



News Flash - PQRI Information Available

A new CMS web page dedicated to providing information on the Physician Quality Reporting Initiative (PQRI) is now available.

On December 20, 2006, the President signed the Tax Relief and Health Care Act of 2006 (TRHCA). Section 101 under Title I authorizes the establishment of a physician quality reporting system for eligible professionals by CMS. CMS has titled the statutory program the Physician Quality Reporting Initiative. For more information, visit <http://www.cms.hhs.gov/pqri> on the CMS website.

MLN Matters Number: MM5521 **Revised**

Related Change Request (CR) #: 5521

Related CR Release Date: May 11, 2007

Effective Date: January 1, 2007

Related CR Transmittal #: R1236CP,R70BP,R69NCD Implementation Date: July 2, 2007

Bone Mass Measurements (BMMs)

Note: This article was revised June 6, 2008, to clarify the Medicare Summary Notices on page 3. 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 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 CR 5521. The URL for the brochure for bone measurements was also changed. All other information remains the same.

Provider Types Affected

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

Provider Action Needed



STOP - Impact to You

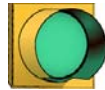
Effective for dates of service on or after January 1, 2007, Medicare will pay for BMM services for dual-energy x-ray absorptiometry (CPT code 77080) when this procedure is used to monitor osteoporosis drug therapy. In addition, new CPTs were assigned to BMMs.

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**CAUTION – What You Need to Know**

Medicare edits will deny claims that are not consistent with revised BMM policy and providers may be liable for noncovered BMMs unless they have issued an advanced beneficiary notice (ABN) as required. This article explains the changes as a result of the CY2007 Physician Fee Schedule Final Rule.

**GO – What You Need to Do**

See the remainder of this article for important information regarding billing Medicare for BMMs.

Background

This article and related Change Request (CR) 5521 wants providers to know 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 BBA by establishing 42 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 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*. The revised manual sections are attached to CR5221. The Web address for viewing CR5221 is available in the "Additional Information" section at the end of this article.

Key Points

Listed is a summary of the revisions and additions to Chapter 13 of the *Medicare Claims Processing Manual* and Chapter 15 of the *Medicare Benefit Policy Manual*.

CHAPTER 13

- 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

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changed the definition of BMM by removing coverage for a single-photon absorptiometry (SPA) as it is not considered reasonable and necessary under section 1862 (a)(1)(A) of the Act.

- Effective for dates of services on and after January 1, 2007, the following changes apply to BMM:
- New 2007 CPT bone mass 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	77081 replaces 76076
77079 replaces 76071	77083 replaces 76078
77080 replaces 76075	

- BMM is not covered when a procedure other than dual-energy x-ray absorptiometry is used to monitor osteoporosis drug therapy. Therefore, Medicare will not pay for procedure codes 76977, 77078, 77079, 77081, 77083 and **G0130** when billed with the following ICD-9-CM diagnosis codes:

733.00	733.01	733.02	733.03	733.09	733.90	255.0
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- 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
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- Medicare will not cover single photon absorptiometry and procedure code 78350 will be denied for services on or after January 1, 2007.
- In informing beneficiaries about the denials of claims processed for BMMs, Medicare will use the following Medicare Summary Notice (MSN) Messages, effective for services on or after January 1, 2007:
 - MSN# 16.10: "Medicare does not pay for this item or service." (FIs should not include this MSN.)
 - If an Advance Beneficiary Notice (ABN) **was issued**, the following MSN will also follow:
 - MSN# 36.1: "Our records show that you were informed in writing, before receiving the service that Medicare would not pay. You are

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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 follow:
 - 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."
- Effective January 1, 2007 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, remark code 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."
- Advance Beneficiary Notices (ABNs) 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.**

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CHAPTER 15

- **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.
 - Includes a physician's interpretation of the results.
 - **Conditions for Coverage**
 - Medicare covers BMM if 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 at least one of the following conditions:
 - A woman who has been determined by the physician or qualified nonphysician practitioner treating her to be estrogen-deficient and at clinical risk for osteoporosis, based on her medical history and other findings.
- NOTE:** Since not every woman who has been prescribed estrogen replacement therapy (ERT) may be receiving an "adequate" dose of the therapy, the fact that a woman is receiving ERT should not preclude her treating physician or other qualified treating nonphysician practitioner from ordering a bone mass measurement for her. If a BMM is ordered for a woman following a careful evaluation of her medical need, however, it is expected that the ordering treating physician (or other qualified treating nonphysician practitioner) will document in her medical record why he or she believes that the woman is estrogen-deficient and at clinical risk for osteoporosis.
- An individual with vertebral abnormalities as demonstrated by an x-ray to be indicative of osteoporosis, osteopenia, or vertebral fracture.
 - An individual receiving (or expecting to receive) glucocorticoid (steroid) therapy equivalent to an average of 5.0 mg of prednisone, or greater, per day, for more than 3 months.

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- An individual with primary hyperparathyroidism.
- An individual being monitored to assess the response to or efficacy of an FDA-approved osteoporosis drug therapy.
- In the case of any individual who 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 (axial skeleton). 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.
 - Confirming baseline BMMs to permit monitoring of beneficiaries in the future.
 - **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).

Additional Information

For complete details regarding this Change Request (CR) please see the official instruction (CR5521) issued to your Medicare carrier, FI or A/B MAC. That instruction consists of 3 transmittals, i.e.:

- Transmittal 69, which contains the Medicare National Coverage Determination, which is at <http://www.cms.hhs.gov/Transmittals/downloads/R69NCD.pdf> on the CMS web site;

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- Transmittal 70, which contains the revised *Medicare Benefit Policy Manual* sections, is at <http://www.cms.hhs.gov/Transmittals/downloads/R70BP.pdf> on the CMS site; 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 site.

If you have questions, please contact your Medicare carrier, FI or A/B MAC, at their toll-free number, which may be found at <http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS website.

A brochure outlining 'Bone Mass Measurements' is available at http://www.cms.hhs.gov/MLNProducts/downloads/Bone_Mass.pdf on the CMS website.

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