RADIOLOGY GUIDELINES

This Fee Schedule has been updated to incorporate by reference the 2019 Edition of the American Medical Association's *Physicians' Current Procedural Terminology*, Fourth Edition (CPT®-4), including the general guidelines, identifiers, modifiers, and terminology changes associated with the adopted codes. In this Fee Schedule *CPT*® codes that contain explanatory language specific to Arizona are preceded by Δ. Codes, however, that are unique to Arizona and not otherwise found in *CPT*®-4 are preceded by an AZ identifier and numbered in the following format: AZ0xx-xxx. Additional information regarding publications (e.g. CMS Guidelines) adopted by reference is found in the Introduction of the Fee Schedule.

The following Commission guidelines are in addition to CMS and CPT® guidelines, and represent additional guidance from the Commission relative to unit values for these services. To the extent that a conflict may exist between an adopted portion of the CPT®-4 and a code, guideline, identifier or modifier unique to Arizona, then the Arizona code, guideline, identifier or modifier shall control.

A. GENERAL GUIDELINES

1. Values include usual contrast media, equipment and materials. An additional charge may be warranted when special surgical trays and materials are provided by the physician.

2. Values include consultation and written reports to the referring physician.

3. X-ray findings and attending physician's written order for x-rays must be included with statement for x-ray services. Bills unsupported by findings will not be paid.

4. X-rays should be taken, reported, and be properly marked for identification and orientation in accordance with the accepted standard of radiologic practice in the State of Arizona.

B. MODIFIERS

Modifiers identify circumstances that alter or enhance the description of the service. For radiology codes, two modifiers affect the assigned unit value and are listed in *The Essential RBRVS.* However, other modifiers may be required for correct reporting of service. See CMS and the 2018 CPT ®-4 publications for additional information on modifiers. Listed radiology modifiers affect the unit values as follows:

1. Total: When no modifier is listed, the unit value represents the global value of the procedure. The five-digit code is used to represent a global service inclusive of professional and technical value of providing that service. The following sections, provide additional definitions for each component.

2. Professional: Modifier 26 is used to designate professional services. The professional component includes examination of the patient, when indicated, performance and/or supervision of the procedure, interpretation and written report of the examination, and consultation with referring physicians.

3. Technical: Modifier TC is used to designate the technical value of providing the service. The technical component includes personnel, materials, space, equipment, and other allocated facility overhead normally included in providing the service. Note that modifier TC is not CPT compatible.

C. REFERENCE TO RELATIVE VALUES

Two patterns of billing currently prevail in radiology. A total charge for the radiology service, to include both professional fees and technical costs, is made by radiologists working in offices, clinics and, under some circumstances, in hospital x-ray departments.

In a majority of voluntary hospital radiology departments, the radiologist submits a separate statement to the patient for his professional services. The hospital charges for use of the department facilities and the services of its employees. This pattern is similar to the charges made by the hospital for the use of delivery rooms or surgical suites. Such charges are entirely separate from the fees charged by obstetricians and surgeons. In most separate radiology billing situations, the total will approximate the amount billed singly by the radiologist in their office or billed singly by the hospital.

The two separate scales in Radiology Relative Values have been devised for use in radiology and are not coordinated with scales for services in other branches of medicine such as surgery, medicine or pathology. The two scales are compatible only within themselves. Within each of the two separate headings, the total dollar value and the PC or professional components dollar value, where appropriate, can be used. Some procedures are noted as a "BR" value or "By Report". This usage is intended to indicate that circumstances involving a given patient procedure may require much more than the average amount of time and effort to perform and thus a value would be unique and could not be anticipated or established. When such added involvement is claimed, a written explanation will usually be required as an addendum to the bill.

The PC values do not include charges made by the hospital in which the procedure was accomplished. Such charges by the hospital cover the services of technologists and other helpers, the films, contrast media, radioactive agents, chemical and other materials, the use of the space and facilities of the x-ray department plus any other hospital costs. Most hospitals have derived their own schedule of charges of these items. The establishment of the hospital's charges is not properly the subject of this publication.

The separation of billing in no way implies a division of responsibility, but only a division of the charge. The radiologist is a physician performing a needed medical service for a patient, and he must retain full responsibility for his own activity and also full responsibility for the

supervision of technologists, the selection and maintenance of equipment, the control of radiation hazards and the general administration of the radiology department.

D. REVIEW OF DIAGNOSTIC STUDIES

No separate charge is warranted for prior studies reviewed in conjunction with a visit, consultation, record review, or other evaluation by the medical provider or other medical personnel; neither the professional component value modifier 26 not the radiological consultation CPT code 76140 is reimbursable. The review of diagnostic tests is included in the evaluation and management codes.