

RADIOLOGY

X-RAY SERVICES

Requirements and Definitions

Attending health care providers who produce or order diagnostic imaging studies are responsible for determining the necessity for the study and must briefly document that justification in their chart notes. Examples include:

- Plain films of the cervical spine to include obliques to rule out foraminal encroachment as possible cause for radiating arm pain.
- PA and lateral chest films to determine cause for dyspnea.

All imaging studies must be of adequate technical quality to rule out radiologically-detectable pathology

Global radiology services include both a technical component (producing the study) and a professional component (interpreting the study).

If only the technical component of a radiology service is performed, the modifier -TC must be used, and only the technical component fees are allowable.

If only the professional component of a radiology service is performed, the modifier -26 must be used, and only the professional component fees are allowable.

Repeat X-rays

The insurer **won't pay** for excessive or unnecessary X-rays. Repeat or serial X-rays may be performed only upon adequate clinical justification to confirm changes in the accepted condition(s). Documented changes in objective findings or subjective complaints must support the need.

Number of Views

There isn't a specific code for additional views for radiology services. Therefore, the number of X-ray views that may be paid is determined by the CPT[®] description for that service.

For example, the following CPT[®] codes for radiologic exams of the spine are payable as outlined below:

CPT [®] Code	Payable
72020	Once for a single view
72040	Once for 2 to 3 cervical views
72050	Once for 4 or more cervical views
72052	Once, regardless of the number of cervical views it takes to complete the series

Incomplete Full Spine Studies

A full spine study is a radiologic exam of the entire spine; anteroposterior (AP) and lateral views. Depending on the size of the film and the size of the patient, the study may require up to 6 films (the AP and lateral views of the cervical, thoracic and lumbar spine). An incomplete full spine study is one in which the entire AP or lateral view is taken, but not both. For example, a study is performed in which all AP and lateral views are obtained except for the lateral thoracic. Incomplete full spine studies in which 5 views are obtained are payable at the maximum fee schedule amount for CPT[®] code 72010. Incomplete full spine studies in which 4 views are taken are payable at one-half the maximum fee schedule amount for CPT[®] code 72010 and must be billed with a -52 modifier to indicate reduced services.

-RT and -LT Modifiers

HCPCS modifiers -RT (right side) and -LT (left side) don't affect payment. They may be used with CPT[®] radiology codes 70010-79999 to identify duplicate procedures performed on opposite sides of the body.

Portable X-rays

Radiology services furnished in the patient's place of residence are limited to the following tests, which must be performed under the general supervision of a physician:

- Skeletal films involving
 - Extremities,
 - Pelvis,
 - Vertebral column or
 - Skull
- Chest or abdominal films that don't involve the use of contrast media
- Diagnostic mammograms

HCPCS codes for transportation of portable X-ray equipment R0070 (one patient) or R0075 (multiple patients) may be paid in addition to the appropriate radiology code(s). R0075 will pay based on the number of patients served and the modifier billed. Payment is outlined in the following table.

HCPCS Code	Modifier	Patients Served	Description	Fee
R0070		1	Transport portable X-ray	\$164.84
R0075	-UN	2	Transport portable X-ray	\$ 82.43
R0075	-UP	3	Transport portable X-ray	\$ 54.95
R0075	-UQ	4	Transport portable X-ray	\$ 41.21
R0075	-UR	5	Transport portable X-ray	\$ 32.97
R0075	-US	6 or more	Transport portable X-ray	\$ 27.48

Custody

X-rays must be retained for 10 years. See WACs [296-20-121](#) and [296-23-140\(1\)](#).

RADIOLOGY CONSULTATION SERVICES

Attending health care providers who request second opinion consulting services are responsible for determining the necessity for the second opinion and must briefly document that justification in their chart notes. Examples include:

- Confirm or deny hypermobility at C5/C6
- Does this T12 compression fracture look old or new?
- Evaluate stability of L5 spondylolisthesis
- What is soft tissue opacity overlying sacrum? Will it affect case management for this injury?
- Is opacity in lung field anything to be concerned about?
- Does this disc protrusion shown on MRI look new or preexisting?

CPT[®] code 76140 **isn't covered**. For radiology codes where a consultation service is performed, providers must bill the specific X-ray code with the modifier -26. The insurer won't pay separately for review of films taken previously or elsewhere if a face-to-face service is performed on the same date as the X-ray review. Review of records and diagnostic studies is bundled into the E/M, chiropractic care visit or other procedure(s) performed. Payment for a radiological consultation will be made at the established professional component (modifier -26) rate for each specific radiology service. A written report of the consultation is required.

RADIOLOGY REPORTING REQUIREMENTS

Documentation for the professional interpretation of radiology procedures is required for all professional component billing whether billed with modifier -26 or as part of the global service. Documentation refers to charting of justification, findings, diagnoses, and test result integration.

Any provider who produces and interprets his/her own imaging studies, and any radiologist who overreads imaging studies must produce a report of radiology findings to bill for the professional component.

The radiology report of findings must be in written form and must include all of the following:

- Patient's name, age, sex, and date of procedure
- The anatomic location of the procedure and type of procedure (lumbar spine plain films, abdomen CT, cervical spine MRI, etc)
- Specific views (eg, AP, lateral, oblique, weight bearing, axial, sagittal, coronal, with or without contrast, etc, as applicable)
- Brief sentence summarizing history and/or reason for the study. Examples:
 - "Lower back pain; evaluate for degenerative changes and rule out leg length inequality."
 - "Neck pain radiating to upper extremity; rule out disc protrusion."
- Description of, or listing of, imaging findings:
 - Advanced imaging reports should follow generally accepted standards to include relevant findings related to the particular type of study.
 - Radiology reports on plain films of skeletal structures should include evaluation of osseous density and contours, important postural/mechanical considerations, assessment of any joint space abnormalities, and assessment of any important abnormal soft tissue findings.
 - Radiology reports on chest plain films should include assessment of lung fields, bronchovascular markings, apices, tracheal air shadow, mediastinal and hilar contours, cardiovascular contours, costophrenic recesses, any abnormalities below the diaphragm, and assessment of any important osseous abnormalities shown incidentally (ribs, clavicles, scapulae, proximal humeri, spine).

NOTE: Chart notes such as "x-rays are negative" or "x-rays are normal" don't fulfill the reporting requirements described in this section and the insurer won't pay for the professional component in these circumstances.

- Impressions

Imaging impressions summarize and provide significance for the imaging findings described in the body of the report. Examples include:

- For a skeletal plain film report that described normal osseous density and contours and no joint abnormalities, the impression could be "No evidence of fracture, dislocation, or gross osseous pathology."
- For a skeletal plain film report that described reduced bone density and thinned cortices, the impression could be "Osteoporosis, compatible with the patient's age."
- For a chest report that described vertically elongated and radiolucent lung fields, low diaphragm, and long vertical heart, the impression could be "Emphysema."

Attending providers who produce or order diagnostic imaging studies are responsible for acknowledging and integrating the imaging findings into their case management. Providers must include brief documentation in their chart notes. Examples include:

- "Imaging rules out fracture, so rehab can proceed."
- "Flexion/extension plain films indicate hypermobility at C4/C5, and spinal manipulation will avoid that region."
- "MRI identifies disc protrusion at L4/L5, and a conservative course of inversion therapy will begin."

CONTRAST MATERIAL

Separate payment will be made for contrast material for imaging studies. Providers may use either high osmolar contrast material (HOCM) or low osmolar contrast material (LOCM). The use of either type of contrast material must be based on medical necessity.

The brand name of the contrast material and the dosage must be documented in the patient's chart. Use the following codes to bill for contrast material:

- LOCM: Q9951, Q9965 – Q9967
- HOCM: Q9958 - Q9964



HCPCS codes for LOCM are paid at a flat rate based on the AWP per ml. Bill 1 unit per ml. Code A9525 **isn't** valid for contrast material.

NUCLEAR MEDICINE

The standard multiple surgery policy applies to the following radiology codes for nuclear medicine services.

CPT® Code
78306
78320
78802
78803
78806
78807

The multiple procedures reduction will be applied when these codes are billed:

- With other codes that are subject to the standard multiple surgery policy, and
- For the same patient,
 - On the same day,
 - By the same physician or
 - By more than 1 physician of the same specialty in the same group practice.

Refer to the Surgery Services section for more information about the standard multiple surgery payment policies.