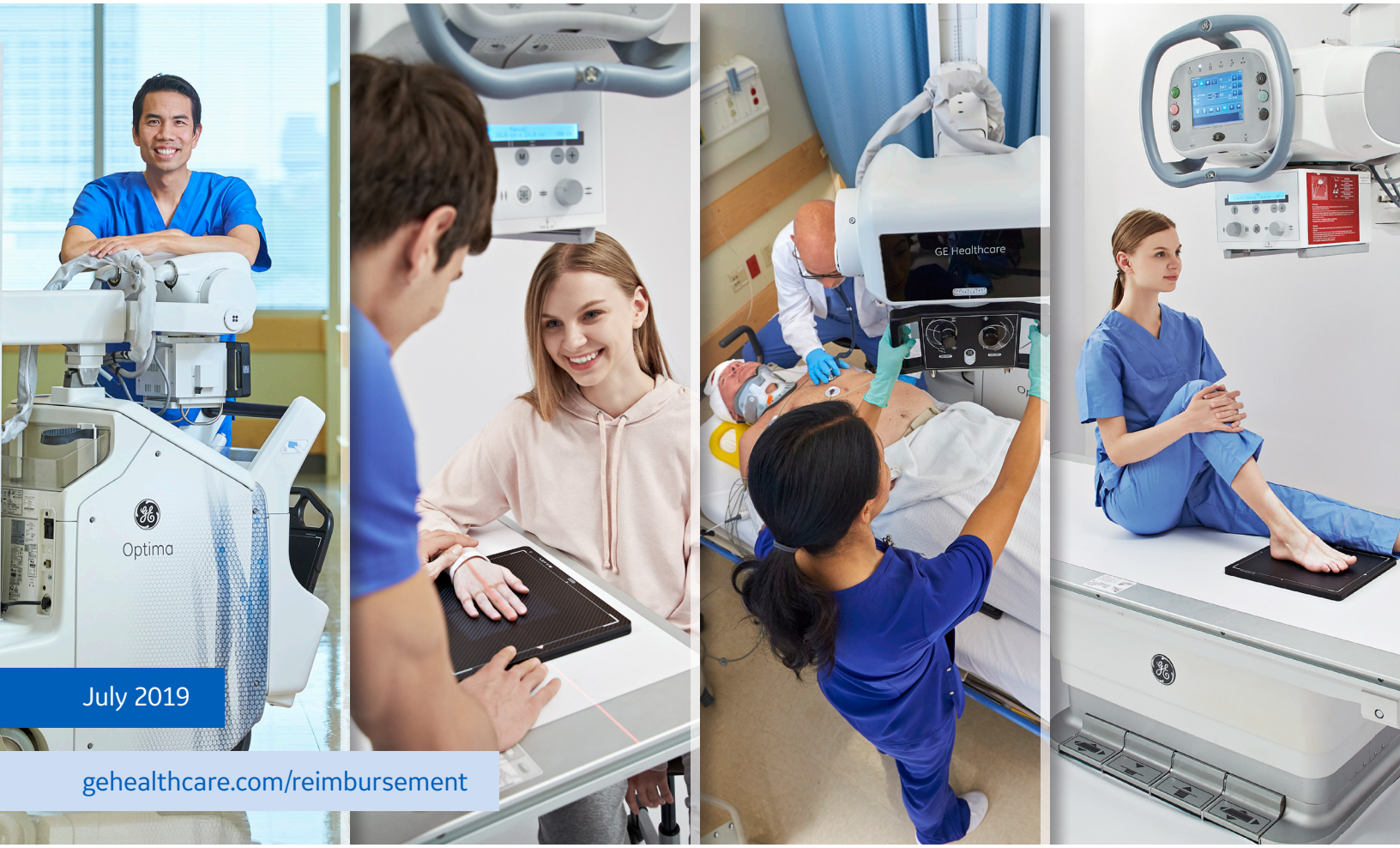
Reimbursement Information for Mobile and Fixed X-Ray Technologies



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This overview addresses coding, coverage, and payment for mobile and fixed x-ray services. The advisory focuses on Medicare program policies. Non-Medicare payers may have different rules and guidelines for coding, coverage and reimbursement for the procedures discussed in this document. For appropriate code selection, it is recommended that you contact your local payer prior to submitting claim(s).

Mobile x-ray services are enlisted to provide diagnostic imaging services at patients' locations—most often residences, including private homes and group living facilities, such as nursing homes—rather than in a traditional clinical setting, such as a doctor's office or hospital. Fixed x-ray services are provided in a facility, and are not mobile.

The Centers for Medicare & Medicaid Services (CMS) pays mobile suppliers separately for up to four components of the service: transporting the equipment to the beneficiary's location, setting it up for use, administering the test (technical component), and interpreting the results (professional component).

Referral of Services and Documentation Requirements

Radiology services are performed only on the order of a physician licensed to practice in the state or by a non-physician practitioner acting within the scope of state law. Patient medical records must show that:

- The x-ray service was ordered by a licensed physician or a non-physician practitioner acting within the scope of state law.
- Physician or non-physician practitioner's written, signed order specifies the reason an x-ray is required, the area of the body to be exposed, the number of radiographs to be obtained, and the views needed; it also includes a statement concerning the condition of the patient which indicates why x-ray services are necessary.[1]

Radiology services performed using either a mobile or fixed x-ray system are reported using the same Current Procedural Terminology (CPT)®2 codes as long as the studies that were performed meet all the following requirements:

- Medical necessity as determined by the payer
- Completeness
- Documented in the patient's medical record

A separate written record of x-ray services must be completed and maintained in the patient record. This should include a description of the structures or organs examined and the findings and reason for the x-ray. X-ray services require the production and retention of image documentation. It is recommended that x-ray images, either electronic or hardcopy, be retained in the patient record or other appropriate archive.

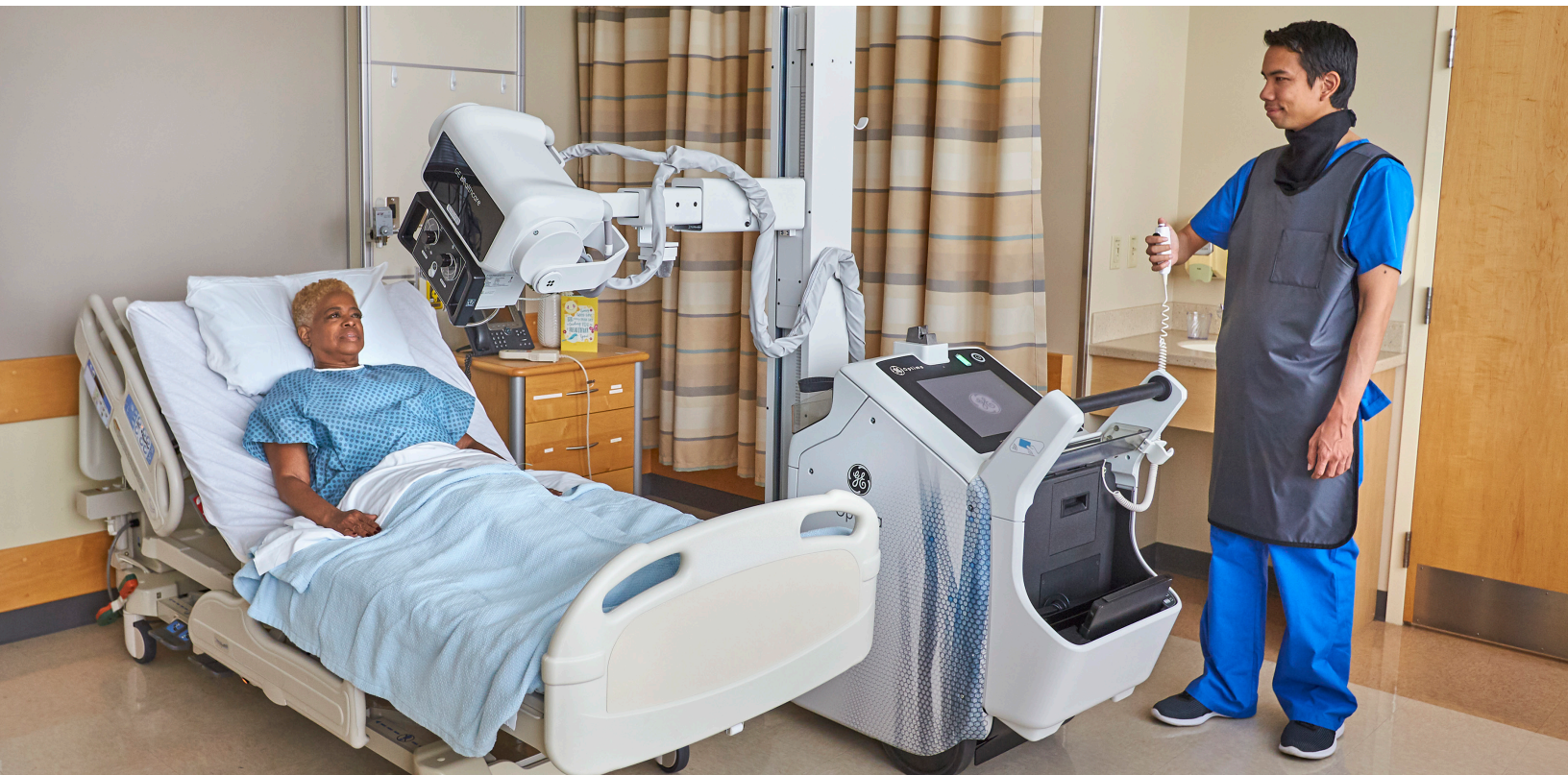
Coverage

Medicare

X-ray services may be a covered benefit if such usage meets all requirements established by the particular payer. It is advisable that you verify coverage policies with your local Medicare Administrative Contractor (MAC). Also, it is essential that each claim be coded appropriately and supported with adequate documentation in the medical record.

Private Payers

Coverage by private payers varies by payer and by plan with respect to which medical specialties may perform radiology services. Some private payer plans will reimburse for radiology services performed by any physician specialist while other plans will limit radiology services to specific types of medical specialties.



Professional and Technical Components

Most radiology services, although described by a single CPT code, comprise of two distinct portions: a professional component and a technical component.

Professional and technical components are payment mechanisms used by Medicare, other government payers and private payers. The professional component of a diagnostic service is provided by the physician, and may include supervision, interpretation, and a written report. The technical component of a diagnostic service accounts for clinical staff (e.g., technicians), equipment and supplies.

The following modifiers indicate which component of a CPT code is professional and technical:

26 – Professional Component
A physician who performs the interpretation of an x-ray exam in the hospital outpatient setting may submit a charge for the professional component of the x-ray service using a modifier (-26) appended to the x-ray code.

TC – Technical Component
This modifier would be used to bill for services by the owner of the equipment only to report the technical component of the service. This modifier is most commonly used if the service is performed in an Independent Diagnostic Testing Facility (IDTF).

Modifiers explain that a procedure or service was changed without changing the definition of the CPT code set. *(This is not an all-inclusive list of available modifiers).*

ICD-10-CM Diagnosis Coding

It is the physician's ultimate responsibility to select the codes that appropriately represent the service performed, and to report the ICD-10-CM code based on his or her findings or the pre-service signs, symptoms or conditions that reflect the reason for services rendered.

Current Procedural Terminology (CPT) Coding, Definitions and Medicare Payment Rates

Physicians and facilities use CPT codes to describe the service and/or procedure being performed, not the outcomes achieved. Table 1 (below) provides an overview of radiology CPT codes that may be applicable to services performed in a mobile or fixed x-ray setting of care, and it includes 2019 Medicare Physician Fee Schedule (MPFS) and the Hospital Outpatient Ambulatory Payment Category (APC) payment rates for the CPT[2] codes identified in this guide. Payment rates provided are national unadjusted rates. Payment will vary by geographic locality.

Payment rates for Medicaid as well as Private (non-Medicare) payers will vary by insurer as well as individual contractual agreements. It is always recommended to check with the payer for coding, coverage and reimbursement requirements.

For payment, it is essential that each claim be coded appropriately and supported with adequate documentation in the medical record.

Table 1.

CPT[2] Description	Reimbursement Component	Physician Payment[3]	APC[4]	Hospital Outpatient Payment[4]
Abdomen				
74018 Radiologic examination, abdomen; 1 view	Global	$28.83	5521	$62.30
	Professional (-26)*	$9.37		
	Technical (-TC)**	$19.46		
74019 Radiologic examination, abdomen; 2 views	Global	$35.32	5522	$112.51
	Professional (-26)*	$11.89		
	Technical (-TC)**	$23.43		
74021 Radiologic examination, abdomen; 3 or more view	Global	$40.72	5522	$112.51
	Professional (-26)*	$14.06		
	Technical (-TC)**	$26.67		
74022 Radiologic examination, abdomen; complete acute abdomen series, including supine, erect, and/or decubitus views, single view chest	Global	$47.21	5522	$112.51
	Professional (-26)*	$16.58		
	Technical (-TC)**	$30.63		

CPT[2] Description	Reimbursement Component	Physician Payment[3]	APC[4]	Hospital Outpatient Payment[4]
Bone Age Study				
77072 Bone age studies	Global	$24.51	5522	$112.51
	Professional (-26)*	$9.73		
	Technical (-TC)**	$14.78		
Chest				
71045 Radiologic examination, chest; single view	Global	$25.23	5521	$62.30
	Professional (-26)*	$9.37		
	Technical (-TC)**	$15.86		
71046 Radiologic examination, chest; 2 views	Global	$32.07	5521	$62.30
	Professional (-26)*	$11.17		
	Technical (-TC)**	$20.90		
71047 Radiologic examination, chest; 3 views	Global	$40.36	5521	$62.30
	Professional (-26)*	$14.42		
	Technical (-TC)**	$25.95		
71048 Radiologic examination, chest; 4 or more views	Global	$43.61	5522	$112.51
	Professional (-26)*	$16.58		
	Technical (-TC)**	$27.03		
71100 Radiologic examination, ribs, unilateral; 2 views	Global	$34.96	5521	$62.30
	Professional (-26)*	$11.53		
	Technical (-TC)**	$23.43		
71101 Radiologic examination, ribs, unilateral; including posteroanterior chest, minimum of 3 views	Global	$40.00	5522	$112.51
	Professional (-26)*	$14.06		
	Technical (-TC)**	$25.95		
71110 Radiologic examination, ribs, bilateral; 3 views	Global	$41.81	5522	$112.51
	Professional (-26)*	$15.14		
	Technical (-TC)**	$26.67		
71111 Radiologic examination, ribs, bilateral; including posteroanterior chest, minimum of 4 views	Global	$49.73	5522	$112.51
	Professional (-26)*	$16.94		
	Technical (-TC)**	$32.80		
71120 Radiologic examination; sternum, minimum of 2 views	Global	$31.71	5521	$62.30
	Professional (-26)*	$10.45		
	Technical (-TC)**	$21.26		
71130 Radiologic examination; sternoclavicular joint or joints, minimum of 3 views	Global	$37.84	5521	$62.30
	Professional (-26)*	$11.17		
	Technical (-TC)**	$26.67		

CPT[2] Description	Reimbursement Component	Physician Payment[3]	APC[4]	Hospital Outpatient Payment[4]
Gastrointestinal Tract				
74210 Radiologic examination; pharynx and/or cervical esophagus	Global	$89.74	5571	$201.74
	Professional (-26)*	$30.27		
	Technical (-TC)**	$59.46		
74220 Radiologic examination; esophagus	Global	$98.39	5571	$201.74
	Professional (-26)*	$34.60		
	Technical (-TC)**	$63.79		
74240 Radiologic examination, gastrointestinal tract, upper; with or without delayed images, without KUB	Global	$124.33	5571	$201.74
	Professional (-26)*	$35.68		
	Technical (-TC)**	$88.66		
74245 Radiologic examination, gastrointestinal tract, upper; with small intestine, includes multiple serial images	Global	$188.84	5523	$230.56
	Professional (-26)*	$46.49		
	Technical (-TC)**	$142.35		
74246 Radiological examination, gastrointestinal tract, upper, air contrast, with specific high density barium, effervescent agent, with or without glucagon; with or without delayed images, without KUB	Global	$138.39	5571	$201.74
	Professional (-26)*	$35.32		
	Technical (-TC)**	$103.07		
74247 Radiological examination, gastrointestinal tract, upper, air contrast, with specific high density barium, effervescent agent, with or without glucagon; with or without delayed images, with KUB	Global	$155.69	5571	$201.74
	Professional (-26)*	$35.32		
	Technical (-TC)**	$120.37		
74249 Radiological examination, gastrointestinal tract, upper, air contrast, with specific high density barium, effervescent agent, with or without glucagon; with small intestine follow-through	Global	$202.54	5571	$201.74
	Professional (-26)*	$46.49		
	Technical (-TC)**	$156.05		
74250 Radiologic examination, small intestine, includes multiple serial images	Global	$114.60	5522	$112.51
	Professional (-26)*	$24.15		
	Technical (-TC)**	$90.46		
74251 Radiologic examination, small intestine, includes multiple serial images; via enteroclysis tube	Global	$265.97†	5523	$201.74
	Professional (-26)*	$35.32		
	Technical (-TC)**	$230.65†		
74270 Radiologic examination, colon; contrast (eg, barium) enema, with or without KUB	Global	$163.62	5571	$201.74
	Professional (-26)*	$35.32		
	Technical (-TC)**	$128.30		

CPT[2] Description	Reimbursement Component	Physician Payment[3]	APC[4]	Hospital Outpatient Payment[4]
Head and Neck				
70030 Radiologic examination, eye, for detection of foreign body	Global	$29.91	5521	$62.30
	Professional (-26)*	$8.65		
	Technical (-TC)**	$21.26		
70100 Radiologic examination, mandible; partial, less than 4 views	Global	$34.96	5521	$62.30
	Professional (-26)*	$9.37		
	Technical (-TC)**	$25.59		
70110 Radiologic examination, mandible; complete, minimum of 4 views	Global	$40.72	5522	$112.51
	Professional (-26)*	$12.97		
	Technical (-TC)**	$27.75		
70120 Radiologic examination, mastoids; less than 3 views per side	Global	$34.96	5522	$112.51
	Professional (-26)*	$9.37		
	Technical (-TC)**	$25.59		
70130 Radiologic examination, mastoids; complete, minimum of 3 views per side	Global	$58.02	5522	$112.51
	Professional (-26)*	$17.66		
	Technical (-TC)**	$40.36		
70134 Radiologic examination, internal auditory meati, complete	Global	$54.42	5524	$497.49
	Professional (-26)*	$18.02		
	Technical (-TC)**	$36.40		
70140 Radiologic examination, facial bones; less than 3 views	Global	$30.99	5521	$62.30
	Professional (-26)*	$10.45		
	Technical (-TC)**	$20.54		
70150 Radiologic examination, facial bones; complete, minimum of 3 views	Global	$44.33	5522	$112.51
	Professional (-26)*	$13.69		
	Technical (-TC)**	$30.63		
70160 Radiologic examination, nasal bones, complete, minimum of 3 views	Global	$34.96	5521	$62.30
	Professional (-26)*	$9.01		
	Technical (-TC)**	$25.95		
70190 Radiologic examination; optic foramina	Global	$37.12	5521	$62.30
	Professional (-26)*	$11.17		
	Technical (-TC)**	$25.95		
70200 Radiologic examination; orbits, complete, minimum of 4 views	Global	$44.69	5522	$112.51
	Professional (-26)*	$14.42		
	Technical (-TC)**	$30.27		
70210 Radiologic examination, sinuses, paranasal, less than 3 views	Global	$32.07	5521	$62.30
	Professional (-26)*	$9.01		
	Technical (-TC)**	$23.07		

CPT[2] Description	Reimbursement Component	Physician Payment[3]	APC[4]	Hospital Outpatient Payment[4]
70220 Radiologic examination, sinuses, paranasal, complete, minimum of 3 views	Global	$39.64	5521	$62.30
	Professional (-26)*	$12.97		
	Technical (-TC)**	$26.67		
70240 Radiologic examination, sella turcica	Global	$32.07	5521	$62.30
	Professional (-26)*	$10.09		
	Technical (-TC)**	$21.98		
70250 Radiologic examination, skull; less than 4 views	Global	$38.56	5522	$112.51
	Professional (-26)*	$12.97		
	Technical (-TC)**	$25.59		
70260 Radiologic examination, skull; complete, minimum of 4 views	Global	$48.29	5522	$112.51
	Professional (-26)*	$18.02		
	Technical (-TC)**	$30.27		
70300 Radiologic examination, teeth; single view	Global	$14.42	5521	$62.30
	Professional (-26)*	$5.77		
	Technical (-TC)**	$8.65		
70310 Radiologic examination, teeth; partial examination, less than full mouth	Global	$38.20	5523	$230.56
	Professional (-26)*	$7.93		
	Technical (-TC)**	$30.27		
70320 Radiologic examination, teeth; complete, full mouth	Global	$55.14	5523	$230.56
	Professional (-26)*	$12.61		
	Technical (-TC)**	$42.53		
70328 Radiologic examination, temporomandibular joint, open and closed mouth; unilateral	Global	$32.07	5521	$62.30
	Professional (-26)*	$9.37		
	Technical (-TC)**	$22.70		
70330 Radiologic examination, temporomandibular joint, open and closed mouth; bilateral	Global	$50.09	5521	$62.30
	Professional (-26)*	$12.61		
	Technical (-TC)**	$37.48		
70360 Radiologic examination; neck, soft tissue	Global	$30.63	5521	$62.30
	Professional (-26)*	$8.65		
	Technical (-TC)**	$21.98		
70370 Radiologic examination; pharynx or larynx, including fluoroscopy and/or magnification technique	Global	$77.48†	5521	$62.30
	Professional (-26)*	$15.14		
	Technical (-TC)**	$62.35†		
70380 Radiologic examination, salivary gland for calculus	Global	$34.24	5521	$62.30
	Professional (-26)*	$8.65		
	Technical (-TC)**	$25.59		
70390 Sialography, radiological supervision and interpretation	Global	$104.51	5523	$230.56
	Professional (-26)*	$19.46		
	Technical (-TC)**	$85.05		

CPT[2] Description	Reimbursement Component	Physician Payment[3]	APC[4]	Hospital Outpatient Payment[4]
Lower Extremities				
73501 Radiologic examination, hip, unilateral, with pelvis when performed; 1 view	Global	$31.35	5521	$62.30
	Professional (-26)*	$9.73		
	Technical (-TC)**	$21.62		
73502 Radiologic examination, hip, unilateral, with pelvis when performed; 2-3 views	Global	$43.61	5521	$62.30
	Professional (-26)*	$11.53		
	Technical (-TC)**	$32.07		
73503 Radiologic examination, hip, unilateral, with pelvis when performed; minimum of 4 views	Global	$54.42	5522	$112.51
	Professional (-26)*	$14.42		
	Technical (-TC)**	$40.00		
73521 Radiologic examination, hips, bilateral, with pelvis when performed; 2 views	Global	$38.92	5522	$112.51
	Professional (-26)*	$11.53		
	Technical (-TC)**	$27.39		
73522 Radiologic examination, hips, bilateral, with pelvis when performed; 3-4 views	Global	$50.82	5522	$112.51
	Professional (-26)*	$15.50		
	Technical (-TC)**	$35.32		
73523 Radiologic examination, hips, bilateral, with pelvis when performed; minimum of 5 views	Global	$59.46	5522	$112.51
	Professional (-26)*	$16.58		
	Technical (-TC)**	$42.89		
73525 Radiologic examination, hip, arthrography, radiological supervision and interpretation	Global	$114.60	5572	$385.88
	Professional (-26)*	$29.91		
	Technical (-TC)**	$84.69		
73551 Radiologic examination, femur; 1 view	Global	$28.83	5521	$62.30
	Professional (-26)*	$8.65		
	Technical (-TC)**	$20.18		
73552 Radiologic examination, femur; minimum 2 views	Global	$33.88	5521	$62.30
	Professional (-26)*	$9.37		
	Technical (-TC)**	$24.51		
73560 Radiologic examination, knee; 1 or 2 views	Global	$32.80	5521	$62.30
	Professional (-26)*	$8.65		
	Technical (-TC)**	$24.15		
73562 Radiologic examination, knee; 3 views	Global	$37.84	5521	$62.30
	Professional (-26)*	$9.73		
	Technical (-TC)**	$28.11		
73564 Radiologic examination, knee; complete, 4 or more views	Global	$42.17	5522	$112.51
	Professional (-26)*	$11.53		
	Technical (-TC)**	$30.63		
73565 Radiologic examination, knee; both knees, standing, anteroposterior	Global	$37.84	5521	$62.30
	Professional (-26)*	$9.01		
	Technical (-TC)**	$28.83		

CPT[2] Description	Reimbursement Component	Physician Payment[3]	APC[4]	Hospital Outpatient Payment[4]
73580 Radiologic examination, knee, arthrography, radiological supervision and interpretation	Global	$129.38	5572	$385.88
	Professional (-26)*	$29.55		
	Technical (-TC)**	$99.83		
73590 Radiologic examination; tibia and fibula, 2 views	Global	$29.91	5521	$62.30
	Professional (-26)*	$8.29		
	Technical (-TC)**	$21.62		
73592 Radiologic examination; lower extremity, infant, minimum of 2 views	Global	$29.19	5521	$62.30
	Professional (-26)*	$8.29		
	Technical (-TC)**	$20.90		
73600 Radiologic examination, ankle; 2 views	Global	$31.35	5521	$62.30
	Professional (-26)*	$8.65		
	Technical (-TC)**	$22.70		
73610 Radiologic examination, ankle; complete, minimum of 3 views	Global	$33.88	5521	$62.30
	Professional (-26)*	$9.01		
	Technical (-TC)**	$24.87		
73615 Radiologic examination, ankle, arthrography, radiological supervision and interpretation	Global	$120.37	5572	$385.88
	Professional (-26)*	$29.91		
	Technical (-TC)**	$90.64		
73620 Radiologic examination, foot; 2 views	Global	$27.39	5521	$62.30
	Professional (-26)*	$7.93		
	Technical (-TC)**	$19.46		
73630 Radiologic examination, foot; complete, minimum of 3 views	Global	$31.71	5521	$62.30
	Professional (-26)*	$8.65		
	Technical (-TC)**	$23.07		
73650 Radiologic examination; calcaneus, minimum of 2 views	Global	$27.39	5521	$62.30
	Professional (-26)*	$8.29		
	Technical (-TC)**	$19.10		
73660 Radiologic examination; toe(s), minimum of 2 views	Global	$29.19	5521	$62.30
	Professional (-26)*	$6.85		
	Technical (-TC)**	$22.34		
Spine and Pelvis				
72020 Radiologic examination, spine, single view, specify level	Global	$23.43	5521	$62.30
	Professional (-26)*	$7.93		
	Technical (-TC)**	$15.50		
72040 Radiologic examination, spine, cervical; 2 or 3 views	Global	$37.12	5521	$62.30
	Professional (-26)*	$11.53		
	Technical (-TC)**	$25.59		
72050 Radiologic examination, spine, cervical; 4 or 5 views	Global	$51.18	5522	$112.51
	Professional (-26)*	$16.22		
	Technical (-TC)**	$34.96		

CPT[2] Description	Reimbursement Component	Physician Payment[3]	APC[4]	Hospital Outpatient Payment[4]
72052 Radiologic examination, spine, cervical; 6 or more views	Global	$60.91	5522	$112.51
	Professional (-26)*	$18.74		
	Technical (-TC)**	$42.17		
72070 Radiologic examination, spine; thoracic, 2 views	Global	$34.60	5522	$112.51
	Professional (-26)*	$11.53		
	Technical (-TC)**	$23.07		
72072 Radiologic examination, spine; thoracic, 3 views	Global	$36.76	5522	$112.51
	Professional (-26)*	$11.17		
	Technical (-TC)**	$25.59		
72074 Radiologic examination, spine; thoracic, minimum of 4 views	Global	$40.36	5522	$112.51
	Professional (-26)*	$11.17		
	Technical (-TC)**	$29.19		
72080 Radiologic examination, spine; thoracolumbar junction, minimum of 2 views	Global	$34.24	5521	$62.30
	Professional (-26)*	$11.53		
	Technical (-TC)**	$22.70		
72082 Radiologic examination, spine, entire thoracic and lumbar, including skull, cervical and sacral spine if performed (eg, scoliosis evaluation); 2 or 3 views	Global	$65.95	5522	$112.51
	Professional (-26)*	$16.58		
	Technical (-TC)**	$49.37		
72100 Radiologic examination, spine, lumbosacral; 2 or 3 views	Global	$37.12	5522	$112.51
	Professional (-26)*	$11.53		
	Technical (-TC)**	$25.59		
72110 Radiologic examination, spine, lumbosacral; minimum of 4 views	Global	$51.90	5522	$112.51
	Professional (-26)*	$16.22		
	Technical (-TC)**	$35.69		
72114 Radiologic examination, spine, lumbosacral; complete, including bending views, minimum of 6 views	Global	$59.10	5522	$112.51
	Professional (-26)*	$16.94		
	Technical (-TC)**	$42.17		
72120 Radiologic examination, spine, lumbosacral; bending views only, 2 or 3 views	Global	$43.61	5522	$112.51
	Professional (-26)*	$11.53		
	Technical (-TC)**	$32.07		
72200 Radiologic examination, sacroiliac joints; less than 3 views	Global	$31.35	5522	$112.51
	Professional (-26)*	$9.01		
	Technical (-TC)**	$22.34		
72202 Radiologic examination, sacroiliac joints; 3 or more views	Global	$35.32	5522	$112.51
	Professional (-26)*	$9.73		
	Technical (-TC)**	$25.59		

CPT[2] Description	Reimbursement Component	Physician Payment[3]	APC[4]	Hospital Outpatient Payment[4]
72220 Radiologic examination, sacrum and coccyx, minimum of 2 views	Global	$30.99	5521	$62.30
	Professional (-26)*	$9.01		
	Technical (-TC)**	$21.98		
72190 Radiologic examination, pelvis; complete, minimum of 3 views	Global	$40.36	5522	$112.51
	Professional (-26)*	$11.17		
	Technical (-TC)**	$29.19		
Upper Extremities				
73000 Radiologic examination; clavicle, complete	Global	$29.55	5521	$62.30
	Professional (-26)*	$8.65		
	Technical (-TC)**	$20.90		
73010 Radiologic examination; scapula, complete	Global	$32.44	5522	$112.51
	Professional (-26)*	$9.37		
	Technical (-TC)**	$23.07		
73020 Radiologic examination, shoulder; 1 view	Global	$24.15	5521	$62.30
	Professional (-26)*	$8.29		
	Technical (-TC)**	$15.86		
73030 Radiologic examination, shoulder; complete, minimum of 2 views	Global	$30.63	5521	$62.30
	Professional (-26)*	$9.73		
	Technical (-TC)**	$20.90		
73040 Radiologic examination, shoulder, arthrography, radiological supervision and interpretation	Global	$112.44	5572	$385.88
	Professional (-26)*	$28.11		
	Technical (-TC)**	$84.33		
73050 Radiologic examination; acromioclavicular joints, bilateral, with or without weighted distraction	Global	$37.84	5521	$62.30
	Professional (-26)*	$10.81		
	Technical (-TC)**	$27.03		
73060 Radiologic examination; humerus, minimum of 2 views	Global	$30.63	5521	$62.30
	Professional (-26)*	$8.65		
	Technical (-TC)**	$21.98		
73070 Radiologic examination, elbow; 2 views	Global	$27.39	5521	$62.30
	Professional (-26)*	$8.29		
	Technical (-TC)**	$19.10		
73080 Radiologic examination, elbow; complete, minimum of 3 views	Global	$30.27	5521	$62.30
	Professional (-26)*	$9.01		
	Technical (-TC)**	$21.26		
73085 Radiologic examination, elbow, arthrography, radiological supervision and interpretation	Global	$107.76	5572	$385.88
	Professional (-26)*	$29.55		
	Technical (-TC)**	$78.20		
73090 Radiologic examination; forearm, 2 views	Global	$28.47	5521	$62.30
	Professional (-26)*	$8.65		
	Technical (-TC)**	$19.82		

CPT[2] Description	Reimbursement Component	Physician Payment[3]	APC[4]	Hospital Outpatient Payment[4]
73092 Radiologic examination; upper extremity, infant, minimum of 2 views	Global	$29.19	5522	$112.51
	Professional (-26)*	$8.29		
	Technical (-TC)**	$20.90		
73100 Radiologic examination, wrist; 2 views	Global	$32.44	5521	$62.30
	Professional (-26)*	$8.65		
	Technical (-TC)**	$23.79		
73110 Radiologic examination, wrist; complete, minimum of 3 views	Global	$37.12	5521	$62.30
	Professional (-26)*	$9.01		
	Technical (-TC)**	$28.11		
73115 Radiologic examination, wrist, arthrography, radiological supervision and interpretation	Global	$120.01	5572	$385.88
	Professional (-26)*	$29.19		
	Technical (-TC)**	$90.82		
73120 Radiologic examination, hand; 2 views	Global	$29.55	5522	$112.51
	Professional (-26)*	$8.65		
	Technical (-TC)**	$20.90		
73130 Radiologic examination, hand; minimum of 3 views	Global	$33.88	5521	$62.30
	Professional (-26)*	$9.01		
	Technical (-TC)**	$24.87		
73140 Radiologic examination, finger(s), minimum of 2 views	Global	$34.24	5521	$62.30
	Professional (-26)*	$7.21		
	Technical (-TC)**	$27.03		
Urinary Tract				
74450 Urethrocystography, retrograde, radiological supervision and interpretation	Global	$0.00	5523	$230.56
	Professional (-26)*	$16.94		
	Technical (-TC)**	$0.00		
74455 Urethrocystography, voiding, radiological supervision and interpretation	Global	$91.90	5523	$230.56
	Professional (-26)*	$16.94		
	Technical (-TC)**	$74.96		
74470 Radiologic examination, renal cyst study, translumbar, contrast visualization, radiological supervision and interpretation	Global	$0.00	5524	$497.49
	Professional (-26)*	$27.03		
	Technical (-TC)**	$0.00		

* Professional - Physician payment

**Technical - Facility payment

†OPPS capped payment amount (Non-capped payment amount is visible but stricken) Section 5102(b) of the Deficit Reduction Act of 2005 requires a payment cap on the technical component (TC) of certain diagnostic imaging procedures and the TC portions of the global diagnostic imaging services. This cap is based on the Outpatient Prospective Payment System (OPPS) payment. To implement this provision, the physician fee schedule amount is compared to the OPPS payment amount and the lower amount is used in the formula to calculate payment.

2019 Medicare Reimbursement for Procedures Related to DTS X-Ray Services

CPT[5] Code / Description	Physician Office		Facility		
	Reimbursement Component	Medicare Physician Payment[6]	APC[7]	Medicare Hospital Outpatient Payment[7]	Medicare Ambulatory Surgery Center[8]
76100 Radiologic examination, single plane body section (eg, tomography), other than with urography	Professional (-26)***	$32.07	5522	$112.51	Bundled service when performed in an ASC – no separate payment.
	Technical (-TC)****	$64.15			
	Global	$96.22			
74400 Urography (pyelography), intravenous, with or without KUB, with or without tomography	Professional (-26)***	$25.23	5571	$201.74	Bundled service when performed in an ASC – no separate payment.
	Technical (-TC)****	$95.86			
	Global	$121.09			
76499 Unlisted diagnostic radiographic procedure	Professional (-26)***	Carrier Priced	5521	$62.30	Bundled service when performed in an ASC – no separate payment.
	Technical (-TC)****	Carrier Priced			
	Global	Carrier Priced			

*** Professional (-26) - The professional component is the interpretation of the results of the test. When the professional component is reported separately the service may be identified by adding modifier "26"

****Technical (-TC) - The technical component is the equipment and technician performing the test. This is identified by adding modifier "TC" to the procedure code identified for the technical component change.

Transportation Billing for Mobile X-Ray Supplies, and Set-up

Medicare allows a single transportation payment for each trip the mobile x-ray supplier makes to a location. The transportation HCPCS R0070 or R0075 must be billed in conjunction with the CPT radiology codes. No transportation charge is payable unless the mobile x-ray equipment used was actually transported to the location where the x-ray was taken. No transportation charge is payable unless the mobile x-ray equipment used was actually transported to the location where the x-ray was taken. For example, MACs do not allow a transportation charge when the x-ray equipment is stored in a nursing home for use as needed.[10]

MACs shall allow only a single transportation payment for each trip the mobile x-ray supplier makes to a particular location. When more than one patient is x-rayed at the same location, the single transportation payment under the Physician Fee Schedule is to be prorated among all patients (Medicare Parts A and B, and non-Medicare) receiving mobile x-ray services during that trip, regardless of their insurance status.[10]

Transportation HCPCS codes

HCPCS[9] Code	Description
R0070	Transportation of mobile x-ray equipment and personnel to home or nursing home, per trip to facility or location, one patient seen
R0075	Transportation of mobile x-ray equipment and personnel to home or nursing home, per trip to facility or location, more than one patient seen
Q0092	Set-up mobile x-ray equipment

Payment is carrier priced.

Transportation HCPCS code R0075 must be billed with the appropriate modifier. See below for modifiers and definitions for each modifier. Only one of these five modifiers should be reported. NOTE: If only one patient is served, R0070 should be reported with no modifier since the descriptor for this code reflects only one patient seen.[10]

- UN - Two patients served
- UP - Three patients served
- UQ - Four patients served
- UR - Five Patients served
- US - Six or more patients served

R0075 must be billed in conjunction with the radiology codes and only when the x-ray equipment used was actually transported to the location where the x-ray was taken.

R0075 would not apply to the x-ray equipment stored in the location where the x-ray was done (e.g., a nursing home) for use as needed.[10]

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References

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3. CMS-1693-F; Medicare Physician Fee Schedule Final Rule CY2019. Effective through December 31, 2019.
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6. Third party reimbursement amounts and coverage policies for specific procedures will vary by payer and by locality. The technical and professional components are paid under the Medicare physician fee schedule (MPFS). The MPFS payment is based on relative value units published in Federal Register, Vol. 83, No. 226 November 23, 2018. Amounts do not necessarily reflect any subsequent changes in payment since publication. To confirm reimbursement rates for specific codes, consult with your local Medicare contractor.
7. Third party reimbursement amounts and coverage policies for specific procedures will vary by payer and by locality. The technical component is a payment amount assigned to an Medicare Ambulatory Payment Classification under the hospital outpatient prospective payment system, as published in the Federal Register, Vol. 83, No. 226, November 21, 2018. Amounts do not necessarily reflect any subsequent changes in payment since publication. To confirm reimbursement rates for specific codes, consult with your local Medicare contractor.
8. Third party reimbursement amounts and coverage policies for specific procedures will vary by payer and by locality. If the procedure is not listed on the ASC covered procedure listing, no technical or professional payment is listed. The technical payment is a payment amount assigned to an APC based payment rate under the ambulatory surgical center prospective payment system as published in Federal Register, Vol. 83, No. 226, November 21, 2018. Amounts do not necessarily reflect any subsequent changes in payment since publication. To confirm reimbursement rates for specific codes, consult with your local Medicare contractor.
9. Healthcare Common Procedure Coding System (HCPCS) Level II Expert, 2019. Centers for Medicare and Medicaid Services (CMS). AAPC.
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