There are only five codes for bone scans, but studies often include several different techniques, and it can be tough for coding and billing professionals to keep track of the code combinations that can be reported together. In this article we'll give you a run-down on the techniques, the codes, and the bundling issues.

**Technique**

Bone scans are performed by giving the patient an intravenous injection of a radiopharmaceutical and then taking images with a gamma camera. A normal bone scan will show uniform distribution of the isotope throughout the skeleton. But there will be increased uptake of the radiopharmaceutical in areas where new bone is being formed or where bone is breaking down. These areas of increased uptake are known as “hot spots.” They can be a sign of a tumor, arthritis, fracture, degenerative bone or joint disease, osteomyelitis, bone necrosis, osteodystrophy, or Paget’s disease. Bone scans are very sensitive and can detect small fractures that are difficult to identify on plain films. Bone scans can also indicate the age of a fracture, because a more recent fracture will show an increased uptake while an old fracture will not.

Bone scans can be performed using planar (2-D) or SPECT (3-D) technique. During a SPECT scan, the gamma camera rotates around the patient and records the radiation emitted from all angles. Special software then translates this data into three-dimensional images.

A three-phase study is a bone scan that includes three different components. In the first phase, rapid sequence imaging is performed during the injection to show the radiopharmaceutical flowing through the patient's blood vessels. This is referred to as vascular flow or angiographic imaging. The second phase consists of static blood pool images taken shortly after the injection. The third phase consists of delayed static images taken several hours after the injection. There is also a technique called a four-phase study in which a three-phase study is performed and then additional static images are taken at 24 hours.

**Coding for Bone Scans**

There are three codes for planar bone scans. You should assign code 78300 (Bone and/or joint imaging; limited area) for imaging of a single body area such as the patient's forearm or foot. You should use code 78305 (... multiple areas) for imaging of multiple body areas, such as the bilateral legs. Finally, code 78306 (... whole body) represents imaging of the complete body (at least head to knees). A whole body scan can be performed by taking separate images of each body part, or by taking a single whole body image.

There is only one code for SPECT studies, 78320 [Bone and/or joint imaging; tomographic (SPECT)]. You should use this same code regardless of whether the SPECT exam involves a limited area, multiple areas, or the entire body. According to CPT® Assistant (January 2008), “It would not be appropriate to report code 78320 multiple times for different sites.”

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**Staying Compliant with Bone Scan Coding**

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Three-phase studies are reported with code 78315 (Bone and/or joint imaging; three phase study). According to Clinical Examples in Radiology (Spring 2010), you can also use this code for a four-phase study. You should not assign a separate code for the additional delayed images in the four-phase study.

**Bundling**

Not too surprisingly, you can assign only one planar bone scan code per encounter—78300, 78305, or 78306, depending on the extent of the study. Additionally, under the CCI edits, a SPECT study (78320) includes limited area and multiple area planar exams (codes 78300 and 78305). However, you can assign a separate code for a whole body planar exam (78306) performed together with a SPECT study.

According to Clinical Examples in Radiology (Spring 2010), the three-phase study (78315) includes all of the planar exam codes (78300, 78305, and 78306). Additionally, the CCI edits bundle the three-phase study into the SPECT code (78320).

Finally, according to SNM (Coding Corner, “Bone Scan Whole Body Coding with Spot Imaging”), you should not assign an additional code when additional spot images are taken the day after a bone scan. However, if the facility performs SPECT spot imaging following a whole body planar bone scan, you can charge separately for the SPECT, regardless of whether it is performed on the same day as the whole body planar scan or on a subsequent day.

**Payment for Bone Scans**

Bone scans performed in non-hospital imaging facilities are subject to a longstanding Medicare discounting policy. When a physician office or IDTF bills for a whole body planar study (78306) together with a SPECT study (78320), the SPECT study will be paid at 100% and the planar study will be discounted by 50%. This discount applies to both the technical component and the professional component.

**Radiopharmaceuticals**

Bone scans are usually performed with the technetium isotopes MDP (Tc-99M medronate) and HDP (Tc-99M oxidronate). MDP is reported with HCPCS code A9503 (Technetium Tc-99M medronate, diagnostic, per study dose, up to 30 millicuries), while HDP is reported with code A9561 (Technetium Tc-99M oxidronate, diagnostic, per study dose, up to 30 millicuries). Notice that both of these codes are defined as “per study dose,” so you should report only one unit of the code per study.

Bone imaging can also be performed with a NaF-18 PET scan. However, you should not use the regular nuclear medicine bone scan codes for this type of study. See the January 2011 issue of Radiology Coding & Compliance Expert for more information about PET bone studies.

The radiopharmaceutical code should always be billed on the same claim as the nuclear medicine study. Providers paid under the Medicare Physician Fee Schedule should receive payment for their radiopharmaceuticals if billed correctly. Some Medicare contractors may request a copy of the pharmacy invoice for the patient’s radiopharmaceutical prior to paying your claim. Medicare does not make separate payments to hospitals for diagnostic radiopharmaceuticals. However, hospitals are still required to report both the code for the imaging study and the code for the radiopharmaceutical. Claims received without the radiopharmaceutical code will be returned to the hospital for correction prior to processing.