2025 Policy Memo 7

Radiology and Pathology/Laboratory Services

BlueCross BlueShield Kansas

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Please note: any timeframe listed in days, refers to calendar days unless otherwise specified.

I. Diagnostic Radiology Policy

A. WHEN BOTH PROFESSIONAL (PC) AND TECHNICAL (TC) COMPONENTS ARE INCLUDED IN THE CHARGE

The provider's usual fee is considered to include cost of materials and technical operating costs associated with securing the x-ray as well as the fee for interpreting and providing a professional opinion based upon an examination of films which constitute an x-ray study.

1. Definition of "Study"
   An x-ray is considered to be the examination of an area of the body as defined by codes and nomenclature. The number of individual x-ray films examined is not considered to affect the fee except as defined in codes and nomenclature.
2. Additional Studies
   Additional studies provided on different dates are considered to be eligible for additional usual fees. Coverage of services may vary in programs, but non-covered x-rays are the obligation of the patient. The only exception would be where a review consultant did not concur with the medical necessity for the x-ray study.
3. Multiple CT, CTA, MRI, MRA and PET Procedures
   a. When multiple CT, CTA, MRI, MRA or PET procedures are performed on the same day and billed as a total component, payment will be made at 100 percent of the primary procedure and 50 percent for each subsequent procedure(s).
   Providers may bill PC and TC components separately for CT, CTA, MRI, MRA or PET services performed on the same day. Payment will be made at 100 percent of the primary and 50 percent for each subsequent procedure(s) for TC services and 100 percent for all PC services. PC and TC services must be billed on separate lines with the appropriate modifier(s).
   b. NOTE: When radiology procedures are performed on a hospital inpatient, the technical component must be billed by the hospital. The physician may charge for the professional component only. When radiology procedures are performed on a hospital outpatient, the rendering provider may charge both professional and technical components only in such cases where the facility makes no charge to BCBSKS, related to the technical component. In those cases where the institution makes a charge, the provider may bill professional component only, and bill using modifier 26.
   c. If performed by different providers in an office setting, the services (PC/TC) may be billed separately as two lines of service as long as all providers are contracting with BCBSKS. If one provider is not contracting, you are required to bill both PC and TC.

B. WHEN THE PROFESSIONAL COMPONENT ONLY IS CHARGED

The provider's usual professional fee is expected to represent the charge for professional examination and opinion of x-ray films taken at the expense of a facility or institution when the patient is hospitalized as an inpatient/outpatient. The content of professional services within the fee for the study would be subject to the same definition and nomenclature qualifications as explained under “Definition of Study.” (above)

C. THE USUAL FEE FOR INTERPRETATION OF AN X-RAY DOES NOT INCLUDE

1. Fees for surgical injection or introduction procedures performed before or during the x-ray examination unless specifically defined by codes and nomenclature as included in the

overall service.
When interventional radiology procedures are involved, the professional component may also include injection of contrast media or other surgical intervention.

2. Fees for the administration of anesthesia (other than local infiltration) necessary for performance of special diagnostic x-ray procedures.
3. Fees for an office call which might include treatment of patient either immediately before or following the interpretation of a diagnostic x-ray.

D. DOCUMENTATION FOR INTERPRETATIONS OF DIAGNOSTIC IMAGING PROCEDURES
Interpretations of diagnostic imaging procedures reported separately for payment must include the following minimum information, either as a separate document or within the main body of the patient's record:

- Patient's name and other appropriate identifier (date of birth, Social Security number, record number, etc.)
- Referring/Ordering physician name
- Name or type of procedure performed
- Date and time procedure was performed
- Name of interpreting physician
- Date and time interpretation was performed
- Body of the report, including
  - Procedures and materials
  - Findings
  - Limitations
  - Complications
  - Clinical issues
  - Comparisons, when indicated and available
  - Clinical impression and diagnosis, including differential diagnosis when appropriate
- Legible signature. Refer to Policy Memo 1, XI, 4 for specific signature requirements.

Records containing only documentation of diagnostic impressions, such as "Chest x-ray normal," "Chest x-ray shows CHF," and even more cryptic notations such as "CXR reviewed," are insufficient to support payment and must not be billed as a separately reported diagnostic imaging or interpretation.

II. Therapeutic Radiology Policy

A. WHEN BOTH PROFESSIONAL AND TECHNICAL COMPONENTS ARE INCLUDED IN THE CHARGE
The provider's usual fee is considered to include the cost of materials and technical operation costs as well as the professional fee for the administration of x-ray and other high energy modalities to include the concomitant office visits and follow-up treatment for 90 days for malignant conditions or 45 days for non-malignant conditions.

B. WHEN THE PROFESSIONAL COMPONENT ONLY IS CHARGED
The provider's usual fee is considered to represent the charge for the administration of radiotherapy provided at the expense of a facility or institution, and follow-up care as outlined

under "When Both Professional and Technical Components Are Included in the Charge." (See II. A. above.)

C. USUAL FEE FOR THERAPEUTIC RADIOLOGY DOES NOT INCLUDE
   1. Consultations on need for radiotherapy.
   2. Treatment planning.
   3. Concomitant surgical, diagnostic radiological or laboratory services.

III. Pathology

A. PATHOLOGY

All anatomic laboratory and cytopathology examinations including gynecological specimens (i.e., Pap tests) must be billed by the entity that performs the entire exam, or a portion of the exam, with the following exception:

> When pathology procedures are performed on a hospital outpatient, the provider may charge both professional and technical components only in such cases where the facility makes no charge to BCBSKS related to the technical component. In those cases where the institution makes a charge to BCBSKS for the technical component, the provider should bill the professional component only, using modifier 26.

B. CLINICAL LABORATORY PANEL CODING

When automatable tests are performed on the same day, they may be billed using the appropriate panel or individually. BCBSKS will lump some automatable procedures specified in CPT panels and reimbursement will be limited to the appropriate panel MAP. When an all-inclusive code exists for commonly available clinical tests, the all-inclusive code must be used. Clinical lab can be billed by providers in those circumstances where they are sending the specimen outside their office for analysis.

NOTE: See Obstetrical Services, Policy Memo No. 8, regarding OB laboratory services.

C. THE ANATOMIC OR CLINICAL LABORATORY PROVIDER'S USUAL GLOBAL FEE IS GENERALLY CONSIDERED TO INCLUDE THE FOLLOWING

Cost of equipment and supplies used in performing a test or examination, as well as the performance of the test and the professional evaluation and report. A contracting BCBSKS provider may bill for a venipuncture when the specimen(s) is drawn.

The usual fee is not considered to include an office call on the same date of the pathology or clinical laboratory service.

D. HANDLING FEE

To compensate for the cost of materials and services provided when specimens are sent to an outside laboratory, the provider may charge one handling fee per patient per date of service in those cases where he/she does not charge for the test itself. The handling fee must be billed with modifier 22. If the provider bills for the laboratory test, the handling fee is considered content of service of the laboratory charge.

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