Medicare Learning Network
MLN Matters®
CMS
Information for Medicare Fee-For-Service Health Care Professionals

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MMA-Cardiovascular Screening Blood Tests

Note: This article was updated on April 6 2013, to reflect current Web addresses. All other information remains unchanged.

Provider Types Affected

Physicians, providers, and suppliers

Provider Action Needed

The information in this article provides guidance for the new national coverage policy related to cardiovascular screening tests covered, effective for services performed on or after January 1, 2005.

Background

In accordance with Section 612 of the Medicare Modernization Act (MMA), Medicare coverage is provided for cardiovascular screening blood tests (tests for the early detection of cardiovascular disease or abnormalities associated with an elevated risk for that disease) effective for services performed on or after January 1, 2005.

The MMA permits coverage of tests for cholesterol and other lipid or triglycerides levels for this purpose. Therefore, effective January 1, 2005, coverage is provided for the following:

- Total Cholesterol Test;
- Cholesterol Test for High Density Lipoproteins; and
- Triglycerides Test.

Effective, January 1, 2005, Medicare provides coverage for the cardiovascular screening blood test for beneficiaries every five years (i.e., 59 months after the last covered screening tests.) Medicare has determined that it is not necessary to test

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more frequently since lipid and cholesterol levels for people often stay fairly consistent beyond age 65.

Medicare Part B covers cardiovascular screening blood tests when ordered by the physician who is treating the beneficiary for the purpose of early detection of cardiovascular disease in individuals without apparent signs or symptoms.

The implementation of this new benefit permits Medicare beneficiaries who have not been previously diagnosed with cardiovascular disease to receive cardiovascular screening blood tests for risk factors associated with cardiovascular disease. This includes individuals who have no prior knowledge of heart problems but recognize that their behavior or lifestyle may be at risk because of diet or lack of exercise.

Payment is provided under the Medicare Clinical Laboratory Fee Schedule. There is no deductible or copayment for this benefit.

HCPCS/CPT Codes/Diagnosis Codes

The following HCPCS/CPT Codes are to be billed for the Cardiovascular Screening Blood Tests:

- 80061 Lipid Panel
- 82465 Cholesterol, serum, or whole blood, total
- 83718 Lipoprotein, direct measurement; high-density cholesterol
- 84478 Triglycerides

(The tests should be performed as a panel; however, they are also available as individual tests.)

The following diagnosis codes must be submitted on the claim for when billing for cardiovascular screening blood test:

- V 81.0 Special Screening for ischemic heart disease
- V81.1 Special Screening for hypertension
- V81.2 Special Screening for other and unspecified cardiovascular conditions

Medicare will pay for cardiovascular disease screening under the Medicare Clinical Laboratory Fee Schedule. Providers and suppliers that bill for the cardiovascular disease screening benefit must point the screening diagnosis (V81.0, V81.1, V81.2) to the line item service.

Other cardiovascular screening blood tests (for which CMS has not specifically indicated approval for national coverage) continue to be non-covered.

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How Carriers and Intermediaries Will Treat Claims

Medicare carriers and intermediaries will treat claims as follows:

- Carriers/intermediaries will accept claims with HCPCS 80061 (Lipid Panel), 82465 (Cholesterol, serum or whole blood, total), 83718 (Lipoprotein, direct measurement; high density cholesterol, HDL Cholesterol), or 84478 (Triglycerides) when there is a reported diagnosis of V81.0 (Special screening for ischemic heart disease), V81.1 (Special screening for hypertension), or V81.2 (Special screening for other and unspecified cardiovascular conditions).
- Carriers/intermediaries will deny claims with code 80061 when there is already evidence of a paid claim within the prior 60 months that was billed with a diagnosis code of V81.0, V81.1, or V81.2, and with a procedure code of 80061, 82465, 83718, or 84478.
- Carriers/intermediaries will deny claims with procedure codes of 82465, 83718, or 84478 when billed within 60 months of a previous paid claim with a diagnosis code of V81.0, V81.1, 0r V81.2 and a procedure code of 80061.

Additional Information

The Medicare Claims Processing Manual, Chapter 18, Section 100 is new. The new manual instructions are attached to the official instruction (CR3411) released to your carrier/intermediary. You may view that instruction by going to http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R408CP.pdf on the CMS website.

If you have any questions, please contact your intermediary at their toll-free number, which may be found at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html on the CMS website.

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