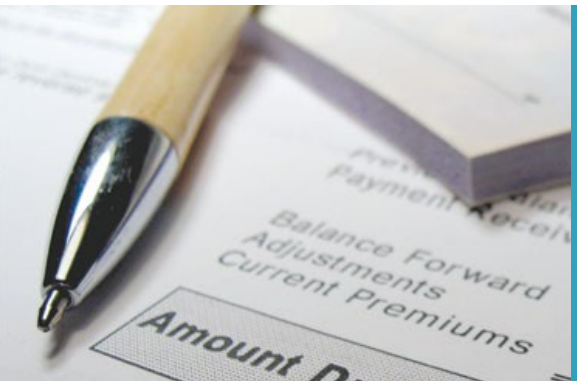
quantifiably better.



2015 Coding and Reimbursement Guide

Bone Densitometry by QCT

Overview

This guide addresses the coding and coverage for bone mineral density (BMD) measurement by Quantitative Computer Tomography (QCT). Although this guide concentrates on Medicare program policies, these policies may also be applicable to selected private insurance payers throughout the country. In order to obtain the appropriate code selection, contact your local payer prior to submitting claims.

Diagnosis (ICD-9) Codes

Medicare carriers and/or private insurance payers that have in place policies for the coverage of bone density testing may or may not have a list of approved diagnosis (ICD-9) codes supporting the medical necessity of a bone densitometry study. Those diagnosis codes that support medical necessity can and do vary by payer; your local payers should be contacted for their guidelines and polices related to coverage and coding to ensure accurate billing.

Current Procedural Terminology (CPT)[1] Coding

77078	CT, bone mineral density study, 1 or more sites; axial skeleton (eg. hips, pelvis, spine).

Reimbursement

The national average global fee for 77078 axial skeleton QCT is approximately $102[2,3]. Actual reimbursement for specific localities vary because of the use of geographical practice cost indices in the calculation of actual reimbursement rates. Consult your local Medicare contractor to confirm local reimbursement rates.

Patients with Established Osteoporosis

QCT bone density studies (CPT code 77078) are not covered for the explicit monitoring of osteoporosis drug therapy. However, Medicare will cover an appropriate and medically necessary QCT bone density screening test every two years if an eligible individual has previously been diagnosed with osteoporosis and/or is on treatment, as long as the claims for such services report both a screening diagnosis code and an osteoporosis code[5]. Consult your local Medicare contractor to confirm local coverage determination, policies and/or coding guidelines.

Medicare Coverage

A national coverage determination has been established by Medicare for bone density studies that address the type of procedures covered for qualified individuals, provider requirements and limitations on frequency of utilisation. Medicare carriers may or may not have a written local coverage determination (LCD) and/or policies outlining additional coding guidelines. Consult your local Medicare contractor to confirm local coverage. Local coverage determinations can and do vary by state.

Medicare[4] will cover bone density testing for qualified individuals in the following categories:

- 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.

References

[1] Current Procedural Terminology © American Medical Association, 2015.
[2] Payment for a given procedure in a given locality is available in the Physician Fee Schedule Search tool of the CMS website. Payment rates are based on the CY 2015 Medicare Physician Fee Schedule Final Rule, which was published in the Federal Register on November 13, 2014. The National Average Medicare rates are based on the 2015 conversion factor of $35.8228.
[3] Rate is capped under the Deficit Reduction Act of 2005.
[4] Medicare Benefit Policy Manual Chapter 15 – Covered Medical and Other Health Services (Rev. 157, 06-08-12), Section 80.5.
[5] MLN Matters Number: MM5847 Revised, "Clarification of Bone Mass Measurement (BMM) Billing Requirements Issued in CR 5521", CMS, August 3, 2012.

Private payers

Private insurance payers may or may not have written coverage guidelines and/or follow the Medicare guidelines outlined above. It is strongly recommended that you seek guidance from your local payers on details regarding coverage because their policies may include additional indications, approved diagnosis codes and/or restrictions.

Utilisation Guidelines[4]

For those eligible individuals, Medicare will pay for a bone density study once every 24 months, or more frequently if the procedure is determined by a physician to be medically necessary. Medically necessary exceptions to the frequency limitation may include individuals on long-term steroid therapy for more than 3 months. Commercial insurers may or may not follow these guidelines, please refer to your local insurer's policy for details.