

## Serum Magnesium

CPT Code 83735



### CMS Policy

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

To provide a source of energy, magnesium is required by the body for the use of adenosine triphosphate (ATP). Magnesium deficiencies can be the cause of numerous neuromuscular disorders, weakness, tremors, tetany, and convulsions. Magnesium is crucial for neuromuscular irritability and blood clotting. 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. Other conditions that may cause magnesium deficiencies include:

- 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 disopyramidephosphate 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, torsade de pointes and ventricular arrhythmias.

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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.

**\*Note—Bolded diagnoses below have the highest utilization**

Code	Description
N18.1	Chronic kidney disease, stage 1
N18.2	Chronic kidney disease, stage 2 (mild)
<b>N18.3</b>	<b>Chronic kidney disease, stage 3 (moderate)</b>
N18.4	Chronic kidney disease, stage 4 (severe)
N18.5	Chronic kidney disease, stage 5
R25.2	Cramp and spasm
<b>I10</b>	<b>Essential (primary) hypertension</b>
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
<b>Z94.0</b>	<b>Kidney transplant status</b>
Z94.4	Liver transplant status
R53.83	Other fatigue
<b>Z79.899</b>	<b>Other long term (current) drug therapy</b>
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
<b>E11.9</b>	<b>Type 2 diabetes mellitus without complications</b>

**Disclaimer:**  
 This diagnosis code reference guide is provided as an aid to physicians and office staff. Diagnosis codes must be applicable to the patient's symptoms or conditions and must be consistent with documentation in the patient's medical record. Kashi Clinical Laboratories does not recommend any diagnosis codes and will only submit diagnosis information provided to us by the ordering physician or his/her designated staff. The CPT codes provided are based on AMA guidelines and are for informational purposes only. CPT coding is the sole responsibility of the billing party. Please direct any questions regarding coding to the payer being billed.