Sonora Quest Laboratories™
A Subsidiary of Laboratory Sciences of Arizona

Serum Magnesium

CPT: 83735

CMS Policy for Alaska, Arizona, Idaho, Montana, North Dakota, Oregon, South Dakota, Utah, Washington, and Wyoming

Local policies are determined by the performing test location. This is determined by the state in which your performing laboratory resides and where your testing is commonly performed.

Medically Supportive ICD Codes are listed on subsequent page(s) of this document.

Coverage Indications, Limitations, and/or Medical Necessity

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.

Medicare Local Coverage Determination Policy

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Please refer to the Limitations or Utilization Guidelines section on previous page(s) for frequency information.

The ICD10 codes listed below are the top diagnosis codes currently utilized by ordering physicians for the limited coverage test highlighted above that are also listed as medically supportive under Medicare's limited coverage policy. **If you are ordering this test for diagnostic reasons that are not covered under Medicare policy, an Advance Beneficiary Notice form is required.**
Note—Bolded diagnoses below have the highest utilization

Code	Description
E11.65	Type 2 diabetes mellitus with hyperglycemia
E11.9	**Type 2 diabetes mellitus without complications**
E83.42	**Hypomagnesemia**
E83.51	Hypocalcemia
E87.6	Hypokalemia
I10	**Essential (primary) hypertension**
I48.0	Paroxysmal atrial fibrillation
I50.22	Chronic systolic (congestive) heart failure
N18.2	Chronic kidney disease, stage 2 (mild)
N18.3	Chronic kidney disease, stage 3 (moderate)
N18.4	Chronic kidney disease, stage 4 (severe)
N25.81	Secondary hyperparathyroidism of renal origin
R25.2	Cramp and spasm
R53.1	Weakness
R53.83	Other fatigue
R79.89	Other specified abnormal findings of blood chemistry
Z51.11	Encounter for antineoplastic chemotherapy
Z79.899	**Other long term (current) drug therapy**
Z94.0	**Kidney transplant status**
Z94.4	Liver transplant status

Visit **SonoraQuest.com/Medicare** to view current limited coverage tests, reference guides, and policy information.
To view the complete policy and the full list of medically supportive codes, please refer to the CMS website reference www.cms.gov ►

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