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Local Coverage Article:
NCD Coding Article for BONE Mass Measurements (A47550)

Contractor Information

Contractor Name	Contractor Number	Contractor Type
Novitas Solutions, Inc. opens in new window	12302	MAC - Part B

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Article Information

General Information

Article ID Number
A47550

Article Type
Article

Key Article
No

Article Title
NCD Coding Article for BONE Mass Measurements

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Primary Geographic Jurisdiction
Maryland

Original Article Effective Date
07/11/2008

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04/02/2012

Article Text

Coding Guidelines

The Balanced Budget Act of 1997, Section 4106 legislated coverage of BONE mass measurements (BMMs) under Medicare. This regulation defined BMM and individuals qualified to receive a BMM, established conditions for coverage under the “reasonable and necessary” provisions of 1862(a)(1)(A) of the Social Security Act, and established frequency standards governing when qualified individuals would be eligible for a BMM. Per this Act, Medicare recognizes that these studies are beneficial to many Medicare patients; however, it is very important that physicians understand and apply Medicare’s coverage and coding guidelines in order for these services to be eligible under Medicare.
Medicare’s coverage of BMMs is provided through a National Coverage Determination (NCD) (150.3). Processing guidelines, covered conditions, and frequency guidelines are found in the Internet-Only Manuals, Pub. 100-02 , Chapter 15 § 80.5, and Pub. 100-04 , Chapter 13, § 140.1. The IOM is available at http://www.cms.gov/Manuals/IOM/list.asp.

The Centers for Medicare and Medicaid Services (CMS) issued CR 5847 that clarified claims processing instructions that were contained in CR 5521. MLN Matters MM5521 and MM5847 were also issued and are available at http://www.cms.gov/mlnmattersarticles/.
Under Medicare, coverage is provided for a BMM to monitor osteoporosis drug therapy, and as a preventive service for those patients meeting the criteria for a screening examination.
Effective January 1, 2007 the Centers for Medicare & Medicaid Services (CMS) has issued revised instructions and coverage for the benefits for BONE mass measurements (BMM). They are as follows:
A BONE mass measurement (BMM) study is defined as a "radiologic or radioisotopic procedure or other procedure that meets all of the following conditions -

- Is performed to identify BONE mass, detect BONE loss, or determine BONE quality;
- Is performed with a BONE densitometer (other than single-photon or dual-photon absorptiometry (DPA)) or a BONE sonometer (i.e., ultrasound) device approved or cleared for marketing for BMM by the Food and Drug Administration (FDA) under 21 CFR Part 807, or approved for marketing under 21 CFR Part 814;
- Includes a physician's interpretation of the results of the procedure."

Medicare will cover a BMM when the following conditions are met:

- It is ordered by the physician or qualified nonphysician practitioner who is treating the beneficiary following an evaluation of the need for a BMM and determination of the appropriate BMM to be used.

Note: A physician or qualified nonphysician practitioner treating the beneficiary for purposes of this provision is one who furnishes a consultation or treats a beneficiary for a specific medical problem, and who uses the results in the management of the patient. For the purposes of the BMM benefit, qualified nonphysician practitioners include physician assistants, nurse practitioners, clinical nurse specialists, and certified nurse midwives.

- It is performed under the appropriate level of physician supervision as defined in 42 CFR 410.32(b).
- It is reasonable and necessary for diagnosing and treating the condition of a beneficiary who meets the conditions described in the section below or in the IOM Pub 100-02 Medicare Benefit Policy, Chapter 15, §80.5.6.
- In the case of an individual being monitored to assess the response to or efficacy of an FDA-approved osteoporosis drug therapy, is performed with a dual-energy x-ray absorptiometry system (axial skeleton).
- In the case of any individual who meets the conditions described in the section below or in the IOM Pub 100-02 Medicare Benefit Policy, Chapter 15, §80.5.6 and who has a confirmatory BMM, is performed by a dual-energy x-ray absorptiometry system (axial skeleton) if the initial BMM was not performed by a dual-energy x-ray absorptiometry system (axial skeleton). A confirmatory baseline BMM is not covered if the initial BMM was performed by a dual-energy x-ray absorptiometry system (axial skeleton).

In order for the BMM to be covered, a beneficiary must meet **at least one** of the five conditions listed below:

- A woman who has been determined by the physician or qualified nonphysician practitioner treating her to be estrogen-deficient and at clinical risk for osteoporosis, based on her medical history and other findings.

Note: Since not every woman who has been prescribed estrogen replacement therapy (ERT) may be receiving an "adequate" dose of the therapy, the fact that a woman is receiving ERT should not preclude her treating physician or other qualified treating nonphysician practitioner from ordering a BONE mass measurement for her. If a BMM is ordered for a woman following a careful evaluation of her medical need, however, it is expected that the ordering treating physician (or other qualified treating nonphysician practitioner) will document in her medical record why he or she believes that the woman is estrogen-deficient and at clinical risk for osteoporosis.

- An individual with vertebral abnormalities as demonstrated by an x-ray to be indicative of osteoporosis, osteopenia, or vertebral fracture.
- An individual receiving (or expecting to receive) glucocorticoid (steroid) therapy equivalent to an average of 5.0 mg of prednisone, or greater, per day, for more than 3 months.

- An individual with primary hyperparathyroidism.
- An individual being monitored to assess the response to or efficacy of an FDA-approved osteoporosis drug therapy.

Frequency of Studies

Medicare pays for a screening BMM once every 2 years (at least 23 months have passed since the month the last covered BMM was performed).
When medically necessary, Medicare may pay for more frequent BMMs. Examples include, but are not limited to, the following medical circumstances:

- Monitoring beneficiaries on long-term glucocorticoid (steroid) therapy of more than 3 months.
- Confirming baseline BMMs to permit monitoring of beneficiaries in the future.

Peripheral BONE measurement scans are used primarily for screening purposes. Peripheral BONE measurement scans are not FDA-approved for continued follow-up of chronic conditions or osteoporosis treatment. Therefore, peripheral studies (CPT/HCPCS codes *77078, 77081, 76977*, G0130) would not be medically necessary more often than every two years.
Non-Covered Procedures
Medicare will not cover BMM claims for single photon absorptiometry (*78350*) effective January 1, 2007, or dual photon absorptiometry (*78351*) since 1983.
Additional References
Contractor provides coding guidelines for the preventive services eligible under Medicare, including BONE mass measurement, in the "Medicare Part B Preventive Services: Quick Reference Chart."
MLN Matters MM5521 Revised
MLN Matters MM5847
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Coding Information

Bill Type Codes:

Contractors may specify Bill Types to help providers identify those Bill Types typically used to report this service. Absence of a Bill Type does not guarantee that the article does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the article should be assumed to apply equally to all claims.

Bill Type Code	Bill Type Description
012x	Hospital Inpatient (Medicare Part B only)
013x	Hospital Outpatient
018x	Hospital - Swing Beds
021x	Skilled Nursing - Inpatient (Including Medicare Part A)
022x	Skilled Nursing - Inpatient (Medicare Part B only)
023x	Skilled Nursing - Outpatient
083x	Ambulatory Surgery Center
085x	Critical Access Hospital

Revenue Codes:

Contractors may specify Revenue Codes to help providers identify those Revenue Codes typically used to report this service. In most instances Revenue Codes are purely advisory; unless specified in the article services reported under other Revenue Codes are equally subject to this coverage determination. Complete absence of all Revenue Codes indicates that coverage is not influenced by Revenue Code and the article should be assumed to apply equally to all Revenue Codes.

Revenue Code	Revenue Code Description
0320	Radiology - Diagnostic - General Classification

CPT/HCPCS Codes
Italicized and/or quoted material is excerpted from the American Medical Association, *Current Procedural Terminology (CPT)* codes.

The following CPT codes are used to describe the type of bone density measurement tests that are currently available and covered.

Group 1 CPT/HCPCS Code	Group 1 CPT/HCPCS Code Description
76977	ULTRASOUND BONE DENSITY MEASUREMENT AND INTERPRETATION, PERIPHERAL SITE(S), ANY METHOD
77078	COMPUTED TOMOGRAPHY, BONE MINERAL DENSITY STUDY, 1 OR MORE SITES; AXIAL SKELETON (EG, HIPS, PELVIS, SPINE)
77080	DUAL-ENERGY X-RAY ABSORPTIOMETRY (DXA), BONE DENSITY STUDY, 1 OR MORE SITES; AXIAL SKELETON (EG, HIPS, PELVIS, SPINE)
77081	DUAL-ENERGY X-RAY ABSORPTIOMETRY (DXA), BONE DENSITY STUDY, 1 OR MORE SITES; APPENDICULAR SKELETON (PERIPHERAL) (EG, RADIUS, WRIST, HEEL)
G0130	SINGLE ENERGY X-RAY ABSORPTIOMETRY (SEXA) BONE DENSITY STUDY, ONE OR MORE SITES; APPENDICULAR SKELETON (PERIPHERAL) (EG, RADIUS, WRIST, HEEL)

ICD-9 Codes that are Covered
It is the provider's responsibility to select codes carried out to the highest level of specificity and selected from the ICD-9-CM code book appropriate to the year in which the service is rendered for the claim(s) submitted.

Patients who qualify by statute for osteoporosis screening may be evaluated by studies that are characterized by CPT codes *77078, 77080, 77081, 76977*, and G0130. The following is a list of ICD-9-CM codes that support the medical necessity of osteoporosis screening.

Group 1 Covered ICD-9 Code	Group 1 Covered ICD-9 Code Description
241.0	NONTOXIC UNINODULAR GOITER
246.9	UNSPECIFIED DISORDER OF THYROID
252.00 - 252.08 opens in new window	HYPERPARATHYROIDISM, UNSPECIFIED - OTHER HYPERPARATHYROIDISM
255.0	CUSHING'S SYNDROME
256.2	POSTABLATIVE OVARIAN FAILURE
256.31	PREMATURE MENOPAUSE
256.39	OTHER OVARIAN FAILURE
259.3	ECTOPIC HORMONE SECRETION NOT ELSEWHERE CLASSIFIED
627.2	SYMPTOMATIC MENOPAUSAL OR FEMALE CLIMACTERIC STATES
627.4	SYMPTOMATIC STATES ASSOCIATED WITH ARTIFICIAL MENOPAUSE
733.00	OSTEOPOROSIS UNSPECIFIED
733.01	SENILE OSTEOPOROSIS
733.02	IDIOPATHIC OSTEOPOROSIS
733.03	DISUSE OSTEOPOROSIS
733.09	OTHER OSTEOPOROSIS
733.11 - 733.16 opens in new window	PATHOLOGICAL FRACTURE OF HUMERUS - PATHOLOGICAL FRACTURE OF TIBIA OR FIBULA
733.19	PATHOLOGICAL FRACTURE OF OTHER SPECIFIED SITE
733.90	DISORDER OF BONE AND CARTILAGE UNSPECIFIED
733.93	STRESS FRACTURE OF TIBIA OR FIBULA
733.94	STRESS FRACTURE OF THE METATARSALS
733.95	STRESS FRACTURE OF OTHER BONE
733.96	STRESS FRACTURE OF FEMORAL NECK
733.97	STRESS FRACTURE OF SHAFT OF FEMUR
733.98	STRESS FRACTURE OF PELVIS
781.91	LOSS OF HEIGHT
V49.81	ASYMPTOMATIC POSTMENOPAUSAL STATUS (AGE-RELATED) (NATURAL)
V58.65	LONG-TERM (CURRENT) USE OF STEROIDS

Once the diagnosis of osteoporosis has been established, the effectiveness of treatment can **ONLY** be monitored using a dual energy x-ray absorptiometry (CPT code *77080*). The valid ICD-9-CM codes for the established diagnosis of osteoporosis are:

Group 2 Covered ICD-9 Code	Group 2 Covered ICD-9 Code Description
255.0	CUSHING'S SYNDROME
733.00	OSTEOPOROSIS UNSPECIFIED
733.01	SENILE OSTEOPOROSIS
733.02	IDIOPATHIC OSTEOPOROSIS
733.03	DISUSE OSTEOPOROSIS
733.09	OTHER OSTEOPOROSIS
733.90	DISORDER OF BONE AND CARTILAGE UNSPECIFIED

ICD-9 Codes that are Not Covered
It is the provider's responsibility to select codes carried out to the highest level of specificity and selected from the ICD-9-CM code book appropriate to the year in which the service is rendered for the claim(s) submitted.

Peripheral scans are characterized by CPT codes *77078, 77081, 76977*, and G0130. These scans are **NOT** covered for the monitoring of the effectiveness of osteoporosis therapy. Therefore, if any of the following codes are the only codes submitted on the claim, the claim will **NOT** be covered.

Group 1 Non-Covered ICD-9 Code	Group 1 Non-Covered ICD-9 Code Description
255.0	CUSHING'S SYNDROME
733.00	OSTEOPOROSIS UNSPECIFIED
733.01	SENILE OSTEOPOROSIS
733.02	IDIOPATHIC OSTEOPOROSIS
733.03	DISUSE OSTEOPOROSIS
733.09	OTHER OSTEOPOROSIS
733.90	DISORDER OF BONE AND CARTILAGE UNSPECIFIED

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Other Information

Revision History Explanation
04/02/2012 A47550 Article revised to reflect contractor name change from Highmark Medicare Services to Novitas Solutions, Inc.

01/01/2012 A47550 Article revised to reflect the annual CPT/HCPCS update effective 01/01/2012. The following codes have been deleted: *77079* and *77083.*

02/21/2011 A47550 Per Change Request 7135, this Article is effective for dates of service on and after 02/21/2011 for those providers in the states of Delaware, Maryland, New Jersey, Pennsylvania and the District of Columbia serviced by Wisconsin Physicians Service (WPS), contractor number 52280, that are being transitioned to Highmark Medicare Services, contractor number 12901, effective 02/21/2011.

09/08/2010 A47550 Article revised effective 09/09/2010. The descriptions have changed for the following bill type codes: 12,13,18, 21, 22, 23, 83, and 85 with an effective date of 07/01/2010. The description has changed for the following revenue code: 0320 with an effective date of 07/01/2010. Some or all of these changes may be in code ranges.

03/10/2010 A47550 Article effective 03/11/2010. Coding information moved from Article Text into correct coding sections.

12/12/2008 A47550 Article effective 12/12/2008 for Pennsylvania Part B. LCD is now effective for DC Part A and DCMA Part B; Delaware Part A and Part B; Maryland Part A and Part B; New Jersey Part A and Part B; Pennsylvania Part A and Part B.

11/14/2008 A47550 Article effective 11/14/2008 for New Jersey Part B and Delaware Part A. Article is now effective for DC Part A and DCMA Part B; Delaware Part A and Delaware Part B; Maryland Part A and Maryland Part B; New Jersey Part A and New Jersey Part B; Pennsylvania Part A.

09/24/2008 A47550 The following ICD-9 code changes will be effective 10/01/2008 due to ICD-9-CM annual updates. New codes added to osteoporosis screening indications only (CPT codes 77078-77081, 77083, 76977, G0130): 733.96, 733.97 and 733.98. Article revision effective 09/25/2008.

08/29/2008 A47550 Article effective 09/01/2008 for New Jersey Part A. Effective 09/01/2008, New Jersey Part A will be added to the other jurisdictions already effective: DC Part A and DCMA Part B; Maryland Part A and Maryland Part B; Pennsylvania Part A; and Delaware Part B.

08/01/2008 A47550 Article effective 08/01/2008 for DC Part A, Maryland Part A, and Pennsylvania Part A. Article is now effective for DC Part A and DCMA Part B; Maryland Part A and Maryland Part B; Pennsylvania Part A; and Delaware Part B.

05/23/2008 A47550 Article to become effective 07/11/2008 for Maryland Part B, DCMA Part B and Delaware Part B.

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All Versions

Updated on 04/06/2012 with effective dates 04/02/2012 - N/A
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