Codify by AAPC

Internal Medicine Coding Alert

Reader Questions: Watch Out for X-Ray Components

Question: How should I bill for x-ray interpretation when we do not own the equipment?

Illinois Subscriber

Answer: The radiological codes (70010-79999) in the CPT manual include both the professional and technical components of the procedure. The technical component encompasses labor and supplies, along with the fee for the technician who takes the x-rays. The professional component includes the physicians work and overhead expenses, such as the interpretation of diagnostic tests, diagnostic and therapeutic radiology, and pathology services. Billing a code such as 71010 (Radiologic examination, chest; single view, frontal) means that the physician performed both the technical and professional components.

There are modifiers that you use with these x-ray codes to specify which of the components the billing physician performed. Medicare recognizes modifier -TC (Technical component), which is appended to the x-ray code to show that the physician only takes the x-rays. You would append modifier -26 (Professional component) to the radiological code when the physician performs only the professional component, such as interpretation. If your office is responsible for the technical component only, the code would read 71010-TC. Your code would read 71010-26 if the physician only interpreted the x-rays, while performing the professional component.

Prepare a separate written report that fully documents the reasons for the examination and the extent of the services provided. Medicare requires this documentation to qualify for reimbursement and ensure that the codes meet the criteria for services provided.

An internist cannot bill for interpretation when a radiologist also performs that service. For example, the internist sees a patient presenting with a cough and respiratory distress. The physician then sends the patient to a diagnostic clinic for a chest x-ray. If the radiologist performs the x-ray and interprets the x-ray before sending the results back to the internist, the internist cannot bill for the professional component.

There are instances, however, when you can bill for the professional component in cases like this. For instance, the physician sends the same patient to a diagnostic center, which only provides the technical component of a chest x-ray, and the patient brings the film directly back to your office. The physician interprets the x-rays and diagnoses 480.2 (Pneumonia due to parainfluenza virus). The appropriate code would be 71010 with modifier -26 appended. If the diagnostic center provided both components, the review by the physician would be included as a component of the medical decision-making and would not be separately billable.

If you perform this same x-ray in your office and provide the interpretation, you would bill 71010 with no modifier appended.

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