Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Break Down Bone Scan Coding By Type, Diagnosis, and Time Frame

Four types of bone density scans mean numerous CPT® options.

If you're confused about which bone scan code to report, you're not alone. To strengthen your claims for bone scans, you need to pay attention to the type of test your radiologist used. Also make note of the diagnosis and look for an acceptable time frame. Here is what experts advise to help you earn for every scan your radiologist performs.

1. Isolate the Correct Type of Scan

Bone density scans (also known as bone mass measurements, or BMM) fall into four general categories. Your first step in coding is to determine the study type and site. "There are different codes for ultrasound, CT, and other types of bone scans," says **Christy Hembree, CPC,** Team Leader, Summit Radiology Services, Cartersville, GA.

Ultrasound bone scan: You'll report 76977 (Ultrasound bone density measurement and interpretation, peripheral site[s], any method) when your radiologist completes a bone scan using ultrasound.

CT bone scan: For a CT bone scan, choose 77078 (Computed tomography, bone mineral density study, 1 or more sites; axial skeleton [e.g., hips, pelvis, spine]).

CT bone scan also is the only commercially available technique to measure three-dimensional bone images and is the most sensitive of all techniques. CT bone scans can be used to diagnose and monitor many bone diseases, for example, arthritis. Your radiologist will also utilize computer software to build and interpret images using these modalities.

DEXA scan: Choose from 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]), or 77082 (... vertebral fracture assessment) when your orthopedic surgeon documents that he performed a DEXA or DXA scan.

"DEXA is a dual energy X-ray absorptiometry bone density study and you report an appropriate code depending upon whether the exam was done for the axial skeleton, appendicular skeleton, or vertebral fracture assessment," says Hembree.

Note: Your radiologist may perform a DEXA scan to measure changes in bone density over a period of time, for example, in response to the treatment prescribed. You will find DEXA assessment usually for the spine and hips.

SEXA scan: Your final category is the SEXA bone density scan. CPT® doesn't include a code for SEXA scans, so turn to HCPCS for G0130 (Single energy X-ray absorptiometry [SEXA] bone density study, one or more sites; appendicular skeleton [peripheral] [e.g., radius, wrist, heel]). "SEXA is a single energy X-ray absorptiometry bone density study," says Hembree.

Before coding any of these or other similar tests, know your payer's guidelines and file accordingly. For example, look at codes 78350 (Bone density [bone mineral content] study, 1 or more sites; single photon absorptiometry) and 78351 (... dual photon absorptiometry, 1 or more sites). "CPT® 78350 is reported for single photon absorptiometry (SPA) and CPT® 78351 is reported for dual photon absorptiometry (DPA). SPA and DPA are non-invasive radiological techniques that

measures absorption of a dichromatic beam by bone material," says Hembree. Medicare does not consider these as medically reasonable and necessary. Any claim you send to Medicare with these codes is a denial just waiting to happen. "SPA and DPA are not considered reasonable and necessary by Medicare. This is because they have been replaced by DEXA technology which is more precise," says Hembree.

2. Check for Complete Diagnosis Documentation

Medicare and other payers also have guidelines regarding accepted diagnoses to support bone density scans and the patients your orthopedist treats. According to Medicare, a qualified individual must meet at least one of these five indications:

- A woman who is estrogen-deficient (256.39) and at clinical risk for osteoporosis (733.0x)
- An individual with vertebral abnormalities indicative of osteoporosis, osteopenia (733.90, Disorder of bone and cartilage, unspecified), or vertebral fracture (805.xx, Fracture of vertebral column without mention of spinal cord injury, or 733.13, Pathologic fracture of vertebrae, if osteoporosis related)
- An individual on glucocorticoid (steroid) therapy equivalent to an average of 5.0 mg of prednisone, or greater, per day, for more than three months (V58.65)
- An individual with primary hyperparathyroidism (252.01)
- A patient who needs monitoring because of osteoporosis drug therapy (such as V58.65, Long term [current] use of steroids).

Some payers might accept other diagnoses to justify bone density scans, so always check their guidelines. Remember, however, that you'll always report the most accurate diagnosis based on your physician's documentation, whether it's payable or not. Choosing a diagnosis code simply because you know you'll get paid for it, rather than because it is the diagnosis your orthopedist documented, is fraudulent and opens you up to audits and investigation.

Example: Policies for National Government Services (formerly Empire Medicare) list 733.12 (Pathological fracture of distal radius and ulna) as a diagnosis that might prove medical necessity. Highmark Medical Services Inc. includes 246.9 (Unspecified disorder of thyroid) in its list of accepted conditions.

Note: The diagnosis used generally depends on if a fracture is involved and if osteopenia is present. Include an appropriate V code for patients over age 50 with osteoporosis related fractures.

3. Verify You're Within the Timeframe

Turn to the calendar for your final checkpoint for successful bone density claims.

Here's why: Medicare will pay for bone mass measurements on qualified individuals every two years. "Every two years" means "at least 23 months have passed since the month" of the last bone mass measurement. "Medicare will cover bone mass measurements every two years under certain guidelines," says Hembree. "The claim must contain a valid ICD-9-CM diagnosis code indicating one or more reasons for the test, example, postmenopausal female, vertebral abnormalities, hyperparathyroidism, steroid therapy, or individuals receiving FDA-approved osteoporosis drug therapy."

"Medicare may pay for more frequent screenings when medically necessary," says Hembree. According to Hembree, examples of such situations include but are not limited to, the following medical circumstances:

- Monitoring a patient who's been on glucocorticoid (steroid) therapy for more than three months
- Needing a baseline measurement (BMM) to monitor a patient who had an initial test using a different technique than the one your radiologist wants to use for monitoring her (such as sonometry versus densitometry).