

# **LCD for Bone Mass Measurement (L28527)**

## **Contractor Information**

### **Contractor Name**

Wisconsin Physicians Service Insurance Corporation

### **Contractor Number**

00951, 00952, 00953, 00954, 52280, 05101, 05201, 05301, 05401, 05102, 05202, 05302, 05402

### **Contractor Type**

Carrier - FI - MAC

## **LCD Information**

### **LCD ID Number**

L28527

### **LCD Title**

Bone Mass Measurement

### **Contractor's Determination Number**

MS-004

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### **CMS National Coverage Policy**

CMS Pub. 100-4 13 §140-140.3; 100-4 13 §10-10.1; 100-4 23 §10-10.1.7;  
CMS Pub. 100-3, Medicare National Coverage Determinations, Ch. 1, Part 2, §150.3  
CMS Pub.100-2, Ch. 15, §80.5

### **Oversight Region**

Region V

### **Original Determination Effective Date**

For services performed on or after 03/18/2009

## **Original Determination Ending Date**

## **Revision Effective Date**

For services performed on or after 11/01/2009

## **Revision Ending Date**

## **Indications and Limitations of Coverage and/or Medical Necessity**

A. Medicare covers a bone mass measurement for a beneficiary once every two years (if at least 23 months have past since the month the last bone mass measurement was performed). The criteria for bone mass measurement every two years are listed below;

1. It is performed with a bone densitometer, other than dual photon absorptiometry (DPA) or a bone sonometer (e.g., ultrasound) device that has been approved or cleared for marketing by the Food and Drug Administration (FDA).

2. It is performed on a qualified individual for the purpose of identifying bone mass, detecting bone loss or determining bone quality. The term "qualified individual" means an individual who meets the medical indications for at least one of the criteria listed below:

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

b. An individual with vertebral abnormalities as demonstrated by an x-ray to be indicative of osteoporosis, osteopenia (low bone mass), or vertebral fracture.

c. An individual receiving (or expecting to receive) glucocorticoid (steroid) therapy equivalent to 5 mg of prednisone, or greater, per day for more than three months.

d. An individual with primary hyperparathyroidism,

e. An individual being monitored to assess the response to or efficacy of an FDA approved osteoporosis drug therapy.

3. 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 (r) of the Social Security Act.

4. If the test is ordered by the individual's physician or qualified non-physician 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.

5. The test is reasonable and necessary for diagnosing, treating or monitoring of a "qualified" individual as defined above.

B. For conditions specified below, Medicare will cover a bone mass measurement for a qualified beneficiary more frequently than every two years, if medically necessary. To be considered at least eleven months must have elapsed since the previous bone mass measurement test. Such conditions are;

1. Monitoring beneficiaries on long-term glucocorticoid (steroid) therapy, equal to 5 mg of prednisone or greater, for more than three months

2. Monitoring beneficiaries on FDA-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.

3. Follow up bone mineral density testing after discontinuation of therapy, until a response to such therapy has been documented.

C. Medicare will cover a confirmatory baseline bone mass measurement (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 (e.g., if the initial test was bone sonometry and the patient will be monitored with bone densitometry, a second test utilizing densitometry will be paid).

There are limited clinical situations, where it may be appropriate to do both axial and peripheral bone mineral density (BMD) studies on the same date of service, or within thirty days of each other. Medicare will not reimburse for both axial and appendicular testing on the same date of service or within thirty days of each other, unless the medical records substantiate that the BMM initially obtained was unreadable. Conditions that verify to Medicare that a BMM is unreadable and a second BMM is medically necessary include documentation the patient has artificial instrumentation in place in either hip or spine, or other conditions that preclude a reading in those locations.

D. These other conditions may include the following;

1. Neither hip nor spine (axial testing ) can be measured. (Reason must be documented in the medical record).
2. Hyperparathyroidism
3. Obese patient over the weight limit of the DEXA exam table.
4. Extreme arthritic changes which precludes accurate measurement.

This documentation (medical records/history or and x-ray report) must be available for submission with the original and all subsequent claims upon request.

E. There are multiple techniques for obtaining bone mass or bone density information. There is a difference in the precision, and accuracy of the different techniques and the sensitivity of measurement in axial (central) or peripheral sites. In general, because cancellous bone changes more rapidly in time and with therapeutic intervention, the sites of cancellous bone (lumbar spine, proximal femur) are more likely than peripheral sites or cortical bone to show a response to FDA approved osteoporosis drug therapy and are preferred for baseline and drug monitoring purposes. The most reliable comparative results for drug monitoring are obtained when the same BMD instrument is used. Based on this, Medicare coverage is limited to those techniques which have been rated favorably in clinical studies.

## Coding Information

### Bill Type Codes:

**Contractors may specify Bill Types to help providers identify those Bill Types typically used to report this service. Absence of a Bill Type does not guarantee that the policy does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the policy should be assumed to apply equally to all claims.**

12x	Hospital-inpatient or home health visits (Part B only)
13x	Hospital-outpatient (HHA-A also) (under OPPTS 13X must be used for ASC claims submitted for OPPTS payment -- eff. 7/00)
22x	SNF-inpatient or home health visits (Part B only)
23x	SNF-outpatient (HHA-A also)
34x	HHA-other (Part B)
71x	Clinic-rural health
72x	Clinic-hospital based or independent renal dialysis facility

73x	Clinic-independent provider based FQHC (eff 10/91)
85x	Special facility or ASC surgery-rural primary care hospital (eff 10/94)

### Revenue Codes:

**Contractors may specify Revenue Codes to help providers identify those Revenue Codes typically used to report this service. In most instances Revenue Codes are purely advisory; unless specified in the policy services reported under other Revenue Codes are equally subject to this coverage determination. Complete absence of all Revenue Codes indicates that coverage is not influenced by Revenue Code and the policy should be assumed to apply equally to all Revenue Codes.**

Revenue codes only apply to providers who bill these services to the fiscal intermediary. Revenue codes do not apply to physicians, other professionals and suppliers who bill these services to the carrier.

Please note that not all revenue codes apply to every type of bill code. Providers are encouraged to refer to the FISS revenue code file for allowable bill types. Similarly, not all revenue codes apply to each CPT/HCPCS code. Providers are encouraged to refer to the FISS HCPCS file for allowable revenue codes.

Revenue codes 096X, 097X and 098X are to be used only by Critical Access Hospitals (CAHs) choosing the optional payment method (also called Option 2 or Method 2) and only for services performed by physicians or practitioners who have reassigned their billing rights. When a CAH has selected the optional payment method, physicians or other practitioners providing professional services at the CAH may elect to bill their carrier or assign their billing rights to the CAH. When professional services are reassigned to the CAH, the CAH must bill the FI using revenue codes 096X, 097X or 098X.

Note: Any explanatory text for this field now allows comments.

0320	Radiology diagnostic-general classification
0333	Radiology therapeutic-radiation therapy
034X	Nuclear medicine-general classification
035X	Computed tomographic (CT) scan-general classification
040X	Other imaging services-general classification
052X	Free-standing clinic-general classification
061X	Magnetic resonance technology (MRT)-general classification
0960	Professional fees-general classification
0969	Professional fees-other
0972	Professional fees-radiology diagnostic
0982	Professional fees-outpatient services
0983	Professional fees-clinic

### CPT/HCPCS Codes

76977	ULTRASOUND BONE DENSITY MEASUREMENT AND INTERPRETATION, PERIPHERAL SITE(S), ANY METHOD
77078	COMPUTED TOMOGRAPHY, BONE MINERAL DENSITY STUDY, 1 OR MORE SITES; AXIAL SKELETON (EG, HIPS, PELVIS, SPINE)
77079	COMPUTED TOMOGRAPHY, BONE MINERAL DENSITY STUDY, 1 OR MORE SITES; APPENDICULAR SKELETON (PERIPHERAL) (EG, RADIUS, WRIST, HEEL)
77080	DUAL-ENERGY X-RAY ABSORPTIOMETRY (DXA), BONE DENSITY STUDY, 1 OR MORE SITES; AXIAL SKELETON (EG, HIPS, PELVIS, SPINE)
77081	DUAL-ENERGY X-RAY ABSORPTIOMETRY (DXA), BONE DENSITY STUDY, 1 OR MORE SITES; APPENDICULAR SKELETON (PERIPHERAL) (EG, RADIUS, WRIST, HEEL)
77083	RADIOGRAPHIC ABSORPTIOMETRY (EG, PHOTODENSITOMETRY, RADIOGRAMMETRY), 1 OR MORE SITES
78350	BONE DENSITY (BONE MINERAL CONTENT) STUDY, 1 OR MORE SITES; SINGLE PHOTON ABSORPTIOMETRY
78351	BONE DENSITY (BONE MINERAL CONTENT) STUDY, 1 OR MORE SITES; DUAL PHOTON ABSORPTIOMETRY, 1 OR MORE SITES
G0130	SINGLE ENERGY X-RAY ABSORPTIOMETRY (SEXA) BONE DENSITY STUDY, ONE OR MORE SITES; APPENDICULAR SKELETON (PERIPHERAL) (EG, RADIUS, WRIST, HEEL)

### ICD-9 Codes that Support Medical Necessity

Note: ICD-9 codes must be coded to the highest level of specificity.

When 77078, 77079, 77081, 77083, 76977 or G0130 is done as an initial diagnostic test that determines a diagnosis of 255.0, 733.00, 733.01, 733.02, 733.03, 733.09 or 733.90, code as a secondary diagnosis the reason for the bone mass density test.

For Use with CPT Codes 77078, 77079, 77080, 77081, 77083, 76977, G0130

242.00	TOXIC DIFFUSE GOITER WITHOUT THYROTOXIC CRISIS OR STORM
242.01	TOXIC DIFFUSE GOITER WITH THYROTOXIC CRISIS OR STORM
242.10 - 242.11	

	TOXIC UNINODULAR GOITER WITHOUT THYROTOXIC CRISIS OR STORM - TOXIC UNINODULAR GOITER WITH THYROTOXIC CRISIS OR STORM
242.20 - 242.21	TOXIC MULTINODULAR GOITER WITHOUT THYROTOXIC CRISIS OR STORM - TOXIC MULTINODULAR GOITER WITH THYROTOXIC CRISIS OR STORM
242.30 - 242.31	TOXIC NODULAR GOITER UNSPECIFIED TYPE WITHOUT THYROTOXIC CRISIS OR STORM - TOXIC NODULAR GOITER UNSPECIFIED TYPE WITH THYROTOXIC CRISIS OR STORM
242.40 - 242.41	THYROTOXICOSIS FROM ECTOPIC THYROID NODULE WITHOUT THYROTOXIC CRISIS OR STORM - THYROTOXICOSIS FROM ECTOPIC THYROID NODULE WITH THYROTOXIC CRISIS OR STORM
242.80 - 242.81	THYROTOXICOSIS OF OTHER SPECIFIED ORIGIN WITHOUT THYROTOXIC CRISIS OR STORM - THYROTOXICOSIS OF OTHER SPECIFIED ORIGIN WITH THYROTOXIC CRISIS OR STORM
242.90 - 242.91	THYROTOXICOSIS WITHOUT GOITER OR OTHER CAUSE AND WITHOUT THYROTOXIC CRISIS OR STORM - THYROTOXICOSIS WITHOUT GOITER OR OTHER CAUSE WITH THYROTOXIC CRISIS OR STORM
246.0	DISORDERS OF THYROCALCITONIN SECRETION
252.00 - 252.02	HYPERPARATHYROIDISM, UNSPECIFIED - SECONDARY HYPERPARATHYROIDISM, NON-RENAL
252.08	OTHER HYPERPARATHYROIDISM
253.2	PANHYPOPITUITARISM
256.2	POSTABLATIVE OVARIAN FAILURE
256.31	PREMATURE MENOPAUSE
256.39	OTHER OVARIAN FAILURE
257.2	OTHER TESTICULAR HYPOFUNCTION
259.3	ECTOPIC HORMONE SECRETION NOT ELSEWHERE CLASSIFIED
262	OTHER SEVERE PROTEIN-CALORIE MALNUTRITION
263.0 - 263.9	MALNUTRITION OF MODERATE DEGREE - UNSPECIFIED PROTEIN-CALORIE MALNUTRITION
268.2	OSTEOMALACIA UNSPECIFIED
268.9	UNSPECIFIED VITAMIN D DEFICIENCY
275.40 - 275.49	UNSPECIFIED DISORDER OF CALCIUM METABOLISM - OTHER DISORDERS OF CALCIUM METABOLISM
555.0 - 555.9	REGIONAL ENTERITIS OF SMALL INTESTINE - REGIONAL ENTERITIS OF UNSPECIFIED SITE

556.0 - 556.9	ULCERATIVE (CHRONIC) ENTEROCOLITIS - ULCERATIVE COLITIS UNSPECIFIED
579.0 - 579.9	CELIAC DISEASE - UNSPECIFIED INTESTINAL MALABSORPTION
585.1 - 585.9	CHRONIC KIDNEY DISEASE, STAGE I - CHRONIC KIDNEY DISEASE, UNSPECIFIED
588.0	RENAL OSTEODYSTROPHY
588.81	SECONDARY HYPERPARATHYROIDISM (OF RENAL ORIGIN)
588.89	OTHER SPECIFIED DISORDERS RESULTING FROM IMPAIRED RENAL FUNCTION
626.0	ABSENCE OF MENSTRUATION
627.0 - 627.9	PREMENOPAUSAL MENORRHAGIA - UNSPECIFIED MENOPAUSAL AND POSTMENOPAUSAL DISORDER
731.0	OSTEITIS DEFORMANS WITHOUT BONE TUMOR
733.10 - 733.19	PATHOLOGICAL FRACTURE UNSPECIFIED SITE - PATHOLOGICAL FRACTURE OF OTHER SPECIFIED SITE
733.93 - 733.95	STRESS FRACTURE OF TIBIA OR FIBULA - STRESS FRACTURE OF OTHER BONE
737.10	KYPHOSIS (ACQUIRED) (POSTURAL)
753.12 - 753.19	POLYCYSTIC KIDNEY UNSPECIFIED TYPE - OTHER SPECIFIED CYSTIC KIDNEY DISEASE
758.6	GONADAL DYSGENESIS
781.91	LOSS OF HEIGHT
805.00 - 805.08	CLOSED FRACTURE OF CERVICAL VERTEBRA UNSPECIFIED LEVEL - CLOSED FRACTURE OF MULTIPLE CERVICAL VERTEBRAE
805.10 - 805.9	OPEN FRACTURE OF CERVICAL VERTEBRA UNSPECIFIED LEVEL - OPEN FRACTURE OF UNSPECIFIED PART OF VERTEBRAL COLUMN WITHOUT SPINAL CORD INJURY
806.00 - 806.09	CLOSED FRACTURE OF C1-C4 LEVEL WITH UNSPECIFIED SPINAL CORD INJURY - CLOSED FRACTURE OF C5-C7 LEVEL WITH OTHER SPECIFIED SPINAL CORD INJURY
806.10 - 806.19	OPEN FRACTURE OF C1-C4 LEVEL WITH UNSPECIFIED SPINAL CORD INJURY - OPEN FRACTURE OF C5-C7 LEVEL WITH OTHER SPECIFIED SPINAL CORD INJURY
806.20 - 806.29	CLOSED FRACTURE OF T1-T6 LEVEL WITH UNSPECIFIED SPINAL CORD INJURY - CLOSED FRACTURE OF T7-T12 LEVEL WITH OTHER SPECIFIED SPINAL CORD INJURY
806.30 - 806.39	

OPEN FRACTURE OF T1-T6 LEVEL WITH  
UNSPECIFIED SPINAL CORD INJURY - OPEN  
FRACTURE OF T7-T12 LEVEL WITH OTHER  
SPECIFIED SPINAL CORD INJURY

806.4	CLOSED FRACTURE OF LUMBAR SPINE WITH SPINAL CORD INJURY
806.5	OPEN FRACTURE OF LUMBAR SPINE WITH SPINAL CORD INJURY
806.60 - 806.69	CLOSED FRACTURE OF SACRUM AND COCCYX WITH UNSPECIFIED SPINAL CORD INJURY - CLOSED FRACTURE OF SACRUM AND COCCYX WITH OTHER SPINAL CORD INJURY
806.70 - 806.9	OPEN FRACTURE OF SACRUM AND COCCYX WITH UNSPECIFIED SPINAL CORD INJURY - OPEN FRACTURE OF UNSPECIFIED VERTEBRA WITH SPINAL CORD INJURY
820.00 - 820.9	FRACTURE OF UNSPECIFIED INTRACAPSULAR SECTION OF NECK OF FEMUR CLOSED - FRACTURE OF UNSPECIFIED PART OF NECK OF FEMUR OPEN
962.0	POISONING BY ADRENAL CORTICAL STEROIDS
995.20	UNSPECIFIED ADVERSE EFFECT OF UNSPECIFIED DRUG, MEDICINAL AND BIOLOGICAL SUBSTANCE
V45.77	ACQUIRED ABSENCE OF ORGAN GENITAL ORGANS
V49.81	ASYMPTOMATIC POSTMENOPAUSAL STATUS (AGE- RELATED) (NATURAL)
V50.42	PROPHYLACTIC OVARY REMOVAL
V58.61	LONG-TERM (CURRENT) USE OF ANTICOAGULANTS
V58.65	LONG-TERM (CURRENT) USE OF STEROIDS
V58.69	LONG-TERM (CURRENT) USE OF OTHER MEDICATIONS
V67.1	FOLLOW-UP EXAMINATION FOLLOWING RADIOTHERAPY
V67.2	FOLLOW-UP EXAMINATION FOLLOWING CHEMOTHERAPY
V67.51	FOLLOW-UP EXAMINATION FOLLOWING COMPLETED TREATMENT WITH HIGH-RISK MEDICATION NOT ELSEWHERE CLASSIFIED
V67.59	OTHER FOLLOW-UP EXAMINATION
V71.89	OBSERVATION FOR OTHER SPECIFIED SUSPECTED CONDITIONS
V82.81	SPECIAL SCREENING FOR OSTEOPOROSIS

**For Use with CPT Code 77080 (DEXA)**

255.0	CUSHING'S SYNDROME
733.00	OSTEOPOROSIS UNSPECIFIED

733.01	SENILE OSTEOPOROSIS
733.02	IDIOPATHIC OSTEOPOROSIS
733.03	DISUSE OSTEOPOROSIS
733.09	OTHER OSTEOPOROSIS
733.90	DISORDER OF BONE AND CARTILAGE UNSPECIFIED

**Diagnoses that Support Medical Necessity**

Diagnoses listed above

**ICD-9 Codes that DO NOT Support Medical Necessity**

ICD-9 Codes not listed above

**ICD-9 Codes that DO NOT Support Medical Necessity Asterisk Explanation**

**Diagnoses that DO NOT Support Medical Necessity**

Diagnoses not listed above

**General Information**

**Documentation Requirements**

1. Physicians' Services and diagnostic tests must be submitted with an ICD-9 code to support the medical necessity for the service and must be coded to the greatest level of accuracy and highest level of digit completeness. This means the precise ICD-9 code that fully explains the narrative description of the diagnosis contained in the medical record or the test interpretation and report including the 4th or 5th digit sub-classification for the diagnosis category. The ICD-9 code based on the results of the test should be the primary diagnosis. If the diagnostic test results are normal or inconclusive the ICD-9 code representing the sign, symptom, illness or injury prompting the ordering of the test should be reported as the primary diagnosis.
2. Medical records should be legible, contain the relevant history, physical findings conforming to the criteria stated in the "Indications and Limitation of Coverage/Medical Necessity" section of this policy and must be made available to the Carrier on request.
3. Documentation supporting medical necessity including the reason for testing, the method used, and the site(s) evaluated, plus a test report should be in the patient's record.
4. The patient's medical record must document that patient meets one of the requirements of a "qualified individual" as described in the Indications and Limitations of Coverage section of this policy.
5. Documentation supporting medical necessity must be indicated in the narrative field and available upon request

## Appendices

### Utilization Guidelines

Refer to "Indications and Limitations of Coverage and/or Medical Necessity" sections A and B.

Notes  
See companion document titled Billing and Coding Guidelines for MS-004, Bone Mineral Density (BMD) Studies

This LCD consolidates and replaces all previous policies and publications on this topic by the carrier and fiscal intermediary predecessors of Wisconsin Physician Services.

For claims submitted to the fiscal intermediary; This coverage determination also applies within states outside the primary geographic jurisdiction with facilities that have nominated Wisconsin Physician Services (formerly Mutual of Omaha) to process their claims

Italicized lettering indicates CMS wording

\* Indicates most recent publishing or revision

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 the Carrier Advisory Committee, which included representatives from various medical specialties.

NCDs and coverage provisions in interpretive manuals are not subject to the Local Coverage Determination (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.

### Sources of Information and Basis for Decision

1. American College of Radiology, ACR Appropriateness Criteria™ - Osteoporosis and bone Mineral Density (2001)
2. DEXA National Workgroup Memo, American Association of Clinical Endocrinologists - Osteoporosis Clinical Practice Guidelines (2001).
3. Institute for Clinical System Improvement, Health Care Guidelines: Diagnosis and Treatment of Osteoporosis (July 2002)
4. National Osteoporosis Foundation - Physicians Guide to Prevention and Treatment of Osteoporosis 2000, Update on Medication (2002)
5. The U.S. Preventive Services Task Force (USPSTF) Recommendation: Screening for Osteoporosis in Postmenopausal Women (September 2002)

6. This LCD is an adaptation of the existing Wisconsin Physician's Service LCD in effect as of 12/01/2007 for Wisconsin, Illinois, Michigan, and Minnesota.

### **Advisory Committee Meeting 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 consideration of the active LCDs maintained by the preceding Medicare contractors for Jurisdiction 5.

#### Meeting Date:

Wisconsin 09/26/2008;

Illinois 09/17/2008;

Michigan 09/24/2008;

Minnesota 09/13/2008;

Iowa 10/16/2008

Kansas 10/16/2008

Missouri 10/17/2008

Nebraska 10/18/2008

### **Start Date of Comment Period**

10/18/2008

### **End Date of Comment Period**

12/03/2008

### **Start Date of Notice Period**

05/01/2009

### **Revision History Number**

7

### **Revision History Explanation**

Correctly removed contract number 05392 effective 8/1/2009, as it is being combined with contractor number 05302 (WPS Part B MAC Missouri - Entire State.) JS 07/30/09

\*11/01/2009, For the purpose of clarity and to be consistent with CMS national language, removed statements from the section entitled Indications and Limitations of Medical Necessity. The statements removed are listed directly below;

Category A, Paragraph 2: FDA-approved osteoporosis drug therapies include, but may not be limited to the following medication list; alendronate (Fosamax), risedronate (Actonel), calcitonin (Calcimar, Miacalcin, Cibacalcin), raloxifene (Evista), iludronate (Skelid), etidronate (Didronel), zoledronate (Zometa), pamidronate (Aredia), parathyroid hormone (Forteo), ibandronate (Boniva). Calcium and Vitamin D supplements are also recommended but are not defined as FDA-approved osteoporosis drug therapy, and therefore, do not meet this criteria. HRT (estrogen) is no longer FDA approved for osteoporosis treatment, only prevention. An individual who has completed drug therapy for osteoporosis and is being monitored for response to therapy. An individual with a history of long term anti-convulsant, heparin, gonadotropin releasing hormone (GnRH) therapy or aromatase inhibitors. An individual with impaired renal function use including chronic renal failure, renal osteodystrophy, and other specified disorders resulting from impaired renal function and cystic kidney disease. An individual with a history of pathologic fracture(s).

Category B, sentence 4. Men with prostate cancer undergoing hormonal manipulation may need yearly examinations.

The inclusion of the statements above did not expand coverage beyond the NCD. The removal of these statements does not effect coverage or restrict reimbursement. (Two);

## **Reason for Change**

## **Last Reviewed On Date**

10/01/2009

## **Related Documents**

This LCD has no Related Documents.

## **LCD Attachments**

[Coding and Billing Guidelines 03/01/2010 \(PDF - 28,827 bytes\)](#)

## **All Versions**

Updated on 02/17/2010 with effective dates 11/01/2009 - N/A

Updated on 10/16/2009 with effective dates 11/01/2009 - N/A

Updated on 07/30/2009 with effective dates 08/01/2009 - 10/31/2009

Updated on 07/30/2009 with effective dates 05/01/2009 - 07/31/2009

Updated on 07/17/2009 with effective dates 05/01/2009 - N/A

Updated on 04/24/2009 with effective dates 05/01/2009 - N/A

Updated on 04/02/2009 with effective dates 03/18/2009 - 04/30/2009

Updated on 03/25/2009 with effective dates 03/18/2009 - N/A

Updated on 02/25/2009 with effective dates 03/18/2009 - N/A