

Background information on Medicare coverage for payment of CompuMed's osteoporosis diagnostic OsteoGram®

COVERAGE

Coverage refers to the process and criteria used to determine whether a product, service or procedure will be reimbursed. We evaluated Medicare coverage policy for bone density studies. Per Medicare guidelines, bone mass measurement is a radiologic or radioisotopic procedure or other procedure that is:

- Performed with a bone densitometer (other than dual photon absorptiometry, DPA) or a bone sonometer device that has been approved or cleared for marketing by the FDA,
- Performed on a qualified individual for the purpose of identifying bone mass or detecting bone loss or determining bone quality, and
- Includes a physician's interpretation of the results of the procedure.

The term "qualified individual" means an individual who meets the medical indications for at least one of the five categories listed below:

- 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;
- 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 therapy equivalent to 7.5 mg of prednisone, or greater, per day, for more than three months;
- An individual with primary hyper-parathyroidism; or
- An individual being monitored to assess the response to or efficacy of a FDA-approved osteoporosis drug therapy.

Frequency Standard

- Medicare may cover a bone mass measurement for a beneficiary once every 2 years (if at least 23 months have passed since the month the last bone mass measurement was performed). However, if medically necessary, Medicare may cover a bone mass measurement for a beneficiary more frequently than every 2 years.

- Allowing for confirmatory baseline bone mineral density studies (either central or peripheral) to permit monitoring of beneficiaries in the future, if the initial test was performed with a technique that is different from the proposed monitoring method.
- Medicare reimbursement for bone densitometry, whether done by SPA, DEXA, or QCT, is allowed only one exam no matter how many sites are studied.

Reasons for Medicare Denial of Bone Mass Measurement Tests

- Dual photon absorptiometry (DPA) is a non-covered service.
- ICD-9-CM diagnostic codes do not support the reason for the test (see coding table below for complete list of diagnostic codes Medicare approves.)
- Bone mass measurement with a portable unit is not covered under the portable-X-ray benefit.
- Medical record documentation does not support the test.
- Routine screening bone densitometry in males is not covered by statute.

Private coverage policies for bone mass measurements.

1. Aetna US Healthcare: Aetna covers bone mass measurements. Aetna has adopted the Medicare policy. Aetna excludes coverage for DPA as it is considered investigational.
2. Kaiser Permanente: Coverage is available. Medicare coverage guidelines are closely followed.
3. Blue Cross Blue Shield of Massachusetts: Medicare coverage policy guidelines are followed. Bone density testing is available to males with idiopathic osteoporosis (ICD-9-CM 733.02). Blue Cross Blue Shield of Massachusetts does not cover ultrasound of the heel for diagnosing osteoporosis.

CODING

Codes are a nomenclature system used by insurers and providers to identify diagnoses and procedures. Codes also serve to track utilization and establish reimbursement rates for facility and professional services.

CPT codes:

The OsteoGram process includes taking a 2-view Posterior-Anterior fingers x-ray, then scanning the developed radiograph to generate a bone density report using the OsteoGram system. The physician or entity that performs the OsteoGram analysis should file for CPT code 76078.

ICD-9-CM codes (International Classification of Diseases, Clinical Modification):

Please refer to Appendix-A for ICD-9-CM codes.

PAYMENT

Radiological payment rates are divided into two parts. A) The Technical Component (TC) is payment for the equipment used and is paid to the equipment owner. B) The Professional Component (PC) is payment for the physician to interrupt the test results. It is possible for both components to be paid to the same facility or physician. For example, if a physician owns his/her X-ray equipment, orders an X-ray and interrupts the results he/she would be able to bill both the TC and the PC. **This is called a global rate.** On the other hand, if a physician orders an X-ray to be done in an imaging center or in a hospital outpatient department, the facility that owns the equipment bills for the TC and the physician interrupting the X-ray bills for the PC.

CPT code 76078: MEDICARE FEE SCHEDULE AMOUNT BY GEOGRAPHIC LOCALITY

Payment rates are geographically based. Basically, each CPT code has its own weight, which is the sum of the work component, the practice expense component and the malpractice component. For CPT code 76078, these are 0.2, 0.86 and 0.05 respectively. These component weights are multiplied by regional weights for each of these components. The sum of all of these weights, regionally adjusted, is then multiplied by the universal Medicare multiplier (\$37.98130841 for 2000) to determine the regional reimbursement for CPT code 76078. For Los Angeles this is \$48.78. Medicare pays 80% of this, with the patient or supplemental insurance paying the remainder.

Please refer to Appendix-B for locality-specific payment amount for CPT codes 73140 and 76078 in MEDICARE PHYSICIAN FEE SCHEDULE (MPFS) for year 2001.

1999 Medicare site of service data where bone density measurement testing was performed for CPT code 76078.

Site of Service	Times Performed	Percentage
Physician's Office	2,899	76.07
Inpatient Hospital	39	1.03
Outpatient Hospital	873	22.90
TOTAL	3,811	100%

Hospital-based tests:

The Health Care Financing Administration (HCFA) issued a final ruling on August 1 that changed the way bone density tests are classified and reimbursed by Medicare in a hospital outpatient setting.

This system groups a list of 4,000 procedures, including bone density tests, into 400 different Ambulatory Payment Classes (APC's).

IMPACT OF CHANGES

- **Bone density technologies that measure axial sites (DXA) are in the same class as technologies that measure peripheral sites (pDXA and RA).**

The only exception is the use of ultrasound to measure bone density, which is categorized in a separate ultrasound class (#265).

- **Medicare reimbursement rates in a hospital outpatient setting will be the same (\$67) for all bone density technologies because they have been put in the same payment class.**

This compares to the current Medicare rate of over \$130 for a hip or spine DXA exam, and approximately \$40 for a RA or pDXA exam done in a health care provider's office. In addition, under this new system, **ultrasound measurements are to be reimbursed at a rate of \$57 compared to approximately \$37 in an office setting.**