Part B Insider (Multispecialty) Coding Alert

Part B Coding: Sidestep These 3 X-Ray Scenario Pitfalls

Supercharge your skills by knowing which guidelines to keep handy.

Medical coders must be masters of all modalities, but even coding for the long-established x-ray can require you to handle new situations and apply complicated coding rules. Here's the how-to on three real-life x-ray scenarios provided by coders like you.

Scenario 1: Your physicians routinely perform AP, lateral, obliques, and spot views that you code using 72110 (Radiologic examination, spine, lumbosacral; minimum of four views). If one doctor also performs flexion and extension views --" in addition to the other views --" for a particular patient, should you report 72100 (two or three views), too?

Solution: No. You should not report 72100 in addition to 72110 for this situation because CPT offers a more appropriate code. If you perform AP, lateral, obliques, spot, and the flexion/extension bending views, you should report 72114 (complete, including bending views) for all the images, says **Rick D. Gladish, RCC, CPC, RMC**, director of operations for **Professional Accounts Management** and president-elect of the Tupelo, Miss., AAPC chapter.

Helpful: Checking Correct Coding Initiative (CCI) edits will help keep you in line. If you try to report 72110 and 72100 together, you'll face an unbundling issue, Gladish says.

72110 explained: If the spine exam includes a minimum of four views, "and the views include an AP, lateral, and the obliques --" LPO (left posterior oblique) and RPO (right posterior oblique) --" then you code a 72110," says Gladish.

What to watch for: "The obliques usually are done by laying the patient on their side and bringing the leg on top forward, which causes the torso to twist, or also by rolling the patient to a 45 degree angle," Gladish says.

You also may see documentation of "a lateral spot, which is a small spot film of the lumbosacral junction (fifth view)," Gladish says.

Code 72110 covers all four views and the spot film, he says.

72114 explained: The descriptor for 72114 states, "complete including bending views" and this exam would include any and all images performed of the lumbar spine during an exam. Bending views include films taken of the spine with the patient standing up and bending to the sides (left and right), flexion views (when you bring the chin down toward the chest), and extension (when you lift your head toward the ceiling)," Gladish says.

Important distinction: CPT also offers 72120 (Radiologic examination, spine, lumbosacral, bending views only, minimum of four views), which you should use "when the only images that are done are the bending views," Gladish says. Key to 72120 is a minimum of four views.

Code 72110 is also for a minimum of four views, but like 72100, the descriptor does not specify the type of views, Gladish says. So, if you have a minimum of four bending views --" all bending --" 72120 is the correct code, not 72110.

Bottom line: "The main thing to look for in your lumbar spine reports is if you have any of the bending/extension views. Without those views you are looking at 72100 or 72110 depending on the number of views you have. If you have bending views or flexion/ extension views in addition to the regular views then look to your 72114," Gladish says.

Keep ICD-9 Guidelines Handy

Scenario 2: Your physician reads a preoperative chest x-ray for a patient with chronic obstructive pulmonary disease

(COPD) who is planning to have a knee replacement. Which diagnosis codes should you report to indicate the medical necessity for the x-ray?

Solution: According to the ICD-9 guidelines, "For patients receiving preoperative evaluations only, sequence first a code from category V72.8 (Other specified examinations) to describe the pre-op consultations. Assign a code for the condition to describe the reason for the surgery as an additional diagnosis. Code also any findings related to the pre-op evaluation."

For example: If your physician reads a pre-knee replacement two-view chest x-ray ordered for a patient with COPD, you should report 71020 (Radiologic examination, chest, two views, frontal and lateral) and append modifier 26 (Professional component) to the x-ray code to indicate you performed only the reading.

Link V72.82 (Pre-operative respiratory examination) to 71020 as the primary diagnosis, says **Becki Garaud, CPC, CPC-E/M, RCC**, compliance education and coding trainer with University of **Washington Physicians.**

Report the appropriate code showing medical necessity for the surgery, such as 715.96 (Osteo-arthritis... lower leg). And code relevant findings, such as diagnosis code 492.8 (Other emphysema).

Good news: Medicare and other payers typically cover medically necessary preoperative chest x-rays if you use the appropriate V code to indicate the pre-operative reason.

Watch Reason for 71010+77001

Scenario 3: The physician places an Ash catheter for dialysis using fluoroscopy. Several hours after leaving the interventional suite, the patient requires a single-view chest x-ray for respiratory distress. Can you report the x-ray in addition to the fluoroscopy?

Solution: In this situation, you may report the chest x-ray (such as 71010, Radiologic examination, chest; single view, frontal) in addition to the fluoro (+77001, Fluoroscopic guidance for central venous access device placement, replacement...). Note that 77001 is an add-on code, and you should report it with the code for the cath placement.

You should append modifier 59 (Distinct procedural service) to 71010 because CCI bundles 71010 into 77001.

You also should report a diagnosis indicating the medical necessity for the x-ray, such as 518.5 (Pulmonary insufficiency following trauma and surgery).

Watch out: If the physician performs the x-ray not because of respiratory distress, but to confirm catheter placement, you should report only the fluoro. Code 77001's descriptor includes "radiographic documentation of final catheter position."