

CMS Guidance Document	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Executive Guidance Number 0184	Date: January 2, 2008
Planned Web Site Address http://www.cms.hhs.gov/manuals/	Release planned: 12/16/08

PROGRAM AREA: Fee for Service

SUBJECT: Clarification of Bone Mass Measurement (BMM) Billing Requirements

APPLIES TO: Hospitals, Physicians

I. SUMMARY OF DOCUMENT: This CR clarifies the claims processing instructions contained in CR 5521. Only those business requirements changing from CR 5521 are listed in this CR. The BMM benefit policy is not changing.

II. CHANGES IN POLICY INSTRUCTIONS: (If not applicable, indicate N/A)

STATUS: R=REVISED, N=NEW, D=DELETED.

Status	CHAPTER/SECTION/SUBSECTION/TITLE
R	13/140/Bone Mass Measurements (BMM)
R	13/140.1/Payment Methodology and HCPCS Coding

III. CLEARANCES:

Clearance & Point of Contact (POC)	Name/Telephone/Component
Senior Official Clearance	Barry Straub, M.D./OCSQ/410-786-6841
Agency POC	William Larson/OCSQ/410-786-4639

IV. TYPE (Check appropriate boxes for type of guidance)

<input type="checkbox"/>	Audit Guide
<input checked="" type="checkbox"/>	Change Request
<input type="checkbox"/>	HPMS
<input type="checkbox"/>	Joint Signature Memorandum/Technical Director Letter
<input type="checkbox"/>	Manual Transmittal/Non-Change Request
<input type="checkbox"/>	State Medicaid Director Letters
<input type="checkbox"/>	Other

V. STATUTORY OR REGULATORY AUTHORITY: N/A

Attachment - Business Requirements

Pub. 100-04	Transmittal:	Date:	Change Request: 5847
-------------	--------------	-------	----------------------

SUBJECT: Clarification of Bone Mass Measurement Billing Requirements

Effective Date: January 1, 2007

Implementation Date: 30 Days from Issuance

I. GENERAL INFORMATION

A. Background: On May 11, 2007, CMS issued change request (CR) 5521 providing benefit policy and claims processing instructions for bone mass measurement (BMM) tests. It has come to CMS's attention that the updated policy described in CR 5521 is not being implemented uniformly and that some covered services are being denied in error.

B. Policy: This CR clarifies the claims processing instructions contained in CR 5521 to allow BMM procedure codes other than CPT code 77080 (i.e., 76977, 77078, 77079, 77081, 77083, and G0130) to be paid even though claims for such services report both a screening diagnosis code and an osteoporosis code. Under CR 5521, claims for procedure codes other than CPT code 77080 reporting both a screening diagnosis code and an osteoporosis code have been inappropriately denied contrary to the original intent of the instruction. Only those business requirements changing from CR 5521 are listed in this CR. The BMM benefit policy is not changing.

II. BUSINESS REQUIREMENTS TABLE

Use "Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B M A C	D M E M A C	F I M A C	C A R R I E R	R H I	Shared-System Maintainers				OTHER
							F I S S	M C S	V M S	C W F	
5847.1	Effective for dates of service on or after January 1, 2007, contractors shall cover certain BMM tests when used to screen patients for osteoporosis subject to the frequency standards described in chapter 15, section 80.5.5 of the Medicare Benefit Policy Manual.	X		X	X						
5847.1.1	Contractors shall pay claims for screening tests when coded as follows: <ul style="list-style-type: none"> • Contains CPT procedure code 77078, 77079, 77080, 77081, 77083, 76977 or G0130, and • Contains a valid ICD-9-CM diagnosis code indicating the reason for the test is postmenopausal female, vertebral fracture, hyperparathyroidism, or steroid therapy. 	X		X	X						
5847.1.1.1	Contractors shall maintain local lists of valid ICD-9-CM diagnosis codes for the benefit's screening categories.	X		X	X						

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B M A C	D M E M A C	F I	C A R R I E R	R H I	Shared-System Maintainers				OTHER
							F I S S	M C S	V M S	C W F	
5847.1.2	<p>Contractors shall deny claims for screening tests when coded as follows:</p> <ul style="list-style-type: none"> • Contains CPT procedure code 77078, 77079, 77081, 77083, 76977 or G0130, but • Does not contain a valid ICD-9-CM diagnosis 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. 	X		X	X						
5847.2	Effective for dates of service on or after January 1, 2007, contractors shall cover dual-energy x-ray absorptiometry (axial) tests when used to monitor FDA-approved osteoporosis drug therapy subject to the frequency standards described in chapter 15 section 80.5.5 of the Medicare Benefit Policy Manual.	X		X	X						
5847.2.1	<p>Contractors shall pay claims for monitoring tests when coded as follows:</p> <ul style="list-style-type: none"> • 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. 	X		X	X						
5847.2.2	<p>Contractors shall deny claims for monitoring tests when coded as follows:</p> <ul style="list-style-type: none"> • Contains CPT procedure code 77078, 77079, 77081, 77083, 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 diagnosis code, but • Does not contain a valid ICD-9-CM diagnosis 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, 	X		X	X						

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B M A C	D M E M A C	F I	C A R R I E R	R H H I	Shared-System Maintainers				OTHER
							F I S S	M C S	V M S	C W F	
	hyperparathyroidism, or steroid therapy.										
5847.3	Contractors need not search their files for claims already processed, however, contractors shall adjust claims brought to their attention.	X		X	X						

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B M A C	D M E M A C	F I	C A R R I E R	R H H I	Shared-System Maintainers				OTHER
							F I S S	M C S	V M S	C W F	
5847.4	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X		X	X						

IV. SUPPORTING INFORMATION

A. For any recommendations and supporting information associated with listed requirements, use the box below:

Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

B. For all other recommendations and supporting information, use this space:

V. CONTACTS

Pre-Implementation Contact(s):

Benefit Policy: Bill Larson, william.larson@cms.hhs.gov, 410-786-4639
Institutional Claims Processing: Bill Ruiz, william.ruiz@cms.hhs.gov, 410-786-9283
Physician Claims Processing: Tom Dorsey, thomas.dorsey@cms.hhs.gov, 410-786-7434

Post-Implementation Contact(s): Regional Office

VI. FUNDING

A. For Fiscal Intermediaries and Carriers: No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

B. For Medicare Administrative Contractors (MAC): The Medicare Administrative Contractor (MAC) is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as changes to the MAC Statement of Work (SOW). The contractor is not obligated to incur costs in excess of the amounts specified in your contract unless and until specifically authorized by the contracting officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the contracting officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

140 - Bone Mass Measurements (BMMs)

(Rev.)

Sections 1861(s)(15) and (rr)(1) of the Social Security Act (the Act) (as added by §4106 of the Balanced Budget Act (BBA) of 1997) standardize 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.

Effective for dates of service on and after January 1, 2007, the CY 2007 Physician Fee Schedule final rule expanded the number of beneficiaries qualifying for BMM by reducing the dosage requirement for glucocorticoid (steroid) therapy from 7.5 mg of prednisone per day to 5.0 mg. It also changed the definition of BMM by removing coverage for a single-photon absorptiometry as it is not considered reasonable and necessary under section 1862 (a)(1)(A) of the Act. *Finally, it required that in the case of monitoring and confirmatory baseline BMMs, they be performed with a dual-energy x-ray absorptiometry (axial) test.*

Conditions of Coverage for BMMs are located in Pub.100-02, Medicare Benefit Policy Manual, chapter 15.

140.1 - Payment Methodology and HCPCS Coding

(Rev.)

Carriers pay for BMM procedures based on the Medicare physician fee schedule. Claims from physicians, other practitioners, or suppliers where assignment was not taken are subject to the Medicare limiting charge.

The FIs pay for BMM procedures under the current payment methodologies for radiology services according to the type of provider.

Do not pay BMM procedure claims for dual photon absorptiometry, CPT procedure code 78351.

Deductible and coinsurance apply.

Any of the following CPT procedure codes may be used when billing for BMMs through December 31, 2006. All of these codes are bone densitometry measurements except code 76977, which is bone sonometry measurements. CPT procedure codes are applicable to billing FIs and carriers.

76070 76071 76075 76076 76078 76977 78350 G0130

Effective for dates of services on and after January 1, 2007, the following changes apply to BMM:

- New 2007 CPT bone mass procedure codes have been assigned for BMM. The following codes will replace current codes, however the CPT descriptors for the services remain the same:

77078 replaces 76070

77079 replaces 76071

77080 replaces 76075

77081 replaces 76076

77083 replaces 76078

- *Certain BMM tests are covered when used to screen patients for osteoporosis subject to the frequency standards described in chapter 15, section 80.5.5 of the Medicare Benefit Policy Manual.*
 - *Contractors will pay claims for screening tests when coded as follows:*
 - *Contains CPT procedure code 77078, 77079, 77080, 77081, 77083, 76977 or G0130, and*
 - *Contains a valid ICD-9-CM diagnosis code indicating the reason for the test is postmenopausal female, vertebral fracture, hyperparathyroidism, or steroid therapy. Contractors are to maintain local lists of valid codes for the benefit's screening categories.*
 - *Contractors will deny claims for screening tests when coded as follows:*
 - *Contains CPT procedure code 77078, 77079, 77081, 77083, 76977 or G0130, but*
 - *Does not contain a valid ICD-9-CM diagnosis 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.*
- *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, 77079, 77081, 77083, 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 diagnosis code, but*
 - *Does not contain a valid ICD-9-CM diagnosis 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.*
- Single photon absorptiometry *tests are not covered. Contractors will deny* CPT procedure code 78350.

The FIs are billed using the ANSI X12N 837 I or hardcopy Form CMS-1450 (UB-92). The appropriate bill types are: 12X, 13X, 22X, 23X, 34X, 71X (Provider-based and independent), 72X, 73X (Provider-based and freestanding), 83X, and 85X. Effective April 1, 2006, type of bill 14X is for non-patient laboratory specimens and is no longer applicable for bone mass measurements.

Providers who use the hard copy UB-92 (Form CMS-1450) report the applicable bill type in Form Locator (FL) 4, Type of Bill.

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.

Carriers are billed for bone mass measurement procedures using the ANSI X12N 837 P or hardcopy Form CMS-1500.