

RADIOLOGY

X-RAY SERVICES

Repeat X-rays

The insurer **will not 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 is no 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) do not 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 do not 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.

HCPSC 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

CPT® code 76140 is **not covered**. For radiology codes where a consultation service is performed, providers must bill the specific X-ray code with the modifier –26. The insurer **will not 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. A written report is required to differentiate the work associated with providing a formal interpretation of the radiology procedure from the work associated with a “review” of a radiology procedure. For non-radiologists to bill for the professional component of a radiology procedure, they must provide a separate written report similar to that report provided by a specialist (radiologist) in the field.

The separate written radiology report must include all of the following:

- The anatomic location of the procedure,
- Specific views (e.g. PA/Lateral, standing, weight bearing),
- Diagnosis,
- Reason for the procedure and
- Professional interpretation.

All information related to the radiology procedure must be present to bill the professional component.

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



HCPSC codes for LOCM are paid at a flat rate based on the AWP per ml. Bill 1 unit per ml. Code **not** valid for contrast material: A9525.

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.