

MARYLAND MEDICARE PART A

Policy No.: 97-12

Topic: Serum Iron Studies

Beginning Effective Date

April 28, 1997

Ending Effective Date

Not applicable at this time.

Description

Serum iron Studies include:

- Iron;
- Total Iron Binding Capacity (TIBC);
- Transferring; and,
- Ferritin.

Iron studies are useful in the evaluation of disorders of iron metabolism, particularly iron deficiency and iron excess. Iron deficiency is the most common cause of anemia. It is usually the result of blood loss, but may occasionally be secondary to iron malabsorption. Serum iron is classically decreased in iron deficiency, but is also low in acute and chronic inflammatory and neoplastic states.

Total Iron Binding Capacity (TIBC), is an indirect measurement of transferrin, a protein that binds and transports iron. It quantifies transferrin in terms of the amount of iron it can bind and is reported as percent of saturation. Classically, TIBC is elevated in iron deficiency pregnancy and by anovulatory agents. Because transferrin levels are depressed in patients who are malnourished or who are in a chronic disease state, it may be normal in many patients who are iron deficient.

Because of the significant limitations of serum iron and TIBC, serum ferritin is a more accurate measurement of storage iron. Low levels are unique to iron deficiency while extremely high values are typical of iron storage disease. Moderate elevations are seen in many chronic inflammatory, infectious, and neoplastic diseases.

Policy Type

Local Medical Policy Review Policy

Indications and Limitations of Coverage and/ or Medical Necessity

Iron studies are selectively indicated in the differential diagnosis of microcytic, hypochromic anemia as well as in iron overload conditions. The need of repeat testing should be infrequent.

Serum ferritin may be covered for the diagnoses listed in the “ICD-9-CM codes that Support Medical Necessity” section of this policy. Although a diagnosis is listed as a covered condition, it should be recognized that the medical necessity for testing should be indicated in the patient’s medical record on the date the specimen is ordered. Frequency of testing will be subject to review.

If a normal serum ferritin level is documented, having been performed for a covered sign, symptom, or disease, repeat testing would not be medically necessary unless there is a change in the patient’s condition verifying the need for repeat testing. For example, if a patient presenting with new-onset insulin-dependent diabetes mellitus has a serum ferritin for diabetes mellitus would be inappropriate).

HCPCS Section(s) &

Benefit Category

Pathology/Laboratory/Chemistry

Type(s) of Bill

Not included at the time the policy was developed.

Revenue Code(s)

Not included at the time the policy was developed

HCPCS Code(s)

82728©	Ferritin
83540©	Iron
83550©	Iron binding capacity
84466©	Transferrin

ICD-9-CM Codes that Support Medical Necessity**Covered for:**

275.0	Disorders of iron metabolism
280.0	Iron deficiency anemia secondary to blood loss (chronic)
280.1	Iron deficiency anemia secondary to inadequate dietary intake
280.8	Other specified iron deficiency anemias
280.9	Iron deficiency anemia, unspecified
282.4	Thalassemia
282.60	Sickle cell anemia, unspecified
282.63	Sickle cell/Hb-C disease
282.69	Other sickle cell anemia
282.7	Other hemoglobinopathies
285.0	Sideroblastic anemia
285.9	Anemia unspecified
307.52	Pica
536.0	Achlorhydria
579.0	Celiac disease
579.2	Blind loop syndrome
579.8	Other and unspecified postsurgical non-absorption
579.9	Unspecified intestinal malabsorption
585	Chronic renal failure
586	Renal failure, unspecified
713.0	Arthropathy associated with other endocrine and

metabolic disorders; code first underlying disease as hemochromatosis
(275.0)

790.6	Other abnormal blood chemistry, iron
999.8	Other transfusion
V56.0	Extracorporeal dialysis
V56.8	Peritoneal dialysis

Non-covered ICD9CM Codes(s)

All diagnosis not listed in the “ICD-9-CM Codes That Support Medical Necessity” section of this policy.

HCFA National Policy

- Establishment of national policy supercedes all previous contractor policy statements, including Local medical Policy coverage guidelines.
- Title XVIII of the Social Security Act, section 1862 (a) (1) (A). This section allows coverage and payment for only those services that are considered to be medically reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.
- Title XVIII of the Social Security Act, section 1862 (a) (7). This section excludes routine physical examinations.

Reasons for Denial:

- All other indications not listed in the ‘Indications and Limitations of Coverage’ section of this policy,
- The services is for screening purposes,
- The services is not medically necessary,
- The service is for automated or manual calculations and/or percentages or extrapolated values,
- The medical record does not verify that the service described by the HCPCS code was provided, and ;
- The service does not follow the guidelines of this policy.

Coding Guidelines:

- To report these services, use the appropriate HCPCS code(s),
- All there coverage criteria must be met before this service can be reimbursed by Medicare,
- ICD-9-CM code V82.9 (special screening tests for other conditions, unspecified condition), should be used in the absence of any signs or symptoms, to indicate screening,
- Diagnosis(es) must be present on any claim submitted, and must be coded to the highest level of specificity, and;
- The diagnosis code (s) must be representative of the patient's condition.

Documentation Requirements

- Documentation supporting the medical necessity should be legible, maintained in the patient's medical record, and must be made available to Medicare upon request.
- The ordering physician should retain in the patient's medical record , history and physical examination notes documenting evaluation and management of one of the Medicare covered conditions/diagnoses with relevant clinical signs/symptoms or abnormal laboratory results, appropriate to one of the covered indications.
- The patients clinical record should further indicate changes/alterations in medications prescribed for the treatment of these conditions. There must be a physician's order for each test documented I the patient's medical/clinical record.

Other Comments:

- Medicare will monitor the utilization of these laboratory tests through the Focused Medical Review (FMR) process.
- This policy does not reflect the sole opinion of the carrier, intermediary, or Carrier/Intermediary Medical Directors. Although the final decision rests with the Carrier Advisory Committee (CAC), which includes representatives from the appropriate specialties.

Start Date of Comment Period

Start Date of Notice Period

March 28, 1997

Revision Date

Revision Number

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