MEDICARE LOCAL COVERAGE DETERMINATION POLICY

SERUM MAGNESIUM TESTING [POLICY L36702]

MEDICARE LOCAL COVERAGE DETERMINATION (LCD)

Noridian, the Medicare Administrative Contractor (MAC) for California, has issued a Medicare local coverage determination (LCD) policy [L36702] applicable to Serum Magnesium, CPT Code 83735. The full text of the LCD for Serum Magnesium Testing is available online. This Reference Guide sets forth excerpts of key information from the LCD, which PDL believes can assist providers to determine:

(1) whether Serum Magnesium Testing is medically appropriate for your patient
(2) circumstances and diagnoses for which Noridian / Medicare will pay for Serum Magnesium Testing
(3) when providers must secure a signed Advance Beneficiary Notice (ABN) from a Medicare patient

The Reference Guide also sets forth (page 2) ICD-10-CM Codes commonly used for Vitamin D Assay Testing

The list of ICD codes provided below consists of *commonly utilized diagnosis codes*.

- This is not a full list of ICD codes for this test. The complete CMS policy and full list of ICD codes can be found at the following website: https://www.cms.gov/
- To view the CMS Local Coverage Determination (LCD) for Serum Magnesium Testing visit the following website: LCD - Serum Magnesium (L36702) (cms.gov).
- It is the responsibility of the ordering provider to ensure appropriate diagnostic coding for a test.
- If you are ordering this test for diagnostic reasons that are not covered under Medicare policy, an Advanced Beneficiary Notice (ABN) form is required.

COVERAGE INDICATIONS, LIMITATIONS, AND/OR MEDICAL NECESSITY

Note: Providers should seek information related to National Coverage Determinations (NCD) and other Centers for Medicare & Medicaid Services (CMS) instructions in CMS Manuals. This LCD only pertains to the contractor's discretionary coverage related to this service.

Magnesium is a mineral required by the body for the use of adenosine triphosphate (ATP) as a source of energy. It is also necessary for neuromuscular irritability and blood clotting. Magnesium deficiency produces neuromuscular disorders. It may cause weakness, tremors, tetany, and convulsions. Hypomagnesemia is associated with hypocalcemia, hypokalemia, long-term hyperalimentation, intravenous therapy, diabetes mellitus (especially during treatment of ketoacidosis); alcoholism and other types of malnutrition; malabsorption; hyperparathyroidism; dialysis; pregnancy; and hyperaldosteronism. The following are other conditions that may cause magnesium deficiencies

- Renal loss of magnesium occurs with cis-platinum therapy.
- Hypomagnesemia may also be induced by amphotericin or anti-EGFR (some monoclonal antibodies) toxicity.
- Magnesium deficiency is described with cardiac arrhythmias. There is evidence that magnesium may cause arrhythmias.

Indications:
Utilization of certain cardiac drugs which cause adverse effects in the presence of low magnesium (i.e., quinidine, procainamide, and disopyramide phosphate or Norpace). Patients taking these drugs should have their magnesium checked approximately once every six months.

- Long term parenteral nutrition. Patients on long term parenteral nutrition that are otherwise asymptomatic should have their serum magnesium checked monthly.
- Malabsorption syndrome. The frequency should depend on the severity of the syndrome, but once the patient's level is stabilized, a monthly check should be adequate.
- Renal loss secondary to diuretic use.

- Chronic alcoholism, diabetic acidosis, and renal tubular acidosis. These patients should be followed on an as needed basis according to their symptomatology. Without symptoms, they should be checked no more than annually.
- Chronic diarrhea, otherwise unexplained and persistent.
- Prolonged nasogastric suction greater than five days. These patients should have a magnesium check every two to three weeks.
- Cisplatin treatment.
- Amphotericin treatment
- EGFR monoclonal antibodies
- Patients receiving IV magnesium therapy for a low serum level. Serum level should be monitored appropriately.
- Patients with hypocalcemia. If the hypocalcemia persists, the level should probably be checked on a six-month basis as long as the patient does not have symptoms of arrhythmias that would warrant closer follow up.
- Lethargy and confusion that are not otherwise explained. Once a patient has been diagnosed with mental health processes such as Alzheimer or psychotic depression, etc., there is no indication to follow their magnesium level on a regular basis.
- Patients receiving oral magnesium in the face of impaired renal function should have their magnesium level checked on a monthly basis.

Other clinical situations:

- Pre-eclampsia
- Unexplained muscular paralysis
- Neuromuscular irritability
- Blood clotting abnormalities
- Evidence (mixed) that magnesium levels are low and increased magnesium may benefit patients with sickle cell anemia, beta thalassemia and hypersplenism– more recent articles dispute this.
- Long Q-T syndrome, torsades de pointes and ventricular arrhythmias.

REMINDER:

The ordering provider is solely responsibility for assigning diagnosis (codes) for Serum Magnesium Testing. PDL does not – through this Reference Guide or otherwise – recommend any particular diagnosis codes. PDL will submit to Medicare only the diagnosis (codes) provided to PDL by the ordering provider and/or his/her authorized staff.

ICD-10-CM Codes commonly used for Serum Magnesium Testing (CPT 83735)

Alias: Magnesium

CODE	DESCRIPTION
N18.1	Chronic kidney disease, stage 1
N18.2	Chronic kidney disease, stage 2 (mild)
N18.3	Chronic kidney disease, stage 3 (moderate)
N18.4	Chronic kidney disease, stage 4 (severe)
N18.5	Chronic kidney disease, stage 5
R25.2	Cramp and spasm
I10	Essential (primary) hypertension
I12.9	Hypertensive chronic kidney disease with stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease
I11.9	Hypertensive heart disease without heart failure
E83.42	Hypomagnesemia

Z94.0	Kidney transplant status
Z94.4	Liver transplant status
R53.83	Other fatigue
Z79.899	Other long term (current) drug therapy
R79.89	Other specified abnormal findings of blood chemistry
I48.0	Paroxysmal atrial fibrillation
N25.81	Secondary hyperparathyroidism of renal origin
E11.65	Type 2 diabetes mellitus with hyperglycemia
E11.29	Type 2 diabetes mellitus with other diabetic kidney complication
E11.9	Type 2 diabetes mellitus without complications