

Blue Cross Blue Shield of Michigan
Medicare Advantage Private Fee-for-Service

Bone Mass Measurement

January 1, 2008
Updated October 1, 2008

BONE MASS MEASUREMENT

Bone mass measurement is a painless, noninvasive and safe test to determine bone density and fracture risk for osteoporosis. The test is usually done to measure bone density in the spine, hip and or wrist. These are the most common sites of fractures due to osteoporosis.

Test results are compared to two standards, or norms, known as age matched and young normal. The age matched reading compares bone density to what is expected in someone of the patient's age, sex and size. The young normal reading compares density to the optimal peak bone density of a healthy young adult of the same sex. The test results enable a doctor to determine whether the patient is at risk for fracture. In general, the lower the bone density, the higher the risk for fracture.

ORIGINAL MEDICARE

According to the Social Security Act¹ and the Balanced Budget Act of 1997², Original Medicare³ covers bone mass measurement once every two years (if at least 23 months have passed since the month the last bone mass measurement was performed).

Bone mass measurement is a radiologic, radioisotopic, or other procedure that is used to:

- Quantify bone mineral density, detect bone loss or determine bone quality
- Establish the diagnosis of osteoporosis
- Assess an individual's risk of fracture
- Assess the response to, or efficacy of, osteoporosis drug therapy

The criteria for bone mass measurement are:

- It is performed with a bone densitometer, other than dual photon absorptiometry or a bone sonometer (e.g., ultrasound) device that has been approved or cleared for marketing by the Food and Drug Administration.
- It is performed on a qualified individual for the purpose of identifying bone mass, detecting bone loss or determining bone quality.

¹ Social Security Act, Title XVIII, §§1861(s)(15) & (rr)(1) of the Social Security Act

² Balanced Budget Act (BBA) of 1997, §4106

³ Medicare Benefit policy manual, CMS publication 100-02, chapter 15, §80.5
Medicare claims processing manual, CMS publication 100-04, chapter 13, §140

- If it is furnished by a qualified supplier or provider of such services, under at least the general level of supervision of a physician as defined in Section 1861 of the Social Security Act.
- If the test is ordered by the individual's physician or qualified nonphysician practitioner, who is treating the beneficiary following an evaluation of the need for the measurement, including a determination as to the medically appropriate measurement to be used for the individual, and who uses the results in the management of the patient.
- The test is reasonable and necessary for diagnosing, treating or monitoring of a qualified individual.

For conditions specified below, Medicare will cover a bone mass measurement more frequently than every two years, if medically necessary. At least eleven months must have elapsed since the previous bone mass measurement test.

Covered conditions include:

- Monitoring beneficiaries on long-term glucocorticoid (steroid) therapy, equal to 5 mg of prednisone or greater, for more than three months.
- Monitoring beneficiaries on Federal Drug Administration-approved osteoporosis drug therapy, to assess response and efficacy of therapy, until a response to such therapy has been documented over time and condition is stabilized.
- Follow up bone mineral density testing after discontinuation of therapy, until a response to such therapy has been documented.
- Men with prostate cancer undergoing hormonal manipulation may need yearly examinations.

Bone mass measurement is covered under Medicare for limited diagnoses and is limited to one bone mass measurement every two years unless one of the above exceptions is noted.

MEDICARE ADVANTAGE

Coverage for bone mass measurement is provided to members on an annual basis under select Medicare Advantage private fee-for-service plans. The member's cost-sharing and other coverage conditions, such as frequency, are determined by the group.

Conditions for Payment

BCBSM Medicare Advantage private fee-for-service plans use the Centers for Medicare & Medicaid Services deemed provider⁴ concept for group specific benefits. The table below specifies payment conditions for bone mass measurement:

Conditions For Payment	
Eligible providers	Consistent with Original Medicare
Deemed provider	See terms and conditions on bcbsm.com/ma
Payable locations	Consistent with Original Medicare
Frequency	Once annually
CPT codes	Consistent with Original Medicare
Diagnosis restrictions	No Restrictions
Age restrictions	

Reimbursement

The maximum payment amount for bone mass measurement benefit is consistent with Original Medicare. The provider will be paid the lesser of Medicare's allowable amount or the provider's charge, minus the member's cost-share. This represents payment in full and providers are not allowed to balance bill the member for the difference between the allowed amount and the charge.

Member Cost-Sharing

- Deemed providers must agree to collect from the member only the cost-sharing amounts described in the table below. They may not otherwise charge or bill the member.
- If the member elects to receive a noncovered service, he or she is responsible for the entire charge associated with the noncovered service.

The cost-sharing chart below identifies members with bone mass measurement coverage.

Member Cost-Sharing Responsibilities								
Group Name and Number	Annual Deductible		Coinsurance				Out-of-Pocket Maximum	
			Professional Claim		Institutional Claim			
	2007	2008	2007	2008	2007	2008	2007	2008
State of MI Retirees ⁵ 81820, 81821, 81828	No MA PFFS plan	\$0	No MA PFFS plan	\$0	No MA PFFS plan	SOB ⁶	No MA PFFS plan	Does not apply

⁴ 2008 Terms and conditions

⁵ State of Michigan Retirees Benefit grid

⁶ 2008 Summary of benefits

Member Cost-Sharing Responsibilities								
Group Name and Number	Annual Deductible		Coinsurance				Out-of-Pocket Maximum	
			Professional Claim		Institutional Claim			
	2007	2008	2007	2008	2007	2008	2007	2008
City of Detroit- Option E ⁷ 81100, 81101	\$175 Waived	\$175 all locations except 21 ⁸	20% all locations except 21	20% all locations except 21	SOB ⁹		\$825	\$825 all locations except 21
City of Detroit- Option F ¹⁰ 54731, 81097			10%	10% all locations except 21				
City of Detroit- Option G ¹¹ 04436								
BCBSM Retirees ¹² 80311, 80312	No MA PFFS plan	\$0	No MA PFFS plan	\$0	No MA PFFS plan		No MA PFFS plan	Does not apply

Member Cost-Sharing Responsibilities								
Group Name and Number	Annual Deductible		Coinsurance				Out-of-Pocket Maximum	
			Professional Claim		Institutional Claim			
	2007	2008	2007	2008	2007	2008	2007	2008
MPSERS ¹³ 59000	\$250		10% all locations except 21	1/1 to 3/31 10% all locations except 21	4/1 to 12/31 10%	SOB ¹⁴	SOB ¹⁵	\$500

⁷ City of Detroit - Option E Benefit grid

⁸ Inpatient hospital - 21

⁹ 2007 Summary of benefits

¹⁰ City of Detroit - Option F Benefit grid

¹¹ City of Detroit - Option G Benefit grid

¹² BCBSM Retirees Benefit grid

¹³ MPSERS Benefit grid

¹⁴ 2007 Summary of benefits

¹⁵ 2008 Summary of benefits

Billing Instructions

1. Bill services on the CMS 1500 (8/05) claim form, UB-04 or the 837 equivalent claim.
2. Use the Medicare Advantage private fee-for-service unique billing requirements.
3. Report CPT/HCPCS codes and diagnosis codes to the highest level of specificity.
4. Report your National Provider Identifier number on all claims.
5. Submit claims to your local BCBS plan.
6. Use electronic billing:
 - a. Michigan providers:
 - A copy of the ANSI ASC X12N 837 and 835 Institutional Health Care Claim and Health Care Claim Payment/Advice (BCBSM Electronic Data Interchange (EDI) Institutional 837/835 Companion Document) is available at:
http://www.bcbsm.com/pdf/837_835_institutional_companion.pdf
 - A copy of the BCBSM EDI Professional 837/835 Companion Document is available at:
http://www.bcbsm.com/pdf/systems_resources_prof_837_835.pdf
 - b. Providers outside of Michigan should contact their local BCBS plan.