



## Radiology

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This section contains general billing guidelines and instructions for billing radiological procedures not included in the radiology sections listed in the *Contents* section of this manual. Subsequent radiology sections are categorized by headings used in the *Current Procedural Terminology – 4<sup>th</sup> Edition*.

### Diagnosis Code Requirement

Providers must submit a diagnosis code when billing for all radiology procedures.

Providers may not submit the following non-specific diagnosis codes when billing for radiology procedures.

#### ICD-9-CM

<u>Code</u>	<u>Description</u>
V72.5	Radiological examination, not elsewhere classified
V72.60	Laboratory examination

### Billing Method Guidelines

Radiology CPT-4 procedure codes 70010 – 78816, 78999 – 79445 and 79999 are billed by different methods. Although the method used depends on the contractual or other type of mutual agreement between the facility and the physician, and applies to both inpatient and outpatient services, the principal determinants are the provisions of the contract that the facility has with the Medi-Cal program. Facilities that are not under contract to Medi-Cal may make an arrangement with the physician that is mutually agreeable within these policy guidelines.

The Department of Health Care Services (DHCS) has defined the billing method options as follows:

### Split-Billable

Split-billable services: These codes are separately reimbursable for the professional and technical component and they may be reimbursed according to one of the following scenarios:

- The facility and physician each bill for their respective component of the service with modifiers 26 or TC.
- Full-Fee Billing – Physician bills for both the professional and technical components and subsequently reimburses the facility for the technical component according to their mutual agreements.
- Standard Billing – Facility bills for both the technical and professional components and reimburses the physician for the professional component according to their mutual agreements.

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Not Split-Billable

Services that are not split-billable: These codes are not separately reimbursable by different providers for the professional nor technical component. Only one provider may be reimbursed for these codes. These codes must not be submitted with any modifier.

Billing Total Service and/or View(s) Codes

Complete view and separate view radiology services codes are not separately reimbursable for the same recipient, same provider and same date of service.

**Invoice Requirements for “No Price on File” Items**

The following codes for radiopharmaceuticals, contrast agents and miscellaneous supplies are listed on the Medi-Cal rates website without a price and therefore require an invoice for pricing purposes. Invoices for these items must be dated prior to the date of service or the claim will be denied: A4648, A4650, A9501, A9509, A9512, A9520, A9527, A9529 – A9532, A9546, A9550, A9552, A9569 – A9572, A9575– A9580, A9582 – A9585, A9604, A9698, C2634, C2635, C2637 – C2640, C2644, C2698, C2699 and Q9951.

**CLIA Number: Billing for Radiology**

Providers billing for CPT-4 radiology codes 78110, 78111, 78120 – 78122, 78130, 78191 and 78270 – 78272 must be Clinical Laboratory Improvement Amendments (CLIA)-certified. Laboratories that do not perform proficiency testing verification for Radiobioassay must have a system for verifying the accuracy and reliability of test results at least twice per year. Questions regarding state and federal requirements for proficiency testing should be directed to the California Department of Public Health (CDPH) Laboratory Field Services at (510) 620-3800.

**Rendering Provider Number**

The rendering provider number is required on claims for services billed with CPT-4 codes 70010 – 79999. However, the provider number of the attending/referring/prescribing physician, if different from the rendering provider, continues to be required on the claim for these procedures.

Radiologists requesting reimbursement for procedures outside these code ranges must meet the rendering provider number requirements.

**Unlisted Services**

Radiology services not covered by listed CPT-4 procedure codes should be billed with the appropriate unlisted CPT-4 code. The following CPT-4 unlisted codes require authorization on a *Treatment Authorization Request (TAR)*:

<u>CPT-4 Code</u>	<u>Description</u>
76496	Unlisted fluoroscopic procedure (eg, diagnostic, interventional)
76497	Unlisted computed tomography procedure (eg, diagnostic, interventional)
76498	Unlisted magnetic resonance procedure (eg, diagnostic, interventional)
76499	Unlisted diagnostic radiographic procedure

Include a comprehensive report of the service billed in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19) of the claim or as an attachment to the claim.

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<b>Reimbursement</b>	In compliance with <i>Welfare &amp; Institutions Code (W&amp;I Code)</i> , Section 14105.08, reimbursement rates for radiology services may not exceed 80 percent of the corresponding Medicare rate.
Restrictions	<p>Reimbursement for split-billable radiology services is limited to one technical component (modifier TC) and one professional component (modifier 26) for each procedure, or an equivalent total amount of the two combined (one claim line without a modifier). Billings in excess of the two combined components will be denied.</p> <p>When using a unilateral radiographic procedure code to bill for bilateral radiographic procedures, providers must bill with the appropriate CPT-4 code and modifier (TC or 26 for split-billed claims, or no modifier when billing for both professional and technical components), enter a quantity of two units and indicate, in the <i>Remarks</i> field (Box 80)/<i>Additional Claim Information</i> field (Box 19) or on an attachment, that the procedure was performed bilaterally. Providers must not use modifiers RT or LT, or bill on multiple claim lines.</p>
Diagnostic Physicians	Diagnostic physicians (radiologists) may claim reimbursement for the professional component (modifier 26) of the procedure. If they also supply the equipment, supplies, housing and technician services, they may claim reimbursement for the technical component (modifier TC) of the procedure.

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Treating Physicians:  
Separate X-Ray Report  
Reimbursement Guidelines

Treating physicians may be reimbursed for the professional component of an X-ray procedure performed on a recipient in an outpatient setting (including an emergency room), in addition to being reimbursed for Evaluation and Management (E&M) CPT-4 codes 99201 – 99499 (except 99211), when a separate report is produced that includes an interpretation and written report for the recipient's medical record. The X-ray interpretation should be a separately written report and not simply contained within the E&M report.

**Note:** Treating physicians (such as but not limited to emergency room physicians, orthopedic surgeons, trauma specialists, surgeons, internists, family physicians and podiatrists) who routinely review radiographs as an integral part of their reimbursed E&M services are usually not entitled to reimbursement for the professional component of the radiographic review. This service, like other diagnostic data evaluations, is usually covered by the reimbursement for the E&M.

The separately written interpretation is reimbursable only for CPT-4 codes 70010 – 77084 and must include the following:

- Recipient's name and hospital identification number (if applicable)
- Name or type of examination
- Date of examination
- Interpretation that includes a complete exam of the X-ray using precise anatomic and radiologic terminology
- Pertinent clinical issues and an "impression" section
- Signature of the physician supplying the interpretation

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Multiple Claims	Medi-Cal reimburses for only one interpretation of an individual X-ray procedure performed on a patient. Reimbursement is allowed for only one technical component (modifier TC) and only one professional component (modifier 26) for each individual X-ray when billed by any providers, for the same recipient and date of service. When multiple claims for the professional and/or technical component of an individual X-ray procedure are billed by different providers for the same recipient and date of service, only the first successfully adjudicated claim is reimbursed.
Two Interpretations	Two interpretations of the same X-ray are reimbursable only under unusual circumstances (for example, a second interpretation of a questionable finding by another physician). A second interpretation or “proof reading” by a second physician of an X-ray is considered a quality control activity and is not separately reimbursable.
Repeated X-Ray	If the same X-ray has been repeated by any provider for the same recipient and date of service, justification for the repeat X-ray must be included in the <i>Remarks</i> field (Box 80)/ <i>Additional Claim Information</i> field (Box 19) of the claim, or on an attachment.
Modifier TC	Only the technical component (modifier TC) of radiology CPT-4 codes 77261 – 79999 is reimbursable when billed with an E&M procedure (other than 99211) when performed by the same provider, for the same recipient, on the same date of service.

**Imaging Procedure**

CPT-4 codes 76376 (3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality; not requiring image postprocessing on an independent workstation) and 76377 (...requiring image postprocessing on an independent workstation) are an integral part of the primary imaging procedure. Therefore, these codes are not separately reimbursable and the recipient should not be billed for these services.

**CPT-4 Codes  
Not Split-Billable**

The following radiology procedure codes are not split-billable and must not be billed with any modifier:

<u>CPT-4 Code</u>	<u>Description</u>
72291	Radiological supervision and interpretation, percutaneous vertebroplasty or vertebral augmentation including cavity creation, per vertebral body; under fluoroscopic guidance
72292	under CT guidance
76140	Consultation on X-ray examination made elsewhere, written report
77071	Manual application of stress performed by physician for joint radiography, including contralateral joint

**Injection Not Separately  
Reimbursable**

Reimbursement for the following procedures includes the value of the injection procedure. When billing for these radiological procedures, providers should not submit a separate charge for the injection procedure.

<u>CPT-4 Code</u>	<u>Description</u>
74400	Urography (pyelography), intravenous, with or without KUB, with or without tomography
74410	Urography, infusion, drip technique and/or bolus technique;
74415	with nephrotomography

**Magnetic Resonance  
Imaging & Magnetic  
Resonance Angiography**

Refer to the *Radiology: Diagnostic* section of this provider manual.

**Ultrasound Frequency  
Limitations**

The following CPT-4 radiological ultrasound procedure codes are reimbursable four times per year, for the same recipient by any provider. More than four complete studies per year may be reimbursed only with documentation of medical necessity or by report. The report should include an adequate definition or description of the nature, extent and need for the procedure, and the time, effort and equipment necessary to provide the service.

<u>CPT-4 Code</u>	<u>Description</u>
76604	Ultrasound, chest (includes mediastinum), real time with image documentation
76700	Ultrasound, abdominal, real time with image documentation; complete
76705	limited (eg, single organ, quadrant, follow-up)
76770	Ultrasound, retroperitoneal (eg, renal, aorta, nodes), real time with image documentation; complete
76775	limited

Either code 76700 or 76705 may be reimbursed for a total four complete studies per year. A combination of either of these two codes is allowed.

Either code 76770 or 76775 may be reimbursed for a total of four complete studies per year. A combination of either of these two codes is allowed.

**Modifiers**

These codes are reimbursable with either:

- One complete component (no modifier) for the same date of service, same provider. This is the preferred billing method.
- One professional component (modifier 26) plus one technical component (modifier TC) for the same date of service, any provider.