Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: 77080: 3 Tips Make Bone Density Coding a Snap

Check your LCDs to see if coverage is once every 2 years.

If you find tracking Medicare's DXA claim restrictions on medical necessity and frequency a real chore, you're not alone. But you can simplify the process and reduce denials by following this expert advice on keeping DXA claims airtight.

Scenario: Your physician orders an axial skeleton DXA for an estrogen-deficient female patient at risk for osteoporosis. You should report 77080 (Dual-energy X-ray absorptiometry [DXA], bone density study, 1 or more sites; axial skeleton [e.g., hips, pelvis, spine]) with V82.81 (Special screening for osteoporosis).

ICD-10: When your diagnosis coding system changes in 2014, V82.81 will become Z13.820 (Encounter for screening for osteoporosis).

For measuring bone density, dual-energy x-ray absorptiometry (DXA) is the gold standard.

Tip 1: Get Your Documentation in Order

Your documentation must include an order from a physician or qualified nonphysician practitioner and an interpretation of the test results (Medicare Benefit Policy Manual, Chapter 15, Section 80.5.4). Signing the machine printout doesn't count as an interpretation.

The physician also needs to document a complete diagnosis. Medicare doesn't offer a national list of covered ICD-9 codes, but it does state that an individual qualifies for coverage when she meets one of these conditions:

- is estrogen-deficient and at risk for osteoporosis
- is being monitored for FDA-approved osteoporosis drug efficacy has been diagnosed by x-ray with osteoporosis, osteopenia, or vertebral fracture
- is receiving glucocorticoid therapy greater than or equal to 7.5 mg of prednisone per day for more than three months has primary hyperparathyroidismcacy.

Check your payer's local coverage determination (LCD) for the specific ICD-9 codes it says support medical necessity.

Example: Aetna lists several diagnoses that may prove medical necessity, such as 627.2, (Symptomatic menopausal or female climacteric states) and 733.90 (Disorder of bone and cartilage, unspecified).

ICD-10: When your diagnosis system changes in 2014, 627.2 will become N95.1 (Menopausal and female climacteric states). Code733.90 will become M89.9 and M94.9 (Disorder of bone and cartilage, unspecified)

Tip 2: Stick With Documented Diagnoses

Only report the documented diagnosis -- never choose a diagnosis simply because you know you'll get paid for it.

Don't forget: You should always code results to the highest level of specificity. For example, for a woman who is postmenopausal and not taking hormones, you should report V49.81 (Asymptomatic postmenopausal status [age-related] [natural]).

ICD-10: When your diagnosis system changes in 2014, V49.81 will become Z78.0 (Asymptomatic menopausal state).

Tip 3: Adhere to Frequency Guidelines

Medicare will pay for bone mass measurements on qualified individuals every two years.

Translation: Every two years means "at least 23 months have passed since the month" of the last bone mass measurement (Medicare Benefit Policy Manual, Chapter 15, Section 80.5.5). Medicare does offer exceptions to this frequency rule. Payers may consider more frequent DXA scans when medically necessary under either of these circumstances, she adds:

you're monitoring a patient on glucocorticoid therapy for more than three months

you need a baseline measurement to monitor a patient who had an initial test using a different technique (such as sonometry) than the one you want to use to monitor the patient (such as densitometry).