedHealthcare will consider reimbursement of the following procedure codes for serum estradiol once per lifetime prior to initiating testosterone therapy in males with any of the condition(s) listed below:

Procedure Code(s)

82670	82681				

Condition(s)

a. Gynecomastia

Serum Dihydrotestosterone

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UnitedHealthcare will consider reimbursement of the following procedure code(s) for serum dihydrotestosterone, for the determination of 5-alpha reductase deficiency, in individuals with any of the condition(s) listed below:

Procedure Code(s)

82642					

Condition(s)

a. Ambiguous genitalia
b. Hypospadias
c. Microphallus

Non-Reimbursable

UnitedHealthcare will not consider reimbursement of the following procedure codes for serum total testosterone, free testosterone, and/or bioavailable testosterone for asymptomatic individuals or for individuals with non-specific symptoms.

Procedure Code(s)

84402	84403	84410			

State Exceptions	
Arizona	Arizona is exempt from this policy.
Florida	Florida is exempt from this policy.
Hawaii	Hawaii is exempt from this policy.
Idaho	Idaho is exempt from this policy.
Indiana	Indiana is exempt from this policy.
Kansas	Kansas is exempt from this policy.
Kentucky	Kentucky is exempt from this policy.
Maryland	Maryland is exempt from this policy.
Massachusetts	Massachusetts is exempt from this policy.
Missouri	Missouri is exempt from this policy.
Nebraska	Nebraska is exempt from this policy.
New Jersey	New Jersey is exempt from this policy.
North Carolina	North Carolina is exempt from this policy.
Ohio	Ohio is exempt from this policy.
Rhode Island	Rhode Island is exempt from this policy.
Tennessee	Tennessee is exempt from this policy.
Texas	Texas is exempt from this policy.
Virginia	Virginia is exempt from this policy.
Washington DC	Washington DC is exempt from this policy.
Washington	Washington is exempt from this policy.

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Wisconsin	Wisconsin is exempt from this policy.

Questions and Answers	
1	**Q:** Are the frequency limitations based on individual provider per member? **A:** Frequency limitations are applicable regardless of billing and/or rendering provider (any individual provider OR any facility) for each individual member for the same date of service.
2	**Q:** Does the frequency limitation of Serum Total Testosterone apply to each procedure code individually or do all count toward the same limit? **A:** The frequency limitation applies to each procedure code individually.
3	**Q:** Does the frequency limitation of Testicular Hypofunction apply to each procedure code individually or do all count toward the same limit? **A:** The frequency limitation applies to each procedure code individually.
4	**Q:** Does the frequency limitation of Serum Estradiol apply to each procedure code individually or do all count toward the same limit? **A:** The frequency limitation applies to each procedure code individually.

Resources

Individual state Medicaid regulations, manuals & fee schedules

American Medical Association, *Current Procedural Terminology (CPT®)* and associated publications and services

Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services

Centers for Medicare and Medicaid Services, Physician Fee Schedule (PFS) Relative Value Files

History

10/1/2026	Policy implemented by UnitedHealthcare Community Plan.
7/1/2026	Policy published
4/28/2026	Policy approved by the Reimbursement Policy Oversight Committee

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