Priority Health	BILLING POLICY No. 132
CARDIOVASCULAR DISEASE RISK ASSESSMENT	
Date of origin: Aug. 2025	**Review dates: 07/26**

DEFINITION

Cardiovascular Disease (CVD) risk is based on standard risk-stratification approaches according to global assessment and traditional risk factor assessment. These factors include cholesterol, diet, smoking, diabetes, family history, and personal health history.

MEDICAL POLICY

Cardiovascular Risk Markers - 91559

FOR MEDICARE

For indications that do not meet criteria of NCD, local LCD or specific medical policy, a Pre-Service Organization Determination (PSOD) will need to be completed. Click here for additional details on PSOD.

POLICY SPECIFIC INFORMATION

Place of Service

Coverage will be considered for services furnished in the appropriate setting to the patient's medical needs and condition. Authorization may be required. Click here for additional information.

Coding specifics

Screening Codes

Code	Description
80061	Lipid panel. This panel must include the following: Cholesterol, serum, total (82465) Lipoprotein, direct measurement, high density cholesterol (HDL cholesterol) (83718) Triglycerides (84478)
81493	Coronary artery disease, mRNA, gene expression profiling by real-time RT-PCR of 23 genes, utilizing whole peripheral blood, algorithm reported as a risk score
82172	Apolipoprotein, each
82465	Cholesterol, serum or whole blood, total
83695	Lipoprotein (a)
83698	Lipoprotein-associated phospholipase A2 (Lp-PLA_2)
83718	Lipoprotein, direct measurement; high density cholesterol (HDL cholesterol)
83719	Lipoprotein, direct measurement; VLDL cholesterol
83721	Lipoprotein, direct measurement; LDL cholesterol
83722	Lipoprotein, direct measurement; small dense LDL cholesterol
84478	Triglycerides
84999	Unlisted chemistry procedure
86141	C-reactive protein; high sensitivity (hsCRP)
G0537	Administration of a standardized, evidence-based atherosclerotic cardiovascular disease (ASCVD) risk assessment lasting 5–15 minutes, limited to no more than once every 12 months.

Modifiers
Priority Health follows standard billing and coding guidelines which include CMS NCCI. Modifiers should be applied when applicable based on this guidance and only when supported by documentation.

Documentation requirements
Complete and thorough documentation to substantiate the procedure performed is the responsibility of the Provider. In addition, the Provider should consult any specific documentation requirements for any applicable defined guidelines.

Reimbursement specifics
Not applicable

Reimbursement rates
Find reimbursement rates for the codes listed on this page in our standard fee schedules for your contract. Go to the fee schedules (login required).

DISCLAIMER
CMS and/or MDHHS guidelines apply unless otherwise specified in this policy or provider manual. Where such guidance is absent, this policy applies. Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS), and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standard, compliant codes defined by CPT, HCPCS, and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim

payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made
07/2026	Added code G0537. All coverage related language removed. Deleted tables for not covered screening and any dx.