Local Coverage Article:
BONE Mass Measurement - Medical Policy Article (A51974)

Contractor Information

Contractor Name
National Government Services, Inc. opens in new window

Contract Number
06302

Contract Type
MAC - Part B

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Article Information

General Information

Article ID
A51974

Article Title
BONE Mass Measurement - Medical Policy Article

AMA CPT / ADA CDT Copyright Statement

Jurisdiction
Wisconsin

Original Effective Date
10/01/2012

Revision Effective Date
10/25/2013

Revision Ending Date
N/A

Retirement Date
N/A

Article Guidance

Article Text:

Abstract:
BONE mass measurement (BMM) studies are *radiologic, radioisotopic or other procedures that meet all of the following conditions:*

- quantify BONE mineral density, *detect BONE loss or determine BONE quality;*
- *are performed with either a BONE densitometer (other than single-photon or dual-photon absorptiometry) or a BONE sonometer system that has been 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;*
- *include a physician's interpretation of the results.*

The following procedures are used to measure BONE mineral density:

- dual energy x-ray absorptiometry (DXA);
- radiographic absorptiometry (RA);
- BONE sonometry (ultrasound);
- single energy x-ray absorptiometry; (SEXA);
- quantitative computed tomography (QCT).

Earlier technologies, such as *single and dual photon absorptiometry* (CPT code 78350 or 78351), are no longer used.

Indications:
Medicare will cover a BONE mass measurement test when it meets all of the following criteria:

1. It is performed with one of the covered tests listed above.

2. It is performed on a qualified individual for the purpose of identifying BONE mass, detecting BONE loss or determining BONE quality. The term "qualified individual" means an individual who meets the medical indications for at least one of the five categories listed below:

    - A woman who has been determined by the physician or a qualified nonphysician practitioner treating her to be estrogen-deficient and at clinical risk for osteoporosis, based on her medical history and other findings;
    - An individual with vertebral abnormalities as demonstrated by an x-ray to be indicative of osteoporosis, osteopenia (low BONE mass), or vertebral fracture;
    - An individual receiving (or expecting to receive) glucocorticoid (steroid) therapy equivalent to 5 mg of prednisone, or greater, per day, for more than three (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.

3. It is furnished by a qualified supplier or provider of such services under at least the general level of supervision of a physician as defined in 42 CFR 410.32(b).

4. The test is ordered by the individual's physician or qualified non-physician practitioner, who is treating the beneficiary following an evaluation of the need for the measurement, including a determination as to the medically appropriate measurement to be used for the individual, and who uses the results in the management of the patient.

5. The test is reasonable and necessary for diagnosing, treating, or monitoring of a "qualified individual" as defined above in #2. Monitoring is defined as subsequent testing in patients on FDA-approved drug therapy.

6. *Medicare may cover a BONE mass measurement for a beneficiary once every 2 years (if at least 23 months have passed since the month the last BONE mass measurement was performed).*

7. For conditions specified, Medicare will cover a BONE mass measurement for a qualified beneficiary more frequently than every two years, if medically necessary for the diagnosis or treatment of the patient and if related to the condition listed. In these instances payment may be made for tests performed after eleven months have elapsed since the previous BONE mass measurement test. Examples include, but are not limited to, the following medical circumstance:

    - *Monitoring beneficiaries on long-term glucocorticoid (≥ 5 mg/day) therapy of more than 3 months* (patients must be on glucocorticoids for greater than three months duration, but BMM monitoring is at yearly intervals).
    - *Confirming baseline BMMs to permit monitoring of beneficiaries in the future.*
      In addition, BONE mass measurement for the following may be reimbursed more frequently than every two years:
    - Follow up BONE mineral density testing to assess FDA-approved osteoporosis drug therapy until a response to such therapy has been documented over time.

8. *A confirmatory baseline BMM is only covered when it is performed with a dual-energy x-ray absorptiometry system (axial skeleton) and 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).

9. *For an individual being monitored to assess the response to, or efficacy of, an FDA-approved osteoporosis drug therapy, the test is only covered if it is performed with a dual-energy x-ray absorptiometry system (axial skeleton).*

10. *The test must include a physician's interpretation of the results.*

11. 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/other qualified nonphysician practitioner from ordering a BONE mass measurement test for her. If a BONE mass measurement test is ordered for a woman following a careful evaluation of her medical need, it is expected that the ordering/treating physician/qualified non-physician practitioner will document, why he or she believes that the woman is estrogen deficient and at clinical risk for osteoporosis.

Limitations:

1. Tests not ordered by the physician/qualified non-physician practitioner, who is treating the beneficiary, are not reasonable and necessary.

2. Medicare reimbursement for an initial BONE mass measurement may be allowed only once, regardless of sites studied (e.g., if the spine and hip are studied, CPT code 77080 should be billed only once).

3. It is not medically necessary to perform more than one type of BMM test in any individual, unless a DXA confirmatory test is performed as a baseline for future monitoring (see Indications #7 and #8).

4. It is not medically necessary to have both peripheral and axial BMM tests performed on the same day.

5. Medicare will not reimburse BMM tests performed by a second provider, when a test has already been performed within the defined coverage period, as stated above, unless as confirmatory testing for future monitoring. Beneficiaries must authorize providers to obtain prior test results. If unsuccessful efforts to obtain prior test results from another provider are documented, new tests may be considered for reimbursement.

6. *Single and dual photon absorptiometry,* CPT code 78350 and 78351, are non-covered services.

7. BONE mass measurement is not covered under the portable x-ray benefit and will be denied when performed by a portable x-ray supplier. Transportation charges for BMM testing will be denied.

8. BONE mass measurement tests provided without an accompanying interpretation and report, as part of the test, will be denied as not medically necessary.

9. BONE mass measurement tests will be denied as not medically necessary if performed by a non-physician practitioner.

10. CPT code 77082 is considered by Medicare to represent vertebral fracture assessment only. Because code 77082 does not represent a BONE density study, it should NOT be billed for screening. This code may be billed when medically necessary (i.e. when a vertebral fracture assessment is required). Symptoms should be present and documented, and it should be anticipated that the results of the test will be used in the management of the patient.

Utilization
BONE mass measurement testing may be repeated once every two years (after 23 months have elapsed since the last test) in a qualified individual.

Beneficiaries in the follow situations may be reimbursed for tests performed once a year (after 11 months have elapsed since the last test):

1. Patients receiving, or about to receive, glucocorticoid therapy as stated in the indications section of this article.
2. *Confirming baseline BMMs to permit monitoring of beneficiaries in the future.*

3. Follow up BONE mineral density testing to assess FDA-approved osteoporosis drug therapy until a response to such therapy has been documented over time.

Documentation Requirements
The patient's medical record must contain documentation that fully supports the medical necessity for services included within this article. (See "Indications and Limitations of Coverage") This documentation includes, but is not limited to, relevant medical history, physical examination, and results of pertinent diagnostic tests or procedures.

Each claim must be submitted with ICD-9-CM codes that reflect the condition of the patient, and indicate the reason(s) for which the service was performed. Claims submitted without ICD-9-CM codes will be returned.

When DXA is performed for subsequent monitoring following a BMM performed by another modality, the secondary ICD-9-CM code 793.7 must also be reported on the claim.

The patient's medical record must document that the patient meets one of the requirements of a "qualified individual" as described in the "Indications and Limitations of Coverage" section of the article.

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).

The ordering physician or qualified non-physician provider should retain, in the patient's medical record, documentation of the history, physical examination, evaluation and management supporting the patient's medical need for these tests, as required in this article. The patient's clinical record should also document changes/alterations in medications prescribed for the treatment of the patient's osteoporosis, when present.

The provider of the BMM testing service must maintain a copy of the treating physician or non-physician provider's order for the BMM test in his/her own file or medical record.

Documentation of why the ordering physician or non-physician provider decided that a patient receiving estrogen replacement therapy was considered not to have been receiving adequate estrogen replacement and is at risk of clinical osteoporosis, must be maintained in the patient's medical record when appropriate.

Documentation must be submitted to Medicare upon request.

Coding Information:
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 NPI of the referring/ordering physician must be reported on the claim.

The diagnosis code(s) must best describe the patient's condition for which the service was performed.

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.

Advance Beneficiary Notice of Noncoverage (ABN) Modifier Guidelines (for outpatient services):

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, revised 09/05/2008, for complete instructions.

ICD-9 Coding:

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].

Report ICD-9 code V58.68 for DXA testing while taking bisphosphonates.

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 Are Covered" 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 coding:

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.

For claims submitted to the Part B MAC:

Place of service guidelines:
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:

Hospital Inpatient Claims:

- 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.)

Hospital Outpatient Claims:

- *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.

CMS National Coverage Policy:
Language quoted from Centers for Medicare and Medicaid Services (CMS), National Coverage Determinations (NCDs) and coverage provisions in interpretive manuals is *italicized* throughout the article. 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.

Unless otherwise specified, italicized text represents quotation from one or more of the following CMS sources:

Title XVIII of the Social Security Act (SSA):

Section 1862(a)(1)(A) excludes expenses incurred for items or services which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

Section 1833(e) prohibits Medicare payment for any claim which lacks the necessary information to process the claim.

Section 1861(r) provides the definition of a physician.

Section 1861(s)(2)(V)(15) includes BONE mass measurement as a physician service.

Section 1861(rr) provides the definition of BONE mass measurement.

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.

CMS Publications:

CMS Manual System, Pub. 100-02, *Medicare Benefit Policy Manual,* Chapter 15:

80.5 BONE Mass Measurements (BMMs)

CMS Manual System, Pub. 100-03, *Medicare National Coverage Determinations (NCD),* Chapter 1:

150.3 BONE (Mineral) Density Studies (Effective January 1, 2007)

CMS Manual System, Pub. 100-04, *Medicare Claims Processing Manual,* Chapter 13:

140 BONE Mass Measurements (BMMs).

Sources of Information:
National Government Services is not responsible for the continuing viability of Web site addresses listed below. © 2002 CPT Physicians' Current Procedural Terminology, American Medical Association.

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Bonnick SL. Osteoporosis in men and women. *Clinical Cornerstone.* 2006;8(1):28-39.

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Greenspan SL, Emkey RD, BONE HG, et al. Significant differential effects of alendronate, estrogen, or combination therapy on the rate of BONE loss after discontinuation of treatment of postmenopausal osteoporosis: a randomized, double-blind, placebo-controlled trial. *Annals of Internal Medicine*. 2002;137:875-883.

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Leslie WD, Tsang JF, Caetano PA, Lix LM, for the Manitoba BONE Density Program. Effectiveness of BONE density measurement for predicting osteoporotic fractures in clinical practice. *The Journal of Endocrinology & Metabolism*. 2007;92:77-81.

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Shaker JL, Lukert BP. Osteoporosis Associated with excess glucocorticoids. endocrinol metabolism. *Clinics of North America*. 2005;34:341-356.
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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
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

Revenue Code	Revenue Code Description

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:
For CPT code 77080 only:

Group 1 Codes:

Group 1 Covered ICD -9 Code	Group 1 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
V58.65	LONG-TERM (CURRENT) USE OF STEROIDS
V58.68	LONG TERM (CURRENT) USE OF BISPHOSPHONATES
V58.69	LONG-TERM (CURRENT) USE OF OTHER MEDICATIONS
V67.51	FOLLOW-UP EXAMINATION FOLLOWING COMPLETED TREATMENT WITH HIGH-RISK MEDICATION NOT ELSEWHERE CLASSIFIED

Group 2 Paragraph:
CPT codes 77078, 77081, 76977 and G0130 may only be reported when performed as screening for osteoporosis. A diagnosis from the list of those *Supporting Need for Screening* MUST be coded on the claim. The claim should also include a diagnosis code indicating the results of the test (if the test was not normal). Claims for 77078, 77081, 76977 and G0130, submitted without a diagnosis supporting the need for screening will be denied.

Diagnoses: Results of Testing:

Group 2 Codes:

Group 2 Covered ICD-9 Code	Group 2 Covered ICD-9 Code Description
255.0	CUSHING'S SYNDROME

Group 2 Covered ICD-9 Code	Group 2 Covered ICD-9 Code Description
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

Group 3 Paragraph:
These following diagnoses may support medical necessity for CPT codes 77078, 77080, 77081, 76977 and G0130, when these tests are performed for bone mass density screening for potential osteopenia/osteoporosis in qualified beneficiaries with estrogen deficiency, vertebral abnormalities/fractures, primary hyperparathyroidism or glucocorticoid administration (see indications section, bullet 2).

Diagnoses: Supporting Need for Screening

Group 3 Codes:

Group 3 Covered ICD-9 Code	Group 3 Covered ICD-9 Code Description
252.01	PRIMARY HYPERPARATHYROIDISM
256.2	POSTABLATIVE OVARIAN FAILURE
256.31	PREMATURE MENOPAUSE
256.39	OTHER OVARIAN FAILURE
259.3	ECTOPIC HORMONE SECRETION NOT ELSEWHERE CLASSIFIED
627.0	PREMENOPAUSAL MENORRHAGIA
627.1	POSTMENOPAUSAL BLEEDING
627.2	SYMPTOMATIC MENOPAUSAL OR FEMALE CLIMACTERIC STATES
627.3	POSTMENOPAUSAL ATROPHIC VAGINITIS
627.4	SYMPTOMATIC STATES ASSOCIATED WITH ARTIFICIAL MENOPAUSE
627.8	OTHER SPECIFIED MENOPAUSAL AND POSTMENOPAUSAL DISORDERS
627.9	UNSPECIFIED MENOPAUSAL AND POSTMENOPAUSAL DISORDER
733.13	PATHOLOGICAL FRACTURE OF VERTEBRAE
756.51	OSTEOGENESIS IMPERFECTA
758.6	GONADAL DYSGENESIS
793.7	NONSPECIFIC (ABNORMAL) FINDINGS ON RADIOLOGICAL AND OTHER EXAMINATION OF MUSCULOSKELETAL SYSTEM
805.00	CLOSED FRACTURE OF CERVICAL VERTEBRA UNSPECIFIED LEVEL
805.01	CLOSED FRACTURE OF FIRST CERVICAL VERTEBRA
805.02	CLOSED FRACTURE OF SECOND CERVICAL VERTEBRA
805.03	CLOSED FRACTURE OF THIRD CERVICAL VERTEBRA
805.04	CLOSED FRACTURE OF FOURTH CERVICAL VERTEBRA
805.05	CLOSED FRACTURE OF FIFTH CERVICAL VERTEBRA
805.06	CLOSED FRACTURE OF SIXTH CERVICAL VERTEBRA
805.07	CLOSED FRACTURE OF SEVENTH CERVICAL VERTEBRA
805.08	CLOSED FRACTURE OF MULTIPLE CERVICAL VERTEBRAE
805.10	OPEN FRACTURE OF CERVICAL VERTEBRA UNSPECIFIED LEVEL
805.11	OPEN FRACTURE OF FIRST CERVICAL VERTEBRA
805.12	OPEN FRACTURE OF SECOND CERVICAL VERTEBRA
805.13	OPEN FRACTURE OF THIRD CERVICAL VERTEBRA
805.14	OPEN FRACTURE OF FOURTH CERVICAL VERTEBRA
805.15	OPEN FRACTURE OF FIFTH CERVICAL VERTEBRA
805.16	OPEN FRACTURE OF SIXTH CERVICAL VERTEBRA
805.17	OPEN FRACTURE OF SEVENTH CERVICAL VERTEBRA
805.18	OPEN FRACTURE OF MULTIPLE CERVICAL VERTEBRAE
805.2	CLOSED FRACTURE OF DORSAL (THORACIC) VERTEBRA WITHOUT SPINAL CORD INJURY
805.3	OPEN FRACTURE OF DORSAL (THORACIC) VERTEBRA WITHOUT SPINAL CORD INJURY
805.4	CLOSED FRACTURE OF LUMBAR VERTEBRA WITHOUT SPINAL CORD INJURY

Group 3 Covered ICD-9 Code	Group 3 Covered ICD-9 Code Description
805.5	OPEN FRACTURE OF LUMBAR VERTEBRA WITHOUT SPINAL CORD INJURY
805.6	CLOSED FRACTURE OF SACRUM AND COCCYX WITHOUT SPINAL CORD INJURY
805.7	OPEN FRACTURE OF SACRUM AND COCCYX WITHOUT SPINAL CORD INJURY
805.8	CLOSED FRACTURE OF UNSPECIFIED PART OF VERTEBRAL COLUMN WITHOUT SPINAL CORD INJURY
805.9	OPEN FRACTURE OF UNSPECIFIED PART OF VERTEBRAL COLUMN WITHOUT SPINAL CORD INJURY
806.00	CLOSED FRACTURE OF C1-C4 LEVEL WITH UNSPECIFIED SPINAL CORD INJURY
806.01	CLOSED FRACTURE OF C1-C4 LEVEL WITH COMPLETE LESION OF CORD
806.02	CLOSED FRACTURE OF C1-C4 LEVEL WITH ANTERIOR CORD SYNDROME
806.03	CLOSED FRACTURE OF C1-C4 LEVEL WITH CENTRAL CORD SYNDROME
806.04	CLOSED FRACTURE OF C1-C4 LEVEL WITH OTHER SPECIFIED SPINAL CORD INJURY
806.05	CLOSED FRACTURE OF C5-C7 LEVEL WITH UNSPECIFIED SPINAL CORD INJURY
806.06	CLOSED FRACTURE OF C5-C7 LEVEL WITH COMPLETE LESION OF CORD
806.07	CLOSED FRACTURE OF C5-C7 LEVEL WITH ANTERIOR CORD SYNDROME
806.08	CLOSED FRACTURE OF C5-C7 LEVEL WITH CENTRAL CORD SYNDROME
806.09	CLOSED FRACTURE OF C5-C7 LEVEL WITH OTHER SPECIFIED SPINAL CORD INJURY
806.10	OPEN FRACTURE OF C1-C4 LEVEL WITH UNSPECIFIED SPINAL CORD INJURY
806.11	OPEN FRACTURE OF C1-C4 LEVEL WITH COMPLETE LESION OF CORD
806.12	OPEN FRACTURE OF C1-C4 LEVEL WITH ANTERIOR CORD SYNDROME
806.13	OPEN FRACTURE OF C1-C4 LEVEL WITH CENTRAL CORD SYNDROME
806.14	OPEN FRACTURE OF C1-C4 LEVEL WITH OTHER SPECIFIED SPINAL CORD INJURY
806.15	OPEN FRACTURE OF C5-C7 LEVEL WITH UNSPECIFIED SPINAL CORD INJURY
806.16	OPEN FRACTURE OF C5-C7 LEVEL WITH COMPLETE LESION OF CORD
806.17	OPEN FRACTURE OF C5-C7 LEVEL WITH ANTERIOR CORD SYNDROME
806.18	OPEN FRACTURE OF C5-C7 LEVEL WITH CENTRAL CORD SYNDROME
806.19	OPEN FRACTURE OF C5-C7 LEVEL WITH OTHER SPECIFIED SPINAL CORD INJURY
806.20	CLOSED FRACTURE OF T1-T6 LEVEL WITH UNSPECIFIED SPINAL CORD INJURY
806.21	CLOSED FRACTURE OF T1-T6 LEVEL WITH COMPLETE LESION OF CORD
806.22	CLOSED FRACTURE OF T1-T6 LEVEL WITH ANTERIOR CORD SYNDROME
806.23	CLOSED FRACTURE OF T1-T6 LEVEL WITH CENTRAL CORD SYNDROME
806.24	CLOSED FRACTURE OF T1-T6 LEVEL WITH OTHER SPECIFIED SPINAL CORD INJURY
806.25	CLOSED FRACTURE OF T7-T12 LEVEL WITH UNSPECIFIED SPINAL CORD INJURY
806.26	CLOSED FRACTURE OF T7-T12 LEVEL WITH COMPLETE LESION OF CORD
806.27	CLOSED FRACTURE OF T7-T12 LEVEL WITH ANTERIOR CORD SYNDROME
806.28	CLOSED FRACTURE OF T7-T12 LEVEL WITH CENTRAL CORD SYNDROME
806.29	CLOSED FRACTURE OF T7-T12 LEVEL WITH OTHER SPECIFIED SPINAL CORD INJURY
806.30	OPEN FRACTURE OF T1-T6 LEVEL WITH UNSPECIFIED SPINAL CORD INJURY
806.31	OPEN FRACTURE OF T1-T6 LEVEL WITH COMPLETE LESION OF CORD
806.32	OPEN FRACTURE OF T1-T6 LEVEL WITH ANTERIOR CORD SYNDROME
806.33	OPEN FRACTURE OF T1-T6 LEVEL WITH CENTRAL CORD SYNDROME
806.34	OPEN FRACTURE OF T1-T6 LEVEL WITH OTHER SPECIFIED SPINAL CORD INJURY
806.35	OPEN FRACTURE OF T7-T12 LEVEL WITH UNSPECIFIED SPINAL CORD INJURY
806.36	OPEN FRACTURE OF T7-T12 LEVEL WITH COMPLETE LESION OF CORD
806.37	OPEN FRACTURE OF T7-T12 LEVEL WITH ANTERIOR CORD SYNDROME
806.38	OPEN FRACTURE OF T7-T12 LEVEL WITH CENTRAL CORD SYNDROME
806.39	OPEN FRACTURE OF T7-T12 LEVEL WITH OTHER SPECIFIED SPINAL CORD INJURY
806.4	CLOSED FRACTURE OF LUMBAR SPINE WITH SPINAL CORD INJURY
806.5	OPEN FRACTURE OF LUMBAR SPINE WITH SPINAL CORD INJURY
806.60	CLOSED FRACTURE OF SACRUM AND COCCYX WITH UNSPECIFIED SPINAL CORD INJURY
806.61	CLOSED FRACTURE OF SACRUM AND COCCYX WITH COMPLETE CAUDA EQUINA LESION
806.62	CLOSED FRACTURE OF SACRUM AND COCCYX WITH OTHER CAUDA EQUINA INJURY
806.69	CLOSED FRACTURE OF SACRUM AND COCCYX WITH OTHER SPINAL CORD INJURY
806.70	OPEN FRACTURE OF SACRUM AND COCCYX WITH UNSPECIFIED SPINAL CORD INJURY
806.71	OPEN FRACTURE OF SACRUM AND COCCYX WITH COMPLETE CAUDA EQUINA LESION
806.72	OPEN FRACTURE OF SACRUM AND COCCYX WITH OTHER CAUDA EQUINA INJURY
806.79	OPEN FRACTURE OF SACRUM AND COCCYX WITH OTHER SPINAL CORD INJURY

Group 3 Covered ICD-9 Code	Group 3 Covered ICD-9 Code Description
806.8	CLOSED FRACTURE OF UNSPECIFIED VERTEBRA WITH SPINAL CORD INJURY
806.9	OPEN FRACTURE OF UNSPECIFIED VERTEBRA WITH SPINAL CORD INJURY
E932.0	ADRENAL CORTICAL STEROIDS CAUSING ADVERSE EFFECTS IN THERAPEUTIC USE
V45.77	ACQUIRED ABSENCE OF ORGAN GENITAL ORGANS
V49.81	ASYMPTOMATIC POSTMENOPAUSAL STATUS (AGE-RELATED) (NATURAL)
V58.65	LONG-TERM (CURRENT) USE OF STEROIDS

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
10/25/2013	R4	10/25/2013: This article was revised to add the Jurisdiction K Maine, Massachusetts, New Hampshire, Rhode Island and Vermont Part B Contract Numbers 14112, 14212, 14312, 14412 and 14512.
10/18/2013	R3	10/18/2013: This article was revised to add Jurisdiction K Maine, Massachusetts, New Hampshire, Rhode Island and Vermont Part A contract numbers 14111, 14211, 14311, 14411 and 14511.
09/07/2013	R2	09/07/2013 - This article was revised to add the Jurisdiction 6 Illinois Part B Contract Number 06102, Minnesota Part B Contract Number 06202 and Wisconsin Part B Contract Number 06302. 08/10/2013 - This article was revised to add the Jurisdiction 6 Minnesota Part A Contract Number 06201. 07/13/2013 - This article was revised to add the Jurisdiction 6 Illinois Part A Contract Number 06101 and Wisconsin MAC Part A Contract Number 06301.
08/10/2013	R1	This medical policy article replaces the retired LCD for Bone Mass Measurement, L26385, and related Supplemental Instructions Article, A45912, effective October 1, 2012.

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Associated Documents

Related Local Coverage Document(s)
N/A

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 08/27/2013 with effective dates 10/25/2013 - N/A
Updated on 08/21/2013 with effective dates 10/18/2013 - N/A
Updated on 07/16/2013 with effective dates 09/07/2013 - N/A
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Keywords

N/A
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