# Part B Insider (Multispecialty) Coding Alert

## Part B Coding Coach: Coding MRIs? Here's 5 Need-To-Know Tips

**If a patient gets claustrophobic,you may be able to bill for an incomplete MRI with modifier -53**

Physicians may order a magnetic resonance imaging study (MRI) for a plethora of reasons, meaning you need to know what diagnoses each carrier will pay for and have the patient sign an ABN if necessary. The alternative is forfeiting payment on this very costly procedure.

Improve your MRI coding and reimbursement success with the following five expert tips on the trickiest aspects of coding for these procedures.

1. Append modifier -53 for an incomplete MRI. But only if the exam was at least half completed before the decision to discontinue, advises **Jeff Fulkerson, BA, CPC,** senior certified coder in the radiology department of Emory Health Care in Stockbridge, Ga. Patients often find that they are claustrophobic and unable to complete an MRI, but a substantial portion of the exam must be completed in order to make it a billable service, he adds.

For example: A patient presents for an MRI of the brain (70551), and a little over half of the exam is completed before the patient becomes unbearably claustrophobic and asks to discontinue the service. You could justifiably **bill 70551** with modifier -53 (Discontinued procedure) if there is enough data that the exam is "clinically helpful for the ordering physician" and the radiologist can do a proper interpretation, Fulkerson says.

Remember the professional component: 70551 or any other MRI code includes a professional component; therefore the codes are an accurate description of the service only if the incomplete exam provides readable data for the physician. "If you didn't perform enough work to document," then you don't deserve payment and should not bill for the service, Fulkerson says. So if, for example, the patient asks to stop after the first few minutes of the exam, that is not a billable service.

Why -53 and not -52? Modifier -52 (Reduced services would be appropriate if the physician made the decision to alter the exam from the CPT description, says **Cheryl A. Schad, BA, CPCM, CPC,** owner of Schad Medical Management in Mullica Hill, N.J. But if the reason for the incomplete exam is patient-generated, as would be the case if the patient becomes claustrophobic, then -53 is the more appropriate modifier, she says.

2. Know the covered diagnosis codes for each of your payers. Many Medicare carriers have a local coverage decision (LCD) regarding MRIs, and coverage by other third-party payers will vary, Fulkerson explains. Knowing ahead of time which diagnosis codes will justify coverage with each of your payers is very important to securing reimbursement. Your practice may be forced to eat the costs on this very expensive exam if you discover the service is non-covered after the fact.

Plan of action: Have the patient sign an ABN if a physician orders an MRI but the diagnosis he lists is not an allowable diagnosis code on your LCD. For non-Medicare cases where the carrier won't cover the listed diagnosis, "patients must be advised that their insurance probably won't cover the service and that they'll need to sign a waiver if they'd like to proceed," Fulkerson says.

Coverage can vary: Covered diagnoses can vary greatly from carrier to carrier. For instance, Medicare fiscal intermediary Blue Cross and Blue Shield of Georgia will not reimburse 70551 (Magnetic resonance imaging, brain (including brain stem); without contrast material) if it's linked to diagnosis code 785.6 (Enlargement of lymph nodes). However, Medicare carrier HGSAdministrators with primary jurisdiction in Pennsylvania will pay for 70551 with diagnosis code 785.6.

3. Don't expect payment for pre-MRI screenings. If there is any possibility that a patient "may have come in contact with a metal foreign body," most radiologists will perform a screening x-ray or CT before the MRI, Schad explains. You cannot bill separately for this screening exam because it "is necessary to successfully accomplish the primary procedure and does not represent a separately identifiable and unrelated service," she says.

The exception: A pre-MRI screening x-ray is not separately billable "unless there is medical necessity," Fulkerson says. For example, if a patient was in an accident that necessitated a skull x-ray in addition to an MRI, the x-ray would be justified by the injury and therefore separately billable. The service is only unjustified in the carrier's eyes when the physician orders the x-ray for no other reason than a pre-MRI screening, he adds.

4. Use 76498 for functional MR. In the past, the coding convention was to use a regular MRI code with a modifier -22 (Unusual procedural services) to report a functional MR study, Fulkerson says. But the procedure is so different from a regular MRI that an MRI code really didn't fit the service. Since functional MR still does not have separate codes to describe this unique service, the recommendation now is to use 76498 (Unlisted magnetic resonance procedure (eg, diagnostic, inter-ventional)), Fulkerson advises.

Tip: Generally speaking, if the description of the service your physician provides does not match up with the CPT code you're thinking of billing, don't use it, Fulkerson counsels. This goes for MRI "combination codes" as well, Schad says. Never try to report services separately if there is a code that combines them. For example, if the medical record documents an MRI of the orbit, face and neck without contrast materials, followed by with contrast material, report 70543 (Magnetic resonance imaging, orbit, face, and neck; without contrast materi-al(s), followed by contrast mate-rial(s) and further sequences), which is the code that combines both services. Don't make the mistake of reporting the two services separately with 70540 (...without contrast material(s)) and 70542 (...with contrast material(s)), Schad warns.

5. Expedite the payment process with E codes. While E codes - which identify external causes of injury - won't alter your reimbursement in any way, they will help your claims to clear some of a carrier's screening steps, Schad explains. For instance, by using an E code to identify a patient's injury and treatment as related to an auto accident, you'll alert the motor vehicle insurance carrier immediately of its responsibility to pay the claim. The carrier won't be able to deny responsibility and try sending the claim over to the patient's private medical insurer, Schad says.

Even if you have no specific information about the patient's accident, you can still use E819.9 (Motor vehicle traffic accident of unspecified nature; unspecified person) to at least inform the carrier that the patient's condition is related to a motor vehicle accident, she adds.