Part B Insider (Multispecialty) Coding Alert

RADIOLOGY: Stay on Your Toes to Keep Imaging Claims on the Straight and Narrow

The OIG is watching your advanced imaging claims, thanks to a new report

Watch out: Yours could be one of the radiology practices where Medicare imaging claims shot up more than 1,000 percent over a 10-year period, and the OIG wants to find out why.

In October, the **OIG** released a report noting that advanced imaging services grew by over 400 percent between 1995 and 2005, based on Medicare reimbursement data. Some states- usage only grew by 24 percent, while others- went through the roof at over 1,000 percent. The OIG wants **CMS** to examine the appropriateness of advanced imaging services across the country.

To keep your radiology claims buttoned up, you should keep a few quick tips in mind. We talked to radiology coding veterans who tackled some of the more pressing imaging questions that our readers have submitted:

1. Screening mammograms: Suppose the physician orders a mammogram for a patient who has only one breast? Keep your modifiers close at hand, advises coder **Jay Pratap.**

-You should report 77057 (Bilateral screening mammogram), and modifier 52 (Reduced services) should be appended,- Pratap suggests, because the physician is not performing the complete bilateral study represented by the code.

-You should always report V76.12 (Other screening mammogram) as the diagnosis, and the important thing is that this service is not always covered,- Pratap advises, so you have to be very careful to follow frequency and medical necessity guidelines.

2. Keep V72.5 on the back burner: You performed an x-ray but can't figure out which diagnosis code to report, so your colleague suggests V72.5 (Radiological exam, not elsewhere classified). It may seem like a simple choice, but unless the patient truly has no diagnoses, signs or symptoms, V72.5 may not be the correct code.

For a true -routine- exam, the official ICD-9 guidelines say to assign V72.5 (Radiological examination, not elsewhere classified) when the patient has no signs, symptoms or associated diagnoses. If you use this code on the claim, however, Medicare will treat it as a non-covered, non-medically necessary service that the patient is financially responsible for. This can result in an unhappy patient who may take his complaints back to his treating physician.

Better idea: The best solution to this problem is to nip it in the bud by not performing the exam without knowing the reason the physician ordered it. Getting the ordering diagnosis is important not only for reimbursement but also for patient care so that the interpreting physician knows what the clinical question is (what the treating physician is looking for). Explain to your referring physician's office staff that you need this information before you can schedule the exam, and then make sure your scheduling staff members adhere to this policy.

Tip: Very few exams are really -routine.- Usually the patient has signs or symptoms, past history of disease, is scheduled for surgery or is being screened for a specific condition. You can assign specific ICD-9 codes in all of these situations.

3. DEXA scans: Suppose the physician orders an axial skeleton DEXA scan for a patient to determine her osteoporosis risk, but also orders an appendicular skeleton DEXA scan to additionally examine the patient's extremities.

The facts: Although no Correct Coding Initiative (CCI) edits bar you from reporting both 77080 (axial skeleton DEXA) and 77081 (appendicular skeleton DEXA) together, your insurer might deny the claim.

-Medicare is very picky with these codes for us and will only pay on one of them and deny the other as not medically necessary,- says **Tina Lee, CPC**, coding specialist with **UACC** in Fresno, Calif. -Usually an appeal is needed for the second code,- she says.