Reimbursement/Billing Policy

PARAMOUNT

HMO AND PPO
ELITE (MEDICARE ADVANTAGE)
MARKETPLACE

X-ray Interpretation

Policy Number: RM036
Last Review: 10/01/2024

GUIDELINES:

- Paramount Reimbursement Policies have been developed to assist in administering proper payment under benefit contracts.
- Reimbursement policies may be superseded by mandates in provider, state, federal, or CMS contracts and/or requirements.
- Paramount utilizes industry standard coding methodology and claims editing in the development of reimbursement policies. Industry standard resources include, but are not limited to, CMS National Correct Coding Initiative (NCCI), Medically Unlikely Edits (MUEs), Integrated Outpatient Code Editor (I/OCE) Clinical edits, Medical Policies, Reimbursement Policies, and Administrative/Provider Manuals. Paramount will not reimburse services determined to be Incidental, Mutually Exclusive, or Unbundled.
- All health care services, devices, and pharmaceuticals must be billed with Current Procedure Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes and/or revenue codes and modifiers, which most accurately represent the services rendered, unless otherwise directed by the Paramount. All billed codes must be fully supported in the member's legal medical record.
- Paramount utilizes CMS pricing algorithms where appropriate based on, National Physician Fee Schedule Relative Value File (NPFSRVF) pricing rules, Inpatient Prospective Payment Systems (MS-DRG, LTC, IPF, IRF & IPSNF) and Outpatient Prospective Payment Systems (OPPS, HHA, ASC, ESRD & OPSNF).
- Paramount liability will be determined after coordination of benefits (COB) and third-party liability (TPL) is applied to the claim. Member liability may include, but is not limited to, co-payments, deductibles, and coinsurance. Members' costs depend on member benefits.
- Paramount routinely reviews reimbursement policies. Updates are published on Paramount's website https://www.paramounthealthcare.com. The information presented in this reimbursement policy is accurate and current as of the date of publication. Paramount communicates policy updates to providers via Paramount's monthly bulletin.

SCOPE:

X Professional
X Facility

DESCRIPTION:

X-rays are a type of electromagnetic radiation, just like visible light. An x-ray machine sends individual x-ray particles through the body. The images are recorded on a computer or film. Structures that are dense (such as bone) will block most of the x-ray particles and will appear white. Metal and contrast media (special dye used to highlight areas of the body) will also appear white. Structures containing air will be black, and muscle, fat, and fluid will appear as shades of gray.

Paramount reimburses contracted providers for radiology services delivered in non-institutional settings such as an office, free-standing facility, or ambulatory surgical centers, and in institutional settings such as hospitals, or comprehensive outpatient rehabilitation facilities.

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 more than the two components combined will be denied.

The professional component represents supervision and interpretation of a procedure furnished to a patient resulting in a written narrative report in the patient's medical record. There is a distinction between an

"interpretation and report" of an X-ray procedure and a "review" of the procedure. An interpretation and report should address findings, relevant clinical issues, and comparative data. A professional component billing based on a review of the findings of these procedures, without a complete written report like that which would be prepared by a specialist in the field, does not meet the conditions for separate payment of the service. The review is already included in the Evaluation and Management (E/M) medical decision-making component.

POLICY:

Paramount Commercial Insurance Plans and Elite (Medicare Advantage) Plans

Reimbursement is warranted for only one physician/radiologist interpretation of any one specific 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 Member 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 Member and date of service, only the first successfully adjudicated claim is reimbursed.

X-ray interpretations do not require prior authorization when appropriately billed as explained below.

Billing and Reimbursement:

Paramount Commercial Insurance Plans and Elite (Medicare Advantage) Plans

Reimbursement is warranted for only one interpretation of an X-ray procedure furnished to an emergency room patient. 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.

An interpretation is supported with a written report and must include the following:

- Patient's name. date-of-birth, age, and hospital identification number (if applicable)
- Name of the ordering physician
- 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

Submit the date of service for the interpretation of the x-ray as the date of service of the diagnostic test.

Reimbursement for a second interpretation (which may be identified using modifier -77) may be warranted only under unusual circumstances (for which documentation is provided) such as a questionable finding for which the physician performing the initial interpretation believes another physician's expertise is needed or changed diagnosis resulting from a second interpretation of the results of the procedure.

Paramount will not reimburse Emergency Room (ER) physicians any additional monies for "interpretive fees" for interpretive services. The interpretation by the ER physician is a necessary component and is included in the global fee for the specific level of E/M service (i.e., problem, expanded problem detailed or complex focused evaluation). A review of findings without a written report is included in the medical decision-making portion of the E/M service, and Paramount will not reimburse this service separately.

Interpretation of x-ray's when performed solely for the purpose of quality control, as a service to the hospital rather than a service to the patient is not reimbursable.

REVISION HISTORY EXPLANATION: ORIGINAL EFFECTIVE DATE: 10/30/2025

Date	Explanation & Changes

04/15/07	• No change
02/01/08	• No change
02/15/09	• Added verbiage
07/26/10	• Editing logic modified • ClaimCheck® editing between procedure code 93010 and E/M services 99201-99215 and 99217-99255 was removed
01/01/11	• Updated
12/10/13	• Changed name of policy from Electrocardiograms (ECG/EKG) to Electrocardiogram and X-ray Interpretation • Policy reviewed and updated to reflect most current clinical evidence • Approved by Medical Policy Steering Committee as revised
04/08/14	• No change after review by Medical Policy Steering Committee
08/27/14	• Removed EKG edit per direction of Medical Director • Title changed from Electrocardiogram and X-ray Interpretation to X-ray Interpretation • Removed codes 93000, 93005, 93010
12/14/2020	• Medical policy placed on the new Paramount Medical Policy Format
11/01/2022	• Policy review completed • Policy coverage statements unchanged
02/01/2023	• Medical Policy updated to reflect Medicaid coverage to Anthem as of 02/01/2023
02/01/2024	• Medical policy placed on the new Paramount Medical Policy Format
10/01/2024	• Medical Policy PG0006 converted to a Reimbursement Policy RM036

Paramount reserves the right to review and revise our policies periodically when necessary. When there is an update, we will publish the most current policy to https://www.paramounthealthcare.com/providers/medical-policies/policy-library

REFERENCES/RESOURCES

Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs

National Physician Fee Schedule Relative Value File Calendar Year XXXX, Centers for Medicare & Medicaid Services (CMS) https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files

NCCI Policy Manual for Medicare Services, current version, Chapter 1, General Correct Coding Policies https://www.cms.gov/files/document/medicare-ncci-policy-manual-2023-chapter-1.pdf

American Medical Association, *Current Procedural Terminology (CPT®)* and associated publications and services https://www.ama-assn.org/amaone/cpt-current-procedural-terminology

Centers for Medicare and Medicaid Services, Healthcare Common Procedure Coding System, HCPCS Release and Code Sets https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/HCPCS-Quarterly-Update

Centers for Medicare & Medicaid Services (CMS), ICD-10-CM Official Guidelines for Coding and Reporting https://www.cms.gov/medicare/coding/icd10

Centers of Medicare & Medicaid Services (CMS), Medicare Claims Processing Manual, Chapter 23-Fee Schedule administration and coding Requirements https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c23.pdf

Centers for Medicare & Medicaid Services (CMS), National Correct Coding Initiative (NCCI) Policy

Manual for Medicare Services https://www.cms.gov/medicare-medicaid-coordination/national-correct-coding-initiative-ncci/ncci-medicare

Center for Medicare and Medicaid Services, Medicare NCCI Medically Unlikely Edits (MUEs) https://www.cms.gov/medicare/coding-billing/national-correct-coding-initiative-ncci-edits/medically-unlikely-edits

U.S. Preventive Services Task Force, https://www.uspreventiveservicestaskforce.org/uspstf/
Industry Standard Review

Hayes, Inc., https://www.hayesinc.com/

Industry Standard Review