

GE Healthcare

Reimbursement Information for Bone Mineral Density (BMD)



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Overview:

This overview addresses coding and coverage for bone mass density procedures. While this advisory focuses on Medicare program policies, these policies may also be applicable to selected private payers throughout the country. For appropriate code selection, contact your local payer prior to claims submittal.

Current Procedural Terminology (CPT)¹ Coding and Definitions:

Computed Tomography (CT)

CPT/HCPCS Code	
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)

CPT/HCPCS Code	
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

Note: For DXA, bone density study, Body Composition study, 1 or more sites, use CPT code 76499, unlisted diagnostic radiographic procedure.



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 performs the interpretation of 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.

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 guidelines²

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 may or may 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 regardless.



Reimbursement

To obtain more information about local Medicare reimbursement rates for selected bone density study procedures, go to the GE Bone Densitometry Medicare Reimbursement Calculator:
www.gehealthcare.com/us/en/community/reimbursement

To confirm local reimbursement rates, consult your local Medicare contractor.

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 www.cms.hhs.gov/mcd/search.asp?from2=search.asp& or your local Medicare contractor's website.

Medicare³ identifies a qualified individual as:

- A women 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.**



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:

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.

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:
www.surgeongeneral.gov/library/bonehealth

The information provided with this notice is general reimbursement information only; it is not legal advice, nor is it advice about how to code, complete or submit any particular claim for payment. It is always the provider's responsibility to determine and submit appropriate codes, charges, modifiers and bills for the services that were rendered. This information is provided as of January 1, 2011, and all coding and reimbursement information is subject to change without notice. Payers or their local branches may have distinct coding and reimbursement requirements and policies. Before filing any claims, providers should verify current requirements and policies with the local payer.

Third party reimbursement amounts and coverage policies for specific procedures will vary including by payer, time period and locality, as well as by type of provider entity. This document is not intended to interfere with a health care professional's independent clinical decision making. Other important considerations should be taken into account when making decisions, including clinical value. The health care provider has the responsibility, when billing to government and other payers (including patients), to submit claims or invoices for payment only for procedures which are appropriate and medically necessary. You should consult with your reimbursement manager or healthcare consultant, as well as experienced legal counsel.

Payer links

- The Centers for Medicare and Medicaid:
www.cms.hhs.gov/mcd/search.asp?from2=search.asp&
- Aetna Healthcare:
www.aetna.com/cpb/cpb_menu.html
- Blue Cross Blue Shield:
(click on your state, medical policies vary by state)
www.bcbs.com/coverage/find/plan
- Cigna Healthcare:
www.cigna.com/customer_care/healthcare_professional/coverage_positions/index.html
- United Healthcare Online:
www.unitedhealthcareonline.com/b2c/CmaAction.do?channelId=016228193392b010VgnVCM100000c520720a_____

Resources

- Information presented in this document is current as of December 22, 2009. 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 © 2009 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.

1. Current Procedural Terminology © 2009 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.
2. American Medical Association, CPT 2007 Changes: An Insider's View
3. 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.

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GE Healthcare provides transformational medical technologies and services that are shaping a new age of patient care. Our broad expertise in medical imaging and information technologies, medical diagnostics, patient monitoring systems, drug discovery, biopharmaceutical manufacturing technologies, performance improvement and performance solutions services help our customers to deliver better care to more people around the world at a lower cost. In addition, we partner with healthcare leaders, striving to leverage the global policy change necessary to implement a successful shift to sustainable healthcare systems.

Our "healthymagination" vision for the future invites the world to join us on our journey as we continuously develop innovations focused on reducing costs, increasing access and improving quality and efficiency around the world. Headquartered in the United Kingdom, GE Healthcare is a \$16 billion unit of General Electric Company (NYSE: GE). Worldwide, GE Healthcare employs more than 46,000 people committed to serving healthcare professionals and their patients in more than 100 countries. For more information about GE Healthcare, visit our website at www.gehealthcare.com.

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