ICD-9-CM Diagnosis Codes

ICD-9-CM Codes	Associated Diagnoses
252.0	Hyperparathyroidism
252.8	Other specified disorders of parathyroid gland
252.9	Unspecified disorder of parathyroid gland
255.0	Cushing's syndrome
255.3	Other corticoadrenal overactivity
256.2, 256.3, 256.8, 256.9	Ovarian failure or dysfunction
257.1, 257.2, 257.8, 257.9	Testicular hypofunction or dysfunction
259.3	Ectopic hormone secretion, not elsewhere classified
259.9	Unspecified endocrine disorder
268.2	Osteomalacia, unspecified
579.9	Unspecified intestinal malabsorption
588.0	Renal osteodystrophy
588.8	Other specified disorders resulting from impaired renal function
626.0	Absence of menstruation
627.0	Premenopausal menorrhagia
627.2	Menopausal or female climacteric states
627.4	States associated with artificial menopause
627.8	Other specified menopausal and postmenopausal disorders
627.9	Unspecified menopausal and postmenopausal disorder
733.00-733.09	Osteoporosis
733.10-733.16, 733.19	Pathologic fracture
733.90	Disorder of bone and cartilage, unspecified
758.6	Gonadal dysgenesis (Turner's Syndrome)
805.00-805.98	Fracture of vertebral column without mention of spinal cord injury
806.00-806.09, 806.10-806.19	Closed or open cervical fracture with spinal cord injury
806-20-806.29, 806.30-806.39	Closed or open dorsal (thoracic) fracture with spinal cord injury
806.4, 806.5	Closed or open lumbar vertebral fracture with spinal cord injury
806.60-806.69 806.70-806.79	Closed or open fracture of sacrum and coccyx with spinal cord injury
806.8	Unspecified fracture of spine, closed
995.2	Unspecified adverse effect of drug, medicinal and biological substance
V07.4	Postmenopausal hormone replacement therapy
V49.81	Postmenopausal status (age-related) (natural)
V58.69	Long-term (current) use of other medications (high-risk medications) (May be used for patients currently taking corticosteroids or anti-androgen therapy.)
V67.51	Follow-up examination following completed treatment with high-risk medications, not elsewhere classified (May be used to report an individual who has completed drug therapy that may have caused osteoporosis, e.g., completed treatment with corticosteroids)
V67.59	Follow-up examination following other treatment; other (May be used to report an individual who has had an orchiectomy and is being monitored for the effects of low androgen.)
V77.99	Other and unspecified endocrine, nutritional, metabolic, and immunity disorders (May be used to bill for screening of the asymptomatic qualified individual.)
V82.81	Special screening code for osteoporosis

Some carriers may have a specific list of ICD-9-CM codes. Please check with your local carrier regarding its current policy.

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Background

Osteoporosis, a systemic skeletal disease characterized by low bone strength and low-trauma fractures, affects 28 million people in the United States today. Ten million sufferers and 18 million others with low bone strength, along with other at-risk populations, require regular bone assessment exams to follow the progress of the costly disease. Annually, 1.5 million osteoporotic fractures in the United States cause massive suffering and require an estimated annual expenditure of $14 billion.

Diagnosing Osteoporosis

Sunlight Omnisense™ 7000S is the only multi-site bone sonometer for the diagnosis and management of osteoporosis on the market today. Its unique patented ultrasound technology, Omnipath™, eliminates the effect of soft tissue on measurement, for a more accurate diagnosis of bone strength. Using Omnisense 7000S, you can provide quick, patient-friendly, reimburseable bone assessment for your patients in your office.

Sunlight

Coverage Policies

Coding and Billing Requirements - Background

Bone strength assessment with Omnisense 7000S may be a covered service, if it meets the requirements established by Medicare and private payers. It is recommended that you check with your local Medicare contractors and private health plans regarding their local coverage policies.

Codes are necessary for physicians and freestanding clinics to report their services and procedures. Accurate coding may lead to faster processing of submitted claims. In the absence of a national coding policy it is advisable to check with your local Medicare contractors or private insurance plans regarding their accepted coding policy. A submission for payment requires two codes for each procedure, a diagnosis code (ICD-9-CM) and a procedure code (CPT).

Coding Requirements

ICD-9-CM Diagnosis Coding

To comply with Medicare and third-party payer requirements, claim forms must indicate the ICD-9-CM code or codes that describe the principal diagnosis responsible for the patient's condition. The principal diagnosis codes that may relate to the Omnisense 7000S bone strength assessment test appear on the overleaf.

CPT Coding

Physicians' Current Procedural Terminology (CPT), Fourth Edition, is a listing of descriptive terms and identifying codes for reporting medical services and procedures that physicians and other medical professionals perform. The CPT code used for bone assessment with Omnisense is CPT Code 76977 (Ultrasound bone density measurement and interpretation, peripheral site(s), any method).

Billing Requirements - Documentation

Documentation is the key to providing a carrier with the information necessary for making a decision whether to approve or deny a claim. Essential medical information should include documentation that Omnisense 7000S was used to assess the patient's bone strength in accordance with approved indications.

Insurance Coverage and Payment Guidelines

Medicare

Effective July 1, 1998, the Bone Mass Measurement Act (BMMA) provides a national coverage policy for the reimbursement of bone strength assessment for qualified Medicare beneficiaries.

A qualified beneficiary is a person meeting at least one of the following criteria:

- An estrogen deficient woman at clinical risk for osteoporosis
- An individual with vertebral abnormalities
- An individual receiving long-term glucocorticoid (steroid) therapy
- An individual with primary hyperparathyroidism
- An individual being monitored to assess the response to or the efficacy of an FDA-approved drug for osteoporosis

Coverage of follow-up testing is generally limited to one measurement every two years. More frequent follow-up tests may be permitted when medically necessary. For example, more frequent testing may be permitted for an individual on long-term (more than 3 months) steroid therapy.

The national average payment by Medicare for peripheral ultrasound bone assessment is approximately $33 per study. Contact your local Medicare carrier to confirm the locally paid amount or look for your local reimbursment rate at: www.sunlightmedical.com/usa/html/reimbursment.html.

Private Insurers

Private payers have different coding and reimbursement guidelines, especially regarding new procedures. Coverage and reimbursement amounts will also vary based on contractual arrangements with the individual payers. Many payers follow Medicare policy in paying for the Omnisense 7000S bone test and reimburse at an equal or higher level per study. Contact the patient's third-party payer for their specific coverage guidelines regarding testing for osteoporosis.

Denial of Payment

Medicare

If the Medicare carrier does not pay for a bone assessment test that seems to meet the criteria for coverage, the physician's office can take the following steps:

1) Assure that the beneficiary is part of one of the five groups of individuals qualified for testing.
2) Confirm that the carrier recognizes the ICD-9 codes used.
3) Send a formal letter with additional information to the carrier to obtain coverage (Form letters are available from Sunlight Medical, Inc.).

Often, there will be instructions regarding next steps on the denial of coverage as well. The appeals process should be utilized if an unsatisfactory decision is made by the local Medicare carrier's office.

Private Insurers

Reimbursement amounts and coverage criteria for bone assessment tests covered with private insurance through employers are variable. There is currently no law similar to Medicare that standardizes coverage criteria and reimbursement rates. We suggest that a denial of payment should be challenged if the test seems to meet the Medicare criteria for coverage. A letter addressed to the medical director with additional information should be considered. Sunlight Medical, Inc. can provide you with a form letter.