

Internal Medicine Coding Alert

Use Screening ICD-9 Code for Routine Bone Density Study

Latest on CPT and ICD-9 Codes for Accurate Reporting of Bone Density (from Codify's Part B Coder)

Stronger claims come from choosing correct scan types and diagnoses.

Paying attention to three details for your patients' bone density scans can make or break your claims success. Follow our experts' advice regarding the types of tests, appropriate diagnoses, and acceptable timeframes, and you'll build strong claims and healthy bottom lines.

1. Report the Correct Type of Scan

Bone density scans (also known as bone mass measurements, or BMM) fall into five general categories. Your first step in coding is to determine...

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Diagnosis coding for laboratory work and screening tests such as CAT scans, x-rays and bone density studies can be tricky. But assigning the correct ICD-9 code is essential to receiving reimbursement.

Can you bill a screening test with the diagnosis established after the test is done? writes **Brigitte Rose** patient accounts manager for Internal Medicine Associates of Grand Junction in Grand Junction CO. For example a patient has a screening bone density during a visit for health maintenance and it showed osteoporosis. Can I bill the screening test with a diagnosis of osteoporosis after the test was performed even though the diagnosis was not yet established when the test was ordered?

No says Dari Bonner CPC CPC-H CCS-P a corporate compliance and coding/reimbursement specialist based in Port St. Lucie FL.

If it starts out as a screening test it must remain a screening test Bonner states. If you are doing it for screening you are talking about an asymptomatic patient who is not having any problems and then you do a screening and then find something. It is still a screening. It would be fraud to report the test with the final diagnosis in this situation.

ICD-9 Code Must Reflect Reason for the Visit

Bonner acknowledges that there is a lot of confusion in this area particularly since there are situations in which you would wait for the final diagnosis before submitting the bill for the test.

In fact the American Medical Associations (AMA) Coding Guidelines for Outpatient Services instruct coders do not code diagnoses documented as probable suspected questionable rule-out or working diagnoses. Rather code the condition to the highest degree of certainty for that encounter/visit such as signs symptoms abnormal test results or other reason for the visit.

The key here is whether the test was a screening test or a diagnostic test. For screening tests the physician orders the

test as a routine to make sure the patient is healthy. He or she is not expecting to find a problem. However if the test is ordered as a result of a sign symptom or presenting complaint then the test is not a screening test but a diagnostic test.

For example notes Bonner if the patient came to the physicians office with a physical complaint such as pain that prompted a bone density study then using the ICD-9 code for the final diagnosis would be appropriate because it is the most specific.

Payment Issues

A problem in this situation is that many third-party payers do not cover screening tests but do pay for diagnostic tests.

The code for a bone density study (e.g. 76070 computerized tomography bone mineral density study one or more sites) when reported with an ICD-9 code indicating a problem (e.g. 733 osteoporosis unspecified) would likely be paid. But the same code linked to a screening diagnosis code (for example V58.69 long-term [current] use of other medications) might not be paid.

Note: Osteoporosis is sometimes caused by prolonged use of certain medications and a physician may order routine screening bone density studies annually for patients on such drugs.

As tempting as it might be to report the final diagnosis if the reason for the test was a routine screening it should be reported as such with a diagnosis code indicating why the test was performed.

The diagnosis code in this case would be the appropriate V code to show that the test was ordered in the absence of signs or symptoms for screening purposes only. Make sure to obtain a waiver from the patient and bill the service with a -GA modifier (waiver of liability statement on file) so the provider is not responsible for the fee and the patient may be charged.

Medicare Covers Some Bone Screenings

Internal medicine coders should remember that Medicare covers screening bone density studies once every two years says Barbara J. Cobuzzi MBA CPC president of Cash Flow Solutions Inc. a coding billing and consulting firm based in Lakewood NJ.

Practices can obtain coverage requirements from their regional Medicare carriers. The studies must be reported with the Medicare-specified HCPCS codes (which are often different from the CPT code for the same study) and you must report an eligible ICD-9 code from the list of codes provided by the carrier for the service.

Basically you have to use the G codes for bone density studies notes Cobuzzi. The screenings are covered once every two years with very specific conditions. And at least 23 months have to have passed since the last screening. However if medically necessary Medicare will cover it more frequently than every two years. The carriers will list the several diagnoses that are covered.

See the box below for coverage requirements listed by Empire Medicare Services for bone density studies. Your carrier requirements may differ slightly.