



Policy Information

Policy Title	Radiology Services	Current Version Publish Date	12/2025
Policy Manual	Reimbursement	Original Effective Date	12/2025
Policy Number	16	Next Review Date	Annual

Policy Applicability (LOB)

<input checked="" type="checkbox"/> Medicare Inc	<input checked="" type="checkbox"/> Commercial IA	<input checked="" type="checkbox"/> Commercial IL	<input checked="" type="checkbox"/> Health Choices
<input checked="" type="checkbox"/> Medicare WI	<input checked="" type="checkbox"/> Commercial WI	<input checked="" type="checkbox"/> CPPHP (Kansas)	

Policy Statement and Purpose

This policy addresses the criteria for reimbursement of radiology services in facility and non-facility settings. The stipulations are based on CMS coding and reimbursement guidelines. Where CMS is silent, industry standards have been applied. Adhering to these guidelines does not guarantee payment, only eligibility for reimbursement. Actual payment for services will be guided our policies, the medical record and the coverage criteria in the patient’s contracted medical plan for whom the services are rendered.

This policy is expressly incorporated into and made a part of all reimbursement agreements and will provide context and clarity to the extent there is ambiguity in payment terms and notwithstanding contrary claims with regard to industry standards or practices.

Policy Definitions

Chest X-Ray: An imaging test that uses x-rays to view structures and organs in the chest. It can be used for diagnostic purposes or to determine the status of a condition in the chest.

CPT: Current Procedural Terminology. A medical code set maintained by the American Medical Association (AMA) that is used to report medical, surgical, and diagnostic procedures and services to entities such as physicians, health insurance companies and accreditation organizations. CPT is included in Level I Healthcare Common Procedure Coding System (HCPCS).

CT Scan: A medical imaging procedure that uses X-rays and computer technology to create detailed cross-sectional images of the body. This imaging process is also known as computed tomography or CAT scan.

Fluoroscopy: A type of medical imaging that shows a continuous x-ray image on a monitor. The image is transmitted so that the movement of a body part or of an instrument or contrast agent through the body can be seen in detail.

Global Period: The period of time before a surgical procedure and after the procedure has been performed. The global period varies and is based on the nature of the procedure.

Interventional Radiology (IR): A specialized field within radiology that utilizes advanced imaging techniques to precisely target therapy or guide the surgeon when performing minimally invasive surgery.

Modifier: Two characters (letters or numbers) appended to a CPT or HCPCS Level II code. The modifier provides additional information about the medical procedure, service, or supply involved without changing the meaning of the code.

MRI: A non-invasive medical imaging technique that uses a powerful magnetic field, radio waves, and a computer to generate detailed images of the internal structures of the body.

Point of Care Test (POCT): Testing that is performed at the bedside or near the site of patient care rather than in a centralized laboratory. Results are usually instantaneous.

Professional Component: Interpretation of the images by a radiologist.

Radiologic supervision and interpretation (S&I): The physician's personal supervision of the performance of the radiologic portion of a procedure and the subsequent interpretation of the findings.

Technical Component: The costs and services associated with the performance of a procedure which includes the use of the facility, supplies, specialized equipment and staff that operate the equipment.

Ultrasound: A diagnostic tool that uses high frequency sound waves to create images of the inside of the body. Ultrasound is also known as sonography.

Policy Provisions and Required Procedures

How should radiology services be billed?

All radiology charges must be reported with the appropriate HCPCS code, date of service, units and modifiers as applicable regardless of setting. Institutional and facility providers must also bill the appropriate revenue code.

Is the technical component (TC) and professional component (PC) of a radiology service eligible for reimbursement?

The eligibility for reimbursement for the technical and professional components of radiology services depends on the setting.

- **Physicians' Offices and Outpatient Settings:** Both the TC and PC are eligible for reimbursement when billed on the CMS-1500 with any applicable modifiers are appended to the charge.
- **Inpatient Facility Setting:** Neither the TC nor PC are eligible for reimbursement. These services are considered a component of the radiology service and not separately payable.

Are radiologic supervision and interpretation (S&I) services eligible for reimbursement?

Radiologic supervision and interpretation services are subject to specific rules that govern their billing and payment including the setting and the procedure and whether or not the physician was present during the imaging. Check the code requirements to determine if supervision and interpretation are a component of the imaging procedure.

Is guidance radiology for interventional invasive diagnostic imaging eligible for reimbursement?

The radiologic guidance or interventional radiology codes include all imaging by the defined modality required to perform the procedure. Localization or guidance is integral to the interventional radiology procedure and is not separately reportable.

What procedures are included in interventional radiology?

Interventional radiology includes 3D renderings to map biopsy sites as well as placement of needles, catheters, wires or small instruments through blood vessels or other pathways for the purpose of aspiration, injection, biopsy, device placement, treating or diagnosing. Interventional radiology can be performed using CT, fluoroscopy, MRI or ultrasound.

Are radiology procedures to confirm the position of tube, catheters, etc. eligible for separate reimbursement?

Procedures that usually require a radiologic examination to confirm the position of a catheter or tube are a component of the procedure and not separately payable. Examples include chest x-rays to confirm proper position of chest tubes, endotracheal tube, central venous catheters, or to determine the presence of pneumothorax when a chest tube has been

inserted. Other examples include ECG monitoring for diagnostic and therapeutic cardiovascular procedures, fluoroscopy for all endoscopic procedures.

Are ultrasound procedures eligible for separate reimbursement?

Ultrasound procedures, such as post-void residuals, when performed by a nurse in an inpatient facility setting is a Point of Care Test (POCT) and not separately reimbursable. These tests are considered a component of room and board and are within the scope of normal nursing practice.

If the ultrasound is performed in a physician’s office or outpatient clinic and a print-out from the scanner is documented in the medical record, such tests may be eligible for separate reimbursement.

What radiology supplies are eligible for reimbursement?

All radiology supplies regardless of the setting that they are used in imaging procedures are a component of the radiology procedure or the surgical procedure and not separately reimbursable. This includes, but is not limited to, catheters, tubing, needles, guide wires, sheaths, introducers, drugs, contrast materials. See **Reimbursement Policy: Items, Services, and Therapies that are Not Payable** for additional information.

Are radiology procedures performed during the global period eligible for separate reimbursement?

CMS stipulates that routine and necessary services including radiology services related to the surgery are included in the fee for the surgical procedure and are not eligible for separate reimbursement during the preoperative, intraoperative, and postoperative period if they are part of the global surgical package. The Global Period is dependent on the complexity of the surgical procedure and this is determined by the CPT code. The CPT code is assigned a *Surgical Indicator Code (SIC)* which will determine the Global Period.

CMS publishes a schedule of *Surgical Indicators* for CPT codes. These are listed in CMS **National Physician Fee Schedule Relative Value (NPF SRV) Files** and updated quarterly. [PFS Relative Value Files | CMS](#)

Radiology procedures performed during the global period for a surgical procedure with a SIC of 010 or 090 are **generally not separately payable**. See **Reimbursement Policy: Surgical Services** for additional information.

Related Policies	Reimbursement Policy: Items, Services, and Therapies that are Not Payable Reimbursement Policy: Surgical Services		
Related Training/ Job Aids			
NCQA Standard			
References	Medicare Claims Processing Manual Chapter 13 Medicare NCCI 2022 Coding Policy Manual PFS Relative Value Files CMS		
Exhibits			

Policy Owners / Reviewers			
Department Owner	Lisa Kuhls	Date Reviewed	11/2025
Department Reviewer	Network Strategy Committee	Date Reviewed	12/2025

Approving Committee if applicable	<input type="checkbox"/> Compliance <input checked="" type="checkbox"/> UMC <input type="checkbox"/> QIC <input checked="" type="checkbox"/> Board of Directors <input type="checkbox"/> Other: _____	Date Approved	2/2026 3/2026
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History

Date of revision	<i>Summary of changes</i> <u>Prior Reviews:</u> Revised: Reviewed:
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