Outpatient Facility Coding Alert

Procedures: Hospital Facilities Build Bone Density Claims on 3 Tips

Know when you can legitimately report 77080.

The restrictions Medicare sets for bone density tests can keep even the most conscientious coders guessing about whether they've met the medical necessity and frequency guidelines. Our experts offer real-world advice that will keep you on track and strengthen your chances of success.

Scenario: Your physician orders an axial skeleton DXA for an estrogen-deficient female patient at risk for osteoporosis. (Dual-energy x-ray absorptiometry (DXA) is the gold standard for measuring bone density.) You should report 77080 (Dual-energy X-ray absorptiometry [DXA], bone density study, 1 or more sites; axial skeleton [e.g., hips, pelvis, spine]) with diagnosis V82.81 (Special screening for osteoporosis).

ICD-10 tip: When your diagnosis coding system changes to ICD-10 in 2014, V82.81 will become Z13.820 (Encounter for screening for osteoporosis).

Tip 1: Gather the Supporting Documentation

Documentation for the bone scan must include an order from a physician or qualified non-physician practitioner and an interpretation of the test results (Medicare Benefit Policy Manual, Chapter 15, Section 80.5.4). Signing the machine printout doesn't count as an interpretation.

The physician also needs to document a complete diagnosis, says **Kent Moore,** senior strategist for physician payment at the American Academy of Family Physicians in Leawood, Ks. Medicare doesn't offer a national list of covered ICD-9 codes, but it does state that an individual qualifies for coverage when she meets one of these conditions:

- is estrogen-deficient and at risk for osteoporosis
- is being monitored for FDA-approved osteoporosis drug efficacy has been diagnosed by x-ray with osteoporosis, osteopenia, or vertebral fracture
- is receiving glucocorticoid therapy greater than or equal to 7.5 mg of prednisone per day for more than three months or has primary hyperparathyroidism.

Check your payer's local coverage determination (LCD) for the specific ICD-9 codes it says support medical necessity. For example, Aetna lists several diagnoses that may prove medical necessity, such as 627.2 (Symptomatic menopausal or female climacteric states) and 733.90 (Disorder of bone and cartilage, unspecified).

ICD-10 change: Diagnosis 627.2 will become N95.1 (Menopausal and female climacteric states) under ICD-10. Code733.90 will become M89.9 (Disorder of bone, unspecified) and M94.9 (Disorder of bone and cartilage, unspecified). You'll choose the appropriate code based on whether the physician includes documentation of affected bone, or affected bone and cartilage.

Tip 2: Go With Documented Diagnosis

Only report the documented diagnosis never choose a diagnosis simply because you know you'll get paid for it.

Remember: You should always code results to the highest level of specificity. For example, for a woman who is

postmenopausal and not taking hormones, you should report V49.81 (Asymptomatic postmenopausal status [age-related] [natural]).

ICD-10 check: When you begin coding with ICD-10, V49.81 will become Z78.0 (Asymptomatic menopausal state).

Tip 3: Get the Frequencies Straight

Medicare will pay for bone mass measurements on qualified individuals every two years.

Translation: Every two years means "at least 23 months have passed since the month" of the last bone mass measurement (Medicare Benefit Policy Manual, Chapter 15, Section 80.5.5). Medicare does offer exceptions to this frequency rule. Payers may consider more frequent DXA scans when medically necessary under either of these circumstances:

- you're monitoring a patient on glucocorticoid therapy for more than three months
- you need a baseline measurement to monitor a patient who had an initial test using a different technique (such as sonometry) than the one you want to use to monitor the patient (such as densitometry).