Codify
BY AAPC

Internal Medicine Coding Alert

Preventive Services: Learn Bone Density Screening Reporting With 4 Simple Steps

Hint: Don't use 'M codes' when the patient comes for screening.

When a physician plans to perform a screening of a patient for osteoporosis or osteopenia, you will need to know whether or not the patient is eligible to undergo the screening and what CPT® and diagnosis codes you need to report for the procedure.

Background: Osteoporosis is a condition which is caused by reduction of estrogen levels and is found to occur commonly in postmenopausal women, although it can occur in women of younger age groups as well as in men. The condition is characterized by reduced bone mass and structural deterioration of bone. These changes cause fragility of the bone, and the person has a higher risk of fractures, especially of the hip, spine, and the wrist. According to World Health Organization (WHO) criteria, patients with osteoporosis have a Dual-energy x-ray absorptiometry (DXA) T-score of less than -2.5 SD (standard deviation)

Osteopenia is another bone condition wherein the patient experiences lower bone mineral density. It is a condition that is less severe than osteoporosis and is sometimes a precursor to the latter. However, it is not a must that all patients who develop osteoporosis should have osteopenia that further progresses and causes osteoporosis. Patients with osteopenia have a DXA T-score of -1 to -2.5 SD.

1. Understand the Indications

Both osteopenia and osteoporosis can occur even in patients who have no risk or few risk factors for the conditions. In most cases, both the conditions remain without any symptoms until there is a fracture that occurs spontaneously or with a minor fall (or trauma). As the condition progresses silently, it is very essential for screening patients for these conditions.

According to section 80.5.6 of chapter 15 of the Medicare Benefit Policy Manual, a qualified patient must meet at least one of five indications:

- Any woman who has reduced levels of estrogen, which is considered an ovarian failure (E28.39, Other primary ovarian failure) and at clinical risk for osteoporosis
- Any person with abnormalities of the vertebra suggestive of osteoporosis, osteopenia, or vertebral fracture
- Any person who is on medications such as glucocorticoids equivalent to an average of 5.0 mg of prednisone, or greater, per day, for more than three months (Z79.52, Long term [current] use of systemic steroids)
- Any person with primary hyperparathyroidism (E21.0, Primary hyperparathyroidism)
- A patient who needs monitoring because of Food and Drug Administration-approved osteoporosis drug therapy (such as Z79.52).

2. Know the Frequency

Medicare will pay for bone mass measurements for patients who meet the required criteria for screening once in every two years. According to section 80.5.5 of chapter 15 of the Medicare Benefit Policy Manual, "every two years" means "at least 23 months have passed since the month" of the last Medicare covered bone mass measurement.

Caveat: Although the usual time gap between screenings is two years, Medicare, in some cases, will permit your clinician to screen a patient even though two years have not passed since the last screening. In order to allow for screening prior to the passage of the required time, you will need to prove the medical necessity of the early screening for the patient.

Some instances where you may be allowed to perform early screening of patients will include patients on glucocorticoid therapy for a span of more than three months or for a patient who had an initial test using a different technique than the one your physician wants to use for monitoring her (such as sonometry versus densitometry).

Remember: You might come across instances where you have no documentation of when the patient last received a bone density scan and the patient also has no recollection of it. In cases where you are unable to correctly verify the date, get the patient to sign an ABN (advance beneficiary notice) before you undertake the screening.

3. Check out the Code Choices

The provider will typically order for a DXA to measure bone mineral density that will help your clinician assess if the patient is suffering from osteopenia or osteoporosis. If the T-score from the DXA is -1 to -2.5 SD, it is indicative of osteopenia, and a score less than -2.5 SD is indicative of osteoporosis. If the patient is also suffering from fractures, a score less than -2.5 SD is indicative of severe osteoporosis.

When your clinician orders for DXA, the CPT® code choices that you will have to choose from depending on the anatomical area which your clinician is assessing will include:

- 77080 (Dual-energy X-ray absorptiometry [DXA], bone density study, 1 or more sites; axial skeleton [e.g., hips, pelvis, spine])
- 77081 (...appendicular skeleton [peripheral] [e.g., radius, wrist, heel])
- 77085 (...axial skeleton [e.g., hips, pelvis, spine], including vertebral fracture assessment)
- 77086 (Vertebral fracture assessment via dual-energy X-ray absorptiometry [DXA]).

Example: Your physician orders an appendicular skeleton (wrist) DXA for an estrogen-deficient 48-year-old female patient at risk for osteoporosis.You should report 77081, assuming your practice provided both the technical and professional components of the service. If your clinician only provided the interpretation for the test, you will need to report only the professional component of the service. For this, you will need to append the modifier 26 (Professional component) to 77081.

Note that Medicare also recognizes other modalities and codes for bone mass measurements. Among these are:

- 76977 – Ultrasound bone density measurement and interpretation, peripheral site(s), any method
- 77078 – Computed tomography, bone mineral density study, 1 or more sites; axial skeleton (e.g., hips, pelvis, spine)
- G0130 – Single energy X-ray absorptiometry (SEXA) bone density study, 1 or more sites; appendicular skeleton (peripheral) (e.g., radius, wrist, heel)

4. Use Appropriate Diagnosis Codes

When your clinician screens the patient for osteoporosis or osteopenia, you should report appropriate diagnosis codes to support the medical necessity of the screening of the patient. When the patient is screened for the bone condition, you will have to use Z13.820 (Encounter for screening for osteoporosis) for the encounter to support the medical necessity of the screening.

You should also report additional diagnosis codes that support the necessity of conducting the screening. For example, if your clinician is performing the screening on a woman who has reached menopause but has no other symptoms, you will

report Z78.0 (Asymptomatic menopausal state) along with Z13.820.

Caveat: You cannot use M codes specific for osteoporosis (M81.0, Age-related osteoporosis without current pathological fracture) or osteopenia (M85.8-, Other specified disorders of bone density and structure) to report the screening of the patient as these codes are to be used after the patient has already been diagnosed with either of the bone conditions and not when they are being screened.

Resources: For more information, check this link at https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/Downloads/MPS-QuickReferenceChart-1TextOnly.pdf.