

RADIOLOGY GUIDELINES

This Fee Schedule has been updated to incorporate by reference the 2014 and 2015 Editions 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 adopted by reference is found in the Introduction of the Fee Schedule.

The following Commission guidelines are in addition to the 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. When multiple x-ray examinations are made at the same visit and without concomitant other services, values for each examination except the major examination will be reduced by \$1.72 for Professional Component and \$8.73 for Total Services, unless otherwise specified.
4. When progress examinations of the same part and for the same illness are made within twenty-four (24) hours, the value of the secondary examination will be reduced \$1.72 for Professional Component and \$8.73 for Total Services, unless otherwise specified.
5. 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.
6. 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. 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.

Professional Component Scale

The PC value of a code, identified by modifier 26, is for use in evaluating the professional services of a radiologist. The units have derived from assessment of the amount of time and effort usually required by a radiologist. The services to the patient may include all or most of the following and be covered properly by the PC dollar value.

1. Determination of the problem, including interviewing the patient, obtaining the history and making appropriate physical examination to decide upon the method of performing the radiologic procedure.
2. Performance of the procedure, including instructions to technologists or other assistants; performance of the diagnostic or therapeutic procedure by the radiologist personally; or by a combination of these.
3. Checking radiographs, if necessary, or checking preliminary readings in nuclear medicine studies.
4. Study and evaluation of results obtained in diagnostic or therapeutic procedures-interpretation of radiographs, nuclear medicine, or ultrasound data-estimation of results of treatment.
5. Dictating report of examination or treatment.
6. Consultation with referring physician regarding results of diagnostic or therapeutic procedures.

7. Submitting to the insurance carrier/self insured employer the bill for professional services rendered.

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.

If other physicians participate in a significant fashion in procedure, the insurance carrier/self-insured employer must anticipate a fee for their services separate from the one asked by the radiologist. Examples of such procedures might be the involvement of a urologist in a retrograde pyelogram, or the performance of injection procedures by a neurosurgeon for a carotid angiogram.

Technical Value (TC)

The TC value of a code, identified by modifier TC, is the value associated with providing the service. The technical component includes personnel, materials, space, equipment and other allocated facility overhead normally included in providing the services.

Total Value

The total value of a code represents the entire cost to the patient for a radiologic procedure. It includes both the professional fee of the radiologist and the cost for non-physician personnel, facilities, supplies and overhead needed to accomplish the procedure.

Miscellaneous

When a radiologist practices in a hospital under an arrangement where the technologists and other departments personnel are his employees, or where the radiologist owns all or part of the equipment, a special arrangement for recovery of these costs will need to be made and brought to the attention of all interested parties.