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Eli's Rehab Report

Medicare is Selective About Screening Tests and Procedures for Osteoporosis Patients

The American Academy of Physical Medicine and Rehabilitation estimates that 1.5 million fractures per year are caused by osteoporosis (733.0-733.09), and many physiatrists routinely treat patients with this condition. However, coding for bone scans, ultrasonic and electrical bone healing methods and therapy for osteoporosis patients requires attention to HCFA's many memoranda. Determining whether a patient is at risk for osteoporosis, or has the disease, is the first step in choosing which ICD-9 Codes to use, and how to submit claims.

Screening for Bone Density

The most common and accurate way to determine whether a patient has osteoporosis is to perform a bone density scan, which indicates whether the patient has had loss of bone mass. The codes for performing the exams are as follows:

76075 -- dual energy x-ray absorptiometry (DEXA) study, one or more sites; axial skeleton (e.g., hips, pelvis, spine)

76076 -- ... appendicular skeleton (peripheral) (e.g., radius, wrist, heel)

76078 -- radiographic absorptiometry (photodensitometry), one or more sites

76977 -- ultrasound bone density measurement and interpretation, peripheral site(s), any method

78350 -- bone density (bone mineral content) study, one or more sites; single photon absortiometry

78351 -- ... dual photon absorptiometry, one or more sites

G0130 -- single energy x-ray absorptiometry (SEXA) bone density study, one or mores sites; appendicular skeleton (peripheral) (e.g., radius, wrist, heel)

G0131 -- computerized tomography bone mineral density study, one or more sites; axial skeleton (e.g., hips, pelvis, spine)

G0132 -- computerized tomography bone mineral density study, one or more sites; appendicular skeleton (peripheral) (e.g., radius, wrist, heel)

Several requirements must be met to receive reimbursement for the above scan codes. All of them refer to "one or more sites," which means that studies of several sites in the same area should be reported as one unit of service, says **Candace Lukamen, RT, CDT,** a densitometry technologist who splits her time between three bone and joint centers in Colorado. "As a rule, we normally test the patient's hip and spine during a bone density scan, but that would only count as one unit. There are people who bill separately for the hip and spine test, and those claims are often denied and have to be resubmitted." You should correct the error and bill only one unit for proper reimbursement.

Note: Some physiatrists perform a scan of the wrist or femur as well, but that does not warrant the billing of additional units.

Requirements for Coding Bone Scans

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Although many patients request bone scans to determine their risk for osteoporosis, these preventive screenings are not normally covered unless the patient is classified as a "qualified individual" under HCFA's standards. "For many years, local Medicare carriers could determine their own rules for covering bone density testing," says **Daniel Michaels,** owner of DM Medical Billing, which handles the coding and billing for six practices (including two PM&R physicians) in New Haven, Conn. "In 1998, HCFA said that Medicare will pay for bone scans every two years for qualified individuals. It's still up to the carrier to decide who is qualified and who isn't. Additionally, some carriers cover bone density scans more often than every two years."

Most carriers have adopted similar regulations that state that the practitioner must request the scan, and that one of the following conditions meet the requirements for a qualified individual:

1. The physician or practitioner has determined that the patient is estrogen-deficient and at clinical risk for osteoporosis, based on medical history and other findings.

2. The patient possesses vertebral abnormalities as demonstrated by an x-ray to be indicative of osteoporosis, osteopenia (low bone mass) or vertebral fracture (733.13).

3. The patient receives glucocorticoid (steroid) therapy of 7.5 or more milligrams of prednisone (J7506) per day for more than three months.

4. The patient has primary hyperparathyroidism (252.0).

5. The patient is being monitored to assess the response to any FDA-approved osteoporosis drug therapy.

"There are practices that will send in a claim for 76075 and say, 'We're confident she has osteoporosis because she broke her leg, so we billed for the scan,' but that's not enough," Michaels says. "If the patient does not have osteoporosis, the ICD-9 code used may be inappropriate and payment will not be made. Check your criteria ahead of time and you'll be better off."

Note: Most insurers will not cover 78351 because it is considered investigational by several Medicare carriers, including Palmetto and Administar. The Office of Inspector General (OIG) has listed bone density screening as a target for investigations this year and is examining the appropriateness of those billed to Medicare.

Get Paid for Osteoporosis Treatment

Once a patient is found to have osteoporosis, most treatments are payable under Medicare, including estrogen therapy and E/M visits to assess progress and advise the patient on exercise routines. However, some procedures are fairly new and have very specific coding guidelines. For example, in April 2000, HCFA released a new policy on electrical stimulation for treating nonunion of long-bone fractures. This procedure is particularly good for patients whose fractures do not heal using standard methods (e.g., casting) and who are opposed to or not recommended for surgery. This is often the case with osteoporosis patients, Michaels says. "We've noticed that our practices have been billing for more patients with unhealed fractures, and we have successfully billed for electrical stimulation."

Michaels reminds practices that HCFA's rules dictate that healing of long bones through electrical stimulation must be proven through at least two sets of radiographs, each including multiple views of the fracture site, separated by a minimum of 90 days. In addition, HCFA defines "long bones" as the clavicle, humerus, radius, ulna, femur, tibia, fibula, metacarpal and metatarsal.

Osteogenic stimulation is billed with two codes:

20974 -- electrical stimulation to aid bone healing; noninvasive
20975 -- ... invasive (operative).

Most carriers accept 733.81 (malunion of fracture) and 733.82 (nonunion of fracture) as diagnoses for these procedures,

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and some carriers will accept additional codes, but that varies state.

Ultrasound for Fracture Healing

Three months after announcing its coverage decision on electrical stimulation for bone healing, HCFA announced a new, updated decision on ultrasonic stimulation for fracture healing. The procedure can be reimbursed when two sets of x-rays, taken at least 90 days apart, along with a physician's report, can prove that a patient has not achieved any clinically significant evidence of fracture healing -- and a surgical attempt at treating the fracture has failed. HCFA will cover ultrasound stimulation (20979) using an ultrasonic osteogenic stimulator (E0760, osteogenesis stimulator, low intensity ultrasound, noninvasive) for most fractures (excluding those of the skull), but this procedure is not payable when used concurrently with an electrical stimulation fracture-healing regimen. Only one type of osteogenic stimulator (either electrical or ultrasound) may be used at a time.

Therapeutic ultrasound (97035) is a separate procedure that is unrelated to the stimulation used for bone healing. The procedure defined by 97035 is mainly used to reduce inflammation in injuries and help increase circulation.

Bill Therapies with Ostoeporosis Diagnoses

Most insurers will reimburse for performing modalities such as gait training (97116), massage (97124), therapeutic activities (97530) and other therapy options when they are billed with osteoporosis diagnoses. "What needs to be avoided," Michaels says, "is billing these codes when used for osteoporosis prevention."

Michaels says that many osteoporosis patients request help in learning how to perform strength-building exercises so they can cut their risk of getting the disease.

"The doctor or therapist cannot bill for teaching how to perform such activities if the patient does not have an applicable diagnosis. If the patient has a gait abnormality from a fracture, that probably is covered when billing for gait training. But, general preventive training will not be payable."

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