Defining Testosterone Deficiency: A Comparison of Professional Guidance and Insurance Coverage Criteria

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BACKGROUND

Professional organizations provide guidance on the diagnosis and management of testosterone deficiency, while insurers establish their own criteria for treatment coverage. Although these policies are informed by clinical evidence and professional recommendations, differences in eligibility requirements may exist. Understanding where clinical guidance and coverage policies align or differ provides a foundation for evaluating how these requirements influence treatment decisions and access to care.

OBJECTIVES

To compare professional recommendations for testosterone deficiency with selected U.S. insurance coverage policies, identify areas of agreement and variation, and assess how diagnostic and treatment eligibility criteria are represented across these sources.

METHODS

Five sets of professional recommendations were reviewed for total testosterone thresholds, symptom requirements, and diagnostic testing criteria. Publicly available coverage policies from five commercial insurers and one Medicare local coverage determination were examined for biochemical thresholds, qualifying diagnoses, and treatment-specific requirements. Findings were compared descriptively, recognizing differences in policy scope and covered formulations.

RESULTS

Professional guidance referenced total testosterone values of approximately **264–350 ng/dL**, representing reference limits, diagnostic thresholds, and treatment recommendations rather than equivalent cutoffs (Figure 1). Reviewed payer policies generally incorporated core clinical criteria, including repeated testosterone measurements and symptom assessment. Additional differences were identified in age-specific thresholds, qualifying diagnoses, and formulation-specific coverage requirements (Figure 2).

FIGURE 1: PROFESSIONAL SOCIETY RECOMMENDATIONS

Organization	TT value and purpose	Clinical interpretation
American Urological Association (AUA)	<300 ng/dL Diagnostic support cutoff	Compatible symptoms/signs and two separate early-morning TT measurements.
Endocrine Society (ES)	264 ng/dL Harmonized lower reference limit	Applies to standardized assays; symptoms/signs and consistently low TT required. Not a universal treatment cutoff.
European Association of Urology (EAU)	~350 ng/dL (12 nmol/L) LOH diagnostic threshold	Symptoms/signs and repeated morning TT measurements; sexual symptoms most specific.
International Society for Sexual Medicine (ISSM) / International Consultation for Sexual Medicine (ICSM)	<350 ng/dL Treatment recommendation	ICSM 2024 recommendations (published 2025): treatment recommended for symptomatic men below this value.
International Society for the Study of the Aging Male (ISSAM)	~350 ng/dL (12.1 nmol/L) Lower normal limit	2015 recommendations: characteristic symptoms/signs; selected symptomatic men above limit may warrant clinical consideration.

Reviewed payer policies largely reflected core clinical recommendations, with variation in specific treatment eligibility requirements.

FIGURE 2: PAYER COVERAGE CRITERIA

Payer	Low T cutoff	Additional criteria
Cigna	No specific numeric cutoff	Two low morning tests; symptoms required
UnitedHealthcare	<300 ng/dL or below lab range	Two tests; symptoms or qualifying condition
Aetna	No specific numeric cutoff	Two low morning tests; age-related low T excluded
Anthem	≤70 years: <300 ng/dL >70 years: <200 ng/dL	Two morning tests; symptoms required
BCBS Michigan	No specific numeric cutoff	At least two symptoms; preferred injections must be tried or unsuitable
Medicare	No specific numeric cutoff	Two low morning tests; qualifying underlying medical condition required

Medicare findings reflect a local coverage determination (LCD L39086), not a national Medicare policy. No specific numeric cutoff usually defaults to using TT values of laboratory where testing is performed.

ADVOCACY PRIORITIES

1. **Evaluate evidence supporting coverage criteria.** Examine how insurers use professional guidelines and clinical evidence to establish specific eligibility requirements.
2. **Examine authorization outcomes.** Investigate approval rates, denial reasons, appeals, and treatment delays to determine whether differences in coverage criteria affect patient access.
3. **Expand policy comparisons across urology.** Identify areas of agreement and variation between professional guidance and coverage requirements for other urologic treatments.

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