

Lipid Testing

MEDICAL POLICY NUMBER: 304

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**INSTRUCTIONS FOR USE:** Company Medical Policies serve as guidance for the administration of plan benefits. Medical policies do not constitute medical advice nor a guarantee of coverage. Company Medical Policies are reviewed annually and are based upon published, peer-reviewed scientific evidence and evidence-based clinical practice guidelines that are available as of the last policy update. The Company reserves the right to determine the application of medical policies and make revisions to medical policies at any time. The scope and availability of all plan benefits are determined in accordance with the applicable coverage agreement. Any conflict or variance between the terms of the coverage agreement and Company Medical Policy will be resolved in favor of the coverage agreement. Coverage decisions are made on the basis of individualized determinations of medical necessity and the experimental or investigational character of the treatment in the individual case. In cases where medical necessity is not established by policy for specific treatment modalities, evidence not previously considered regarding the efficacy of the modality that is presented shall be given consideration to determine if the policy represents current standards of care.

**SCOPE:** Providence Health Plan, Providence Health Assurance, and Providence Plan Partners as applicable (referred to individually as “Company” and collectively as “Companies”).

## PLAN PRODUCT AND BENEFIT APPLICATION

Commercial

Medicaid/OHP\*

Medicare\*\*

### \*Medicaid/OHP Members

*Oregon:* Services requested for Oregon Health Plan (OHP) members follow the OHP Prioritized List and Oregon Administrative Rules (OARs) as the primary resource for coverage determinations. Medical policy criteria below may be applied when there are no criteria available in the OARs and the OHP Prioritized List.

### \*\*Medicare Members

This Company policy may be applied to Medicare Plan members only when directed by a separate Medicare policy. Note that investigational services are considered “**not medically necessary**” for Medicare members.

## COVERAGE CRITERIA

### Medically Necessary

- I. Lipid testing may be considered **medically necessary** when performed as part of the evaluation for any of the following conditions (A.-K.):
  - A. Atherosclerotic cardiovascular disease;
  - B. Primary dyslipidemia;
  - C. Any form of disease, or any disease leading to the formation of atherosclerotic disease;
  - D. Disease associated with altered lipid metabolism (e.g. nephrotic syndrome, pancreatitis, hepatic disease, and hypo and hyperthyroidism);
  - E. Secondary dyslipidemia, including diabetes mellitus, disorders of gastrointestinal absorption, chronic renal failure;
  - F. Signs or symptoms of dyslipidemias (e.g. skin lesions);
  - G. As follow-up to the initial screen for coronary heart disease (total cholesterol + HDL cholesterol) when either of the following are met (1.-2.):
    1. Total cholesterol is determined to be high (>240 mg/dL); **or**
    2. Total cholesterol is determined to be borderline-high (200-240 mg/dL) and either of the following are met (a.-b.):
      - a. Patient has two or more coronary heart disease risk factors; **or**
      - b. Patient has an HDL cholesterol <35 mg/dl; **or**
  - H. To monitor long-term anti-lipid dietary or pharmacologic therapy (note: no more than 6 tests may be performed during the first year);
  - I. To monitor patients with borderline high total or low-density lipoprotein (LDL) cholesterol levels;
  - J. Severe psoriasis when all of the following are met (1.-3.)
    1. Symptoms have not responded to conventional therapy; **and**

2. Retinoid etretinate has been prescribed; **and**
  3. Patients has developed either hyperlipidemia or hepatic toxicity (e.g. erythrodermia and generalized pustular type and psoriasis associated with arthritis); **or**
- K. Non-specific chronic abnormalities of the liver (e.g. elevations of transaminase, alkaline phosphatase, abnormal imaging studies) (note: tests may not be performed more than twice every 12 months).

#### **Not Medically Necessary**

- II. Lipid testing is considered **not medically necessary** when criterion I. above is not met, including but not limited to either of the following (A.-B):
- A. Routine screening and prophylactic testing for lipid disorder (e.g. asymptomatic individuals with risk factors);
  - B. Individuals with vague diagnoses (e.g. other chest pain).

Link to [Evidence Summary](#)

## **POLICY CROSS REFERENCES**

None

The full Company portfolio of current Medical Policies is available online and can be [accessed here](#).

## **POLICY GUIDELINES**

This policy may be primarily based on the following Center for Medicare and Medicaid Services (CMS) guidance resources:

- National Coverage Determination (NCD) for Lipid Testing (190.23)<sup>1</sup> and the Medicare NCD Coding Policy Manual and Change Report (ICD-10-CM).<sup>2</sup>

To monitor the progress of patients on anti-lipid dietary management and pharmacologic therapy for the treatment of elevated blood lipid disorders, total cholesterol, HDL cholesterol and LDL cholesterol may be used. Triglycerides may be obtained if this lipid fraction is also elevated or if the patient is put on drugs (for example, thiazide diuretics, beta blockers, estrogens, glucocorticoids, and tamoxifen) which may raise the triglyceride level.

When monitoring long term anti-lipid dietary or pharmacologic therapy and when following patients with borderline high total or LDL cholesterol levels, it may be reasonable to perform the lipid panel annually. A lipid panel at a yearly interval will usually be adequate while measurement of the serum total cholesterol or a measured LDL should suffice for interim visits if the patient does not have hypertriglyceridemia.

Any one component of the panel or a measured LDL may be reasonable and necessary up to six times the first year for monitoring dietary or pharmacologic therapy. More frequent total cholesterol HDL cholesterol, LDL cholesterol and triglyceride testing may be indicated for marked elevations or for changes to anti-lipid therapy due to inadequate initial patient response to dietary or pharmacologic therapy. The LDL cholesterol or total cholesterol may be measured three times yearly after treatment goals have been achieved.

Electrophoretic or other quantitation of lipoproteins may be indicated if the patient has a primary disorder of lipid metabolism.

## CLINICAL EVIDENCE AND LITERATURE REVIEW

### EVIDENCE SUMMARY

Policy criteria are based on the Centers for Medicare & Medicaid (CMS) National Coverage Determination (NCD) for Lipid Testing (190.23)<sup>1</sup> and the Medicare NCD Coding Policy Manual and Change Report (ICD-10-CM).<sup>2</sup> As such, no evidence review or search of clinical practice guidelines was conducted.

## BILLING GUIDELINES AND CODING

The CPT/HCPCS codes below are covered when billed with one of the ICD-10 codes included in the most recent “Medicare National Coverage Determinations (NCD) Coding Policy Manual and Change Report (ICD-10-CM),” available for download at “[Lab NCDs – ICD-10](#).”<sup>2</sup> Please see the coding policy manual for a complete list of diagnosis codes.

CODES*		
CPT	80061	Lipid panel This panel must include the following: Cholesterol, serum, total (82465) Lipoprotein, direct measurement, high density cholesterol (HDL cholesterol) (83718) Triglycerides (84478)
	82465	Cholesterol, serum or whole blood, total
	83700	Lipoprotein, blood; electrophoretic separation and quantitation
	83701	Lipoprotein blood; high resolution fractionation and quantitation of lipoproteins including lipoprotein subclasses when performed (e.g., electrophoresis, ultracentrifugation)
	83704	Lipoprotein, blood; quantitation of lipoprotein particle numbers and lipoprotein particle subclasses, when performed
	83718	Lipoprotein, direct measurement; high density cholesterol (HDL cholesterol)
	83721	Lipoprotein, direct measurement, LDL cholesterol
	84478	Triglycerides

#### \*Coding Notes:

- The above code list is provided as a courtesy and may not be all-inclusive. Inclusion or omission of a code from this policy neither implies nor guarantees reimbursement or coverage. Some codes may not require routine review for

medical necessity, but they are subject to provider contracts, as well as member benefits, eligibility and potential utilization audit.

- All unlisted codes are reviewed for medical necessity, correct coding, and pricing at the claim level. If an unlisted code is submitted for non-covered services addressed in this policy then it will be **denied as not covered**. If an unlisted code is submitted for potentially covered services addressed in this policy, to avoid post-service denial, **prior authorization is recommended**.
- See the non-covered and prior authorization lists on the Company [Medical Policy, Reimbursement Policy, Pharmacy Policy and Provider Information website](#) for additional information.
- HCPCS/CPT code(s) may be subject to National Correct Coding Initiative (NCCI) procedure-to-procedure (PTP) bundling edits and daily maximum edits known as “medically unlikely edits” (MUEs) published by the Centers for Medicare and Medicaid Services (CMS). This policy does not take precedence over NCCI edits or MUEs. Please refer to the CMS website for coding guidelines and applicable code combinations.

## REFERENCES

1. Centers for Medicare & Medicaid Services. National Coverage Determination (NCD) for Lipid Testing (190.23). <https://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=102>. Published 2005. Accessed 6/8/2023.
2. Centers for Medicare & Medicaid Services. Lab NCDs - ICD-10. <https://www.cms.gov/Medicare/Coverage/CoverageGenInfo/LabNCDsICD10>. Published 2020. Accessed 6/8/2023.

## POLICY REVISION HISTORY

DATE	REVISION SUMMARY
2/2023	Annual review, no changes. Converted to new policy template.
9/2023	Annual Review; updated diagnosis code configuration to align with CMS.