RADIOLOGY GUIDELINES

A. PROFESSIONAL/TECHNICAL COMPONENT FEE

1. A professional component fee (PC/26) and a technical component fee (TC/27) shall only be payable once for any radiological procedure. A physician will not be paid for a consultative interpretation.
2. When applicable, the payment for the professional (26/PC) and technical (27/TC) portions for codes 70000 - 79999 may be billed and reimbursed separately. Payment shall be made at 67% of the fee schedule allowance for the technical portion (TC/27) and at 33% of the fee schedule allowance for the professional portion (26/PC). Under no circumstance shall more than 100% of the fee schedule allowance be reimbursable in aggregate. Any radiology charges performed in a hospital setting covered under a cost to charge ratio are assumed to be the full procedure and a separate professional component billing would not be allowable unless clearly documented by the hospital and unless separation of professional billing was standard hospital practice at the time of the cost to charge reimbursement rate determination.

B. DUPLICATION OF X-RAYS

1. Every attempt should be made to minimize the number of x-rays taken. The attending doctor or other person or institution having possession of x-rays which pertain to the patient that are deemed to be needed for diagnostic or treatment purposes shall make these x-rays available upon request.

2. The insurer or employer shall reimburse a physician or facility a reasonable fee to be set by the Department of Labor for providing a copy of the x-ray. The current maximum rate to be billed is $17.72 per x-ray copy.

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