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# Outpatient Facility Coding Alert

## Test Yourself: Does Your X-ray Coding Pass Muster With CMS?

**Here are the answers to your quiz.**

How did you do with answering the x-ray scenarios? Find out by reading the answers below.

**Beef Up Your Bilateral Expertise**

**Answer 1:** The statement that you should use modifier 50 (Bilateral procedure) on all bilateral x-ray claims is false. Although your payer may sometimes require you to use modifier 50 for bilateral claims, this is not true for all bilateral x-ray claims.

Modifier 50 tells the payer that the provider performed a unilateral procedure (described by a unilateral CPT® code) bilaterally during the same session.

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

**Example**: Code 73521 (Radiologic examination, hips, bilateral, with pelvis when performed; 2 views) includes the word "bilateral" and instructs you that you need two views of each hip to use the code. You should report 73521 without a bilateral modifier to indicate a bilateral service.

But even knowing this isn't enough. You should 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.

**Example:** You report a bilateral 73620 (Radiologic examination, foot; two views) service to a payer requiring you to follow this one-line reporting rule.

**You would submit 73620-50.**

**Option 2:** Other payers may instruct you to list the procedure code twice and append 50 to the second code. If this were the case with the example above, you would report the following:

- 73620
- 73620-50.

**Option 3:** Still other payers want you to report the code twice, using modifiers RT (Right side) and LT (Left side). This is the most common method for reporting bilateral x-rays, such as the following:

- 773620-RT
- 7773620-LT.

**Lesson:** Get your payers' preferences in writing, and apply them every time.

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**CMS Clears Up View Questions**

**Answer 2:** No. The minimum view requirement is the key.

**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.

**Rule:** 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.

**Factor in Face-to-Face for Accuracy**

**Answer 3:** Yes, you may consider this patient new.

You should typically consider a patient "established" if any physician in your group (or, more precisely, any physician of the same specialty billing under the same group number) has seen that patient for a face-to-face service within the past 36 months, says **Marvel J. Hammer, RN, CPC, CCS-P, ACS-PM, CHCO,** owner of MJH Consulting in Denver.

Because interpreting an x-ray is not a face-to-face service, you may consider the patient to be new.

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