Local Coverage Article:
BONE Mass Measurement– Supplemental Instructions Article (A50737)

Contractor Information

Contractor Name
CGS Administrators, LLC opens in new window

Contract Number
15202

Contract Type
MAC - Part B

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Article Information

General Information

Article ID
A50737

Article Title
BONE Mass Measurement– Supplemental Instructions Article

Jurisdiction
Ohio

Original Effective Date
04/30/2011

Revision Effective Date
01/01/2012

Revision Ending Date
N/A

Retirement Date
N/A

Article Guidance

Article Text:

The information in this Supplemental Instruction Article (SIA) contains coding or other guidelines that complement the Local Coverage Determination (LCD) for BONE Mass Measurement. The LCD can be accessed through our contractor Web site at www.cgsmedicare.com. It can also be found on the Medicare Coverage Database at www.cms.hhs.gov/mcd

Coding Guidelines:

General Guidelines for claims submitted to Part A or Part B MAC:

Procedure codes may be subject to National Correct Coding Initiative (NCCI) edits or OPPS packaging edits. Refer to NCCI and OPPS requirements prior to billing Medicare.

For services requiring a referring/ordering physician, the name and UPIN/NPI of the referring/ordering physician must be reported on the claim.

A claim submitted without a valid ICD-9-CM diagnosis code will be returned to the provider as an incomplete claim under Section 1833(e) of the Social Security Act.

The diagnosis code(s) must best describe the patient's condition for which the service was performed. For diagnostic tests, report the result of the test if known; otherwise the symptoms prompting the performance of the test should be reported.

ICD-9-CM Code 733.13 is to be reported for collapse of vertebrae NOS.

Claims for BONE mass measurement studies performed for subsequent monitoring following a BMM performed by another modality must include the secondary ICD-9-CM codes 793.7.

ICD-9-CM code V45.77 code is for use only in women s/p oophorectomy.

Claims for services rendered to patients receiving, or expected to receive, glucocorticoid therapy equivalent to 5 mg prednisone or greater, for more than three months, should be reported with ICD-9-CM code V58.65 [Long term (current) use of steroids].

ICD-9-CM code V67.51 should be used for reporting an individual who has COMPLETED drug therapy for osteoporosis and is being monitored for response to therapy.

ICD-9-CM code V58.69 should be used with CPT code 77080 to report DXA testing while taking medicines for osteoporosis/osteopenia.

ICD-9-CM code V82.81 (Special screening for osteoporosis) may be billed on the claim, but this code by itself does not support medical necessity for the BONE mass measurement benefit.

When claims for the screening BMM tests (77078, 77081, 76977 and G0130) are submitted, the diagnosis indicating the reason for the test should **always** be included on the claim. If the result of the test indicates osteoporosis/osteopenia then the appropriate diagnosis 733.00-733.09, 733.90 and 255.0) should **also** be coded.

For osteoporosis, osteopenia, and vertebral fracture, use the corresponding ICD-9-CM code(s) from the "ICD-9-CM Codes That Support Medical Necessity" section to code the vertebral abnormality. Use diagnosis code 733.90 to indicate osteopenia,(only when billing 77080-DXA) when used to follow treatment with FDA approved osteoporosis medications. For osteoporosis, osteopenia, and vertebral fracture, the medical record must include an x-ray or other study report of the spine that demonstrates the applicable vertebral abnormality(ies).

CPT code 77082 is considered by Medicare to represent vertebral fracture assessment only. Because code 77082 does not represent a BONE density study, when a BONE density study with vertebral fracture assessment is performed, bill the code for the appropriate BONE density study (e.g., 77080) plus code 77082.

Advance Beneficiary Notice of Noncoverage (ABN) Modifier Guidelines
An ABN may be used for services which are likely to be non-covered, whether for medical necessity or for other reasons. Refer to CMS Publication 100-04, Medicare Claims Processing Manual, Chapter 30, for complete instructions.

Effective from April 1, 2010, non-covered services should be billed with modifier –GA, -GX, -GY, or –GZ, as appropriate.

The –GA modifier (“Waiver of Liability Statement Issued as Required by Payer Policy”) should be used when physicians, practitioners, or suppliers want to indicate that they anticipate that Medicare will deny a specific service as not reasonable and necessary and they **do have** an ABN signed by the beneficiary on file. Modifier GA applies only when services will be denied under reasonable and necessary provisions, sections 1862(a) (1), 1862(a)(9), 1879(e), or 1879(g) of the Social Security Act. Effective April 1, 2010, Part A MAC systems will automatically deny services billed with modifier GA. An ABN, Form CMS-R-131, should be signed by the beneficiary to indicate that he/she accepts responsibility for payment. The -GA modifier may also be used on assigned claims when a patient refuses to sign the ABN and the latter is properly witnessed. For claims submitted to the Part A MAC, occurrence code 32 and the date of the ABN is required.

Modifier GX (“Notice of Liability Issued, Voluntary Under Payer Policy”) should be used when the beneficiary has signed an ABN, and a denial is anticipated based on provisions *other* than medical necessity, such as statutory exclusions of coverage or technical issues. An ABN is not required for these denials, but if non-covered services are reported with modifier GX, FI and Part A MAC systems will automatically deny the services.

The –GZ modifier should be used when physicians, practitioners, or suppliers want to indicate that they expect that Medicare will deny an item or service as not reasonable and necessary and they **have not** had an ABN signed by the beneficiary.

If the service is statutorily non-covered, or without a benefit category, submit the appropriate CPT/HCPCS code with the -GY modifier. An ABN is not required for these denials, and the limitation of liability does not apply for beneficiaries. Services with modifier GY will automatically deny.

For claims submitted to the Part B MAC:

Claims for global BONE density measurement (77078, 77080, 77081, and G0130) should indicate one of the following payable places of service for reimbursement: office (11), mobile (15), and independent clinic (49).

If an Independent Diagnostic Testing Facility (IDTF) performs the global service in a location other than its own office location, that location where the service was furnished should be the place of service billed on the claim.

Claims for global ultrasonic BONE density measurement (76977) should indicate one of the following payable places of service for reimbursement: office (11), home (12), assisted living facility (13), group home (14), mobile (15), temporary lodging (16), skilled nursing facility, non-Part A stay (32), custodial care facility (33), and independent clinic (49).

When billing for the technical component only, a TC modifier must be appended to the CPT/HCPCS code. Claims for the technical component only (77078/TC, 77080/TC, 77081/TC and G0130/TC) should indicate one of the following payable places of service for reimbursement: office (11), mobile (15), independent clinic (49), federally qualified health centers (50) and rural health clinics (72).

Claims for the technical component only for ultrasonic BONE density testing (76977TC) should indicate one of the following payable places of service for reimbursement: office (11); home (12); assisted living facility (13); group home (14); mobile (15); temporary lodging (16), skilled nursing facility, non-Part A stay (32); custodial care facility (33); independent clinic (49), federally qualified health centers (50) and rural health clinics (72).

When billing for the professional component only, a 26 modifier must be appended to the CPT/HCPCS code. Claims for the professional component only (77078/26, 77080/26, 77081/26 and G0130/26) should indicate one of the following payable places of service for reimbursement: office (11), mobile (15), inpatient hospital (21), outpatient hospital (22), and independent clinic (49).

Claims for the professional component only for ultrasonic BONE density testing (76977/26) should indicate one of the following payable places of service for reimbursement: office (11); home (12); assisted living facility (13); group home (14); mobile (15); temporary lodging (16), inpatient hospital (21); outpatient hospital (22); skilled nursing facility for patients in a Part A stay (31); skilled nursing facility, non-Part A stay (32); custodial care facility (33); and independent clinic (49).

All services/procedures performed on the same day for the same beneficiary by the physician/provider should be billed on the same claim.

For claims submitted to the Part A MAC:

<u>Hospital Inpatient Claims:</u>

- The hospital should report the patient's principal diagnosis in Form Locator (FL) 67 of the UB-04. *The principal diagnosis is the condition established after study to be chiefly responsible for this admission.*
- *The hospital enters ICD-9-CM codes for up to eight additional conditions in FLs 67A-67Q if they co-existed at the time of admission or developed subsequently, and which had an effect upon the treatment or the length of stay. It may not duplicate the principal diagnosis listed in FL 67.*
- For inpatient hospital claims, the admitting diagnosis is required and should be recorded in FL 69. (See CMS Publication 100-04, *Medicare Claims Processing Manual*, Chapter 25, Section 75 for additional instructions.)

<u>Hospital Outpatient Claims:</u>

- *The hospital should report the full ICD-9-CM code for the diagnosis shown to be chiefly responsible for the outpatient services in FL 67.* If no definitive diagnosis is made during the outpatient evaluation, the patient's symptom is reported. If the patient arrives without a referring diagnosis, symptom or complaint, the provider *should report an ICD-9-CM code for Persons Without Reported Diagnosis Encountered During Examination and Investigation of Individuals and Populations (V70-V82).*
- *The hospital enters the full ICD-9-CM codes in FLs 67A-67Q for up to eight other diagnoses that co-existed in addition to the diagnosis reported in FL 67.*

Providers are required to report the number of units, and line item dates of service per revenue code line for each BONE mass measurement reported. Line item processing requires that each line item of a claim for services and/or tests include the appropriate HCPCS code for each service/test performed. For every line item that contains a HCPCS code you must also report a date of service, including bills where the "from" and "through" date are equal.

For dates of service prior to April 1, 2010, FQHC services should be reported with bill type 73X. For dates of service on or after April 1, 2010, bill type 77X should be used to report FQHC services.
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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
022x	Skilled Nursing - Inpatient (Medicare Part B only)
023x	Skilled Nursing - Outpatient
034x	Home Health - Other (for medical and surgical services not under a plan of treatment)
071x	Clinic - Rural Health
072x	Clinic - Hospital Based or Independent Renal Dialysis Center
073x	Clinic - Freestanding
077x	Clinic - Federally Qualified Health Center (FQHC)
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 codes only apply to providers who bill these services to the Part A MAC. Revenue codes do not apply to physicians, other professionals and suppliers who bill these services to the Part B MAC.

Please note that not all revenue codes apply to every type of bill code. Providers are encouraged to refer to the FISS revenue code file for allowable bill types. Similarly, not all revenue codes apply to each CPT/HCPCS code. Providers are encouraged to refer to the FISS HCPCS file for allowable revenue codes.

Providers must report HCPCS codes for bone mass measurements under revenue code 320 with number of units and line item dates of service per revenue code line for each bone mass measurement reported (CMS Publication 100-04, *Medicare Claims Processing Manual*, Chapter 13, Section 140.1).

Revenue Code	Revenue Code Description

Revenue Code	Revenue Code Description
0320	Radiology - Diagnostic - General Classification
0333	Radiology - Therapeutic and/or Chemotherapy Administration - Radiation Therapy
034X	Nuclear Medicine - General Classification
035X	CT Scan - General Classification
040X	Other Imaging Services - General Classification
052X	Free-Standing Clinic - General Classification
061X	Magnetic Resonance Technology (MRT) - General Classification
0960	Professional Fees - General Classification
0969	Professional Fees - Other Professional Fee
0972	Professional Fees - Radiology - Diagnostic
0982	Professional Fees - Outpatient Services
0983	Professional Fees - Clinic

CPT/HCPCS Codes

Group 1 Paragraph:
CPT codes 78350 and 78351 are non-covered procedures under Medicare.

Group 1 Codes:

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)
78350	BONE DENSITY (BONE MINERAL CONTENT) STUDY, 1 OR MORE SITES; SINGLE PHOTON ABSORPTIOMETRY
78351	BONE DENSITY (BONE MINERAL CONTENT) STUDY, 1 OR MORE SITES; DUAL PHOTON ABSORPTIOMETRY, 1 OR MORE SITES
G0130	SINGLE ENERGY X-RAY ABSORPTIOMETRY (SEXA) BONE DENSITY STUDY, ONE OR MORE SITES; APPENDICULAR SKELETON (PERIPHERAL) (EG, RADIUS, WRIST, HEEL)

Covered ICD-9 Codes

Group 1 Paragraph:
Please see LCD.

Group 1 Codes: N/A

Group 1 Covered ICD-9 Code	Group 1 Covered ICD-9 Code Description

Non-Covered ICD-9 Codes

Group 1 Paragraph:
Not applicable

Group 1 Codes: N/A

Group 1 Non-Covered ICD-9 Code	Group 1 Non-Covered ICD-9 Code Description

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Revision History Information

Please note: The Revision History information included in this Article prior to 06/20/2013 will now display with a Revision History Number of "R1" at the bottom of this table. All new Revision History information entries completed on or after 06/20/2013 will display as a row in the Revision History section of the Article and numbering will begin with "R2".

Revision History Date	Revision History Number	Revision History Explanation
01/01/2012	R2	Revision Effective Date: N/A Revision Explanation: Annual review and corrected website for CGS. Revision Effective Date: 1/1/2012 Revision Explanation: The following non-covered CPT/HCPCS codes were deleted by CMS: 77079 and 77083 Revision Effective date: 10/17/11 Revision Explanation: Added MAC Part A Contractor #'s 15101 and 15201 to all MAC Part B Contractor # 15102 Articles. Contractors 15101 and 15201 will be part of the Jurisdiction 15 MAC Contract as of October 17, 2011. This Article was converted from A45912 for Jurisdiction 15 A/B MAC on 04/30/2011. All prior notes were retained with the previous carriers version that has been archived in the Medicare Coverage Database. Revision Effective date: 06/18/11 Revision Explanation: Added MAC Part B Contractor # 15202 to all MAC Part B Contractor # 15102 Articles. Contractor 15202 will be part of the Jurisdiction 15 MAC Contract as of June 18, 2011. 07/02/2011 - The J15 Contractor adopted a new business name. This article revision only includes the change from CIGNA Government Services to CGS Administrators, LLC. No coverage information was included in this revision and no provider action is needed regarding this revision.
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Associated Documents

Related Local Coverage Document(s)
LCD(s)
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Related National Coverage Document(s)
N/A

Statutory Requirements URL(s)
N/A

Rules and Regulations URL(s)
N/A

CMS Manual Explanations URL(s)
N/A

Other URL(s)
N/A

Public Version(s)
Updated on 07/22/2013 with effective dates 01/01/2012 - N/A
Updated on 12/12/2011 with effective dates 01/01/2012 - N/A
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Keywords

N/A

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