Information regarding publications incorporated by reference is found in the Introduction Section of the Fee Schedule.

The following Commission guidelines are in addition to CMS and CPT® guidelines and represent additional guidance from the Commission relative to unit values for these services. To the extent that a conflict may exist between an incorporated portion of the CPT® and a code, guideline, identifier, or modifier unique to Arizona, then the Arizona code, guideline, identifier or modifier shall control. Codes that are unique to Arizona are preceded by an AZ identifier and numbered in the following format: AZxxx.

A. GENERAL GUIDELINES

1. Values include usual contrast media, equipment, and materials. An additional charge may be warranted when special surgical trays and materials are provided by the healthcare provider.

2. Values include consultation and written reports to the referring healthcare provider.

3. X-ray findings and attending healthcare provider's written orders for x-rays must be included with the statement for x-ray services. Bills unsupported by findings will not be paid.

4. X-rays should be taken, reported, and be properly marked for identification and orientation in accordance with the accepted standard of radiologic practice in the State of Arizona.

B. MODIFIERS

Modifiers identify circumstances that alter or enhance the description of the service. For radiology codes, two modifiers affect the assigned unit value and are listed in *The Essential RBRVS.* However, other modifiers may be required for correct reporting of service. See CMS and the 2024 CPT® publication for additional information on modifiers. Listed radiology modifiers affect the unit values as follows:

1. Total: When no modifier is listed, the unit value represents the global value of the procedure. The five-digit code is used to represent a global service inclusive of the professional and technical value of providing that service. The following sections provide additional definitions for each component.

2. Professional: Modifier 26 is used to designate professional services. The professional component includes examination of the patient, when indicated, performance and/or supervision of the procedure, interpretation and written report of the examination, and consultation with referring healthcare providers.

3. Technical: Modifier TC is used to designate the technical value of providing the service. The technical component includes personnel, materials, space, equipment, and other allocated facility overhead normally included in providing the service.

C. REFERENCE TO RELATIVE VALUES

Two patterns of billing currently prevail in radiology. The first pattern occurs when a total charge for the radiology service, including both the professional component ("PC") and technical component ("TC"), is billed by appropriately licensed health care providers working in offices, clinics, and, independent diagnostic testing facilities. The second pattern occurs when services are performed in settings such as a hospital or ambulatory surgery center radiology department. The radiologist submits a separate statement to the payer for services that compose the professional component. The hospital or ambulatory surgery center charges for use of the department facilities and the services of its employees as the technical component.

The Radiology Relative Values scales have been devised for use in radiology and are not coordinated with scales for services in other branches of medicine such as surgery, medicine or pathology. The two scales are compatible only within themselves. Some procedures are noted as a "BR" value or "By Report". This usage is intended to indicate that circumstances involving a given patient procedure may require much more than the average amount of time and effort to perform and thus a value would be unique and could not be anticipated or established. When such added involvement is claimed, a written explanation will usually be required as an addendum to the bill.

The PC values do not include TC charges made by the hospital in which the procedure was accomplished. Such charges by the hospital or ambulatory surgery center cover the services of technologists and other helpers, the films, contrast media, radioactive agents, chemical and other materials, the use of the space and facilities of the x-ray department plus any other hospital or ambulatory surgery center costs. Most hospitals or ambulatory surgery centers have derived their own schedule of charges for these items. Establishment of hospital or ambulatory surgery center charges is not the subject of the Fee Schedule.

The separation of billing in no way implies a division of responsibility, but only a division of the charge. The radiologist is a physician performing a needed medical service for a patient, and ~~he~~ must retain full responsibility for his or her own activity and full responsibility for the potential supervision of technologists, the selection and maintenance of equipment, the control of radiation hazards, and the general administration of the radiology department.

D. REVIEW OF DIAGNOSTIC STUDIES

No separate charge is warranted for prior studies reviewed in conjunction with a visit, consultation, record review, or other evaluation by a healthcare provider; neither the professional component value modifier 26 nor the radiological consultation CPT® code 76140 is reimbursable. The review of diagnostic tests is included in the evaluation and management codes.