



Related MLN Matters Article #: MM5521 **Revised**

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Related CR #: 5521

### *Bone Mass Measurements (BMMs)*

#### Key Words

MM5521, CR5521, R1236CP, R70BP, R69NCD, Bone, BMM

#### Provider Types Affected

Physicians, practitioners and hospitals that bill Medicare carriers, Fiscal Intermediaries (FIs), or Part A/B Medicare Administrative Contractors (A/B MACs) for BMM services

**Note:** MLN Matters article MM5521 was revised to clarify the Medicare Summary Notices on page 2 below. Essentially, MSN 16.10 will be issued with a denied claim as well as either MSN 36.1 or MSN 36.2, depending on if an Advance Beneficiary Notice (ABN) is issued. A link (<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5847.pdf>) to related MLN Matters article MM5847 was also added. MM5847 clarifies the claims processing instructions contained in Change Request (CR) 5521. The URL for the brochure for bone measurements was also changed.

#### Key Points

- The effective date of the instruction is January 1, 2007.
- The implementation date is July 2, 2007.
- MLN Matters article MM5521 and related CR5521 inform providers that on June 24, 1998, the Centers for Medicare & Medicaid Services (CMS) published an Interim Final Rule with Comment Period (IFC) in the Federal Register entitled, "*Medicare Coverage of and Payment for Bone Mass Measurements.*"
- This IFC implemented Section 4106 of the Balanced Budget Act by establishing 42 Code of Federal Regulations (CFR) 410.31, Bone Mass Measurement: Conditions for Coverage and Frequency Standards.
- This new regulation defined BMM and individuals qualified to receive a BMM, established conditions for coverage under the "reasonable and necessary" provisions of 1862(a)(1)(A) of the Act, and established frequency standards governing when qualified individuals would be eligible for a BMM.
- On December 1, 2006, CMS published the calendar year (CY) 2007 Physician Fee Schedule final rule, which included changes to 42 CFR 410.31. These changes can be found in Chapter 15, Section 80.5

of the *Medicare Benefit Policy Manual* and in Chapter 13, Section 140 of the *Medicare Claims Processing Manual*.

**Changes to Chapter 13 of the *Medicare Claims Processing Manual*  
(Effective for dates of service on or after January 1, 2007)**

- MM5521 lists a summary of the revisions and additions to Chapter 13 of the *Medicare Claims Processing Manual*. Below is a brief description of those changes:
  - 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.
  - The table on page 3 of MM5521 lists the new 2007 Current Procedural Terminology (CPT) bone mass codes that have been assigned for BMM. The CPT descriptors for the services remain the same.
  - BMM is not covered when a procedure other than dual-energy x-ray absorptiometry is used to monitor osteoporosis drug therapy. Medicare will not pay for procedure codes 76977, 77078, 77079, 77081, 77083 and G0130 when billed with the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) diagnosis codes: 733.00, 733.01, 733.02, 733.03, 733.09, 733.90, 255.0.
  - BMM is covered when dual-energy x-ray absorptiometry is used to monitor osteoporosis drug therapy. Therefore, Medicare will pay procedure code 77080 when billed with the following ICD-9-CM diagnosis codes or any of the other valid ICD-9-CM diagnoses that are recognized by Medicare contractors appropriate for bone mass measurements: 733.00, 733.01, 733.02, 733.03, 733.09, 733.90, 255.0.
  - In informing beneficiaries about the denials of claims processed for BMMs, Medicare will use the following Medicare Summary Notice (MSN) Messages:
    - MSN16.10: "Medicare does not pay for this item or service." **(FIs should not include this MSN.)**
    - If an ABN **was issued**, the following MSN will also be used:
      - MSN36.1: "Our records show that you were informed in writing, before receiving the service that Medicare would not pay. You are liable for this charge. If you do not agree with this statement, you may ask for a review."
    - If an ABN **was not** issued the following MSN will also be used:
      - MSN 36.2: "It appears that you did not know that we would not pay for this service, so you are not liable. Do not pay your provider for this service. If you have paid your provider for this service, you should submit to this office three things: (1) a copy of this notice, (2) your provider's bill, and (3) a receipt or proof that you have paid the bill. You must file your written request for payment within 6 months of the date of this notice. Future services of this type provided to you will be your responsibility."

**Note:** Effective for services on or after January 1, 2007, Medicare will not pay BMM claims for single photon absorptiometry, procedure code 78350, and will use MSN16.10 when denying the claim.

- The following Remittance Advice (RA) Messages will be issued when Medicare denies BMM claims:
  - Claim adjustment reason code 50: "These are non-covered services because this is not deemed a "medical necessity" by the payer."
    - If an ABN was issued, the RA issued is M38: *"The patient is liable for the charges for this service as you informed the patient in writing before the service was furnished that we would not pay for it, and the patient agreed to pay."*
    - If an ABN was not issued, RA issued is M27: *"The patient has been relieved of liability of payment of these items and services under the limitation of liability provision of the law. You, the provider, are ultimately liable for the patient's waived charges, including any charges for coinsurance, since the items or services were not reasonable and necessary or constituted custodial care, and you knew or could reasonably have been expected to know, that they were not covered. You may appeal this determination. You may ask for an appeal regarding both the coverage determination and the issue of whether you exercised due care. The appeal request must be filed within 120 days of the date you receive this notice. You must make the request through this office."*

**Note:** Physicians, practitioners and hospitals are liable for payment unless they issue an appropriate ABN. More information on ABNs may be found in Chapter 30, Sections 40.3 - 40.3.8 of the *Medicare Claims Processing Manual*, located at <http://www.cms.hhs.gov/Manuals/IOM/list.asp#TopofPage> on the CMS website.

### Changes to Chapter 15 of the *Medicare Benefit Policy Manual*

- MM5521 list a summary of the revisions and additions to Chapter 15 of the *Medicare Benefit Policy Manual*. Below is a brief description of those changes (effective January 1, 2007):
  - **Definition of BMM:** A radiologic, radioisotopic, or other procedure that meets all of the following conditions:
    - Is performed to identify bone mass, detect bone loss, or determine bone quality;
    - Is 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; and
    - Includes a physician's interpretation of the results.
  - **Conditions for Coverage**
    - Medicare covers BMM when it is ordered by a qualified physician or non-physician practitioner who is treating the beneficiary, following an evaluation of the need for a BMM and the appropriate BMM to be used.
    - The BMM must be performed under the appropriate level of supervision as defined in 42 CFR 410.32(b).

- The BMM must be reasonable and necessary for diagnosis and treatment of a beneficiary who meets the conditions stated in Section 80.5.6 of the *Medicare Benefit Policy Manual*. (See Important Links section below.)
- In the case of any individual who is being monitored to assess the response to or efficacy of an FDA-approved osteoporosis drug therapy, the BMM must be performed with a dual-energy x-ray absorptiometry system (axial skeleton).
- In the case of any individual who meets the above conditions and who has a confirmatory BMM, the BMM is performed by a dual-energy x-ray absorptiometry system (axial skeleton) if the initial BMM was not performed by a dual-energy x-ray absorptiometry system.
- A confirmatory baseline BMM is not covered if the initial BMM was performed by a dual-energy x-ray absorptiometry system (axial skeleton).
- **Frequency Standards**
  - Medicare pays for a screening BMM once every 2 years.
  - Medicare may pay for more frequent screenings when medically necessary. Examples include, but are not limited to, the following medical circumstances:
    - Monitoring beneficiaries on long-term glucocorticoid (steroid) therapy of more than 3 months; and
    - Confirming baseline BMMs to permit monitoring of beneficiaries in the future.
- The following **Noncovered BMMs** occur when they are not considered reasonable and necessary under section 1862 (a)(1)(A) of the Act.
  - Single photon absorptiometry (effective January 1, 2007).
  - Dual photon absorptiometry (established in 1983).

## Important Links

The related MLN Matters article can be found at

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5521.pdf> on the CMS website.

A brochure outlining 'Bone Mass Measurements' is available at

[http://www.cms.hhs.gov/MLNProducts/downloads/Bone\\_Mass.pdf](http://www.cms.hhs.gov/MLNProducts/downloads/Bone_Mass.pdf) on the CMS website.

For complete details regarding this CR please see the official instructions (CR5521) issued in the following three transmittals:

- Transmittal 69 contains the *Medicare National Coverage Determination* is at <http://www.cms.hhs.gov/Transmittals/downloads/R69NCD.pdf> on the CMS website;
- Transmittal 70 contains the revised *Medicare Benefit Policy Manual* sections is at <http://www.cms.hhs.gov/Transmittals/downloads/R70BP.pdf> on the CMS website; and
- Transmittal 1236 contains the *Medicare Claims Processing Manual* revisions and is at <http://www.cms.hhs.gov/Transmittals/downloads/R1236CP.pdf> on the CMS website.