2019 Bone Density & Supplementary DXA Exam Reimbursement Guide[1]

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Overview

This overview addresses coding and payment for bone mineral density studies and dual-energy absorption (DXA) procedures to assess risk of atypical femoral fracture (AFF).[2] These studies may be performed in hospital outpatient, independent diagnostic test facilities (IDTFs), or physician office settings.[3] While this advisory focuses on Medicare program policies, these policies may also be applicable to selected private payers throughout the country.

Current Procedural Terminology (CPT)[4] Coding and Definitions:

Dual Energy X-ray Absorptiometry (DXA)

CPT[4]/HCPCS Code	
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)
76977	Ultrasound, bone density measurement and interpretation, peripheral site(s), any method

Modifiers

Modifiers explain that a procedure or service was changed without changing the definition of the CPT code set. Here are some common modifiers related to the use of bone density test/study procedures.

26 – Professional Component

A physician who interprets an exam in the hospital outpatient setting may submit a charge for the professional component of the bone density test/study service using a modifier (-26) appended to the appropriate CPT code.

TC – Technical Component

This modifier would be used to bill for services by the owner of the equipment only to report the technical component of the service.

ICD-10-CM and ICD-10-PCS Codes

ICD-10-CM (diagnosis) and ICD-10-PCS (procedure) codes were implemented October 1, 2015. It is the physician's ultimate responsibility to select the codes that appropriately represent the service performed, and to report the ICD-10-CM code based on his or her findings or the pre-service signs, symptoms or conditions that reflect the reason for doing the bone mineral density procedures.

Frequency guidelines[5]

For 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 function in your organization may or may not follow these guidelines; please refer to your local policy for details.

Payment Methodologies

Medicare reimburses for bone density services when the services are within the scope of the provider's license and are deemed medically necessary. The following describes the various payment methods by site of service.

Site of Service

Physician Office Setting

In the office setting, a physician who owns the equipment and performs the service may report the global code without a -26 modifier.

Hospital Outpatient Setting

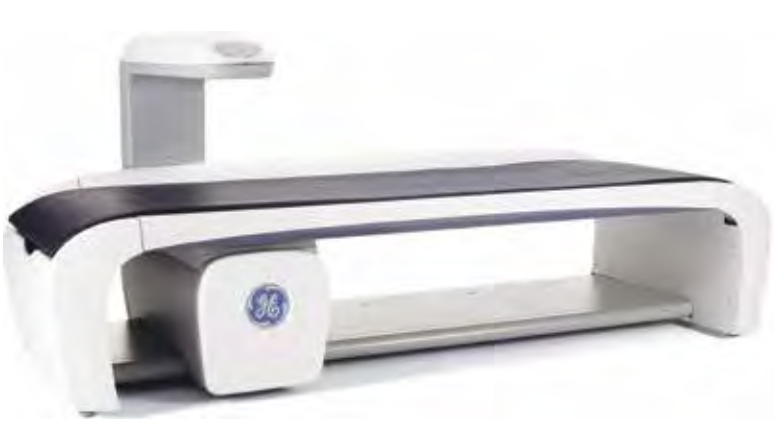
When the bone density test/study is performed in the hospital outpatient setting, physicians may not submit a global charge to Medicare because the global charge includes both the professional and technical components of the service.

If the procedure is performed in the hospital outpatient setting, the hospital may bill for the technical component of the bone density test/study service as an outpatient service.

The CPT code filed by the hospital will be assigned to a hospital outpatient system Ambulatory Payment Classification (APC) payment system, and payment will be based on the APC grouping. However, for Medicare, the hospital outpatient facility and the physician must report the same CPT code. If the physician is a hospital employee, the hospital may submit a charge for the global service.

Hospital Inpatient Setting

Charges occurring in the hospital inpatient setting would be considered part of the charges submitted for the inpatient stay and payment would be made under the Medicare MS-DRG payment system. However, the physician may still submit a bill for his/her professional services when performed in a hostpital-inpatient site of service.



Coding and Payment Information

The following provides 2019 national Medicare Physician Fee Schedule (MPFS) and the Hospital Outpatient Ambulatory Payment Category (APC) payment rates for the CPT[1] codes identified in this guide. Payment will vary in geographic locality.

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 at ***https://www.cms.gov/medicare-coverage-database/*** or your local Medicare contractor's website.

Medicare[6] identifies a qualified individual as:

- 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,
- An individual with vertebral abnormalities
- Individuals getting (or expecting to get) glucocorticoid therapy for more than 3 months
- An Individual with primary hyperparathyroidism
- An individual being monitored to assess response to U.S. Food and Drug Administration (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 your local payers for details on coverage as their policies may include additional indications, approved diagnosis codes and/or restrictions.

Table 1: 2019 Medicare Reimbursement for bone density procedures[7] – DXA and Ultrasound (Reflects national rates, unadjusted for locality)

CPT[4] Code Description	Reimbursement Component	Medicare Physician Reimbursement[8]	APC[9]	Medicare Outpatient Hospital Reimbursement[9]
Dual-Energy X-ray Absorptiometry (DXA)				
77080 Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites, axial skeleton (eg, hips, pelvis, spine)	Professional (-26)*	$10.09	5522	$112.51
	Technical (-TC)**	$30.63		
	Global	$40.72		
77081 Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites, appendicular skeleton (peripheral) (eg, radius, wrist, heel)	Professional (-26)	$10.45	5521	$62.30
	Technical (-TC)	$23.43		
	Global	$33.88		
77085 Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites, axial skeleton (eg, hips, pelvis, spine), including vertebral fracture assessment	Professional (-26)	$15.50	5522	$112.51
	Technical (-TC)	$40.00		
	Global	$55.50		
77086 Vertebral fracture assessment via dual-energy X-ray absorptiometry (DXA)	Professional (-26)	$8.65	5521	$62.30
	Technical (-TC)	$27.03		
	Global	$35.68		
76977 Ultrasound, bone density measurement and interpretation, peripheral site(s), any method	Professional (-26)	$2.88	5522	$112.50
	Technical (-TC)	$4.69		
	Global	$7.57		
DXA Atypical Femoral Fracture[10]				
73551 Radiologic examination, femur, 1 view	Professional (-26)	$8.65	5521	$62.30
	Technical (-TC)	$20.18		
	Global	$28.38		

* Professional – Physician Payment
** Technical – Facility Payment

Other Helpful Information

Bone mineral 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: ***www.cms.hhs.gov/PrevntionGenInfo***.

To find more information about osteoporosis and secondary causes of low bone mineral density and coverage guidelines, please visit the websites listed below by clicking on the name. To ensure all patients who may qualify for a bone mineral density test with the national payers, either visiting their websites or directly contacting a payer representative is recommended.

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.*

National Organizations Links

- World Health Organization: ***www.who.int/en***
- National Osteoporosis Foundation: ***www.nof.org***
- International Osteoporosis Foundation: ***www.iofbonehealth.org***
- International Society of Densitometry: ***www.iscd.org***
- HHS, office of the Surgeon General: ***https://www.surgeongeneral.gov/***

Payer Links

- The Centers for Medicare and Medicaid: ***https://www.cms.gov/medicare-coverage-database/***
- Aetna Healthcare: ***http://www.aetna.com/cpb/medical/data/100_199/0134.html***
- Humana: ***Preventive Care Services (click to access)***
- United Healthcare Online: ***Preventive Care Services (click to access)***

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Atypical Femoral Fracture Examination Reporting

For 2017, the American College of Radiology (ACR) updated their guidance for reporting imaging related to the diagnosis of atypical femoral fractures. Specifically ACR has indicated CPT code 73551 (Radiologic examination; femur, 1 view) may be reported when an examination is performed with a DXA imaging technique. This guidance is reported online at The ACR Radiology Coding Source™ May-June 2017, Q&A section.[10]

Resources

1. Information presented in this document is current as of January 1, 2019. Any subsequent changes, which may occur in coding and coverage, are not reflected herein
2. 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
3. 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
4. Current Procedural Terminology © 2018 American Medical Association. All Rights Reserved. No fee schedules, basic units, relative values, or related listings are included in CPT. The AMA assumes no liability for the data contained herein. Applicable FARS/DFARS restrictions apply to government use.
5. American Medical Association, CPT 2007 Changes: An Insider's View.
6. CMS Manual System, Pub 100-02 Medicare Benefit Policy, Transmittal 70 MAY 11, 2007, ***https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R70BP.pdf***. Click **here** to activate hyperlink.
7. The payment amounts indicated are estimates only based upon data elements derived from various CMS sources. Actual Medicare payment rates may vary based on any deductibles, copayments and sequestration rules that apply.
8. Third party reimbursement amounts and coverage policies for specific procedures will vary by payer and by locality. The technical and professional components are paid under the Medicare physician fee schedule (MPFS). The MPFS payment is based on relative value units published in the Federal Register/Vol. 83, No. 226/Friday, November 23, 2018 and subsequent updates based upon legislation enacted by CMS. These changes are effective for services provided from 1/1/19 through 12/31/19. CMS may make adjustments to any or all of the data inputs from time to time. Amounts do not necessarily reflect any subsequent changes in payment since publication. To confirm reimbursement rates for specific codes, consult with your local Medicare contractor.
9. Third party reimbursement amounts and coverage policies for specific procedures will vary by payer and by locality. The technical component is a payment amount assigned to an Ambulatory Payment Classification under the hospital outpatient prospective payment system. The payment amounts indicated are based upon data elements published in the Federal Register/Vol. 83, No. 225/Wednesday, November 21, 2018. These changes are effective for services provided from 1/1/19 through 12/31/19. CMS may make adjustments to any or all of the data inputs from time to time. Amounts do not necessarily reflect any subsequent changes in payment since publication. To confirm reimbursement rates for specific codes, consult with your local Medicare contractor.
10. The ACR Radiology Coding Source™ May-June 2017, Q& A section, ***https://www.acr.org/Advocacy/Economics-Health-Policy/Billing-Coding/Coding-Source-List/2017/May-June-2017/QA***
    Click **here** to activate the hyperlink

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