

Billing and Coding Guidelines

Contractor Name

Wisconsin Physicians Service Insurance Corporation

Title

Billing and Coding Guidelines for MS-004, Bone Mass Measurement

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CMS National Coverage

Sections 1861(s) (15) and (rr) (1) of the Act (as added by §4106 of the Balanced Budget Act (BBA) of 1997 standardized Medicare coverage of medically necessary bone mass measurements by providing for uniform coverage under Medicare Part B. This coverage is effective for claims with dates of service furnished on or after July 1, 1998.

Title XVIII of the Social Security Act section 1862 (a) (1) (A). This section allows coverage and payment for those services that are considered medically reasonable and necessary.

Title XVIII of the Social Security Act section 1862 (a) (7). This section excludes routine physical examinations and services.

Title XVIII of the Social Security Act section 1833 (e). This section prohibits Medicare payment for any claim which lacks the necessary information to process the claim.

Code of Federal Regulations:

Title IV of the Balanced Budget Act of 1997, Section 4106 includes language providing for Medicare coverage of bone mass measurement procedures and coverage of FDA approved bone mass measurement techniques and equipment for “qualified individuals.” These procedures are only covered when medically necessary.

42CFR410.32 Diagnostic tests may only be ordered by the treating physician (or other treating practitioners acting within the scope of their licenses and Medicare requirements) and diagnostic tests payable under the Physicians Fee Schedule must be furnished under the appropriate level of supervision by the physician

CMS Pub. 100-2, Ch. 15, §80.5

CMS Pub. 100-3, Ch.1, Part 2, §150.3; *(Conditions for coverage of bone mass measurements are now contained in Pub. 100-2, Ch. 15, §80.5 (effective 01-01-07)

CMS Pub. 100.4 13 §140-140.3; 100-4 13 §10-10.1; 100-4 23 §10-10.1.7

CR 5521; (Transmittal 1236) Changes in conditions for coverage of BMMs issued in the Federal Register Final Rule (71 FR 69624) 12/01/2006.

CR 7012 provides a complete list of the Healthcare Common Procedure Coding System (HCPCS) codes that are defined as preventive services under Medicare and also identifies the HCPCS codes for the IPPE and the AWV. The CR announces that (effective for dates of service on or after January 1, 2011) Medicare will provide 100 percent payment (in other words, will waive any coinsurance or copayment) for the Initial Preventive Physical Examination (IPPE), the Annual Wellness Visit (AWV), and for those preventive services that: 1) Are identified with a grade of A or B by the United States Preventive Services Task Force (USPSTF) for any indication or population; and 2) Are appropriate for the individual.

CR5847, (Transmittal 1416); Clarification of Bone Mass Measurement (BMM) Billing Requirements.

CMS Pub. 100-4, Ch. 23, §10.1.1 paragraph A; This states; *If the physician has confirmed a diagnosis based on the results of the diagnostic test, the physician interpreting the test should code that diagnosis. The signs and/or symptoms that prompted ordering the test may be reported as additional diagnoses if they are not fully explained or related to the confirmed diagnosis*

Text

This document contains the coding guidelines and reasons for denial for Bone Mineral Density Studies. This article should be used in combination with LCD Bone Mass Measurement (MS-004). Medicare's coverage of bone mass measurement testing 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.

Coding Guidelines:

1. List the appropriate ICD-9 code that best supports the medical necessity for the bone density study. ICD-9code(s) must be present on all Physicians' Service claims and must be coded to the highest level of accuracy and digit level completeness.
2. List the appropriate CPT/HCPCS code that represents the service performed; include any necessary modifiers (e.g. 26, TC)
3. The CPT code descriptions listed in this policy indicates that one or more sites are included, and should be billed as one unit of service.
4. When medical documentation is required with an initial or subsequent electronic claim, identify in the electronic comment field that additional information is available.
5. The codes that describe bone biopsies may be used for indications including a bone density evaluation. When a bone biopsy is used for bone density measurement, the covered indications are the same as other covered studies. When the service is provided for a non-covered or screening indication, the appropriate screening ICD-9 code must be submitted as the reason for the service
6. Bone density studies (77078, 77080, 77081, 76977, G0130) are only covered when medically necessary. When the beneficiary specifically requests that the service be billed for denial, list the appropriate screening ICD-9 code (e.g., V70.0, V89.89) and the GY modifier with the CPT code for the appropriate denial

When the patient does not meet the definition of a “qualified individual” or the other medical criteria listed in sections A-D of the LCD, the service should be reported with a GA modifier when an ABN signed by the beneficiary is on file. When the medical criteria are not met and there has not been an ABN signed by the beneficiary, the service should be reported with a GZ modifier – item or service expected to be denied as not reasonable and necessary.

7. *The technical component (TC) of bone mass measurements furnished to hospital inpatients and outpatients are not payable by Part B. The technical services are reimbursed through the Part A Intermediary*
8. Bone mass density studies *include a physician's interpretation of the results as part of the procedure* (Pub. 100-4 §140.1)
9. When a bone density study (77078, 77081, 76977, G0130) is done as the initial procedure and the ordering provider determines a diagnosis of 255.0, 733.00, 733.01, 733.02, 733.03, 733.09, or 733.90, code the appropriate secondary diagnosis that was the medical reason for the test.
10. Place the name of the FDA approved osteoporosis drug therapy in box 19 or the electronic equivalent on the claim form.
11. Osteoporosis drug therapies include, but may not be limited to the following medication list;
 1. alendronate (Fosamax)
 2. risedronate (Actonel)
 3. calcitonin (Calcimar, Miacalcin, Cibacalcin)
 4. raloxifene (Evista)
 5. tiludronate (Skelid)
 6. etidronate (Didronel)
 7. zoledronate (Zometa)
 8. pamidronate (Aredia)
 9. parathyroid hormone (Forteo)
 10. ibandronate (Boniva)
 11. zolodronic acid (Reclast)
12. Calcium and Vitamin D supplements are also recommended but are not defined as FDA-approved osteoporosis drug therapy, and therefore, do not meet the criteria of number ten (10) or eleven (11) discussed above. HRT (estrogen) is FDA approved for osteoporosis prevention but is no longer FDA approved for osteoporosis treatment and does not meet the criteria of number ten (10) or eleven (11) discussed above.
13. Documentation supporting medical necessity must be indicated in the narrative field and available upon request

Reasons for Denial

1. Services submitted without an ICD-9 code to support medical necessity will be denied as not medical necessity.
2. Services performed in other than approved setting or using other than FDA approved equipment will be denied as non-covered.

3. Services in the absence of associated signs, symptoms, illness or injury will be denied as non-covered
4. Physicians' services submitted without an ICD-9 code or not coded to the highest level of accuracy and digit level completeness will be denied as unprocessable.
5. Redundant, duplicate and excessive testing will be denied as not medically necessary.
6. Services submitted without medical records where specified will be denied as not medically necessary.
7. *Dual-photon absorptiometry (DPA) - 78351*
*DPA is a non-invasive radiological technique that measures absorption of a dichromatic beam by bone material. It is usually used to measure bone density in the spine and hip but can also be used to quantify total body bone mass. This procedure is **not covered** under Medicare (Coverage Issues 50-44).*
8. *Bone biopsy is covered under Medicare when used for qualitative evaluation of bone not more than four times per patient, unless there is special justification given. When used more than four times on a patient, bone biopsy leaves a deficit in the pelvis and may produce some patient discomfort.*
9. *Effective for dates of service after January 1, 2007; (CPT code 78350 – single photon absorptiometry). Medicare will not pay BMM claims for single photon absorptiometry. Deny CPT code 78350 as it is not considered reasonable and necessary under section 1862 (a)(1)(A()) of the Act.*
10. *Dual-energy x-ray absorptiometry (axial) tests are covered when used to monitor FDA-approved osteoporosis drug therapy subject to the 2-year frequency standards described in chapter 15, section 80.5.5 of the Medicare Benefit Policy Manual.*

*Contractors will pay claims for monitoring tests when coded as follows;
Contains CPT procedure code 77080 and*

Contains 733.00, 733.01, 733.02, 733.03, 733.09, 733.90, or 255.0 as the ICD-9-CM diagnosis code

*Contractors will deny claims for monitoring tests when coded as follows:
Contains CPT procedure code 77078, 77081, 76977 or G0130 and*

Contains 733.00, 733.01, 733.02, 733.03, 733.09, 733.90 or 255.0 as the ICD-9-CM code but

Does not contain a valid ICD-9-CM code from the local lists of valid ICD-9-CM diagnosis codes maintained by the contractor for the benefit's screening categories indicating the reason for the test is postmenopausal female, vertebral fracture, hyperparathyroidism, or steroid therapy.

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

Noncovered ICD-9 Code(s)

V70.0-V70.9, V82.89

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07/01/2011

Revision History, Explanation/Number

*04/01/2012: Removed references to deleted CPT code 77083, effective 01/01/2012 (two).

01/01/2012: Removed references to deleted CPT code 77079. Removed from sentence number 11, under header Coding Guidelines, the words FDA approved (one).

10/01/2011: removed statement duplication from CMS National Coverage section (one).

Notes:

Italicized lettering (font) indicates CMS wording

* An asterisk indicates most recent publishing or revision

NCDs and coverage provisions in interpretive manuals are not subject to the Local Coverage Determination (LCD) Review Process (42 CFR 405.860[b] and 42 CFR 426 [Subpart D]). In addition, an administrative law judge may not review an NCD. See §1869(f)(1)(A)(i) of the Social Security Act.