MEDICARE PART A BULLETIN

July 22, 1998 General Medicare Bulletin G-341

TO: All Medicare Participating Providers

FROM: Program Relations

SUBJECT: **STANDARDIZATION OF MEDICARE COVERAGE OF BONE MASS MEASUREMENTS**

ATTENTION MEDICARE BUSINESS OFFICE MANAGER: Please distribute to the appropriate health care personnel.

Section 4106 of the Balanced Budget Act (BBA) of 1997 standardizes Medicare coverage of medically necessary bone mass measurements by providing for uniform coverage under Medicare Part B, as provided under §1861(s)(15) of the Social Security Act. **This standardized coverage is effective for claims with dates of service furnished on or after July 1, l998**. Bone mass measurement is a radiologic or radioisotopic procedure or other procedure:

•Performed with a bone densitometer (other than dual photon absorptiometry (DPA)) or a bone sonometer (i.e., ultrasound) device that has been approved or cleared for marketing by the Food and Drug Administration (FDA); or

•Performed on a qualified individual for the purpose of identifying bone mass or detecting bone loss or determining bone quality; and includes a physician's interpretation of the results of the procedure.

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 7.5 mg of prednisone, or greater, per day, for more than 3 months;

•An individual with primary hyperparathyroidism; or

•An individual being monitored to assess the response to or efficacy of an FDA- approved

osteoporosis drug therapy.

Tests not ordered by the appropriate physician or qualified nonphysician practitioner who is treating the beneficiary are not reasonable and necessary. 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.

Coverage criteria for bone mass measurements are as follows:

- Are ordered by the individual's physician or qualified nonphysician practitioner treating the beneficiary following an evaluation of the need for a measurement, including a determination as to the medically appropriate measurement to be used for the individual;
- Are furnished by a qualified supplier or provider of such services under at least the general level of supervision of a physician as defined in 1861(r) of the Social Security Act;
- Are reasonable and necessary for diagnosing, treating, or monitoring a "qualified individual" as defined above; and
- Are performed with a bone densitometer or a bone sonometer device approved or cleared for marketing by the FDA for bone mass measurement purposes, with the exception of DPA devices.

Frequency Standard

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). However, if medically necessary, Medicare may cover a bone mass measurement for a beneficiary more frequently than every 2 years. Examples of situations where more frequent bone mass measurements procedures may be medically necessary include, but are not limited to, the following medical circumstances:

Monitoring beneficiaries on long-term glucocorticoid (steroid) therapy of more than 3 months; and

Allowing for a confirmatory baseline bone mass measurement (either central or peripheral) to permit monitoring of beneficiaries in the future if the initial test was performed with a technique that is different from the proposed monitoring method (for example, if the initial test was performed using bone sonometry and monitoring is anticipated using bone densitometry, Medicare will allow coverage of baseline measurement using bone densitometry).

HCPCS Coding

The following existing HCPCS codes should be used for these bone mass measurements:

- 76075 - Dual energy x-ray absorptiometry (DEXA), bone density study, one or more sites; axial skeleton (eg, hips, pelvis, spine);

•76076 - Dual energy x-ray absorptiometry (DEXA), bone density study, one or more sites; appendicular skeleton (peripheral) (eg, radius, wrist, heel);

•76078 - Radiographic absorptiometry (photodensitometry), one or more sites; and

•78350 - Bone density (bone mineral content) study, one or more sites, single photon absorptiometry.

In addition, the following new HCPCS codes have been established for bone mass measurements:

•G0130 - Single energy x-ray absorptiometry (SEXA) bone density study, one or more sites, appendicular skeleton (peripheral) (eg, radius, wrist, heel) (Short descriptor: SINGLE ENERGY X-RAY STUDY);

•G0131 - Computerized tomography bone mineral density study, one or more sites; axial skeleton (eg, hips, pelvis, spine) (Short descriptor: CT SCAN, BONE DENSITY STUDY);

•G0132 - Computerized tomography bone mineral density study, one or more sites; appendicular skeleton (peripheral) (eg, radius, wrist, heel) (Short descriptor: CT SCAN, BONE DENSITY STUDY); and

•G0133 - Ultra-sound bone mineral density study, one or more sites, appendicular skeleton (peripheral) (eg, radius, wrist, heel) (Short descriptor: ECHO EXAM, BONE DENSITY STUDY).

All of the aforementioned, HCPCS codes are bone densitometry measurements except HCPCS code G0133 which qualifies as a bone sonometry measurement. Any of the above HCPCS codes, as appropriate, should be used when billing for bone mass measurements.

NOTE: For claims with dates of service on or after July 1, 1998, HCPCS codes G0131 and G0132 replace code 76070 which is no longer valid for Medicare purposes.

Applicable Bill Types

The appropriate bill types are 12X, 13X, 14X, 22X, 23X, 34X, 71X (Provider-based and independent), 72X, 73X (Provider-based and freestanding), 83X, and 85X.

Coding Requirements

Providers must report HCPCS codes for bone mass measurements under revenue code 320. In addition, they must report the number of units, and line item dates of service per revenue code line for each bone mass measurement reported. Line item date of service reporting is effective for claims with dates of service on or after October 1, 1998. Effective with services provided on and after October 1, 1998, when the bill spans two or more dates if a line item date of service is not entered for each HCPCS reported the claim will be returned to the provider indicating a billing error has occurred. Providers utilizing the UB-92 flat file use record type 61 to report the bone mass procedure. Record

type (Field No. 1), sequence number (Field No.2), patient control number (Field No. 3), revenue code 320 (Field No. 4), HCPCS code, as appropriate (Field No. 5), units of service (Field No. 8), date of service (Field No. 12, Field No. 9 may be utilized in version 4.1 until September 30, 1998) and outpatient total charges (Field No. 10) are required.

Providers utilizing the hard copy UB-92 (HCFA Form 1450) report the appropriate HCPCS code in Form Locator 44 "HCPCS/Rates," and revenue code 320 in Form Locator 42 "Revenue Code." The date of service is reported in Form Locator 45 "Service Date" (MMDDYY) and the number of service units in Form Locator 46 "Service Units."

Questions regarding this bulletin may be addressed to the Medicare Part A Customer Service Department by calling (904) 355-8899.