

BONE MASS DENSITY ADVISORY REIMBURSEMENT OVERVIEW

Effective Date:

January 1st, 2007

Medicare Coverage:

Medicare has established a national coverage determination for bone density study procedures that address the type of procedures covered, qualified individuals, provider requirements and frequency limitations. Medicare carriers may or may not have a written local coverage determination (LCD) and/or articles outlining additional coding guidelines. Local coverage determinations can and do vary by state. For local coverage details refer to [Medicare's Coverage Database](#) (click on name) or your local Medicare contractor's website.

¹ Medicare identifies a qualified individual as: (Indications)

- ◆ A woman who has been determined by the physician or a qualified non-physician 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 5.0mg of prednisone, or greater per day for more than three months;
- ◆ An individual with primary hyperparathyroidism
- ◆ An individual being monitored to assess the response to or efficacy of a FDA-approved osteoporosis drug therapy.

Please note: The above indications do not pertain to Vertebral Fracture Assessment or Body Composition, both procedures may or may not be a covered service, coverage and payment is left to the discretion of the Medicare contractor.

Private Payers:

Private payers may or may not have written coverage guidelines and/or follow Medicare guidelines outlined above. **Therefore, it is strongly recommended that you consult with your local payers for details on coverage as their policies may include additional indications, approved diagnosis codes and/or restrictions.**

Coding:

²The American Medical Association (AMA) updates for 2007 included a new subsection for Bone/Joint Studies. This section established new codes 77078-77082 to replace codes 76070, 76071, 76075-76077 for bone density studies. (Please note: the codes listed below are the codes pertaining to bone density testing by Dual-Energy X-Ray Absorptiometry only and do not reflect all of the code changes and/or additions for this new subsection. (CPT codes 78350-78351 are non-covered services))

Computed Tomography (CT)

77078 – CT, bone mineral density study, 1 or more sites; axial skeleton (eg. hips, pelvis, spine)

77079 – CT, bone mineral density study, 1 or more sites; appendicular skeleton (peripheral) (eg. radius, wrist, heel)

Dual Energy X-Ray Absorptiometry (DXA)

77080 – DXA, bone density study, 1 or more sites; axial skeleton (eg. hips, pelvis, spine)

77081 – DXA, bone density study, 1 or more sites: appendicular skeleton (peripheral) (eg. radius, wrist, heel)

77082 – DXA, bone density study, Vertebral Fracture Assessment

76977- Ultrasound, bone density measurement and interpretation, peripheral site(s), any method

0028T - DXA, bone density study, Body Composition study, 1 or more sites

Diagnosis (ICD-9) codes:

Medicare and/or private payers with coverage policies may or may not include an approved list of diagnosis codes that support medical necessity. Diagnosis codes that support medical necessity can and do vary by payer; therefore, it is important to contact your local payers for coverage and coding guidelines to ensure accurate billing.

Frequency Guidelines:

¹For those individuals who are eligible, Medicare will pay for a bone density study once every two years, or more frequently if the procedure is determined to be medically necessary. Medically necessary exceptions to the frequency limitation may include individuals on long-term steroid therapy for more than 3 months, individuals with hyperparathyroidism, or a confirmatory baseline measurement to permit monitoring in the future on an axial densitometer when the initial measurement was not performed by this system. Commercial may or may follow these guidelines, please refer to your local policy for details.

Reimbursement:

Medicare reimbursement for bone density study procedures is comprised of a professional component, the amount paid for the physician's interpretation of the results of the scan, and a technical component, the amount paid for all other services (including staffing and equipment costs). When these components are combined and paid to the same individual or entity, this amount is often referred to as the global or total reimbursement.

Currently, Medicare reimburses imaging procedures differently based on the site of care. The technical component of procedures performed in an IDTF or a physician's office is reimbursed under the Medicare physician fee schedule. In a hospital outpatient department, the technical component of a procedure is reimbursed under an Ambulatory Payment Classification (APC 0288) under Medicare's hospital outpatient department prospective payment system (HOPPS). In a hospital inpatient site of care, the technical (facility) payment is subsumed within the payment to the hospital that is determined based on the Diagnosis Related Group (DRG) to which the patient is assigned and the professional component is reimbursed under the Medicare physician fee schedule regardless of the setting.

³The Deficit Reduction Act (DRA) provision calls for capping reimbursement of the technical component for x-ray and imaging services as defined by The Centers for Medicare and Medicaid Services at the lesser rate of the hospital outpatient rate or the physician fee schedule. The professional component is not affected by the DRA provision although it is added in to the global reimbursement amount. Bone density procedures are subject to the DRA provisions.

To obtain more information about local Medicare reimbursement rates for selected bone density study procedures, go to the [GE Bone Densitometry Medicare Reimbursement Calculator](#) (click on name). To confirm local reimbursement rates, consult your local Medicare contractor.

Other helpful information:

Bone Density testing is one of twelve Preventive Services offered by CMS. CMS has developed a variety of educational products for health care professionals to help increase awareness of preventive services covered by Medicare and provide coverage / billing information needed to effectively bill Medicare for preventive services provided to Medicare patients. The link to information and resources to help

communicate with beneficiaries about these benefits are available at:

<http://www.cms.hhs.gov/PrevntionGenInfo/>.

To find more information about osteoporosis and secondary causes of low bone mass and coverage guidelines, please visit the websites listed below by clicking on the name. To ensure all patients who may qualify for a bone density test with the national payers, we strongly recommend visiting their websites and/or contact your provider representative. Please note, payment for any service depends on several factors to include but is not limited to the patients' benefit plan, medical necessity, medical coverage policy, and the physicians' contract.

The following are electronic hyperlinks

NATIONAL ORGANIZATIONS LINK:

- ◆ [World Health Organization](#)
- ◆ [National Osteoporosis Foundation](#)
- ◆ [International Osteoporosis Foundation](#)
- ◆ [International Society of Densitometry](#)
- ◆ [HHS, office of the Surgeon General](#)

PAYER LINKS:

- ◆ [The Centers for Medicare and Medicaid](#)
- ◆ [Aetna Healthcare](#)
- ◆ [Blue Cross Blue Shield](#) (click on your state, medical policies vary by state)
- ◆ [Cigna Healthcare](#)
- ◆ [United Healthcare Online](#)

Resources:

¹ Final 2007 Medicare physician fee schedule, Federal Register, Vol. 71, No. 231, December 1, 2006. Title 42 CFR §410.31 Bone Density study: Conditions for coverage and frequency standards, Medicare Intermediary (Paper-Based), Part 3, §3631 and Medicare Carriers Manual (Paper-Based), Part 3, §4181.1 and §418.2.

² American Medical Association, CPT 2007 Changes: An Insider's View

³ Per the Deficit Reduction Act of 2005, designated imaging services with a 2007 Medicare physician fee schedule technical payment (prior to geographic adjustment) that exceeds the comparable 2007 hospital outpatient prospective payment system (HOPPS) technical payment (prior to geographic adjustment), as published in Federal Register, Vol. 71, No. 226, November 24, 2006, will be capped at the 2007 HOPPS payment amount.

Additional Resources:

* Information presented in this document is current as of January 1st, 2007. Any subsequent changes, which may occur in coding and coverage, are not reflected herein.

* The Food and Drug Administration (FDA) approved labeling for a particular item of GEHC equipment may not specifically cover all of the procedures discussed in this customer advisory. Some payers may in some instances treat a procedure, which is not specifically covered by the equipment's FDA-approved labeling as a non-covered service.

* The federal statute known as the Stark Law (42 U.S.C. §1395nn) imposes certain requirements, which must be met in order for physicians to bill Medicare patients for in-office radiology services. In some states, similar laws cover billing for all patients. In addition, licensure, certificate of need, and other restrictions may be applicable.

* CPT codes and descriptions only are copyright © 2007 American Medical Association. All rights reserved. No fee schedules are included in CPT. The American Medical Association assumes no liability for data contained or not contained herein.

* American Medical Association. Appendix M- "Summary of Crosswalked Deleted CPT Codes." CPT® 2007 Professional Edition.