If a conflict arises between a Clinical Payment and Coding Policy and any plan document under which a member is entitled to Covered Services, the plan document will govern. If a conflict arises between a CPCP and any provider contract pursuant to which a provider participates in and/or provides Covered Services to eligible member(s) and/or plans, the provider contract will govern. "Plan documents" include, but are not limited to, Certificates of Health Care Benefits, benefit booklets, Summary Plan Descriptions, and other coverage documents. Blue Cross and Blue Shield of Texas may use reasonable discretion interpreting and applying this policy to services being delivered in a particular case. BCBSTX has full and final discretionary authority for their interpretation and application to the extent provided under any applicable plan documents.

Providers are responsible for submission of accurate documentation of services performed. Providers are expected to submit claims for services rendered using valid code combinations from Health Insurance Portability and Accountability Act approved code sets. Claims should be coded appropriately according to industry standard coding guidelines including, but not limited to: Uniform Billing Editor, American Medical Association, Current Procedural Terminology, CPT® Assistant, Healthcare Common Procedure Coding System, ICD-10 CM and PCS, National Drug Codes, Diagnosis Related Group guidelines, Centers for Medicare and Medicaid Services National Correct Coding Initiative Policy Manual, CCI table edits and other CMS guidelines.

Claims are subject to the code edit protocols for services/procedures billed. Claim submissions are subject to claim review including but not limited to, any terms of benefit coverage, provider contract language, medical policies, clinical payment and coding policies as well as coding software logic. Upon request, the provider is urged to submit any additional documentation.

Cardiovascular Disease Risk Assessment

Policy Number: CPCPLAB020

Version 1.0

Approval Date: July 25, 2025

Plan Effective Date: November 7, 2025

Description

The Plan has implemented certain lab management reimbursement criteria. Not all requirements apply to each product. Providers are urged to review Plan documents for eligible coverage for services rendered.

Reimbursement Information:

For homocysteine testing for indications other than cardiovascular disease, see CPCPLAB010 Vitamin B12 and Methylmalonic Acid Testing, or CPCPLAB067 Testing of Homocysteine Metabolism-Related Conditions**.**

1. For individuals 18 years of age and older, lipid panel testing (see **NOTE 1**) **may be reimbursable** under **any** of the following conditions:
    a. To screen for cardiovascular disease (CVD) risk;
        i. Every 4 years for individuals ages 18 to 79 years.
        ii. Annually for individuals at increased risk for cardiovascular disease (as defined by 2013 ACC/AHA Pooled Cohort Equations [PCEs] to calculate 10-year risk of CVD events [see **NOTE 2**]).
    b. Annually for individuals at an increased risk of dyslipidemia due to **any** of the following conditions:
        i. Obesity or metabolic syndrome;
        ii. Nephrotic syndrome;
        iii. Hypothyroidism;
        iv. Hyperthyroidism;
        v. Pancreatitis;
        vi. Diabetes;
        vii. Chronic kidney disease;
        viii. Cushing Syndrome;
        ix. Pregnancy;
        x. Cholestatic liver disease;
        xi. Lipid metabolism disorders, such as Gaucher disease in adults.
    c. For individuals who are about to begin or who are currently receiving statin therapy at the following intervals:
        i. To establish baseline levels before initiating statin therapy;
        ii. Every 4 to 12 weeks after initiation or change of therapy;
        iii. Annually when no medication changes have occurred.
    d. Annually for individuals on a long-term drug therapy that requires lipid monitoring (e.g., Accutane, anti-psychotics).
    e. For HIV positive individuals who are about to begin or who are currently receiving antiretroviral therapy (ART) at the following intervals:
        i. To establish baseline levels before initiating ART;
        ii. Every 1 to 3 months after initiation or change of therapy;
        iii. Every 6 to 12 months when no medication changes have occurred.

2. Measurement of apolipoprotein B (apoB) **may be reimbursable** for **any** of the following situations:
    a. For individuals with hypertriglyceridemia;
    b. For individuals with diabetes mellitus;
    c. For individuals with obesity or metabolic syndrome
    d. For individuals with other dyslipidemias (such as very low LDL-C)
    e. For individuals who are on lipid therapy
    f. For individuals who are suspected to have familial Dysbetalipoproteinemia or familial combined hyperlipidemia.

3. Measurement of lipoprotein a (Lp(a)) **is not reimbursable** as an adjunct to low-density lipoproteins (LDL) cholesterol in the risk assessment and management of cardiovascular disease.

4. For individuals for whom a risk-based treatment decision is uncertain (after quantitative risk assessment using ACC/AHA PCEs to calculate 10-year risk of CVD events [see **NOTE 2**]), testing for C-reactive protein with the high-sensitivity method (hsCRP) **may be reimbursable** at the following frequency:
    a. One test for initial screening;
    b. If the initial screen was abnormal, confirmatory testing no sooner than two weeks after the initial test;
    c. Annual screening for those with elevated hs-CRP that has been confirmed.

5. The following testing for CPR **is not reimbursable:**
    a. Hs-CRP testing for all other cardiovascular disease risk assessments not described above
    b. Conventional CRP testing for cardiovascular disease risk assessment**.**

6. For CVD risk assessment and stratification in the outpatient setting, measurement of high-sensitivity cardiac troponin (hs-cTnT) **is not reimbursable.**

7. For CVD risk assessment screening, evaluation and management, homocysteine testing **is not reimbursable.**

8. For CVD risk assessment, measurement of novel lipid and non-lipid biomarkers (e.g., apolipoprotein AI, apolipoprotein E, B-type natriuretic peptide, cystatin C, fibrinogen, leptin, LDL subclass, HDL subclass) **is not reimbursable.**

9. Other than simple lipid panels (see **NOTE 1**), CVD risk panels consisting of multiple individual biomarkers intended to assess CVD **are not reimbursable.**

10. For CVD risk assessment, measurement of serum intermediate density lipoproteins **is not reimbursable.**

11. For CVD risk assessment, measurement of lipoprotein-associated phospholipase A2 (Lp-PLA2) **is not reimbursable.**

12. For measurement of cardiovascular risk for all indications, measurement of secretory type II phospholipase A2 (SPLA2-IIA) **is not reimbursable.**

13. For all situations, measurement of long-chain omega-3 fatty acids in red blood cell membranes **is not reimbursable.**

14. All other tests for assessing CVD risk **are not reimbursable.**

NOTE 1: A simple lipid panel is generally composed of the following lipid markers:

- Total cholesterol
- LDL cholesterol
- HDL cholesterol
- Triglycerides

Certain calculated ratios, such as the total/HDL cholesterol may also be reported as part of a simple lipid panel.

Other types of lipid testing, i.e., apolipoproteins, lipid particle number or particle size, lipoprotein (a), etc., are not considered to be components of a simple lipid profile.

NOTE 2: 2013 ACC/AHA Guideline on the Assessment of Cardiovascular Risk (1): Risk factors include gender, age, race, smoking, hypertension, diabetes, total cholesterol, high- and low-density lipoprotein cholesterol. A race- and sex-specific PCE ASCVD Risk Estimator is available at: https://tools.acc.org/ldl/ascvd_risk_estimator/index.html#!/calulate/estimator/.

The 2018 AHA/ACC/AACVPR/AAPA/ABC/ACPM/ADA/AGS/APhA/ASPC/NLA/PCNA Guideline on the Management of Blood Cholesterol affirms that "the PCE is a powerful tool to predict population risk, but it has limitations when applied to individuals." Hence a clinician-patient risk discussion can individualize risk status based on PCE, but with the inclusion of additional risk-enhancing factors. These additional factors may include:

- A family history of premature atherosclerotic cardiovascular disease (ASCVD) (males, age <55 y; females, age <65 y)
- Primary hypercholesterolemia (LDL-C, 160–189 mg/dL [4.1–4.8 mmol/L); non–HDL-C 190–219 mg/dL [4.9–5.6 mmol/L])
- Metabolic syndrome (increased waist circumference, elevated triglycerides [>150 mg/dL], elevated blood pressure, elevated glucose, and low HDL-C [<40 mg/dL in men; <50 in women mg/dL] are factors; tally of 3 makes the diagnosis)
- Chronic kidney disease (eGFR 15–59 mL/min/1.73 m2 with or without albuminuria; not treated with dialysis or kidney transplantation)
- Chronic inflammatory conditions such as psoriasis, RA, or HIV/AIDS

- History of premature menopause (before age 40 y) and history of pregnancy-associated conditions that increase later ASCVD risk such as preeclampsia
- High-risk race/ethnicities (eg, South Asian ancestry)
- Lipid/biomarkers: Associated with increased ASCVD risk
- Persistently elevated, primary hypertriglyceridemia (≥175 mg/dL)
- Elevated high-sensitivity C-reactive protein (≥2.0 mg/L)
- Elevated Lp(a): A relative indication for its measurement is family history of premature ASCVD. An Lp(a) ≥50 mg/dL or ≥125 nmol/L constitutes a risk-enhancing factor especially at higher levels of Lp(a)
- Elevated apoB ≥130 mg/dL: A relative indication for its measurement would be triglyceride ≥200 mg/dL. A level ≥130 mg/dL corresponds to an LDL-C ≥160 mg/dL and constitutes a risk-enhancing factor
- ABI <0.9

Procedure Codes

The following is not an all-encompassing code list. The inclusion of a code does not guarantee it is a covered service or eligible for reimbursement.

Codes
80061, 81599, 82172, 82465, 82610, 83090, 83695, 83698, 83700, 83701, 83704, 83718, 83719, 83721, 83722, 83880, 84478, 84484, 84512, 84999, 85384, 85415, 86140, 86141, 0052U, 0308U, 0309U, 0377U, 0415U, 0541U, 0019M

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Policy Update History:

Approval Date	Effective Date; Summary of Changes
07/25/2025	11/07/2025; Document updated with literature review. The following changes were made to Reimbursement Information: Revised frequency of testing in #4a and #4b, and added #4c, which now reads: 4.For individuals for whom a risk-based treatment decision is uncertain (after quantitative risk assessment using ACC/AHA PCEs to calculate 10-year risk of CVD events [see NOTE 12]), testing for C-reactive protein with the high-sensitivity method (hsCRP) may be reimbursable at the following frequency: a. One test for initial screening; b. If the initial screen was abnormal, confirmatory testing no sooner than two weeks after the initial test; c. Annual screening for those with elevated hs-CRP that has been confirmed. #5 revised to read: 5. The following testing for CPR is not reimbursable: a. Hs-CRP testing for all other cardiovascular disease risk assessments not described above; b. Conventional CRP testing for cardiovascular disease risk assessment. References revised
02/05/2025	05/15/2025; Document updated with literature review. The following changes were made to Reimbursement Information: revised 1.a.i to read every 4 years for individuals ages 18 to 79 years. Added “annually” to 1.d. Added code 84512 and 0541U, and removed 0423T. References revised.
09/13/2024	01/01/2025: New policy.