2015 Radiology Coding Survival Guide

Chapter 5: Lower Extremities (73500-73725)

Radiology's "Lower Extremities" section is similar in format to the "Upper Extremities" section in terms of offering codes for various modalities. The section includes codes for hips, the sacroiliac joint, and the legs. You'll also find an X-ray code for the pelvis and hips here: 73540 (Radiologic examination, pelvis and hips, infant or child, minimum of 2 views).

CPT® includes a note at the beginning of the section: "For stress views, any joint, use 77071."

Key Concepts:

Bilateral Reporting Requires Research

Although your payer may sometimes require you to use modifier 50 (Bilateral procedure) for bilateral claims, this is not true for all bilateral X-ray claims.

Modifier 50 tells the payer that the provider performed a 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 the test is bilateral.

Example: Code 73520 (Radiologic examination, hips, bilateral, minimum of 2 views of each hip, including anteroposterior view of pelvis) includes the word "bilateral" and instructs you that you need two views of each hip to use the code. You should report 73520 without a bilateral modifier to indicate a bilateral service.

But even knowing this isn't enough. You need to 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 (Bilateral procedure) on one line only.

Example: You report a bilateral 73620 service (Radiologic examination, foot; 2 views) to a payer requiring you to follow this one-line reporting rule.

You report the following:

- 73620-50.

Option 2: Other payers may want you to report the code twice, using modifiers RT (Right side) and LT (Left side).

Example: You report the following:

- 73620-RT
- 73620-LT.

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

Key Concepts:

Determine What Constitutes a 'Formal Report'

The American College of Radiology (ACR) has established very specific guidelines for documenting diagnostic image reports. For example, they advise physicians that the "report should include a description of the studies and/or procedures performed and any contrast media (including concentration, volume, and route of administration when applicable), medications, catheters, or devices used, if not recorded elsewhere." The report should address any specific clinical
questions and offer a precise diagnosis if possible.

In addition, most payers like to see at least a separate note either in the report or following the op note.

**Standing Knee View Won't Always Warrant 73565**

**Scenario:** The patient receives a two-view left knee X-ray while lying flat, and another left knee X-ray while standing up. Can you report both 73560 (Radiologic examination, knee; 1 or 2 views) and 73565 (Radiologic examination, knee; both knees, standing, anteroposterior)?

**Answer:** No. Because 73565 describes “both knees,” you cannot report this code if the physician examines only one knee. Instead, you should add up the total number of views that the physician took. Therefore, if the doctor performs two views of the left knee while the patient lies in the supine position and one standing view of the left knee, you should report 73562 (Radiologic examination, knee; 3 views). You should report 73565 only if the physician orders anteroposterior (AP) upright views of both knees.

**Bonus tip:** Clinical Examples in Radiology, Fall 2006, says “This code (73565) should be reported when the anteroposterior (AP) standing view is the only view taken. This code should not be used for studies involving two or three views of each knee even if one of the views happens to be upright.”

**Special Feature:**

**Expect Denials with Knee Comparison X-Rays**

Although your payer may reimburse comparison views of children's knees, you can't usually collect for comparison views that the physician orders of adult patients.

Doctors sometimes order comparison views of children because they suspect growth-plate injuries, and comparing the left side to the right can confirm this type of injury. But in an adult patient, the insurer sometimes considers the non-injured side a screening X-ray because you lack the appropriate diagnosis to justify medical necessity on the healthy knee.

If the ordering physician thinks he requires the comparison view for medically necessary reasons, you should submit the claims with modifiers LT (Left side) and RT (Right side) and include a letter in which the physician describes medical necessity for the comparison knee X-ray. He should link the X-rays to V72.5 (Radiological examination, not elsewhere classified).

**Sidestep Foot Code for Toe Exam**

If the toes are the only part of the foot X-rayed, select the appropriate toe X-ray code, such as 73660 (Radiologic examination; toe[s], minimum of 2 views).

**Example:** The radiologist diagnoses a bone spur under the nail using an X-ray of the toe.

You should select diagnosis code 726.91 (Exostosis of unspecified site), which applies to bone spurs. And for the X-ray, report 73660.

**Foot/Ankle MRI May Equal 1 Code**

If an MRI order is for “foot and ankle,” you should be able to report these with one joint code and one lower extremity code.

The CPT® index points you to lower extremity codes 73718-73720 (Magnetic resonance [e.g., proton] imaging, lower extremity other than joint ...) for “MRI, foot” and joint codes 73721-73723 (Magnetic resonance [e.g., proton] imaging, any joint of lower extremity ...) for “MRI, ankle,” but the answer is not always that simple.

Reporting a foot MRI depends on the study. If the physician orders an ankle study, but the radiologist decides to expand the field of view to include more of the foot, you should report only the appropriate joint code (73721-73723). But if you have separate setups for each, you may report both a joint (73721-73723) and non-joint (73718-73720) code.

**Remember:** The codes you bill must match the ordered and, perhaps, precertified services.
Get Hip to These Lower-Extremity MRI Rules

You may be familiar with coding lower-body MRIs, but what happens when the radiologist images more than one joint? We'll show you how to breeze through selecting an accurate code and appending appropriate modifiers.

Straightforward Coding for a Standard MRI

**Problem:** You won't find "MRI; Hip" in your CPT® index. Instead: When the order is for a hip MRI, you should choose the proper code from 73721-73723 (Magnetic resonance [e.g., proton] imaging, any joint of lower extremity ...) because the hip is a joint.

Bolster Your Bilateral Hip MRI Coding

If your documentation reveals a bilateral MRI of the hips (meaning imaging of both hips), your modifier choice could be the difference between payment and denial.

Some payers — especially Medicare — seem to prefer that you report the MRI code with modifiers LT (Left side) and RT (Right side). Some coders report Medicare carriers suggesting use of LT and RT with 76 (Repeat Procedure or Service by Same Physician or Other Qualified Health Care Professional). Example: The radiologist reviews bilateral hip MRIs performed on his own equipment with contrast. Report 73722- LT (... with contrast material[s]), 73722-RT-76.

Other payers prefer that you use modifier 50 (Bilateral procedure) to keep it simple.

Medicare recognized all joint MRI exams as eligible for bilateral payment as of Jan. 1, 2004, so securing reimbursement for this service should not be a problem — as long as you code according to your carrier.

Some payers require you to report the CPT® code twice, appending 50 to the second code, while for others, you should report the code once and append 50 to indicate a bilateral procedure.

**Bottom line:** Codes 73721-73723 represent unilateral studies — CPT® Assistant (July 2001) tells you that to report bilateral studies you need to check your payer policies to determine the correct modifier to indicate two studies.

Steer Clear of This Pelvis MRI Pitfall

When you need to code for bilateral hip MRIs, don't be tempted to report an MRI of the pelvis (72195-72197, Magnetic resonance [e.g., proton] imaging, pelvis ...). The CPT® codes for a pelvis MRI are not joint codes. When the order is for a hip MRI, only use the lower-extremity joint codes 73721-73723.

Use the MRI pelvis codes only if the order is specifically for a pelvis MRI and/or the physician looks at the pelvic viscera, such as the organs and soft tissue.

If you have an order for MRIs of both hips as well as the pelvis and written reports for all three services, you may claim all three. Experts warn: Before you code for multiple studies, be sure the documented clinical indications support them. You should also have full and complete exams of all the anatomic sites — not just one exam that superficially includes all of the sites — with complete reports for each coded exam.

**Tip from the field:** When you have a question about the proper use of a CPT® code, you'd be wise to check with your local carrier. If your carrier won't offer a specific answer, consider the descriptor and use your best judgment to decide the most ethical way to use the code. For 73721, for example, because the descriptor refers to "any joint" in the singular, you should feel comfortable reporting this code per joint and defending your choice in an audit.

Key Concepts:

Boost Your Modifier 52 Know-How

**Scenario:** You receive a report with the title "Complete X-ray of the knee." The documentation clearly states that the radiologist performed a three-view exam. Should you report 73564 (Radiologic examination, knee; complete, 4 or more views) and append modifier 52 (Reduced services) to indicate the reduced service?

**Answer:** No. You should always check your CPT® manual to determine whether you have a more appropriate choice before
you append 52. This is especially important for X-ray codes, which are often defined by the number of views.

Because you should base your coding on the body of the report (which explains what actually happened) rather than the title/header, you should see if you have a code for three views of the knee. Your best option is 73562 (Radiologic examination, knee; 3 views).

**Knee + Ankle = 73721 x 2**

Proper reporting of an MRI for a knee and an ankle, both on a single leg, depends on your payer's preferences.

Note that 73721 (Magnetic resonance [e.g., proton] imaging, any joint of lower extremity; without contrast material) states "any joint" — singular — in its descriptor, so reporting the code twice for two separate joints (knee, ankle) on the same leg is appropriate.

Whether appending modifiers LT (Left side) or RT (Right side) and 59 (Distinct procedural service) is appropriate depends on your payer's modifier preference.

Some coders report that their Medicare carriers prefer appending modifier 76 (Repeat Procedure or Service by Same Physician or Other Qualified Health Care Professional) with the code, although the physician actually isn't performing a repeat procedure — he's performing two different procedures. Be sure to get your payer's preference in writing.

**Break Up Hip and Knee Claims, Too**

The same concept applies to the hip and knee. Even though these MRI joint codes (73721-73723) are unilateral, don't assume you can only code for one MRI when your patient requires an MRI of both the hip and knee on the same leg.

**Reason:** To perform an MRI, the provider obtains high-resolution images by using coils made specifically for different areas of the anatomy. Translation: You need separate coils for the hip and the knee to obtain detailed images, so the MRI of each joint is a separate procedure.

**Example:** Your radiologist reads MRIs performed at a hospital. The patient had an MRI of the hip and of the knee of his left leg with and without contrast. His insurance company requires you to append modifiers to distinguish sides and to report two separate procedures that merit the same code. The MRI code you need is 73723 (... without contrast material[s], followed by contrast material[s] and further sequences). Report 73723-26-LT and 73723-26-LT-59 as per your radiologist's documentation of the services.

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