Part B Insider (Multispecialty) Coding Alert

Part B Revenue Booster: Say Goodbye to X-Ray Denials With These Simple Tips

Palmetto providers: Add this 'history of' code to the list of covered conditions.

If you provide X-ray services, consider this: A chest X-ray's global fee is only $25 or so. Multiply that $25 by the number of services you perform, however, and you'll quickly see how getting these claims right is important to your practice's financial health.

Below, you'll find essential information for 71010 (Radiologic examination, chest; single view, frontal) and 71020 (Radiologic examination, chest, 2 views, frontal and lateral), including example services, typical supporting diagnosis codes, and advice on avoiding the most common causes of audit-related denials.

A tip to start: Codes 71010 and 71020 have separate professional and technical components under the Medicare physician fee schedule. So if you're reporting only the professional service, you should append modifier 26 (Professional component). To report the technical component only, append TC (Technical component). If you're reporting the global service (both professional and technical components), you shouldn't append modifier 26 or TC.

Boost Your X-Ray Skills by Understanding Views

The key element distinguishing 71010 from 71020 is that the first represents a single "frontal" view and the second represents two views, "frontal and lateral."

71010: The documentation for a 71010 service may refer to an "AP view," says **Alice Wonderchek, CPC,** billing and coding specialist with Ohio-based Radisphere National Radiology Group. AP stands for anteriorposterior, meaning the X-rays pass from the anterior (front) to the posterior (back) of the patient.

You also may see reference to a "PA view" (posterioranterior), in which the X-rays pass from the back to the front of the patient. The AP view can be more difficult to interpret than a PA view because of quality issues andthe way the heart appears enlarged on an AP view. As a result, the PA view usually is preferred over the AP view.

You typically will see an AP view when the patient cannot stand for the imaging service. As a result, another term you'll often see connected to 71010 services is "portable," meaning the tech takes the X-ray using a portable machine. You may see this particularly for services performed at bedside, Wonderchek says.

Example: A patient exhibits decreased breath sounds and low oxygen levels. The physician orders a portable AP chest X-ray to be performed at the patient's bedside. You should report 71010 for the single-view X-ray.

71020: You may see a 71020 service referred to as a "PA & Lat," Wonderchek says. The abbreviation refers to the PA (posterior-anterior) view and the Lat (lateral) view. Lateral means "side." Generally, the tech will take a left lateral X-ray, meaning the patient's left side is closer to the film than the right side is. But the physician may ask for a right lateral X-ray instead.

Example: A patient with a history of lung cancer presents complaining of fever and shortness of breath. Her physician orders PA and lateral X-ray imaging. This service merits code 71020.

Whittle Down the List of Likely Diagnoses

Physicians order chest X-rays for a wide variety of reasons. The potential exam findings also add up to a long list.

Consequently, there are many ICD-9 codes that may apply to a chest X-ray claim.

Smart move: Check your MAC's local coverage determination (LCD) to see which codes it says support medical necessity so you'll know ahead of time whether the x-ray is covered for the patient's condition. If not, you should consider asking the patient to sign an advance beneficiary notice (ABN).

You also should check for updates to your policies. For example, effective May 26, 2011, Palmetto GBA added V10.3 (Personal history of malignant neoplasm; breast) to the list of codes supporting medical necessity in its LCD for "Radiologic Examination, Chest" (L28298).

Some of the other diagnosis codes that Wonderchek frequently links to chest X-rays, per the documentation, include:

- 511.9, Unspecified pleural effusion
- 786.05, Shortness of breath
- 786.09, Respiratory abnormality other
- 786.3x, Hemoptysis
- 786.50, Unspecified chest pain.

Keep in mind, you should never choose an ICD-9 code simply because you know it will get the claim paid. You should report only those diagnosis codes supported by the documentation, which in turn must clearly support the reason and intent of the test rendered as documented/ ordered by the physician or other qualified healthcare practitioner.