Local Coverage Determination (LCD): C-Reactive Protein High Sensitivity Testing (hsCRP) (L34856)

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Contractor Information

CONTRACTOR NAME	CONTRACT TYPE	CONTRACT NUMBER	JURISDICTION	STATE(S)
Novitas Solutions, Inc.	A and B MAC	04111 - MAC A	J - H	Colorado
Novitas Solutions, Inc.	A and B MAC	04112 - MAC B	J - H	Colorado
Novitas Solutions, Inc.	A and B MAC	04211 - MAC A	J - H	New Mexico
Novitas Solutions, Inc.	A and B MAC	04212 - MAC B	J - H	New Mexico
Novitas Solutions, Inc.	A and B MAC	04311 - MAC A	J - H	Oklahoma
Novitas Solutions, Inc.	A and B MAC	04312 - MAC B	J - H	Oklahoma
Novitas Solutions, Inc.	A and B MAC	04411 - MAC A	J - H	Texas
Novitas Solutions, Inc.	A and B MAC	04412 - MAC B	J - H	Texas
Novitas Solutions, Inc.	A and B MAC	04911 - MAC A	J - H	Colorado New Mexico Oklahoma Texas
Novitas Solutions, Inc.	A and B MAC	07101 - MAC A	J - H	Arkansas
Novitas Solutions, Inc.	A and B MAC	07102 - MAC B	J - H	Arkansas
Novitas Solutions, Inc.	A and B MAC	07201 - MAC A	J - H	Louisiana
Novitas Solutions, Inc.	A and B MAC	07202 - MAC B	J - H	Louisiana
Novitas Solutions, Inc.	A and B MAC	07301 - MAC A	J - H	Mississippi
Novitas Solutions, Inc.	A and B MAC	07302 - MAC B	J - H	Mississippi
Novitas Solutions, Inc.	A and B MAC	12101 - MAC A	J - L	Delaware
Novitas Solutions, Inc.	A and B MAC	12102 - MAC B	J - L	Delaware
Novitas Solutions, Inc.	A and B MAC	12201 - MAC A	J - L	District of Columbia
Novitas Solutions, Inc.	A and B MAC	12202 - MAC B	J - L	District of Columbia
Novitas Solutions, Inc.	A and B MAC	12301 - MAC A	J - L	Maryland
Novitas Solutions, Inc.	A and B MAC	12302 - MAC B	J - L	Maryland
Novitas Solutions, Inc.	A and B MAC	12401 - MAC A	J - L	New Jersey
Novitas Solutions, Inc.	A and B MAC	12402 - MAC B	J - L	New Jersey
Novitas Solutions, Inc.	A and B MAC	12501 - MAC A	J - L	Pennsylvania
Novitas Solutions, Inc.	A and B MAC	12502 - MAC B	J - L	Pennsylvania

CONTRACTOR NAME	CONTRACT TYPE	CONTRACT NUMBER	JURISDICTION	STATE(S)
Novitas Solutions, Inc.	A and B MAC	12901 - MAC A	J - L	Delaware District of Columbia Maryland New Jersey Pennsylvania

LCD Information

Document Information

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L34856

LCD Title
C-Reactive Protein High Sensitivity Testing (hsCRP)

Proposed LCD in Comment Period
N/A

Source Proposed LCD
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CMS National Coverage Policy

This LCD supplements but does not replace, modify or supersede existing Medicare applicable National Coverage Determinations (NCDs) or payment policy rules and regulations for hsCRP testing. Federal statute and subsequent Medicare regulations regarding provision and payment for medical services are lengthy. They are not repeated in this LCD. Neither Medicare payment policy rules nor this LCD replace, modify or supersede applicable state statutes regarding medical practice or other health practice professions acts, definitions and/or scopes of practice. All providers who report services for Medicare payment must fully understand and follow all existing laws, regulations and rules for Medicare payment for hsCRP testing and must properly submit only valid claims for them. Please review and understand them and apply the medical necessity provisions in the policy within the context of the rules. Relevant CMS manual instructions and policies may be found in the following Internet-Only Manuals (IOMs) published on the CMS Web site:

IOM Citations:

- CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*
  - Chapter 6, Section 20.4 Outpatient Diagnostic Services
  - Chapter 15, Section 80.1 Clinical Laboratory Services
- CMS IOM Publication 100-04, *Medicare Claims Processing Manual*
  - Chapter 16, Laboratory Services
  - Chapter 23, Section 40 Clinical Diagnostic Laboratory Fee Schedule

Social Security Act (Title XVIII) Standard References:

- Title XVIII of the Social Security Act, Section 1833(e) states that no payment shall be made to any provider for any claim that lacks the necessary information to process the claim.
- Title XVIII of the Social Security Act, Section 1862(a)(1)(A) states that no Medicare payment shall be made for items or services which are not reasonable and necessary for the diagnosis or treatment of illness or injury.
- Title XVIII of the Social Security Act, Section 1862(a)(7). This section excludes routine physical examinations.

Federal Register References:

- 42 CFR, Section 410.32 Diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests: Conditions.

Coverage Guidance

Coverage Indications, Limitations, and/or Medical Necessity

Notice: It is not appropriate to bill Medicare for services that are not covered (as described by this entire LCD) as if they are covered. When billing for non-covered services, use the appropriate modifier.

Compliance with the provisions in this policy may be monitored and addressed through post payment data analysis and subsequent medical review audits.

History/Background and/or General Information

C-reactive protein (CRP), is a nonspecific, acute-phase reactant produced in response to tissue injury, inflammation or infection. As an acute phase reactant, concentrations rise rapidly and half-life is short. Studies have shown that chronic, low-grade inflammation contributes to atherogenesis and the development of coronary artery disease (CAD). Inflammatory changes lead to progressive disease, which culminates in plaque instability, rupture, thrombosis, and myocardial infarction (MI).

CRP testing is eligible for coverage as a diagnostic test for the detection and evaluation of infection, tissue injury, and inflammatory disease. High sensitivity C-reactive protein (hsCRP) testing is the subject of this policy.

A high sensitivity C-reactive protein (hsCRP) assay measures low levels of CRP, which allows for measurement of conditions indicative of chronic, low-grade inflammation. The stimulus for the rise in serum CRP in CAD remains undetermined, although it may result from local inflammation within atheromatous plaques, from a systemic or local inflammation or infection elsewhere in the body that contributes to atherogenesis, or to unrelated conditions. Increased CRP may reflect plaque instability and an increased risk for a CAD event. Published literature presents strong evidence to refute the hypothesis that CRP itself has a causative effect on coronary heart disease.

High-sensitivity assays can measure levels as low as 0.175 mg/L, which may be associated with CAD. HsCRP assays are based on nephelometric analysis of antigen-antibody complexes using monoclonal antibodies with sufficient sensitivity to detect low levels of CRP.

Covered Indications

This contractor will consider high-sensitivity C-reactive protein (hsCRP) testing reasonable and necessary when **ALL** of the following criteria are met:

1. When the hsCRP would add substantial incremental information in the decision making process to optimize/maximize lipid lowering pharmacologic therapy, (e.g., use of statins), in a patient who has been identified as being at intermediate risk for CAD (10-year risk of coronary heart disease between 10-20% per the ATPIII Guidelines). This is to be used for a one time decision point and is not intended to monitor therapy.
2. The test is performed in patients considered to be metabolically stable and without obvious inflammatory or infectious conditions.

The American Heart Association (AHA) recommends the following cutpoints for hsCRP corresponding to three levels of risk:

- Low risk less than 1.0 mg/L
- Average risk greater than 1.0 to less than 3.0 mg/L
- High risk greater than 3.0 mg/L

Limitations

1. Medicare does not provide coverage for routine screening performed without a relationship to the evaluation or treatment of a symptom, sign, illness or injury. If high sensitivity C-reactive protein (hsCRP) testing is performed for cardiovascular risk assessment, in the absence of signs or symptoms of illness or injury, then the service will be denied as not reasonable and necessary.
2. Medicare does not cover hsCRP testing as a screening test for the general population or for monitoring response to therapy.
3. Although hsCRP is commonly elevated in inflammatory conditions (e.g., rheumatic fever, rheumatoid arthritis, systemic vasculitis, myocardial infarction, acute pancreatitis), measurements in these illnesses is not appropriate and is considered not reasonable and necessary.

This LCD imposes frequency limitations. For frequency limitations, please refer to the Utilization Guidelines section below.

Notice: Services performed for any given diagnosis must meet all of the indications and limitations stated in this policy, the general requirements for medical necessity as stated in CMS payment policy manuals, any and all existing CMS national coverage determinations, and all Medicare payment rules. Refer to Billing and Coding: C-Reactive Protein High Sensitivity Testing (hsCRP), A56643, for applicable CPT codes and diagnosis codes.

The redetermination process may be utilized for consideration of services performed outside of the reasonable and necessary requirements in this LCD.

Summary of Evidence

N/A

Analysis of Evidence
(Rationale for Determination)

N/A

General Information

Associated Information

Refer to the Local Coverage Article: Billing and Coding: C-Reactive Protein High Sensitivity Testing (hsCRP), A56643, for all coding information.

Documentation Requirements

1. All documentation must be maintained in the patient's medical record and made available to the contractor upon request.
2. Every page of the record must be legible and include appropriate patient identification information (e.g., complete name, dates of service[s]). The documentation must include the legible signature of the physician or non-physician practitioner responsible for and providing the care to the patient.
3. The medical record documentation must support the medical necessity of the services as stated in this policy.
4. The ordering physician should retain in the patient's medical record, history and physical examination notes documenting evaluation and management of one of the Medicare covered conditions/diagnoses, with relevant clinical signs/symptoms or abnormal laboratory test results, appropriate to clinical signs/symptoms or abnormal laboratory test results, appropriate to one of the covered indications.
5. The patient's clinical record should further indicate changes/alterations in medications or management prescribed for the treatment of the patient.
6. There must be an attending/treating physician's order for each test documented in the patient's medical/clinical record.

Utilization Guidelines

In accordance with CMS Ruling 95-1 (V), utilization of these services should be consistent with locally acceptable standards of practice.

Generally, the measurement of hsCRP markers is performed twice (averaging results), optimally two weeks apart and fasting or nonfasting, with the average expressed in mg/L, in metabolically stable patients.

It is considered reasonable and necessary to perform no more than 3 hsCRP services per patient lifetime.

Notice: This LCD imposes utilization guideline limitations. Despite Medicare's allowing up to these maximums, each patient's condition and response to treatment must medically warrant the number of services reported for payment. Medicare requires the medical necessity for each service reported to be clearly demonstrated in the patient's medical record. Medicare expects that patients will not routinely require the maximum allowable number of services.

Sources of Information

Contractor is not responsible for the continued viability of websites listed.

Other Contractor(s)' Policies

Contractor Medical Directors

Bibliography

1. Bruno G, Fornengo P, Novelli G, et al. C-reactive protein and 5-year survival in type 2 diabetes. *Diabetes.* 2009; 58:926-933.
2. Cushman M, Arnold AM, Psaty BM, et al. C-reactive protein and the 10-year incidence of coronary heart disease in older men and women. *Circulation.* 2005; 112:25-31.
3. Dehghan A, van Hoek M, Sijbrands EJG, et al. Risk of type 2 diabetes mellitus attributable to C-reactive protein and other risk factors. *Diabetes Care.* 2007; 7-10-2007.
4. Di Napoli M, Papa F; for the Villa Pini Stroke Data Bank Investigators. Inflammation, hemostatic markers, and antithrombotic agents in relation to long-term risk of new cardiovascular events in first-ever ischemic stroke patients. *Stroke.* 2002; 33:1763-1771.
5. Elliott P, Chambers JC, Zhang W, et al. Genetic Loci Associated With C-Reactive Protein Levels and Risk of

Coronary Heart Disease. *JAMA.* 2009; 302(1):37-48.
6. Goff DC, Lloyd-Jones DM, Bennett G, et al. 2013 ACC/AHA Guidelines in the Assessment of Cardiovascular Risk. A Report of the American College of Cardiology/American heart Association Task Force on Practice Guidelines. DOI: 10.1161/01.cir 000043774148606.98.
7. Greenland P, Alpert JS, Beller GA, et al. 2010 ACCF/AHA Guideline for Assessment of Cardiovascular Risk in Asymptomatic Adults: A Report of the American College of Cardiology Foundation/American Heart Association Task Force on Practice Guidelines. *Circ Cardiovasc Qual Outcomes.* 2010; 122:e584-e636.
8. Grundy SM, Cleeman JL, Merz NB, et al. Implications of Recent Clinical Trials for the National Cholesterol Education Program Adult Treatment Panel III Guidelines. *Circulation*. 2004; 110:227-239.
9. Hegele RA, Kraw ME, Ban MR, et al. Elevated serum C-reactive protein and free fatty acids among nondiabetic carriers of missense mutations in the gene encoding lamin A/C (LMNA) with partial lipodystrophy. *Arterioscler Thromb Vasc Biol.* 2003; 23:111-116.
10. Jellinger PS, Handelsman Y, Rosenblit PD, et al. American association of clinical endocrinologists and American college of endocrinology guidelines for management of dyslipidemia and prevention of cardiovascular disease. *Endocrine Practice*. 2017; 23(S2): 1-87.
11. Kanapuru B, Ershler WB. Inflammation, Coagulation, and the Pathway to Frailty. *Am J Med.* 2009; 122:605-613.
12. Kshirsagar AV, Bombeck AS, Bang H, et al. Association of C-Reactive Protein and Microalbuminuria (from the National Health and Nutrition Examination Surveys, 1999 to 2004). *Am J Cardiol.* 2008; 101:401-406.
13. Lamblin N, Mouquet F, Hennache B, et al. High-sensitivity C-reactive protein: potential adjunct for risk stratification in patients with stable congestive heart failure. *European Heart Journal.* 2005; 26:2245-50.
14. Lloyd-Jones DM, Liu K, Tian L, et al. Narrative Review: Assessment of C-Reactive Protein in Risk Prediction for Cardiovascular Disease. *Ann Intern Med*. 2006; 145:35-42.
15. McCulloch DK, Robertson RP. Risk Factors for Type 2 Diabetes Mellitus. In: UpToDate (electronic version). Hudson, Ohio, USA. Available at: http://www.uptodateonline.com (Accessed 04/30/2011).
16. McPherson & Pincus: Henry's Clinical Diagnosis and Management by Laboratory Methods, 21st ed. http://www.mdconsult.com. (Accessed 04/30/2009)
17. Melander O, Newton-Cheh C, Almgren P, et al. Novel and Conventional Biomarkers for Prediction of Incident Cardiovascular Events in the Community. *JAMA.* 2009; 302(1):49-57.
18. Morrow DA. C-Reactive Protein in Cardiovascular Disease In: UpToDate (electronic version). Hudson, Ohio, USA. Available at: http://www.uptodateonline.com (Accessed 04/30/2011).
19. Morrow DA, de Lemos JA, Sabatine MS. Clinical relevance of C-reactive protein during follow-up of patients with acute coronary syndromes in the aggrastat-to-zocor trial. *Circulation.* 2006; 114:281-288.
20. O'Keefe JH, Carter MD, Lavie CJ. Primary and Secondary Prevention of Cardiovascular Diseases: A Practical Evidence-Based Approach. *Mayo Clin Proc.* 2009;84(8):741-757.
21. Pearson TA, Mensah GA, Alexander RW, et al. Markers of inflammation and cardiovascular disease: application to clinical and public health practice: A statement for healthcare professionals from the Centers for Disease Control and Prevention and the American Heart Association. *Circulation.* 2003; 107:499-511.
22. Pradhan AD, Manson JE, Rifai N, et al. C-reactive protein, interleukin 6, and risk of developing type 2 diabetes mellitus. *JAMA.* 2001; 286:327-334.
23. Ridker PM, Danielson E, Fonseca FAH, et al. Rosuvastatin to prevent vascular events in men and women with elevated C-reactive protein. *N Engl J Med.* 2008; 359(21):2195-2207.
24. Ridker PM, Danielson E, Rifai N, et al. Valsartan, Blood Pressure Reduction, and C-reactive protein. *Hypertension.* 2006; 48:73-79.
25. Ridker PM, MacFadyen JG, Nordestgaard BG, et al. Rosuvastatin for Primary Prevention Among Individuals with Elevated High-Sensitivity C-Reactive Protein and 5% to 10% and 10% to 20% 10-Year Risk: Implications of the Justification for Use of Statins in Prevention: An Intervention Trial Evaluating Rosuvastatin (JUPITER) Trial for "Intermediate Risk". *Circ Cardiovasc Qual Outcomes.* 2010; 3:447-452.
26. Ridker PM, Rifai N, Cook NR, et al. Non-HDL cholesterol apolipoproteins A-1 and B100, standard lipid measures, lipid rations, and CRP as risk factors for cardiovascular disease in women. *JAMA.* 2005; 294:326-333.
27. Ridker PM, Rifai N, Rose L, et al. Comparison of C-reactive protein and low-density lipoprotein cholesterol

levels in the prediction of first cardiovascular events. *N Engl J Med.* 2002; 347:1557-1565.
28. Rogers AM, Shlipak MG. C-Reactive Proteins, Statins, and Cardiovascular Risk: What Can JUPITER Teach Us, Commentary on Ridker PM, Danielson E, Fonseca FA et al. *Am J of Kidney Dis.* 2009; 53 (5) 737-740.
29. Rossi E, Biasucci LM, Citterio F, et al. Risk of myocardial infarction and angina in patients with severe peripheral vascular disease: predictive role of C-reactive protein. *Circulation.* 2002; 105:800-803.
30. Rost NS, Wolf PA, Kase CS, et al. Plasma concentration of C-reactive protein and risk of ischemic stroke and transient ischemic attack: The Framingham Study. *Stroke.* 2001; 32:2575-2579.
31. Schulze MB, Rimm EB, Li T, et al. C-reactive protein and incident cardiovascular events among men with diabetes. *Diabetes Care.* 2004; 27:889-894.
32. Shah SH, de Lemos JA. Editorial: Biomarkers and Cardiovascular Disease; Determining Causality and Quantifying Contribution to Risk Assessment. *JAMA.* 2009; 302(1):92-93.
33. Sesso HD, Buring JE, Rifai N, et al. C-reactive protein and the risk of developing hypertension. *JAMA.* 2003; 290:3000-3002.
34. Spatz ES, Canavan ME, Desai MM. From Here to JUPITER: Identifying New Patients for Statin Therapy Using Data From the 1999 2004 National Health and Nutrition Examination Survey. *Circ Cardiovasc Qual Outcomes.* 2009;2:41-48.
35. Stone NJ, Robinson JG, Lichtenstein AH, et al. 2013 ACC/AHA Guideline on the Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Risk in Adults. *J Am College of Cardiology*. 2014;63(25):2889-2934.
36. Tanne D, Benderly M, Goldbourt U, et al. C-reactive protein as a predictor of incident ischemic stroke among patients with preexisting cardiovascular disease. *Stroke.* 2006; 37:1720-1724.
37. Tchernof A, Nolan A, Sites CK, et al. Weight loss reduces C-reactive protein levels in obese postmenopausal women. *Circulation.* 2002; 105:564-569.
38. Vainas T, Lubbers T, Stassen FRM, et al. Serum C-reactive protein level is associated with abdominal aortic aneurysm size and may be produced by aneurysmal tissue. *Circulation.* 2003; 107:1103-1105.
39. Ventetuolo C E, Levy M M. Biomarkers: Diagnosis and Risk Assessment in Sepsis. *Clin Chest Med.* 2008; 29:591-603.
40. Walston J, McBurnie MA, Newman A, et al. Frailty and Activation of the Inflammation and Coagulation Systems With and Without Clinical Comorbidities; Results From the Cardiovascular Health Study. *Arch Intern Med.* 2002; 162:2333-2341.
41. Wilson P, Pencina M, Jacques P, et al. C-Reactive Protein and Reclassification of Cardiovascular Risk in the Framingham Heart Study. *Circ Cardiovasc Qual Outcomes.* 2008; 1:92-97.
42. Yin WH, Chen JW, Jen HL, et al. Independent prognostic value of elevated high-sensitivity C-reactive protein in chronic heart failure. *Am Heart J.* 2004; 147:931-938.
43. Zebrack JS, Muhlestein JB, Horne BD, et al. C-reactive protein and angiographic coronary artery disease: independent and additive predictors of risk in subjects with angina. *J Am Coll Cardiol.* 2002; 39:632-637.

Revision History Information

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION	REASON(S) FOR CHANGE
11/07/2019	R8	LCD revised and published on 11/07/2019. Consistent with CMS Change Request 10901, the entire coding section has been removed from the LCD and placed into the related Billing and Coding Article, A56643. All CPT codes and coding information within the text of the LCD has been placed in the Billing and Coding Article.	• Other (CMS Change Request 10901)

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION	REASON(S) FOR CHANGE
06/27/2019	R7	LCD revised and published on 06/27/2019. Consistent with Change Request (CR) 10901 CMS IOM language has been removed from the LCD. All CPT and ICD-10 codes have been removed from the LCD and placed in the related Billing and Coding Article, A56643. The references have been moved to the Bibliography section and a link to A56643 has been added as a related document. There has been no change in coverage with this LCD revision.	• Other (Change in LCD process per CMS CR 10901)
10/01/2018	R6	LCD revised and published on 10/25/2018 effective for dates of service on and after 10/01/2018 to reflect the Annual ICD-10-CM Code Updates. The following ICD-10-CM code has been deleted and therefore removed from the LCD: E78.4. The following ICD-10-CM code has been added to the LCD Group 1 codes: E78.49. The Group 1 asterisk note has been revised to reflect the ICD-10 code updates. At this time 21st Century Cures Act will apply to new and revised LCDs that restrict coverage which requires comment and notice. This revision is not a restriction to the coverage determination; therefore, not all the fields included on the LCD are applicable as noted in this policy.	• Revisions Due To ICD-10-CM Code Changes
05/10/2018	R5	LCD revised and published on 05/10/2018 to add sources submitted with a reconsideration request for the addition of multiple ICD-10 codes. All literature was reviewed. No changes to the policy were made based on the reconsideration request. IOM citations for diagnostic laboratory services added per annual review. At this time, 21st Century Cures Act will apply to new and revised LCDs that restrict coverage which requires comment and notice. This revision is not a restriction to the coverage determination; therefore, not all the fields on the LCD are applicable as noted in this policy.	• Other (Reconsideration Request and Annual Review)
10/01/2016	R4	LCD revised and published on 09/29/2016 effective for dates of service on and after 10/01/2016 to reflect the ICD-10 Annual Code Updates. The following ICD-10 code(s) have been deleted and therefore removed from	• Revisions Due To ICD-10-CM Code Changes

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION	REASON(S) FOR CHANGE
		the LCD: Group 1 code E78.0. The following ICD-10 code(s) have been added to the LCD: Group 1 codes E78.00 and E78.01. The Group 1 asterisk note has been revised to reflect the ICD-10 updated codes.	
04/07/2016	R3	Added standard language to the Utilization Guidelines section.	• Other (Clarification)
04/07/2016	R2	LCD posted for notice on 02/19/2016 to become effective 04/07/2016. 09/17/2015 DL34856 Draft LCD posted for Comments.	• Creation of Uniform LCDs With Other MAC Jurisdiction
10/01/2015	R1	LCD revised and published on 12/10/2015 effective for dates of service on and after 10/01/2015. ICD-10 codes I25.110; I25.111; I25.118 and I25.119 have been added as covered diagnoses.	• Other (Additional codes added to policy to allow for higher specificity.)

Associated Documents

Attachments

N/A

Related Local Coverage Documents

Article(s)
A56643 - Billing and Coding: C-Reactive Protein High Sensitivity Testing (hsCRP)
LCD(s)
DL34856
- (MCD Archive Site)

Related National Coverage Documents

N/A

Public Version(s)

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