Blue Cross Blue Shield of Massachusetts (Blue Cross®) reimburses contracted health care providers for covered, medically necessary radiology services.

**General benefit information**

Covered services and payment are based on the member’s benefit plan and provider Agreement. Providers and their office staff may use our online tools to verify effective dates and member copayments before providing services. Visit our eTools page for information on member eligibility and benefits. Member liability may include, but is not limited to: copayments, deductibles, and co-insurance. Members’ costs depend on member benefits.

Certain services require prior authorization or referral.

**Payment information**

Blue Cross reimburses health care providers based on your contracted rates and member benefits.

Claims are subject to payment edits, which Blue Cross updates regularly.

**Blue Cross reimburses:**

- The following diagnostic imaging modalities:
  - Angiography
  - Bone densitometry
  - Computed tomography (CT) scan
  - Fluoroscopy
  - Mammography
  - Magnetic resonance imaging (MRI) (including magnetic resonance angiography)
  - Nuclear medicine
  - Other interventional modalities
  - Ultrasound
  - Breast tomosynthesis

- Two or more applicable payable services reported by the same provider at the same session, with a 50% fee reduction to the lesser resource intensive service. Please refer to the Radiology - Multiple Imaging Services Payment Policy for more information and applicable code set.

All professional providers, non-hospital-based free-standing facilities, and technical providers must have privileges to receive reimbursement for the above-listed modalities.

**Blue Cross does not reimburse:**

- Transportation and set up costs associated with performing portable diagnostic imaging services such as mobile x-rays for members enrolled in commercial products. The set up and transportation costs are covered for members enrolled in the Federal Employee Program (FEP) and Medicare Advantage and supplemental products.
- X-ray consultation services when reported with an evaluation and management (E/M) service.
- Procedures in the following list of diagnostic test screening categories when they are performed as screening tests for managed care members and/or billed with non-medical diagnoses (for example, a routine diagnosis)
  - CT bone mineral density studies
  - Cardiac applications of positron emission tomography (PET) scanning
  - Echocardiography
  - Electron beam CT scan
  - Miscellaneous applications of PET
  - Ultrasound
- Radiology services provided by an outpatient imaging facility during an inpatient admission. Such services are included in the admitting hospital’s inpatient reimbursement and should be billed to the admitting hospital.
- C-codes when an equivalent CPT code exists. If an equivalent does not exist, a claim submitted with a C-code may be reimbursable.
Billing information

Specific billing guidelines
- Facilities should bill mammograms on a separate UB-04 form if other services require a different diagnosis.
- When reporting both the technical and professional service components, bill each component separately with the correct modifiers.
- The list of codes below is included for informational purposes only. This may not be a complete list of all the codes related to this service. Whether or not a code is listed here does not guarantee coverage or reimbursement.

<table>
<thead>
<tr>
<th>Code</th>
<th>Service description</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Modifier 26</td>
<td>Professional component</td>
<td>• Use to bill for the professional only component of a radiology service</td>
</tr>
<tr>
<td>Modifier CT</td>
<td>Computed tomography services furnished using equipment that does not meet each of the attributes of the National Electrical Manufacturers Association (NEMA) xr-29-2013 standard</td>
<td>• 15% payment reduction applies</td>
</tr>
<tr>
<td>Modifier TC</td>
<td>Technical component</td>
<td>• Use to bill the technical component of a radiology procedure</td>
</tr>
<tr>
<td>Revenue code 0255</td>
<td>Drugs incident to radiology</td>
<td>• Use when billing for drugs related to the radiology service</td>
</tr>
<tr>
<td>Revenue code 0401</td>
<td>Diagnostic mammography</td>
<td>• Use when billing for a medically necessary mammogram</td>
</tr>
<tr>
<td>Revenue code 0403</td>
<td>Screening mammography</td>
<td>• Bill with the appropriate Z diagnosis code for a routine mammogram</td>
</tr>
<tr>
<td>Revenue code 0621</td>
<td>Supplies incident to radiology</td>
<td>• Use when billing for supplies related to the radiology service</td>
</tr>
<tr>
<td>71045-71048</td>
<td>Radiologic examination, chest</td>
<td>• Report the code representing the specific number of views taken</td>
</tr>
<tr>
<td>74018, 74019 74021</td>
<td>Radiologic examination, abdomen</td>
<td>• Report the code representing the specific number of views taken</td>
</tr>
<tr>
<td>77065</td>
<td>Diagnostic mammography, including computer-aided detection (CAD) when performed; unilateral</td>
<td></td>
</tr>
<tr>
<td>77066</td>
<td>Diagnostic mammography, including computer-aided detection (CAD) when performed; bilateral</td>
<td></td>
</tr>
<tr>
<td>77067</td>
<td>Screening mammography, bilateral (two-view study of each breast), including computer-aided detection (CAD) when performed</td>
<td>• Bill with a count of one</td>
</tr>
<tr>
<td>77061</td>
<td>Digital breast tomosynthesis; unilateral</td>
<td></td>
</tr>
<tr>
<td>77062</td>
<td>Digital breast tomosynthesis; bilateral</td>
<td></td>
</tr>
<tr>
<td>77063</td>
<td>Screening digital breast tomosynthesis, bilateral</td>
<td></td>
</tr>
<tr>
<td>G0279</td>
<td>Diagnostic digital breast tomosynthesis, unilateral or bilateral (list separately in addition to 77065 or 77066)</td>
<td></td>
</tr>
<tr>
<td>Q0092</td>
<td>Set-up portable x-ray equipment</td>
<td>• Not reimbursed</td>
</tr>
</tbody>
</table>

When submitting claims, report all services with:
- Up-to-date industry-standard procedure and diagnosis codes, and
- Modifiers that affect payment in the first modifier field, followed by informational modifiers
Related policies

General Coding and Billing
Observation Services
Outpatient Surgical Services
Non-Reimbursable Services
Radiology - Multiple Imaging Services

Policy update history

05/20/2015  Documentation of existing policy.
07/15/2015  Template update; annual review; inclusion of information on mobile x-ray services.
10/23/2015  Inclusion of information on diagnostic imaging modalities; inclusion of information on billing the professional component and technical component of a radiologic service; inclusion of information on 3D imaging reimbursement.
01/01/2016  Removal of information on billing guidelines for transrectal echography for payment policy clarification.
03/31/2016  Annual review; template update; inclusion of existing documentation on radiology services, non-reimbursed services, and general billing guidelines; removal of information on E/M services reported with radiology services reported with modifier 26.
09/30/2016  Update to reimbursement guidelines for CPT code 76376.
01/01/2017  Annual review; template update; inclusion of updated CPT coding information; addition of information on breast tomosynthesis effective 1/1/17; addition of information on modifier CT reduction effective 1/1/17.
01/01/2018  Annual review; coding update; addition of new chest and abdomen x-ray codes; removal of deleted codes G0202, G0204, G0206.
3/31/2018   Edits for clarity, removed medical policy information, addition of information regarding equivalent C codes.
12/31/2018  Annual coding update; correction code definition G0279 in coding grid.
03/31/2019  Annual review; template update; revisions to list of diagnostic test screening categories.

This document is designed for informational purposes only and is not an authorization, an explanation of benefits, or a contract. Receipt of benefits is subject to satisfaction of all terms and conditions of the coverage. Medical technology is constantly changing, and we reserve the right to review and update our policies periodically.

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Payment policies are intended to help providers obtain Blue Cross Blue Shield of Massachusetts’ payment information. Payment Policy determines the rationale by which a submitted claim for service is processed and paid. Payment Policy development takes into consideration a variety of factors, including: the terms of the participating provider’s contract(s); scope of benefits included in a given member’s benefit plan; clinical rationale, industry-standard procedure code edits, and industry-standard coding conventions.