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Coding Guidance

Interpretation of X-rays and Other Imaging Studies

Introduction:

The American Chiropractic Association (ACA) receives numerous requests for clarification regarding coding for X-rays and other imaging services. In response to common questions, this guidance addresses key concepts related to diagnostic imaging coding. This information is for educational purposes only, and the application may vary from one third-party payer to another or from one procedure code to another. Providers should consider any statutes, regulations, payer-specific policies, or contractual obligations that apply to each encounter.

Definition:

Imaging procedures performed by chiropractors are usually comprised of both technical and professional components. The technical component includes all equipment, supplies, personnel, and other costs involved in taking the images. The professional component consists of the physician's service, including an interpretation of the results, any required supervision, and a signed written report (handwritten or electronic).[4]

Modifier 26 ("Professional Component") is appended to any appropriate radiology code when a provider performs the professional component alone.[4]

Modifier TC ("Technical Component") indicates that the billing provider only performed the technical component.[1]

Application:

Providers are faced with a variety of scenarios involving the interpretation of X-rays or other imaging studies. These services should be reported using the correct CPT® code(s). The rules regarding the use of radiology codes and modifiers may vary from code to code and from payer to payer.
There are four ways to report the interpretation and reporting components of an imaging study. These include global radiology services codes, professional component only, records review or independent interpretation, and consultation of imaging that was previously taken and interpreted elsewhere.

1. Global Radiology Codes

The global imaging service code includes both the professional and technical components. No modifier is needed with a radiology code when a provider takes an X-ray in their facility, interprets the study, and writes a report.[2] Since the radiology service is reimbursed separately in this situation, the ordering, performance, interpretation, and report are not considered when calculating the medical decision making (MDM) or time to determine the level of the E/M service.[4]

Example: Dr. A evaluates his patient for complaints of low back and lower extremity pain. He takes A-P and lateral lumbar spine X-rays, interprets 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 billable. Since the radiology code is separately reported, the ordering, performance, interpretation, and report are not considered when selecting the level of the E/M service based on time or MDM.

2. Professional Component Only

When the physician performs only the initial interpretation and report of an imaging study, the radiology service code is reported with modifier 26 (professional component). Preparation of a written report is mandatory.[4]

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 draft a report. Instead, she forwards the films to an independent chiropractic radiologist for the initial interpretation. The radiologist interprets the X-rays and provides Dr. A with a written report of the findings. The radiologist, who only performed the interpretation and report, would bill 72050 (Radiologic examination, spine, cervical, 4 or 5 views) with modifier 26 (professional component). Dr. A, who only performed the studies, would report 72050 (Radiologic examination, spine, cervical; 4 or 5 views) with modifier TC (technical component). ACA advises providers to check with third-party payers regarding their individual policies on the use of modifier TC.

3. Records Review or Independent Interpretation

Sometimes a patient presents to a provider for a visit and brings their medical records, including X-rays or other imaging studies. In this situation, the review of the radiology report or an independent review of the imaging is not separately reportable with a radiology code.

When the imaging is reviewed on the same date as a face-to-face patient encounter, it is part of the Evaluation and Management (E/M) code billed for the face-to-face encounter.[3] Consequently, the imaging review may impact the level of medical decision making or the time of the E/M service, thus increasing the level of the E/M code. Except for 99211, the time used to calculate the level of any office visit or other outpatient E/M codes (99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215) includes the total time spent by the physician or other qualified health professional on the date of the encounter, both face-to-face and non-face-to-face time.[4]

Codes 99358 and 99359 are sometimes used instead when a prolonged service is performed for more than 30 minutes **without** direct patient contact on a date other than the face-to-face patient encounter. This includes time spent reviewing records or performing an independent evaluation of prior imaging.[4] Providers can learn more about these non-face-to-face E/M codes in a separate ACA coding guidance on "Prolonged E/M Service on a Date Without a Face-to-Face Encounter".

Example: A new patient presents for an office visit and brings copies of lumbar spine and pelvis X-rays. The provider examines the patient and reviews the X-ray copies. She includes her independent interpretation of these studies in the patient record. The proper office or other outpatient E/M code (99202-99205) is reported for this new patient encounter. No separate radiology code is billed. However, the imaging review on the same date as the E/M service may impact the time or the MDM associated with the E/M service.

Example: Dr. A asks Dr. B, a chiropractic orthopedist, to see his patient for a second opinion. Dr. A sends patient records to Dr. B. before the patient visit. These include cervical spine X-rays and a cervical spine MRI. Dr. B reviews the medical records and imaging studies for 20 minutes. On the following day, the patient presents for evaluation. Dr. B completes his evaluation and provides Dr. A with a written report. Depending on the third-party payer, Dr. B would report the appropriate consultation code (99242-99245) or office visit code (99202-99205) on the date of the visit. ACA provides additional information on consultation codes in a separate coding guidance entitled “Office or Other Outpatient Consultations”. No separate radiology code is reported. Since Dr. B spent less than 30 minutes reviewing records on the day before the face-to-face visit, the time

spent reviewing the records and imaging is not reportable using 99358 (Prolonged evaluation and management service before and/or after direct patient care; first hour).

Example: An established patient presents for evaluation of a recent injury. She went to the local hospital's emergency department and had X-rays of the left knee, lumbar spine, and cervical spine. A lumbar CT was also performed. The next day, a chiropractor examines the patient and requests the X-ray images and records from the hospital. Two days later, the X-rays and records arrive and the provider reviews them. The provider summarizes the records and documents the X-ray findings from the independent review in the patient record. The provider does not see the patient on the date the records and imaging are reviewed. The chiropractor's documentation reflects that 35 minutes were spent summarizing the records and independently reviewing the images. Since more than 30 minutes were spent reviewing the records and imaging on a date without a face-to-face patient encounter, it is appropriate to bill code 99358 (Prolonged evaluation and management service before and/or after direct patient care; first hour) for the non-face-to-face E/M service.

4. Consultation on X-ray examination made elsewhere (Overreads)

CPT code 76140 (Consultation on X-ray examination made elsewhere, written report) is used when one provider asks a second provider in a different facility to provide advice or a second opinion on an imaging study. The second provider independently interprets the studies again and provides a written report.[3] The consulting provider does not actually see the patient. ACA advises providers to check with third-party payers regarding their individual policies on billing for overreads.

Example: Dr. A from ABC clinic performs a lumbar spine X-ray series, interprets the imaging, and completes a report. Dr. A then asks Dr. B, a chiropractic radiologist, to re-review and provide a report on the X-rays. Dr. B reviews the imaging studies and provides Dr. A with a written report. Dr. B would report 76140 for the second review of the lumbar X-rays.

References:

1. American Association of Professional Coders. (2021). HCPCS Level II Expert: Service/Supply Codes for Caregivers & Suppliers. Salt Lake City: AAPC.
2. American Medical Association. (2018, September). Page 3. CPT Assistant Online. American Medical Association.
3. American Medical Association. (2021, March). Page 9. CPT Assistant Online. American Medical Association.
4. CPT 2023 Professional Edition. American Medical Association.