In the course of clinical practice, providers are faced with a variety of scenarios involving interpretation of x-rays or other imaging studies. Each of these services should be reported using the proper CPT® code. Basically, reporting of imaging evaluation with report can be broken down into four categories. These include standard radiology services codes; professional component -26 modifier; records review and consultation on x-rays made elsewhere.

An explanation of these codes with examples follows.

1. Radiology Codes

When a provider takes an x-ray in his/her facility, interprets the study and writes a report, the appropriate radiology code is reported.

**Example:** Dr. A examines the patient for complaint of low back and lower extremity pain. He takes an A-P lumbar spine x-ray series, reads the x-rays and documents the findings in the patient record. In addition to the appropriate E/M code, procedure code 72100- *Radiologic examination, spine, lumbosacral, 2 or 3 views* is reported.

2. Professional Component -26 Modifier

Imaging procedures may be comprised of both a technical component and a professional component. The professional component only is indicated with a -26 modifier and is used only for the initial interpretation of films. Preparation of a separate written report is mandatory.

**Example:** A 4 view cervical spine x-ray series is taken at Dr. A’s facility. She does not read the films, nor does she write a report. Instead she forwards the films to a radiologist for initial interpretation. The radiologist reads the x-rays and provides Dr. A with a written report. Dr. A reports procedure code 72050- *Radiologic examination, spine, cervical, 4 or 5 views* and the consulting radiologist would report 72050-26. In certain circumstances Dr. A would report 72050-TC (technical component). It is advisable to check with specific carriers regarding use of the -TC modifier.

3. E/M consultation Services

When a patient presents to a provider for a new or established patient visit or for a consultation visit and brings his/her medical records, including x-rays or other imaging studies, the proper E/M or consultation service is reported. Imaging studies that have been read and include an initial report are considered medical records; therefore review of these studies is considered a portion of the E/M service. E/M codes include work done before, during or after the E/M visit.

Please note, however, that the amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed and analyzed is included as one of the elements of medical decision making when choosing the appropriate E/M service to report.

**Example:** Patient presents for a new patient visit and brings copies of lumbar spine and pelvis x-rays. Provider examines the patient and reviews the x-ray copies. He includes his interpretation of these studies in the patient record. The proper E/M service is reported (99201-99205) for this new patient encounter. No separate radiology code is reported.
**Example:** Dr. A asks Dr. B, a chiropractic orthopedist, to see his patient for a second opinion. Dr. A sends patient records including cervical spine x-rays and cervical spine MRI to Dr. B prior to the patient visit. Dr. B reviews the medical records and imaging studies and the patient presents the following day for evaluation. Dr. B completes his evaluation and provides Dr. A with a written report. Dr. B would report the appropriate consultation code (99241-99245). No separate radiology code is reported.

**Example:** An established patient presents for evaluation of a recent injury. She went to the emergency department of the local hospital and had x-rays of the left knee. The provider examines the patient and requests the x-rays from the hospital. Two days later the x-rays arrive and are reviewed by the provider. The x-ray findings are documented in the patient record. This is reported as part of the established patient E/M service. Remember that E/M services include work done before, during or after the E/M visit.

4. **Consultation on x-ray examination made elsewhere, procedure code 76140**

This code is reported when one provider asks a second provider in a different facility to provide advice and/or opinion on an imaging study. The second provider interprets the studies and provides a written report. The consulting provider does not actually see the patient.

**Example:** Dr. A from ABC clinic asks Dr. B from XYZ hospital to review and provide a report on lumbar spine x-ray series and lumbar spine CT. Dr. B reviews the imaging studies and provides Dr. A with a written report. Dr. B would report 76140.

**References**

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