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MLN Matters Number: MM5847 **Revised**

Related Change Request (CR) #: 5847

Related CR Release Date: January 18, 2008

Effective Date: January 1, 2007

Related CR Transmittal #: R1416CP

Implementation Date: February 20, 2008

## **Clarification of Bone Mass Measurement (BMM) Billing Requirements Issued in CR 5521**

**Note: This article was updated on August 3, 2012, to reflect current Web addresses. All other information remains the same.**

### **Provider Types Affected**

Physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, Fiscal Intermediaries (FIs), and/or Part A/B Medicare Administrative Contractors (A/B MACs)) for BMM services provided to Medicare beneficiaries.

### **Provider Action Needed**

This article is based on Change Request (CR) 5847 which clarifies the claims processing instructions contained in CR 5521. Only those business requirements changing from CR 5521 are listed in CR 5847, and the BMM benefit policy is not changing. The basic clarification is that Medicare allows 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.

#### Disclaimer

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## Background

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The Social Security Act (Sections 1861(s)(15) and (rr)(1)) (as added by the Balanced Budget Act of 1997 (BBA; §4106)) standardize Medicare coverage of medically necessary BMMs by providing for uniform coverage under Medicare Part B. Effective for dates of service on and after January 1, 2007, the Calendar Year (CY) 2007 Physician Fee Schedule (PFS) 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 the Social Security Act (Section 1862 (a)(1)(A)). Finally, it required in the case of monitoring and confirmatory baseline BMMs, that they be performed with a dual-energy x-ray absorptiometry (axial) test.

The Centers for Medicare & Medicaid Services (CMS) issued change request (CR) 5521 (Transmittal 70; May 11, 2007) to provide benefit policy and claims processing instructions for BMM tests. CMS has learned that the updated policy described in CR 5521 is not being implemented uniformly and some covered services are being denied in error.

You can review the MLN Matters article related to CR 5521 at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM5521.pdf> on the CMS website. CR 5847 clarifies the claims processing instructions contained in CR 5521 and lists only those business requirements changing from CR 5521. The key clarifications are as follows, effective for dates of services on and after January 1, 2007, the following apply to BMM:

- Certain BMM tests are covered when used to screen patients for osteoporosis subject to the frequency standards described in section 80.5.5 of the Medicare Benefit Policy Manual, which may be found at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html> on the CMS website.
- Medicare Contractors will pay claims for screening tests when coded as follows:
  - Contains Current Procedural Terminology (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,

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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 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 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 Medicare 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.

Note: As mentioned, these are clarifications and the BMM benefit policy is not changing. Also, note that while Medicare contractors will not search their files to reprocess claims already processed, they will adjust claims that you bring to their attention.

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## Additional Information

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The official instruction, CR5847, issued to your Medicare carrier, FI, and A/B MAC regarding this change may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1416CP.pdf> on the CMS website.

If you have any questions, please contact your Medicare carrier, FI, or A/B MAC at their toll-free number, which may be found at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html> on the CMS website.

**News Flash** - It's Not Too Late to Get the Flu Shot. We are in the midst of flu season and a flu vaccine is still the best way to prevent infection and the complications associated with the flu. But re-vaccination is necessary each year because flu viruses change each year. Please encourage your Medicare patients who haven't already done so to get their annual flu shot. – And don't forget to immunize yourself and your staff. Protect yourself, your patients, and your family and friends. Get Your Flu Shot – Not the Flu! Remember - Influenza vaccination is a covered Part B benefit. Note that influenza vaccine is NOT a Part D covered drug. Health care professionals and their staff can learn more about Medicare's coverage of adult immunizations and related provider education resources, by reviewing Special Edition MLN Matters article SE0748 at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE0748.pdf> on the CMS website.

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