Dynamic Chiropractic

CODE CORNER

76499: Can I Use This Code?

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QUESTION: *I recently learned of the CPT code 76499; the description seen on an actual EOB says, "Unlisted diagnostic radiographic procedure," with a modifier 22. A doctor is billing this code for a specialized digital X-ray report that analyzes and quantifies "alteration of motion segment integrity (AOMSI) by using the flexion, extension and neutral stress views." Allowing an objective and accurate diagnosis of "ligament laxity" (M24.28) is a key relating to spinal-injury cases. Can you clarify the appropriate use of this code?*

CPT Code 76499

CPT code 76499 is the unlisted radiographic code, which is a catch-all code for X-ray services that do not have their own codes. This code is similar the to the PT codes 97039 and 97139, which are the unlisted physical medicine modality or procedure codes, utilized when a physical medicine procedure or modality does not have a CPT code that accurately describes the service.

In general, use of 76499 in addition to the primary X-ray code would not be appropriate, as taking, reading/interpretation, report and counseling are all bundled into the primary code for the X-ray. Use would only be appropriate when the X-ray procedure has no code otherwise defined by CPT. (See my comments on this later.) Note there are multiple codes for the films and views you indicate. The report is considered integral for the service to be billable.

Per CPT, "Written reports [e.g., handwritten or electronic] signed by the interpreting individual should be considered an integral part of the radiologic procedure or interpretation, and [it]does not matter whether films are attained with analog (film) or digital (electronic) manner."

Certainly, a provider can feel that the level of the report is of such detail and expertise that an additional code would be warranted, and could additionally bill this code with a detailed explanation.

For a special report, the CPT manual indicates it is a service rarely provided, unusual, variable or new and may require a special report. Pertinent information should include an adequate definition or description of the nature, extent and need for the procedure; and the time, effort and equipment necessary to provide the service.

Now let's discuss your statement, "A doctor is billing this code for a specialized digital X-ray report that analyzes and quantifies the alteration of motion segment integrity (AOMSI) by using the flexion, extension, and neutral stress views." First, what is specialized about the digital X-ray beyond any other digital X-ray? For example, CPT codes 72040 through 72052, which are for cervical spine views (2-3, up to six), do not change whether the X-ray is done via analog or digital. Therefore, use of 76499 in this example would not be appropriate.

Modifier 22: Yes or No for 76499?

This modifier is used for an unusual procedural service. Each procedure code has an expected range of complexity, length, risk and difficulty. When the service provided exceeds these normal ranges, you can add modifier 22 to the procedure code. However, this adds a further layer of complication and need for explanation.

Modifier 22 would appear inappropriate for 76499, which is already unlisted and therefore, if being defined by you, would not require that it is unusual. Your interpretation and documentation of the service would already define all factors, *including* any unusual issues of complexity or length.

In general, you can report modifier 22 when work to provide a service is substantially greater than typically required. Documentation must support the substantial additional work and the reason, which may include increased intensity, time, technical difficulty of the procedure, severity of patient's condition, and/or physical and mental effort required.

Your documentation should provide reviewers with a clinical picture of the patient, the procedures/services performed, and support use of modifier 22.

The Bottom Line

I would suggest that unless the films you are taking do not have their own code in CPT, you should not use 76499, but instead simply use the appropriate X-ray code with modifier 22 and send with an explanation of the greater and unusual service beyond what is typically provided. Many plans will increase the value of the primary code 50 percent when modifier 22 is utilized and justified.

Keep in mind what professional medical billers think about the use of codes that are unlisted, particularly those ending in 99. An experienced medical biller knows a claim containing code 76499 will be denied with a request for records. Of the many codes used to describe diagnostic radiographic procedures, there is probably one that will match what the radiologist performed. In addition, the patient's medical record will contain the language to assign an accurate and correct code, ensuring a clean claim submitted for reimbursement.

Billing unlisted radiology CPT codes slows down the reimbursement process and can increase scrutiny from third-party payers, including Medicare. That increased scrutiny may result in a RAC audit to determine if a practice codes *all* of its services appropriately.

Editor's Note: Feel free to submit billing questions to Mr. Collins at sam@hjrossnetwork.com. Your question may be the subject of a future column.

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