Cardiovascular Screening Blood Tests

Overview

Every year, thousands of Americans die of heart disease and stroke. Millions more currently live with one or more types of cardiovascular disease, including, coronary heart disease, stroke, high blood pressure, congestive heart failure, congenital cardiovascular defects, and hardening of the arteries. Heart disease and stroke are also among the leading causes of disability for both men and women in the United States.

Recognizing the need for early detection to effectively combat the risks of cardiovascular disease, Congress expanded preventive services to include the coverage of cardiovascular screening blood tests. Section 612 of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 established Medicare coverage of cardiovascular screening blood tests.

On January 1, 2005, Medicare began providing coverage of cardiovascular screening blood tests for the early detection of cardiovascular disease or abnormalities associated with an elevated risk of heart disease and stroke. These tests can help determine a beneficiary's cholesterol and other blood lipid levels such as triglycerides. CMS recommends that all eligible beneficiaries take advantage of this coverage, which can determine whether beneficiaries are at high risk for cardiovascular disease.

Stand Alone Benefit

It is important to emphasize that the cardiovascular screening benefit covered by Medicare is a stand alone billable service separate from the Initial Preventive Physical Examination (IPPE) and does not have to be obtained within a certain time frame following a beneficiary's Medicare Part B enrollment.

The cardiovascular screening blood tests covered by Medicare include the following:

- Total Cholesterol Test
- Cholesterol Test for High Density Lipoproteins
- Triglycerides Test

NOTE: The beneficiary must fast for 12 hours prior to testing. Other cardiovascular screening blood tests remain non-covered.

Risk Factors

The coverage of cardiovascular screening blood tests presents an opportunity for health care professionals to help Medicare beneficiaries learn if they have an increased risk of developing heart disease and how they can control their cholesterol levels through diet, physical activity, or if necessary with medication. While anyone can develop cardiovascular disease, some factors that may put individuals at a higher risk include the following:

- Diabetes
- Family history of cardiovascular disease
- High fat diet
- History of previous heart disease
- Hypercholesterolemia (high cholesterol)
- Hypertension
- Lack of exercise

- Obesity
- Smoking
- Stress

Coverage Information

Medicare provides coverage of cardiovascular screening blood tests for all asymptomatic beneficiaries every 5 years (i.e., at least 59 months after the last covered screening tests). The physician or qualified non-physician practitioner treating the beneficiary must order the screening blood tests for the purpose of early detection of cardiovascular disease. The beneficiary must have no apparent signs or symptoms of cardiovascular disease.

Medicare provides coverage of cardiovascular screening blood tests as a Part B benefit. The beneficiary will pay nothing for the blood tests (there is no coinsurance or copayment and no deductible for this benefit).

Who Are Qualified Physicians and Non-Physician Practitioners?

Physician

A physician is defined as a doctor of medicine or osteopathy.

Qualified Non-Physician Practitioner

For the purpose of the cardiovascular screening blood test, a qualified non-physician practitioner is a physician assistant, nurse practitioner, or clinical nurse specialist.

NOTE: Laboratories must offer the ability to order a lipid panel without the low density lipoprotein (LDL) measurement. The frequency limit for each test applies regardless of whether tests are provided in a panel or individually.

Documentation

Medical record documentation must show that a physician or qualified non-physician practitioner treating an asymptomatic beneficiary for the purpose of early detection of cardiovascular disease ordered the screening tests. The beneficiary must have the test performed after a 12-hour fast, and the Medicare provider should document the appropriate supporting procedure and diagnosis codes.

Coding and Diagnosis Information

Procedure Codes and Descriptors

Medicare providers must use the following Current Procedural Terminology (CPT) codes listed in Table 1 to report the cardiovascular screening blood tests:

Table 1 – CPT Codes for Cardiovascular Screening Blood Tests

CPT Code	Code Descriptor
80061	Lipid Panel This panel must include the following: Cholesterol, serum, total (82465) Lipoprotein, direct measurement, high density cholesterol (HDL cholesterol) (83718) Triglycerides (84478)

CPT Code	Code Descriptor
82465	Cholesterol, serum or whole blood, total (For high density lipoprotein HDL, use 83718)
83718	Lipoprotein, direct measurement; high density cholesterol (HDL cholesterol)
84478	Triglycerides

NOTE: The tests should be ordered as a lipid panel; however, they may be ordered individually.

Diagnosis Requirements

Medicare providers must report one or more of the following International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) screening ("V") diagnosis code(s) for cardiovascular screening blood tests:

Table 2 – Diagnosis Codes for Cardiovascular Screening Blood Tests

ICD-9-CM Diagnosis Code	Code Descriptor
V81.0	Special screening for ischemic heart disease
V81.1	Special screening for hypertension
V81.2	Special screening for other and unspecified cardiovascular conditions

Billing Requirements

Billing and Coding Requirements When Submitting Claims to Carriers/AB Medicare Administrative Contractors (AB MACs)

When physicians and qualified non-physician practitioners are submitting claims to carriers/AB MACs, they must report the appropriate CPT code, and the appropriate diagnosis code in the HIPAA 837 Professional electronic claim format.

NOTE: In those cases where a supplier qualifies for an exemption to the ASCA requirement, Form CMS-1500 may be used to submit these claims on paper. Form CMS-1500 has been revised to accommodate the reporting of the National Provider Identifier (NPI). All Medicare providers must use Form CMS-1500 (08-05) when submitting paper claims. Additional information on Form CMS-1500 can be found at http://www.cms.hhs.gov/ElectronicBillingEDITrans/16_1500.asp on the CMS website.

Administrative Simplification Compliance Act Claims Requirements

The Administrative Simplification Compliance Act (ASCA) requires that claims be submitted to Medicare electronically to be considered for payment with limited exceptions. Claims are to be submitted electronically using the X12 837-P (professional) or 837-I (institutional) format as appropriate, using the version adopted as a national standard under the Health Insurance Portability and Accountability Act (HIPAA). Additional information on these formats can be found at http://www.cms.hhs.gov/ElectronicBillingEDITrans/08_HealthCareClaims.asp on the CMS website.

Billing and Coding Requirements When Submitting Claims to Fiscal Intermediaries/AB Medicare Administrative Contractors (FIs/AB MACs)

When submitting claims to FIs/AB MACs, the Medicare provider must report the appropriate CPT code, the appropriate revenue code, and the appropriate diagnosis code in the HIPAA 837 Institutional electronic claim format.

NOTE: In those cases where an institution qualifies for an exception to the ASCA requirement, Form CMS-1450 may be used to submit these claims on paper. As of May 23, 2007, all Medicare providers must use Form CMS-1450 (UB-04) when submitting paper claims. Additional information on Form CMS-1450 can be found at http://www.cms.hhs.gov/ElectronicBillingEDITrans/15_1450.asp on the CMS website.

Types of Bills for FIs/AB MACs

The FI/AB MAC will reimburse for the cardiovascular screening blood tests when submitted on the following Type of Bills (TOBs) listed in Table 3:

Table 3 – Facility Types and Types of Bills for Cardiovascular Screening Blood Tests

Facility Type	Type of Bill
Hospital Inpatient Part B including Critical Access Hospital (CAH)	12X
Hospital Outpatient	13X
Hospital Non-patient Laboratory Specimens including CAH	14X
Skilled Nursing Facility (SNF) Inpatient Part B	22X
SNF Outpatient	23X
CAH	85X

The service is covered when it is performed on an inpatient or outpatient basis in a hospital, CAH, or SNF.

Special Billing Note

Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) may only bill for RHC or FQHC services; laboratory services are not within the scope of the RHC or FQHC benefit. However, if the RHC or FQHC is provider-based, and the base provider furnishes the lab test apart from the RHC or FQHC, then the base provider may bill the lab test using the base provider's provider ID number. Payment will be made to the base provider, not the RHC or FQHC. If the facility is freestanding, then the individual practitioner bills the carrier/AB MAC for the lab test using the provider ID number.

Reimbursement Information

General Information

Medicare provides coverage of the cardiovascular screening blood tests as a Medicare Part B benefit. The beneficiary will pay nothing for the blood tests (there is no coinsurance or copayment and no Medicare Part B deductible for this benefit).

Reimbursement of Claims by Carriers/AB Medicare Administrative Contractors (AB MACs)

Medicare provides reimbursement for the cardiovascular screening blood tests under the Medicare Clinical Laboratory Fee Schedule, when the Medicare provider bills the carrier/AB MAC.

> Additional information about the Clinical Laboratory Fee Schedule can be found at http://www.cms.hhs.gov/ClinicalLabFeeSched/01_overview.asp on the CMS website.

Reimbursement of Claims by Fiscal Intermediaries/AB Medicare Administrative Contractors (FIs/AB MACs)

Reimbursement for the cardiovascular screening blood tests depends on the type of facility providing the service. Table 4 lists the type of payment that facilities receive for cardiovascular screening blood tests:

Table 4 – Facility Payment Methodology for Cardiovascular Screening Blood Tests

If the Facility Is a…	Then Payment is Based On…
Critical Access Hospital (CAH)	Reasonable Cost Basis **(Paid at 101% of their reasonable cost)**
Hospital	Clinical Laboratory Fee Schedule
Skilled Nursing Facility (SNF)	Clinical Laboratory Fee Schedule

NOTE: Maryland hospitals will be reimbursed for inpatient or outpatient services according to the Maryland State Cost Containment Plan.

Reasons for Claim Denial

The following are examples of when Medicare may deny coverage of cardiovascular screening blood tests:

- The beneficiary received a covered lipid panel during the past five years.
- The beneficiary received the same individual cardiovascular screening blood test during the past five years.

> **Medicare Contractor Contact Information**
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> To obtain carrier/AB MAC and FI/AB MAC contact information, visit http://www.cms.hhs.gov/MLNProducts/Downloads/CallCenterTollNumDirectory.zip on the CMS website.

- Medicare providers may find specific payment decision information on the remittance advice (RA). The RA will include Claim Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs) that provide additional information on payment adjustments. The most current listing of these codes can be found at http://www.wpc-edi.com/Codes on the Web. Additional information about claims can be obtained from the carrier/AB MAC or FI/AB MAC.

Remittance Advice Information

To obtain more information about the remittance advice (RA), visit http://www.cms.hhs.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf on the CMS website.

Written Advance Beneficiary Notice of Noncoverage (ABN) Requirements

Please refer to the Advance Beneficiary Notice of Noncoverage (ABN) Reference Section G of this publication.

Cardiovascular Screening Blood Tests

Resource Materials

Beneficiary Notices Initiative Website
http://www.cms.hhs.gov/BNI

Carrier/AB MAC and FI/AB MAC Contact Information
http://www.cms.hhs.gov/MLNProducts/Downloads/CallCenterTollNumDirectory.zip

Clinical Laboratory Fee Schedule Information
http://www.cms.hhs.gov/ClinicalLabFeeSched/01_overview.asp

Electronic Claim Submission Information
http://www.cms.hhs.gov/ElectronicBillingEDITrans/08_HealthCareClaims.asp

Final Rule, 42 CFR Parts 409, 410, et al: Revisions to Payment Policies under the Physician Fee Schedule, and Other Part B Payment Policies for CY 2008; Revisions to the Payment Policies of Ambulance Services Under the Ambulance Fee Schedule for CY 2008; and the Amendment of the E-Prescribing Exemption for Computer Generated Facsimile Transmissions
http://www.cms.hhs.gov/PhysicianFeeSched/PFSFRN/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=4&sortOrder=ascending&itemID=CMS1204957&intNumPerPage=10

Form CMS-1450 Information
http://www.cms.hhs.gov/ElectronicBillingEDITrans/15_1450.asp

Form CMS-1500 Information
http://www.cms.hhs.gov/ElectronicBillingEDITrans/16_1500.asp

Heart Disease and Stroke: The Nation's Leading Killers
http://www.cdc.gov/nccdphp/publications/AAG/dhdsp.htm

Medicare Claims Processing Manual – Pub. 100-04, Chapter 18, Section 100
http://www.cms.hhs.gov/manuals/downloads/clm104c18.pdf

Medicare Fee-For-Service Providers Website
This site contains detailed provider-specific information, including information about the Clinical Laboratory Fee Schedule.
http://www.cms.hhs.gov/center/provider.asp

Medicare Learning Network (MLN)
The Medicare Learning Network (MLN) is the brand name for official CMS educational products and information for Medicare fee-for-service providers. For additional information visit the Medicare Learning Network's web page at http://www.cms.hhs.gov/MLNGenInfo on the CMS website.

Medicare Preventive Services General Information
http://www.cms.hhs.gov/PrevntionGenInfo

Beneficiary-related resources can be found in Reference F of this Guide.

MLN Preventive Services Educational Resource Website
http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp

National Correct Coding Initiative Edits Website
http://www.cms.hhs.gov/NationalCorrectCodInitEd

National Provider Identifier Information
http://www.cms.hhs.gov/NationalProvIdentStand

Physician Information Resource for Medicare Website
This site contains physician-specific information, including updates to policies, regulations, coding and coverage information, program integrity information, and other valuable resources.
http://www.cms.hhs.gov/center/physician.asp

Remittance Advice Information
http://www.cms.hhs.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf

U.S. Preventive Services Task Force (USPSTF) Guide to Clinical Preventive Services
This website provides the USPSTF written recommendations.
http://www.ahrq.gov/clinic/cps3dix.htm

Washington Publishing Company (WPC) Code Lists
WPC assists in the maintenance and distribution of HIPAA-related code lists that are external to the X12 family of standards.
http://www.wpc-edi.com/Codes

Beneficiary-related resources can be found in Reference F of this Guide.