Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Make the Coding Grade With This True/False X-Ray Checkup

Don't fall prey to this common bilateral coding trap

Medical X-rays have been around since 1895, so you might expect to have a well-honed set of coding rules by now.

Reality: You may have as many rule sets as you have payors. See whether you-ve got these two X-ray coding subtleties down.

1. True or False: Use Modifier 50 on All Bilateral X-Ray Claims

Answer: This statement is false. Although your payor may sometimes require you to use modifier 50 (Bilateral procedure) for bilateral claims, this is not true for all bilateral X-ray claims.

Modifier 50 tells the payor that the provider performed a unilateral procedure (described by a unilateral CPT code) bilaterally during the same session, says **Lori Hendrix, CPC, CPC-H,** of **Coding Strategies Inc**., in her -Diagnostic Radiology Coding- presentation at The Coding Institute's 2006 Radiology and Cardiology Coding and Reimbursement Conference in Naples, FL.

If a code includes the word -bilateral- in the descriptor, you should not add a modifier to show the test is bilateral.

Example: Code 73520 (Radiologic examination, hips, bilateral, minimum of two views of each hip, including anteroposterior view of pelvis) includes the word -bilateral- and instructs you that you need two views of each hip to use the code. You should report 73520 without a bilateral modifier to indicate a bilateral service.

But even knowing this isn't enough. You need to know how to report the appropriate codes and modifiers when you do report a unilateral code bilaterally.

Option 1: Medicare typically requires you to report the relevant CPT code with modifier 50 on one line only, Hendrix says. Example: You report a bilateral 73620 service (Radiologic examination, foot; two views) to a payor requiring you to follow this one-line reporting rule. You report the following: 73620-50.

Option 2: Other payors may instruct you to list the procedure code twice and append 50 to the second code, Hendrix says. Example: You report the following: 73620, 73620-50.

Option 3: Still other payors want you to report the code twice, using modifiers RT (Right side) and LT (Left side), Hendrix says. Example: You report the following: 73620-RT, 73620-LT.

Lesson: Get your payors- preferences in writing, and apply them every time.

2. True or False: Poor View Choice = Audit Troubles

Answer: Unfortunately, this one is true.

Views not documented: You choose an X-ray code by the number of views the physician performed, but when a physician leaves the number of views blank, an auditor will downcode that claim to the minimum amount, says **Maxine Lewis, BA, CMM, CPC, CCS-P**, of **Medical Coding Reimbursement Management** in Cincinnati.

Result: The cost of downcoding really adds up. In Ohio, Medicare pays $27.31 for one or two knee views (73560, Radiologic examination, knee; one or two views) and $35.24 for four or more views (73564, - complete, four or more views). Be sure your providers understand how the simple act of documenting the number of views pays off.

- **Over-reporting views:** The CMS National Correct Coding Policy Manual, Chapter 9, explains that -CPT code descriptors which specify a minimum number of views should be reported when the minimum number of views or if more than the minimum number of views must be obtained in order to satisfactorily complete the radiographic study. For example, if three views of the shoulder are obtained, CPT code 73030, one unit of service, should be reported, not 73020 and 73030.-

Translation: When you have a code that specifies a minimum number of views, and the documented number of views meets or exceeds that minimum, you should only report that -minimum- code.

Example: The doctor takes three shoulder views.

Right way: You report 73030 (Radiologic examination, shoulder; complete, minimum of two views) because three views meets or exceeds the two-view minimum the code requires.

Wrong way: Trying to report three shoulder views with 73020-59 (- one view; Distinct procedural service) for one view and 73030 to report the other two views is not correct.