

Part B Insider (Multispecialty) Coding Alert

PART B CODING COACH: Build Bone Density Scan Success With These 3 Coding Keys

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 the study type and site.

Ultrasound bone scan: You'll report 76977 (Ultrasound bone density measurement and interpretation, peripheral site[s], any method) when your orthopedist 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] or 77079 (... appendicular skeleton [peripheral] [e.g., radius, wrist, heel]). "These are used together with computer software to determine the bone density, usually at the spine," says **Sandy Swartz**, manager of the central billing office for Sturgis Orthopedics in Sturgis, Mich. "CT is the most sensitive scan to detect bone disease and can take into account other diseases that might affect the bone, such as arthritis." CT bone scan also is the only commercially available technique to measure three-dimensional bone images, Swartz adds.

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. "A DXA scan measures the spine and often one or both hips. It's more sensitive and accurate than the CT at measuring small changes in bone density over time or in response to drug therapy," Swartz explains.

Radiologic scan: Code 77083 (Radiologic absorptiometry [e.g., photodensitometry, radiogrammetry], 1 or more sites) applies to radiologic scans.

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]).

Before coding any of these or other similar tests, know your payer's guidelines and file accordingly. For example, Medicare considers 78350 (Bone density [bone mineral content] study, 1 or more sites; single photon absorptiometry) and 78351 (... dual photon absorptiometry, 1 or more sites) not medically reasonable and necessary. Any claim you send to Medicare with these codes is a denial just waiting to happen.

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.

"The diagnosis used generally depends on if a fracture is involved, but will also include osteopenia," Swartz says. "We 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 Carriers Manual, Part 3, Section 4181.2).

"If you can document medical necessity on the patient, Medicare will allow you to bill within the two-year window but it must be medically necessary," advises **Martha A. Conradson**, administrator for Desert Bloom Family Medicine in Phoenix. "Otherwise, the two-year rule for all 'healthy' individuals is a good guideline to follow."

Two examples of when earlier tests might be necessary include:

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