CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1236	Date: MAY 11, 2007
	Change Request 5521

Subject: Bone Mass Measurements (BMMs)

I. SUMMARY OF CHANGES: Implements changes in conditions for coverage of BMMs issued in the Federal Register Final Rule (71 FR 69624) on December 1, 2006. All benefit policy information formerly contained here has been moved to Pub. 100-02, chapter 15, section 80.5.

New / Revised Material
Effective Date: January 1, 2007
Implementation Date: July 2, 2007

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	13/Table of Contents
R	13/140/Bone Mass Measurements (BMMs)
R	13/140.1/Payment Methodology and HCPCS Coding
R	13/140.2/Medicare Summary Notice (MSN) Messages
R	13/140.3/Remittance Advice Messages
N	13/140.4/Advance Beneficiary Notices (ABNs)

III. FUNDING:
No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2007 operating budgets.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

*Unless otherwise specified, the effective date is the date of service.

Attachment - Business Requirements

Pub. 100-04	Transmittal: 1236	Date: May 11, 2007	Change Request: 5521

SUBJECT: Bone Mass Measurements (BMMs)

Effective Date: **January 1, 2007**

Implementation Date: July 2, 2007

I.   GENERAL INFORMATION

A.   Background: On June 24, 1998, 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 Social Security Act, and established frequency standards governing when qualified individuals would be eligible for a BMM.

B.   Policy: On December 1, 2006, CMS published the CY 2007 Physician Fee Schedule final rule, which included changes to 42 CFR 410.31. Complete coverage instructions for BMMs can be found in chapter 15, section 80.5 of Pub.100-02, Medicare Benefit Policy Manual. Claims processing instructions can be found in chapter 13, section 140 of Pub.100-04, Claims Processing Manual.

II.   BUSINESS REQUIREMENTS TABLE

Use "Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A / B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5521.1	Effective for dates of service on and after January 1, 2007, contractors shall pay BMM claims for dual-energy x-ray absorptiometry (CPT procedure code 77080) when this procedure is used to monitor osteoporosis drug therapy.	X		X	X							
5521.1.1	Contractors shall accept/allow CPT procedure code 77080 when billed with the following ICD-9-CM diagnoses codes or any of the other valid ICD-9-CM diagnoses codes that are recognized by Medicare contractors as appropriate for BMMs.	X		X	X							

Number	Requirement	A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
	• 733.00, • 733.01, • 733.02, • 733.03, • 733.09, • 733.90, or • 255.0.											
5521.2	Effective for dates of service on and after January 1, 2007, contractors shall not pay BMM claims when a procedure other than dual-energy x-ray absorptiometry (CPT procedure code 77080) is used to monitor osteoporosis drug therapy.	X		X	X							
5521.2.1	Contractors shall deny CPT procedure codes 77078, 77079, 77081, 77083, 76977 and G0130 when billed with ICD-9-CM diagnosis codes 733.00, 733.01, 733.02, 733.03, 733.09, 733.90, or 255.0.	X		X	X							
5521.3	Effective for dates of service on or after January 1, 2007, contractors shall not pay BMM claims for single photon absorptiometry.	X		X	X							
5521.3.1	Contractors shall deny CPT procedure code 78350. **Note: CPT procedure code 78350 is non-covered in the 2007 MPFSDB.**	X		X	X							
5521.4	Contractors shall advise physicians and hospitals that they will be liable for noncovered BMMs unless they issue an appropriate advance beneficiary notice (ABN) as required in 5521.8.	X		X	X							
5521.4.1	Contractors shall advise physicians and hospitals to include the following language in the ABN form: "Items or Service" Section: Insert name of the denied procedure. "Because" Section: "As specified in chapter 15, section 80.5 of Pub.100-02, Medicare Benefit Policy	X		X	X							

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B MAC	D M E MAC	F I	C A R R I E R	D M E R C	R H H I	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
	Manual, Medicare will not pay for this test as it is not reasonable and necessary for Medicare beneficiaries undergoing bone mass measurement."											
5521.5	Contractors shall use the following messages when denying BMM claims as specified in BRs 5521.2 and 5521.3 and an ABN was issued. Medicare Summary Notice (MSN) # 16.10: "Medicare does not pay for this item or service." Or "Medicare no paga por este articulo o servicio." (Spanish Version) Claim Adjustment Reason Code 50: "These are non-covered services because this is not deemed a "medical necessity" by the payer". Remittance Advice Remark Code 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." Group code PR: "Patient Responsibility." MSN# 36.1: "Our records show that you were informed in writing, before receiving the service, that Medicare would not pay. You are liable for this charge. If you do not agree with this statement, you may ask for a review." (English version) or "Nuestros archivos indican que usted fue informado por escrito, antes de recibir el servicio, que Medicare no pagaría. Usted es	X			X							

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A / B MAC	D M E MAC	F I	C A R R I E R	D M E R C	R H H I	Shared-System Maintainers				OTHER
								F I S S	M C S	V M S	C W F	
	responsable por esta cantidad. Si usted no está de acuerdo, usted puede pedir una revisión." (Spanish version)											
5521.5.1	Contractors shall use the following messages when denying BMM claims as specified in BRs 5521.2 and 5521.3 and an ABN was issued. MSN# 36.1: "Our records show that you were informed in writing, before receiving the service, that Medicare would not pay. You are liable for this charge. If you do not agree with this statement, you may ask for a review." (English version) or "Nuestros archivos indican que usted fue informado por escrito, antes de recibir el servicio, que Medicare no pagaría. Usted es responsable por esta cantidad. Si usted no está de acuerdo, usted puede pedir una revisión." (Spanish version) Claim Adjustment Reason Code 50: "These are non-covered services because this is not deemed a "medical necessity" by the payer". Remittance Advice Remark Code 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." Group code PR: "Patient Responsibility."	X		X								

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A / B MAC	D M E MAC	F I	C A R R I E R	D M E R C	R H H I	Shared-System Maintainers				OTHER
								F I S S	M C S	V M S	C W F	
5521.5.2	Contractors shall use the following messages when denying BMM claims as specified in BRs 5521.2 and 5521.3 and an ABN was NOT issued. MSN # 16.10: "Medicare does not pay for this item or service. (English Version) Or "Medicare no paga por este articulo o servicio." (Spanish Version) Claim Adjustment Reason Code 50: "These are non-covered services because this is not deemed a "medical necessity" by the payer". Remittance Advice Remark Code 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." Group code CO: "Contractual Obligations." MSN# 36.2: "It appears that you did not know that we	X			X							

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A / B MAC	D M E MAC	F I	C A R R I E R	D M E R C	R H H I	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
	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." (English version) or "Aparentemente, usted no sabia que nosotros no pagamos por este servicio, por lo tanto usted no es responsable. Si usted le pagó al proveedor por este servicio debe enviarnos lo siguiente: (1) Copia de esta notificación; (2) Factura del proveedor; (3) El recibo o prueba de que usted le pagó. Debe enviar su petición por escrito dentro de 6 meses de la fecha de esta notificación. Servicios de este tipo prestados en el futuro serán su responsabilidad." (Spanish Version)											
5521.5.3	Contractors shall use the following messages when denying BMM claims as specified in BRs 5521.2 and 5521.3 and an ABN was NOT issued. 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." (English version)	X		X								

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A / B MAC	D M E MAC	F I	C A R R I E R	D M E R C	R H H I	Shared-System Maintainers				OTHER
								F I S S	M C S	V M S	C W F	
	or "Aparentemente, usted no sabia que nosotros no pagamos por este servicio, por lo tanto usted no es responsable. Si usted le pagó al proveedor por este servicio debe enviarnos lo siguiente: (1) Copia de esta notificación; (2) Factura del proveedor; (3) El recibo o prueba de que usted le pagó. Debe enviar su petición por escrito dentro de 6 meses de la fecha de esta notificación. Servicios de este tipo prestados en el futuro serán su responsabilidad." (Spanish Version) Claim Adjustment Reason Code 50: "These are non-covered services because this is not deemed a "medical necessity" by the payer". Remittance Advice Remark Code 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." Group code CO: "Contractual Obligations."											

Number	Requirement	A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5521.6	Contractors shall advise physicians and hospitals of these payment changes via the MLN Matters Article as required in 5521.8.	X		X	X							
5521.7	Contractors shall not search for and adjust claims that have been paid prior to the implementation date. However contractors shall adjust claims brought to their attention.	X		X	X							

III.   PROVIDER EDUCATION TABLE

Number	Requirement	A/B MMAAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5521.8	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X		X	X							

IV.   SUPPORTING INFORMATION

A. For any recommendations and supporting information associated with listed requirements, use the box below:

Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

B. For all other recommendations and supporting information, use the space below:

V. CONTACTS

Pre-Implementation Contact(s):
Coverage: Bill Larson at william.larson@cms.hhs.gov or 410-786-4639.
FI Claims: Bill Ruiz at william.ruiz@cms.hhs.gov or 410-786-9283.
Carrier Claims: Tom Dorsey at thomas.dorsey@cms.hhs.gov or 410-786-7434.

Post-Implementation Contact(s): Regional Office

VI. FUNDING

A. *For Fiscal Intermediaries, Carriers, and the Durable Medical Equipment Regional Carrier (DMERC)***:**

No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2007 operating budgets.

B. Medicare Administrative Contractors:

The contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the Statement of Work (SOW). The contractor is not obligated to incur costs in excess of the amounts specified in your contract unless and until specifically authorized by the contracting officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the contracting officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

Medicare Claims Processing Manual
Chapter 13 - Radiology Services and Other Diagnostic Procedures

Table of Contents
(Rev. 1236, 05-11-07)

140 - Bone Mass Measurements *(BMMs)*

(Rev. 1236, Issued: 05-11-07, Effective: 01-01-07, Implementation: 07-02-07)

Sections 1861(s)(15) and (rr)(1) of *the Social Security Act* (the Act) (as added by §4106 of the Balanced Budget Act (BBA) of 1997) standardize Medicare coverage of medically necessary bone mass measurements by providing for uniform coverage under Medicare Part B. This coverage is effective for claims with dates of service furnished on or after July 1, l998.

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

Conditions of Coverage for BMMs are located in Pub.100-02, Medicare Benefit Policy Manual, chapter 15.

140.1 - *Payment Methodology and HCPCS Coding*
(Rev. 1236, Issued: 05-11-07, Effective: 01-01-07, Implementation: 07-02-07)

Carriers pay for *BMM* procedures based on the Medicare physician fee schedule. Claims from physicians, other practitioners, or suppliers where assignment was not taken are subject to the Medicare limiting charge.

The FIs pay for *BMM p*rocedures under the current payment methodologies for radiology services according to the type of provider.

Do not pay BMM procedure claims for dual photon absorptiometry, CPT procedure code 78351.

Deductible and coinsurance apply.

Any of the following *CPT procedure* codes may be used when billing for *BMMs through December 31, 2006*. All of these codes are bone densitometry measurements except code 76977, which is bone sonometry measurements. *CPT procedure* codes are applicable to billing FIs and carriers.

76070 76071 76075 76076 76078 76977 78350 G0130

Effective for dates of services on and after January 1, 2007, the following changes apply to BMM:

- *New 2007 CPT bone mass procedure 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
  77079 replaces 76071
  77080 replaces 76075
  77081 replaces 76076
  77083 replaces 76078

- *Medicare will pay BMM claims when dual-energy x-ray absorptiometry is used to monitor osteoporosis drug therapy. Accept/allow CPT procedure code 77080 when billed with the following ICD-9-CM diagnoses codes or any of the other valid ICD9-CM diagnoses codes that are recognized by Medicare contractors as appropriate for BMMs: 733.00, 733.01, 733.02, 733.03, 733.09, 733.90, or 255.0.*

- *Medicare will not pay BMM claims when a procedure other than dual-energy x-ray absorptiometry is used to monitor osteoporosis drug therapy. Deny CPT procedure codes 77078, 77079, 77081, 77083, 76977 and G0130 when billed with ICD-9-CM diagnosis codes 733.00, 733.01, 733.02, 733.03, 733.09, 733.90, or 255.0.*

- *Medicare will not pay BMM claims for single photon absorptiometry. Deny CPT procedure code 78350.*

The FIs are billed using the ANSI X12N 837 I or hardcopy Form CMS-1450 (UB-92). The appropriate bill types are: 12X, 13X, 22X, 23X, 34X, 71X (Provider-based and independent), 72X, 73X (Provider-based and freestanding), 83X, and 85X. Effective April 1, 2006, type of bill 14X is for non-patient laboratory specimens and is no longer applicable for bone mass measurements.

Providers who use the hard copy UB-92 (Form CMS-1450) report the applicable bill type in Form Locator (FL) 4, Type of Bill.

Providers must report HCPCS codes for bone mass measurements under revenue code 320 with number of units and line item dates of service per revenue code line for each bone mass measurement reported.

Carriers are billed for bone mass measurement procedures using the ANSI X12N 837 P or hardcopy Form CMS-1500.

140.2 – *Medicare Summary Notice (MSN) Messages*
(Rev. 1236, Issued: 05-11-07, Effective: 01-01-07, Implementation: 07-02-07)

Use appropriate MSN messages when processing claims.

For denials effective January 1, 2007, use the following MSN messages:

Include the following messages if an ABN was issued:

- *MSN# 16.10: "Medicare does not pay for this item or service." (English version) or "Medicare no paga por este articulo o servicio." (Spanish version)*

- *MSN# 36.1: "Our records show that you were informed in writing, before receiving the service, that Medicare would not pay. You are liable for this charge. If you do not agree with this statement, you may ask for a review." (English version) or "Nuestros archivos indican que usted fue informado por escrito, antes de recibir el servicio, que Medicare no pagaría. Usted es responsable por esta cantidad. Si usted no está de acuerdo, usted puede pedir una revisión." (Spanish version)*

NOTE: FIs are not to include MSN 16.10.

Include the following messages if an ABN was not issued:

- *MSN# 16.10: "Medicare does not pay for this item or service." (English version) or "Medicare no paga por este articulo o servicio." (Spanish Version)*

- *MSN number 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." (English version) or "Aparentemente, usted no sabia que nosotros no pagamos por este servicio, por lo tanto usted no es responsable. Si usted le pagó al proveedor por este servicio debe enviarnos lo siguiente: (1) Copia de esta notificación; (2) Factura del proveedor; (3) El recibo o prueba de que usted le pagó. Debe enviar su petición por escrito dentro de 6 meses de la fecha de esta notificación. Servicios de este tipo prestados en el futuro serán su responsabilidad." (Spanish Version)*

NOTE: FIs are not to include MSN 16.10.

140.3 - *Remittance Advice (RA) Messages*
(Rev. 1236, Issued: 05-11-07, Effective: 01-01-07, Implementation: 07-02-07)

Use appropriate RA messages when processing claims.

For denials effective January 1, 2007, use the following RA messages:

Claim adjustment reason code 50:

"These are non-covered services because this is not deemed a "medical necessity" by the payer".

Include the following RA messages if an ABN was issued:

- *RA remark code 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."

- *Group code PR:*

"Patient Responsibility."

 If an ABN was not issued include the following messages:

- *RA remark code 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."

- *Group code CO:*

"Contractual Obligations."

140.4 – Advance Beneficiary Notices (ABNs)
(Rev. 1236, Issued: 05-11-07, Effective: 01-01-07, Implementation: 07-02-07)

For the denial situations listed in Section 140.1, physicians, practitioners and hospitals are liable for payment unless they issue an appropriate ABN. Contractors will utilize the appropriate messages, see sections 140.2 and 140.3.