FIRST COAST SERVICE OPTIONS
MEDICARE PART B
LOCAL COVERAGE DETERMINATION

CPT/HCPCS Codes

G0130 Single energy x-ray absorptiometry (SEXA) bone density study, one or more sites, appendicular skeleton (peripheral) (eg, radius, wrist, heel)

76070 Computed tomography, bone mineral density study, one or more sites; axial skeleton (eg, hips, pelvis, spine)

76071 appendicular skeleton (eg, radius, wrist, heel)

76075 Dual energy x-ray absorptiometry (DXA), bone density study, one or more sites; axial skeleton (eg, hips, pelvis, spine)

76076 appendicular skeleton (peripheral) (eg, radius, wrist, heel)

76078 Radiographic absorptiometry (eg, photodensitometry, radiogrammetry), one or more sites

76977 Ultrasound bone density measurement and interpretation, peripherial site(s), any method

78350 Bone density (bone mineral content) study, one or more sites; single photon absorptiometry

LCD Number

76070

LCD Database ID Number

L5829 - Florida
L12548 - Connecticut

Contractor Name

First Coast Service Options, Inc.

Contractor Number

00590 - Florida
00591 - Connecticut

Contractor Type

Carrier

LCD Title

Bone Mineral Density Studies

AMA CPT Copyright Statement

CMS National Coverage Policy

Language quoted from CMS National Coverage Determinations (NCDs) and coverage provisions in interpretive manuals are italicized throughout the Local Coverage Determination (LCD). NCDs and coverage provisions in interpretive manuals are not subject to the LCD Review Process (42 CFR 405.860[b] and 42 CFR 426 [Subpart D]). In addition, an administrative law judge may not review an NCD. See §1869(f)(1)(A)(i) of the Social Security Act.

Unless otherwise specified, *italicized* text represents quotation from one or more of the following CMS sources:

Medicare Claims Processing Manual, Pub 100-4, Chapter 13, Section 140
Medicare National Coverage Determinations Manual, Chapter 1, Section 150
CR 3719, Transmittal 501, dated 03/11/2005

Primary Geographic Jurisdiction

Florida
Connecticut

Secondary Geographic Jurisdiction

N/A

CMS Region

Region IV - Florida
Region I - Connecticut

CMS Consortium

Southern - Florida
Northeastern - Connecticut

Original Determination Effective Date

07/19/1993 - Florida
03/01/1996 - Connecticut

Original Determination Ending Date

N/A

Revision Effective Date

06/07/2005

Revision Ending Date

06/06/2005

Indications and Limitations of Coverage and/or Medical Necessity

Osteoporosis has classically been defined as skeletal fragility due to low bone mass, which results in fractures associated with minimal trauma. To quantify this concept, osteoporosis has been defined as bone mass more than 2.5 standard deviations below the mean of young normals.

Bone mineral density studies are performed to establish the diagnosis of osteoporosis and to assess the individual's risk for subsequent fracture. Bone densitometry includes the use of single photon absorptiometry (SPA), single energy x-ray absorptiometry (SEXA), dual photon absorptiometry (DPA), dual energy radiographic absorptiometry (DXA), quantitative computed tomography (QCT), and bone ultrasound densitometry (BUD). Low radiation dose, availability and ease of use have made DXA the most widely used technique for measuring bone density in clinical trials and epidemiological studies.

Bone density can be measured at the wrist, spine, hip or calcaneus. The medical literature is divided on the accuracy of predicting osteoporosis of the spine or hip by measuring peripheral sites (wrist, calcaneus). It does appear, however, that measurement of bone density of the bone involved gives a better measurement of osteoporosis than does measurement of another bone not known to be involved.

Precise calibration of the equipment is required for accuracy and to reduce variation of test results and risk of misclassification of the degree of bone density. Lack of standardization in bone mineral measurement remains an issue, and tests are best done on the same suitably precise instrument to insure accuracy. It is important to use results obtained with the same scanner when comparing a patient to a control population, as systematic differences among scanners have been found. To ensure reliability of bone mass measurements, the densitometry technologist must have proper training in performing this procedure. Malpositioning of a patient or analyzing a scan incorrectly can lead to great errors in bone mineral density studies.

Medicare considers a bone mineral density study to be medically reasonable and necessary for the following indications. In addition, all coverage criteria listed below must be met.

• *A patient with vertebral abnormalities as demonstrated by an x-ray to be indicative of osteoporosis, osteopenia (low bone mass), or vertebral fracture*. For this indication use **ICD-9 code 733.02** for idiopathic osteoporosis, use **ICD-9 code 733.90** for osteopenia, or use **ICD-9 codes 805.00-806.9** for vertebral fractures.

• *A patient is being monitored to assess the response to or efficacy of an FDA-approved osteoporosis drug therapy*. Use **ICD-9 code 733.00** for unspecified osteoporosis, **ICD-9 code 733.01** for postmenopausal osteoporosis, or **ICD-9 code 733.02** for idiopathic osteoporosis.

• *A patient with known primary hyperparathyroidism*. Use **ICD-9 range 252.00-252.08** for hyperparathyroidism.

• *A patient receiving (or expecting to receive) glucocorticoid (steroid) therapy (greater than 3 months, on the equivalent dose of 30 mg cortisone or 7.5 mg prednisone or greater per day*. Use **ICD-9 code 733.09** for drug-induced osteoporosis and **E932.0** for adrenal cortical steroids.

• *A woman who has been determined by the physician or a qualified nonphysician practitioner treating her to be estrogen-deficient and at clinical risk for osteoporosis, based on her medical history and other*

findings. For this indication use **ICD-9 code 256.2** (postablative ovarian failure), **256.31-256.39** (other ovarian failure) or **627.2** (menopausal states).

Coverage criteria for bone mass measurements are as follows:

• There must be an order by the individual's physician or qualified nonphysician practitioner treating the patient following an evaluation of the need for a measurement, including a determination as to the medically appropriate measurement to be used for the individual. A physician or qualified nonphysician practitioner treating the beneficiary for purposes of this provision is one who furnishes a consultation or treats a beneficiary for a specific medical problem and who uses the results in the management of the patient. For the purpose of the bone mass measurement benefit, qualified nonphysician practioners include physician assistants, nurse practioners, clinical nurse specialists and certified nurse midwives.

• This service must be furnished by a qualified supplier or provider of such services under at least the general level of supervision of a physician;

• This service must be reasonable and necessary for diagnosing, treating, or monitoring a qualified individual as defined above; and

• This service must be performed with a bone densitometer or a bone sonometer device approved or cleared for marketing by the FDA for bone mass measurement purposes, with the exception of dual photon absorptiometry devices.

• Is performed at a frequency that conforms to the requirements described below.

***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 bone mass measurement 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.*

Medicare may cover a bone mass measurement for a patient once every 2 years. However, if medically necessary, Medicare may cover a bone mass measurement for a patient more frequently than every 2 years. Examples of situations where more frequent bone mass measurements procedures may be medically necessary include, but are not limited to, the following medical circumstances:

• Monitoring patients on long-term glucocorticoid (steroid) therapy of more than 3 months; and

• Allowing for a confirmatory baseline bone mass measurement (either central or peripheral) to permit monitoring of patients in the future if the initial test was performed with a technique that is different from the proposed monitoring method (for example, if the initial test was performed using bone sonometry and monitoring is anticipated using bone densitometry, Medicare will allow coverage of baseline measurement using bone densitometry).

Coverage Topic

Bone Mass Measurement

CPT/HCPCS Codes

G0130 Single energy x-ray absorptiometry (SEXA) bone density study, one or more sites, appendicular skeleton (peripheral) (eg, radius, wrist, heel)

76070 Computed tomography, bone mineral density study, one or more sites; axial skeleton (eg, hips, pelvis, spine)

76071 appendicular skeleton (eg, radius, wrist, heel)

76075 Dual energy x-ray absorptiometry (DXA), bone density study, one or more sites; axial skeleton (eg, hips, pelvis, spine)

76076 appendicular skeleton (peripheral) (eg, radius, wrist, heel)

76078 Radiographic absorptiometry (eg, photodensitometry, radiogrammetry), one or more sites

76977 Ultrasound bone density measurement and interpretation, peripherial site(s), any method

78350 Bone density (bone mineral content) study, one or more sites; single photon absorptiometry

ICD-9 Codes that Support Medical Necessity

252.00-252.08	Hyperparathyroidism
256.2	Postablative ovarian failure
256.31-256.39	Other ovarian failure
627.2	Symptomatic menopausal or female climacteric states
733.00	Osteoporosis, unspecified
733.01	Senile osteoporosis (Postmenopausal osteoporosis)
733.02	Idiopathic osteoporosis
733.09	Other osteoporosis (Drug-induced osteoporosis)
733.90	Disorder of bone and cartilage, unspecified (Osteopenia)
805.00-805.9	Fracture of vertebral column without mention of spinal cord injury
806.00-806.9	Fracture of vertebral column with spinal cord injury
*E932.0	Drugs, medicinal and biological substances causing adverse effects in therapeutic use, adrenal cortical steroids

* According to the ICD-9-CM book, diagnosis code E932.0 is a secondary diagnosis and should not be billed as a primary diagnosis.

Diagnoses that Support Medical Necessity

N/A

ICD-9 Codes that DO NOT Support Medical Necessity

N/A

Diagnoses that DO NOT Support Medical Necessity

N/A

Documentation Requirements

Medical record documentation maintained by the ordering/referring physician must indicate the medical necessity for performing the test and the test results. In addition, if the service exceeds the frequency parameter listed in this policy, documentation of medical necessity must be submitted. This information is usually found in the history and physical, office/progress notes, or test results.

If the provider of the service is other than the ordering/referring physician, that provider must maintain hard copy documentation of test results and interpretation, along with copies of the ordering/referring physician's order for the studies. The physician must state the clinical indication/medical necessity for the study in his order for the test.

Utilization Guidelines

Medicare may cover a bone mass measurement for a patient once every 2 years. However, if medically necessary, Medicare may cover a bone mass measurement for a patient more frequently than every 2 years.

A bone mineral density study code should be billed only once regardless of the number of sites being tested or included in the study (i.e., if the spine and hip are performed as part of the same study only one can be billed).

Sources of Information and Basis for Decision

Banks, Linda M. (2001) Dual Energy X-ray absorptiometry (DXA). R. G. Grainger, D. Allison, A. Adams and A. Dixon (Eds.), Diagnostic Radiology: A Textbook of Medical Imaging, 4th ed (pp. 185-186). Churchill Livingstone, Inc, London.

Harris, Edward D., Budd, Ralph C., Genovese, Mark C., Firestein, Gary S. Sargent, John S., Clement, Seldge B. Kelly's Textbook of Rheumatology, 7th ed (pp1458-59 & 1474-85). Elseiver Science, 2005 Philadelphia.

Lewiecki, E. Michael, Watts, Nelson B., McClung, Michael R., et al (2004). Journal of Clinical Endocrinology and Metabolism, 89(8), 3651-55

Navas, Luis R., Lyles, Kenneth W. (1998). Practice of Geriatrics 3rd ed chapter 21(pp 217-227). W.B. Saunders Company, Philadelphia.

Plotnikoff, Gregory A. and Norling, Sharon (2003). Osteoporosis. Rakel (Ed), Integrative Medicine, 1st ed. (pp 247-254). W.B. Saunders, Philadelphia

U.S. Preventative Services Task Force. (2002). Screening for osteoporosis in postmenopausal women: recommendations and rationale. American Family Physician, 66(8), 1430-1432.

Ulrich, U., Browning, M., Gaffney, E.V., Schoter, K.-H., Chesnut III, C.H. (1997). Implementation of an osteoporosis research program with a mobile dual-energy x-ray absorptiometry unit: The Montana/Wyoming experience. Osteoporosis International.

Advisory Committee Notes

This policy does not reflect the sole opinion of the contractor or Contractor Medical Director. Although the final decision rests with the contractor, this policy was developed in cooperation with advisory groups, which includes representatives from numerous societies.

Carrier Advisory Committee Meeting held on July 9, 2002

Start Date of Comment Period

N/A

End Date of Comment Period

N/A

Start Date of Notice Period

08/01/2005

Revision History

Florida Revision Number:	19	LCR B2005-028FL/CT
Connecticut Revision Number:	10	
Start Date of Comment Period	N/A	4th Quarter 2005 Update
Start Date of Notice Period	08/01/2005	
Revised Effective Date:	06/07/2005	

Explanation of Revision: Policy was converted to LCD format. CMS National Coverage Policy Section was updated to reflect the new references. A disclaimer was added about National coverage language found in the policy being identified by italics. Indications and Limitations section of the LCD was updated. ICD-9 code E932.0 was identified as a secondary diagnosis and a note was added to the end of the ICD-9 list located under the ICD-9 codes that support medical necessity. The reference section of the LCD was updated. FL B and CT B LCD's were combined.

Florida Revision History

Revision Number:	18	LCR B2005-005
Start Date of Comment Period	N/A	
Start Date of Notice Period	02/01/2005	2nd Quarter 2005 Update
Revised Effective Date:	01/01/2005	

Explanation of Revision: Annual 2005 HCPCS update. Descriptor revised for procedure code 76075. The effective date of policy revision is based on date of service.

Revision Number:	17	LCR B2004-020FL
Start Date of Comment Period	N/A	
Start Date of Notice Period	11/01/2004	1st Quarter 2005 Update
Revised Effective Date:	10/01/2004	

Explanation of Revision: Annual 2005 ICD-9 Update. Code 252.0 changed to range 252.00-252.08. The effective date of policy revision is based on date of service.

Revision Number:	16	PCR B2003-029
Start Date of Comment Period	N/A	
Start Date of Notice Period	02/01/2003	2nd Quarter 2003 Update
Revised Effective Date:	01/01/2003	

Explanation of Revision: Annual 2003 HCPCS Update.

Revision Number:	15	PCR B2002-166
Start Date of Comment Period	N/A	
Start Date of Notice Period	11/01/2002	1st Quarter 2003 Update
Revised Effective Date:	10/01/2002	

Explanation of Revision: Annual ICD-9 Update

Revision Number:	14	PCR B2002-030
Start Date of Comment Period	N/A	
Start Date of Notice Period	02/01/2002	2nd Quarter 2002 Update
Revised Effective Date:	01/01/2002	

Explanation of Revision: Annual 2002 HCPCS Update

Revision Number:	13	PCR B2001-159
Start Date of Comment Period	N/A	
Start Date of Notice Period	11/01/2001	1st Quarter 2002 Update
Revised Effective Date:	10/01/2001	

Explanation of Revision: Annual ICD-9 Update

Revision Number:	12	PCR B99-105
Start Date of Comment Period		
Start Date of Notice Period	09/01/1999	Sept./Oct. 1999 Update
Revised Effective Date:	07/16/1999	

Revision Number:	11	PCR B99-008
Start Date of Comment Period		
Start Date of Notice Period		
Revised Effective Date:	01/01/1999	

Explanation of Revision: 1999 HCPCS

Revision Number:	10	PCR B98-137
Start Date of Comment Period	N/A	
Start Date of Notice Period	09/18/1998	Sept./Oct. 1998 Update
Revised Effective Date:	10/26/1998	

Revision Number:	9	PCR B98-118
Start Date of Comment Period	N/A	
Start Date of Notice Period		
Revised Effective Date:	07/01/1998	

Revision Number:	8	PCR B98-032A
Start Date of Comment Period	N/A	
Start Date of Notice Period	01/07/1998	
Revised Effective Date:	01/05/1998	

Revision Number:	7	PCR B98-032

Start Date of Comment Period	N/A	
Start Date of Notice Period	01/07/1998	
Revised Effective Date:	01/05/1998	

Explanation of Revision: 1998 HCPCS

Revision Number:	6	PCR B97-123C
Start Date of Comment Period	04/19/1997	
Start Date of Notice Period	09/04/1997	
Revised Effective Date:	10/27/1997	

Revision Number:	5	PCR B97-123B
Start Date of Comment Period	04/19/1997	
Start Date of Notice Period	09/04/1997	
Revised Effective Date:	10/20/1997	

Revision Number:	4	PCR B97-123A
Start Date of Comment Period	04/19/1997	
Start Date of Notice Period	09/04/1997	
Revised Effective Date:	10/20/1997	

Revision Number:	3	PCR B97-123
Start Date of Comment Period	04/19/1997	
Start Date of Notice Period	09/04/1997	
Revised Effective Date:	10/20/1997	

Explanation of Revision: Original Policy struck out

Revision Number:	2	PCR 95-060
Start Date of Comment Period		
Start Date of Notice Period		
Revised Effective Date:	04/03/1995	

Revision Number:	1	PCR 95-042
Start Date of Comment Period		
Start Date of Notice Period		
Revised Effective Date:	03/15/1995	

Revision Number:	Original	PCR 93-156
Start Date of Comment Period		
Start Date of Notice Period		
Original Effective Date:	07/19/1993	

Connecticut Revision History

Revision Number:	9	LCR B2005-005CT
Start Date of Comment Period	N/A	
Start Date of Notice Period	02/01/2005	2nd Quarter 2005 Update
Revised Effective Date:	01/01/2005	

Explanation of Revision: Annual 2005 HCPCS update. Descriptor revised for procedure codes 76075. The effective date of policy revision is based on date of service.

Revision Number:	8	LCR B2004-020CT
Start Date of Comment Period	N/A	
Start Date of Notice Period	11/01/2004	1st Quarter 2005 Update
Revised Effective Date:	10/01/2004	

Explanation of Revision: Annual 2005 ICD-9 Update. Code 252.0 changed to range 252.00-252.08. The effective date of policy revision is based on date of service.

Revision Number	7	
Start Date of Comment Period:	N/A	
Start Date of Notice Period:	02/01/2003	2nd Quarter 2003 Update
Revised Effective Date	01/01/2003	

Explanation of Revision: Annual 2003 HCPCS Update.

Revision Number	6	
Start Date of Comment Period:	07/05/2002	
Start Date of Notice Period:	11/01/2002	1st Quarter 2003 Update
Revised Effective Date	01/01/2003	

Explanation of Revision: This policy replaces the existing policy and reflects the covered indications and frequency of testing based on national guidelines (Section 50-44 if the Coverage Issues Manual and Section 4181 of the Medicare Carriers Manual).

Revision Number	5	
Start Date of Comment Period:	N/A	
Start Date of Notice Period:	N/A	Aug/Oct 2000 Provider News
Revised Effective Date	08/17/2002	
Revision Number	4	PCR B2002-
Start Date of Comment Period:		
Start Date of Notice Period:		
Revised Effective Date	03/15/1999	
Revision Number	3	
Start Date of Comment Period:		
Start Date of Notice Period:		
Revised Effective Date	07/01/1998	
Revision Number	2	
Start Date of Comment Period:		
Start Date of Notice Period:		
Revised Effective Date	05/01/1997	
Revision Number	1	
Start Date of Comment Period:		
Start Date of Notice Period:		
Revised Effective Date	03/01/1997	
Revision Number	Original	
Start Date of Comment Period:	N/A	
Start Date of Notice Period:	02/01/1996	
Original Effective Date	03/01/1996	

Related Documents

N/A

LCD Attachments

N/A

Document formatted: 06/02/2005 (SH/st)