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Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: 3 Expert Tips Upgrade Your Chest X-Ray Coding

Radiologists report 71010 more frequently than any other code -- make sure that your practice reports it correctly

Although radiologists routinely report 71010 (Radiologic examination, chest; single view, frontal), chest x-ray coding can still challenge even the most seasoned coders.

"Physicians order chest x-rays for a really wide variety of reasons," says **Laura Colletti, RT(R),** a radiologic technologist at UNC Healthcare in Chapel Hill, NC. Secure reimbursement for these common radiologic exams with these three tips for success:

1. Order diagnosis codes correctly for pre-operative chest x-rays.

Many practices complain of denials on claims for pre-op chest x-rays. Here's why, and what you can do about it:

Background: For years, standard medical care has dictated that a physician should order a chest x-ray for any patient about to have surgery. The chest x-ray looks for cardiopulmonary disorders that would prevent the physician from putting the patient under general anesthesia, explains **Cheryl A. Schad, BA, CPCM, CPC,** owner of Schad Medical Management in Mullica Hill, N.J. However, since these pre-op chest x-rays seldom reveal cardiopulmonary problems in the general public, Medicare reexamined the cost of all these pre-op x-rays and decided to pay only for patients who have a documented cardiopulmonary history, Schad says. Many other payers followed suit.

Two payable codes: Medicare does list two diagnosis codes that are payable for pre-op chest x-rays: V72.81 (Pre-operative cardiovascular examination) and **V72.82** (Preoperative respiratory examination), says **Jeff Fulkerson, BA, CPC,** senior certified coder in the radiology department of Emory Health Care in Atlanta, Ga. In order to use either V code, you must confirm that the medical record documents the patient's risk factors that necessitated the chest x-ray, he says. So these codes are appropriate and payable if the patient is not currently exhibiting any symptoms, but has a documented history of cardiovascular or pulmonary problems, Fulkerson explains.

Know correct code order: There are potentially three diagnosis codes you can report for a pre-op chest x-ray, Schad says. And reporting them in the correct order is the key to avoiding a swift denial. The first code should be the pre-operative screening code, such as V72.81, V72.82 or V72.83 (Other specified pre-operative examination). The second code should be the medical condition that is the reason for surgery. And the third diagnosis code should report any relevant findings on the chest x-ray, she says. For example, if the x-ray reveals a pulmonary embolism you would report 415.1 (Pulmonary embolism and infarction) as the third diagnosis. If the x-ray findings are normal, however, there is no need to report a third diagnosis code.

Watch out: If the patient is scheduled for a chest x-ray to assess the status of a known condition, you should report the known condition as your first diagnosis code, followed by the ICD-9 codes that represent the findings. V codes V72.81, V72.82 and V72.83 do not apply if the patient has a condition that the physician has already diagnosed.

Slim chance: If the patient's chart shows no documentation of a history of cardiopulmonary problems, chances are a carrier will not pay for a pre-operative chest exam. While some providers may have the patient sign an ABN, it may not be worth your while to chase after payment for this service, Fulkerson says. A pre-op chest x-ray is a low-cost exam, and many physicians still consider it a part of good preoperative patient care.

2. Append appropriate -TC or -26 modifier. Some hospitals report a chest x-ray with no -TC modifier (Technical component) and assume the carrier will know to only pay for the technical portion of the service, Schad says. This is a

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dangerous practice considering today's various radiology clinic arrangements. There's no way for the carrier to tell whether the claim is truly from a hospital setting, or from a separate imaging center associated with the hospital, she adds. You're at risk of securing inappropriate payment for your facility's services if you neglect the -TC modifier.

How it works: If you report a 71010 with no modifier you are telling the carrier your facility deserves payment for both the professional and technical components of the radiologic exam. Generally, a hospital will bill the x-ray code with a -TC modifier to indicate it is billing for the equipment, room charge, film and radi-ologic technician, but not for the physician's interpretation, Schad explains. If the physician who renders the interpretation is with a separate professional group and is not a hospital employee, he will report the service with a -26 modifier (Professional component) to obtain his share of the reimbursement.

Best bet: You should check with your payers to see what modifier they prefer. The reality is that "a lot of carriers don't want to see the -TC modifier," Schad says. But don't assume anything - ask first.

3. Remember modifiers for multiple chest x-rays. An inpatient with respiratory problems may have several chest x-rays during one day to monitor the status of the condition. Depending on the scenario, there are three possible modifiers that you may apply to secure payment.

Append -76 if the same radiologist reads both studies. To use modifier -76 (Repeat procedure by same physician), you must also be reporting two or more of the exact same examson the same date of service. For example, the same physician interprets two, one-view chest x-rays (71010) performed at different times on the same date, Fulkerson says. You would bill 71010 for the first exam and 71010-76 for the second exam.

Choose -77 if a different physician reads each exam. As with modifier -76, you can only use modifier -77 (Repeat procedure by another physician) if you are reporting multiple identical CPT codes. For example, the medical chart indicates that Dr. A interpreted a two-view chest x-ray (71020) in the morning and Dr. B did the same in the afternoon. You would bill 71020 for Dr. A's service and 71020-77 for Dr. B's service.

Use modifier -59 when the physician orders different exams on the same day. If you are billing different CPTcodes on the same day, you'll need a modifier -59 (Distinct procedural service) to show the payer that you deserve reimbursement for two or more separately identifiable services.

Check out this example: A radiologist interprets a two-view chest x-ray (71020) performed at 9 a.m. for an inpatient with respiratory failure. The same radiologist interprets another two-view chest x-ray performed at noon. Since the patient is showing signs of improvement, the attending physician orders a one-view chest x-ray (71010) at 6 p.m. For the day's services, you would bill 71020 for the first x-ray, 71020-76 for the noon exam, and 71010-59 for the 6 p.m. exam because it's not exactly the same procedure as the first two x-rays, Fulkerson explains. And you can bill the 71010 with a -59 modifier whether the same radiologist or a different one reads the film, he adds. Whereas modifiers -76 & -77 apply only to the exact same study performed on the same date of service, modifier -59 can apply to any two services as long as they are distinctly separate.

Crucial: Tell physicians to document the time of each x-ray

If you're looking at multiple reports for the same service on the same day, there's no way for you to know if the services are duplicate or separate without a documented time for each exam, Schad explains. Quite frequently the physician might dictate the same order number twice, making it appear that there were two separate x-rays when in fact there was only one, she says.

Warning: You should never assume there were repeat x-rays unless the physician clearly states the separate time of each exam. Without this information, it will be very difficult foryou to defend your billing of multiple services in the event of an insuranceaudit.

Plan of action: Tell your physicians it is "absolutely essential" for them to dictate the time of each radio-logic study, especially inpatient chest x-rays, Schad recommends.

Report -76, -77, or -59 in first modifier field

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"There are two modifier fields on any insurance claim, and the first one is where you need to tell the carrier that the service you're billing is separately payable," Schad explains. Some coders make the mistake of placing a modifier -26 or -TC in this first modifier field, but that won't prevent your claim from being rejected as a duplicate if you're billing for two or more of the same CPT code. If you report the -76, -77 or -59 in the second modifier field, you're providing the information too late. Remember, "the most critical modifier needs to go first," and that's the modifier that indicates why the carrier should pay for the service, she says.

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