DIAGNOSTIC RADIOLOGY

PREAMBLE

SPECIFIC ELEMENTS

Diagnostic Radiology procedures are divided into a *professional component* listed in the column headed with a "P", and a *technical component* listed in the column headed with an "H". The *technical component* of the procedures subject to the conditions stated under "Diagnostic Services Rendered at a Hospital" on page GP8, is *eligible for payment* only if the service is:

a. rendered at a hospital; or

b. rendered at an off-site premise operated by a hospital corporation that has received approval under section 4 of the *Public Hospital Act*.

[Commentary:
As described in Regulation 552 of the *Health Insurance Act*, for a service to be insured, the interpreting physician must physically be present in Ontario when the interpretation service is rendered.]

In addition to the *common elements*, the components of Diagnostic Radiology procedures include the following *specific elements*.

For Professional Component P

A. Providing clinical supervision, including approving, modifying and/or intervening in the performance of the procedure where appropriate, and quality control of all elements of the *technical component* of the procedure.

B. Performance of any clinical procedure associated with the diagnostic procedure which is not separately billable (e.g. injections which are an integral part of the study) and of any fluoroscopy.

C. Where appropriate, post-procedure monitoring, including intervening except where this constitutes a separately billable service.

D. Interpreting the results of the diagnostic procedure.

E. Providing premises for any aspect(s) of A and D that is (are) performed at a place other than the place in which the procedure is performed.

If the physician claiming the fee for the service is personally unable to perform elements A, B and C, these may be delegated to another physician who must personally perform the service. Element D must be personally performed by the physician who claims for the service.

For Technical Component H

A. Preparing the patient for the procedure.

B. Performing the diagnostic procedure or assisting in the performance of fluoroscopy.

C. Making arrangements for any appropriate follow-up care.

D. Providing records of the results of the procedure to the interpreting physician.

E. Discussion with, and providing information and advice to, the patient or patient's representative, whether by telephone or otherwise, on matters related to the service.

F. Preparing and transmitting a written, signed and dated interpretive report of the procedure to the referring physician.

G. Providing premises, equipment, supplies and personnel for all *specific elements* of the technical and professional components except for the premises for any aspect(s) of A and D of the *professional component* that is (are) not performed at the place in which the procedure is performed.

DIAGNOSTIC RADIOLOGY

PREAMBLE

OTHER TERMS AND DEFINITIONS

1. Professional and *technical component*s are claimed separately. Claims for *technical component* H are submitted using the listed fee code with suffix B. Claims for *professional component* P are submitted using the listed fee code with suffix C.
2. For services rendered outside a hospital setting the only fees billable under the *Health Insurance Act* are listed under the column P (use suffix C). Fees for the *technical component* of these services are only claimed under the *Independent Health Facilities Act*. Fees for the *technical component* of services rendered in an Independent Health Facility are listed in the *Schedule* of Facility Fees.
3. Benefits for clinical procedures related to x-ray examinations are listed in the following section, or under Diagnostic and Therapeutic or Surgical Procedures. 'Clinical Procedures', in this context, are those by which contrast media are introduced, except oral or rectal administration for study of the alimentary tract, and intravenous injections, which are an integral part of the study, performed by the physician collecting the benefit for the procedure.
4. If less than the minimum number of views are performed, reduce listed fees by 25%.
5. If insured diagnostic radiology procedures yield abnormal findings or if they would yield information which in the opinion of the radiologist would be insufficient governed by the needs of the patient and the requirements of the referring physician or practitioner, the radiologist may add further views and claim for them (if listed).
6. All benefits listed apply to unilateral examinations unless otherwise specified. When a radiologist is asked to x-ray one extremity only, no additional claim should be made for comparison x-rays initiated by the radiologist.
7. A stereo pair is to be counted as two views.
8. No additional claim is warranted for the use of the image intensifier in diagnostic radiology.
9. Complex head CT scans are meant to be multiplanar (multidirectional) head CT scans - to include one or more of the following areas: pituitary fossa, posterior fossa, internal auditory meati, orbits and related structures, the temporal bone and its contents and the temporomandibular joints. X400, X401 and X188 are not to be billed in addition to those fees for complex head studies.
10. Nasal bones or accessory nasal sinuses should not be routinely claimed in skull examination requests.
11. Mandible X006 and Temporomandibular joints X007 are not both to be routinely claimed on the same patient but only when specifically ordered.
12. Conventional films of the spine should not be routinely done and claimed for before myelography. The necessity of having plain film studies of the spine prior to interpreting the myelographic studies is obvious. It is not essential, however, that these be done at the institution where the myelogram was done. If they have been done at an outside office, then it is a matter for the radiologist and the referring physician to have the films available. If they cannot be made available to the radiologist, it is an acceptable practice for him to do the required procedure of these areas and to claim for them so that they may be available for interpretation along with the myelographic study.
13. Lumbar or lumbosacral spine X028 does not include the entire sacrum. An x-ray of the sacrum may be carried out and claimed for only when specifically indicated.
14. Three or more views of the chest should not be done routinely and claimed when a chest examination is requested.
15. Chest studies should not be routinely done and claimed in mammography cases.
16. Fluoroscopy claims should not be submitted for any examination performed by the radiologist where fluoroscopy is generally regarded as an integral part of the examinations e.g. examinations of the GI tract, urinary tract, and special procedures.
17. 'Colon - air contrast' may be claimed when performed according to generally accepted criteria. The colon should be scrupulously prepared. Five to eight full size views of the abdomen should be obtained after fluoroscopically controlled introduction of air and barium.
18. 'Oesophagus, stomach and duodenum - double contrast' presupposes the introduction of gas, the use of antifoam agent and a suitable barium mixture.
19. 'Pharynx and oesophagus - cine or videotape' (X106) should not be claimed routinely with X108 and X109 but only when specifically indicated.
20. Abdomen and chest studies should not be routinely done and claimed in gastrointestinal examinations.
21. Abdomen and/or pelvis should not be routinely claimed in lumbar spine examination requests.
22. A survey film of the abdomen is a single view. The ordering of additional films should be left to the discretion of the radiologist who should have the power to determine what examination is adequate for a specific patient. Obviously, if progress of a long tube is being followed, a survey film is sufficient. If, however, an intestinal obstruction is being followed, a single film is usually inadequate.

PREAMBLE

23. No extra fee should be claimed for rapid sequence IVP.

24. Nephrotomography is covered by the listings for intravenous pyelogram and planigram.

25. Preoperative and Routine Chest X-rays

a. The technical and professional fee components for chest x-ray, X090, X091 and X092 are not eligible for payment in the routine preoperative preparation or screening of a patient for non-cardiac, non-thoracic surgery, unless there is a clinical indication requiring a chest x-ray other than solely for preoperative preparation or screening of the patient.

[Commentary:
Examples of indications could include but are not limited to:

1. suspected active airway or airspace disease
2. workup of shortness of breath
3. metastatic workup]

b. The technical and professional fee components for chest x-ray, X090, X091 and X092 are only eligible for payment when rendered for a patient who has symptoms, signs or an indication supported by current clinical practice guidelines relevant to the individual patient's circumstances.

Routine chest x-rays for screening or for admission to hospital without clinical indication are not payable.]

26. Mammography or x-ray of the chest, ribs, arm, wrist, hand, leg, ankle or foot, rendered in an Independent Health Facility or a hospital in-patient or out-patient department is insured when referred by a registered nurse holding an extended certificate of registration (RN(EC)).

27. Plain x-rays of the head, neck, pelvis, tibia or chest, computed tomography of the head, examinations of fistulas or sinuses or sialograms ordered by an oral and maxillofacial surgeon and rendered in a hospital out-patient department are insured when the plain x-rays of the head, neck, pelvis, tibia or chest, computed tomography of the head, examinations of fistulas or sinuses or sialograms are rendered:

a. in connection with a dental surgical procedure provided by an oral and maxillofacial surgeon in a hospital and it is medically necessary for the patient to receive the dental surgical procedure in a hospital; or

b. on the order of an oral and maxillofacial surgeon who has reasonable grounds to believe that a dental surgical procedure, performed by an oral and maxillofacial surgeon, will be required in connection with the plain x-rays of the head, neck, pelvis, tibia and chest, computed tomography of the head, examinations of fistulas or sinuses or sialograms and that it will be medically necessary for the patient to receive the dental surgical procedure in a hospital.

28. X-ray or CT studies of the lumbar spine should not be routinely ordered or rendered for low back pain without suspected or known pathology.

[Commentary:
Examples of suspected or known pathology include infection, tumour, osteoporosis, ankylosing spondylitis, fracture, inflammatory process, radicular syndrome, and cauda equina syndrome.]

DIAGNOSTIC RADIOLOGY

HEAD AND NECK

		H	P
	Skull		
X001	- four views	29.90	13.25
X009	- five or more views	37.25	16.40
X003	Sella turcica (when skull not examined)	14.90	6.40
	Facial bones		
X004	- three views	21.70	10.30
	Nose		
X005	- two views	14.90	6.40
	Mandible		
X006	- three views (unilateral or bilateral)	21.70	10.35
X012	- four or more views	29.90	13.25
X007	Temporomandibular joints - four views including open and closed mouth views	21.70	10.35
	Sinuses		
X008	- three views	21.70	10.35
	Mastoids		
	- bilateral		
X010	- six views	28.65	14.25
X011	- Internal auditory meati (when skull not examined)	21.70	10.35
	Note: Dental x-rays of the teeth are not an insured benefit.		
X016	Eye, for foreign body	14.85	9.05
X017	Eye, for localization, additional	15.30	20.40
X018	Optic foramina	16.85	9.05
X019	Salivary gland region	13.75	7.95
	Neck for soft tissues		
X020	- two views	13.75	7.95

DIAGNOSTIC RADIOLOGY

SPINE AND PELVIS

		H	P
	Cervical spine		
X025	- two or three views	25.90	7.95
X202	- four or five views	33.40	10.75
X203	- six or more views	40.35	13.25
	Thoracic spine		
X027	- two views	23.65	7.95
X204	- three or more	29.90	10.65
	Lumbar or lumbosacral spine		
X028	- two or three views	25.90	7.95
X205	- four or five views	33.40	10.75
X206	- six or more views	40.35	13.35
	Entire spine (scoliosis series)		
X032	- four views	53.55	20.75
	Orthoroentgenogram (3 foot film)		
X033	- single view	21.70	10.15
X031	- two or more views	29.70	13.35
	Sacrum and/or coccyx		
X034	- two views	23.95	6.40
X207	- three or more views	31.05	10.65
	Sacro-iliac joints		
X035	- two or three views	21.70	10.35
X208	- four or more views	28.95	13.05
	Pelvis and/or hip(s)		
X036	- one view	14.90	6.40
X037	- two views (e.g. AP and frog view, both hips, or AP both hips plus lateral one hip)	27.75	9.20
X038	- three or more views (e.g. pelvis and sacro-iliac joints, or AP both hips plus lateral each hip)	31.90	10.35

DIAGNOSTIC RADIOLOGY

UPPER EXTREMITIES

		H	P
	Clavicle		
X045	- two views	14.90	6.40
X209	- three or more views	22.90	8.90
	Acromioclavicular joints (bilateral) with or without weighted distraction		
X046	- two views	21.70	10.35
X210	- three or more views	29.60	13.05
	Sternoclavicular joints (bilateral)		
X047	- two or three views	17.95	7.95
X211	- four or more views	25.60	10.90
	Shoulder		
X048	- two views	17.95	7.95
X212	- three or more views	25.60	10.65
	Scapula		
X049	- two views	17.95	7.95
X213	- three or more views	25.80	10.65
	Humerus including one joint		
X050	- two views	14.90	6.40
X214	- three or more views	22.75	9.30
	Elbow		
X051	- two views	14.90	6.40
X215	- three or four views	22.90	9.05
X216	- five or more views	30.85	11.65
	Forearm including one joint		
X052	- two views	14.90	6.40
X217	- three or more views	22.90	9.05
	Wrist		
X053	- two or three views	14.90	6.40
X218	- four or more views	22.90	9.05
	Hand		
X054	- two or three views	14.90	6.40
X219	- four or more views	22.90	9.05
	Wrist and hand		
X055	- two or three views	21.70	13.05
X220	- four or more views	27.65	15.70
	Finger or thumb		
X056	- two views	11.50	4.70
X221	- three or more views	14.90	6.40

DIAGNOSTIC RADIOLOGY

LOWER EXTREMITIES

		H	P
	Hip (unilateral)		
X060	- two or more views	23.75	7.65
	Femur including one joint		
X063	- two views	14.90	6.40
X223	- three or more views	22.20	9.05
	Knee including patella		
X065	- two views	14.90	6.40
X224	- three or four views	22.90	9.05
X225	- five or more views	30.85	11.65
	Tibia and fibula including one joint		
X066	- two views	14.90	6.40
X226	- three or more views	22.90	9.05
	Ankle		
X067	- two or three views	14.90	6.40
X227	- four or more views	22.90	9.05
	Calcaneus		
X068	- two views	14.90	6.40
X228	- three or more views	22.90	9.05
	Foot		
X069	- two or three views	14.90	6.40
X229	- four or more views	22.90	9.05
	Toe		
X072	- two views	11.50	4.70
X230	- three or more views	14.90	9.05
X064	Leg length studies (orthoroentgenogram)	21.70	10.35

DIAGNOSTIC RADIOLOGY

SKELETAL SURVEYS

		H	P
	Skeletal survey for bone age		
X057	- single film	14.90	6.40
X058	- two or more films or views	21.70	10.65
	Other survey studies - e.g. rheumatoid, metabolic or metastatic		
X080	- single view	7.45	3.30
X081	- each additional film or view	7.45	3.30

DIAGNOSTIC RADIOLOGY

CHEST AND ABDOMEN

		H	P
	Chest		
X090	- single view	14.90	6.40
X091	- two views	21.90	10.75
X092	- three or more views	28.15	12.45
	Note: Miniature chest film for survey purposes only is not an insured benefit.		
	Ribs		
X039	- two or more views	17.95	7.85
	Sternum		
X040	- two or more views	17.95	7.85
	Thoracic inlet		
X096	- two or more views	14.90	6.40
	Abdomen		
X100	- single view	14.90	6.40
X101	- two or more views	22.80	9.20

DIAGNOSTIC RADIOLOGY

GASTROINTESTINAL TRACT

		H	P
	Palatopharyngeal analysis		
X105	- cine or videotape	29.50	36.90
	Pharynx and oesophagus		
X106	- cine or videotape	29.50	36.90
X107	Oesophagus when X103, X104, X108 or X109 not claimed	26.70	21.40
	Oesophagus, stomach and duodenum		
X108	- including survey film, if taken	46.30	38.15
X104	- double contrast, including survey film, if taken	48.50	46.40
X103	- double contrast, including survey film, if taken, and small bowel	60.95	58.40
X110	Hypotonic duodenogram	39.35	32.95
X109	Oesophagus, stomach and small bowel	59.10	49.80
	Small bowel only		
X111	- when only examination performed during patient's visit	26.40	21.80
	Colon		
X112	- barium enema including survey film, if taken	48.40	29.40
X113	- air contrast, primary or secondary, including survey films, if taken	61.30	49.80
	Gallbladder		
X114	- one or multiple *day* examinations	29.95	11.60
X120	- one or multiple *day* examinations with preliminary plain film	39.80	11.60
X116	T-tube cholangiogram	21.70	9.90
X117	Operative cholangiogram	21.70	11.10
X123	Operative pancreatogram or ERCP	21.70	9.00

DIAGNOSTIC RADIOLOGY

GENITOURINARY TRACT

		H	P
X129	Retrograde pyelogram, unilateral or bilateral	21.70	9.00
X130	Intravenous pyelogram including preliminary film	49.65	22.75
X137	Cystogram (catheter)	23.85	8.40
X135	Cystourethrogram, stress or voiding (catheter)	27.50	13.80
X131	Cystourethrogram (non-catheter)	5.75	4.75
X191	Intestinal conduit examination or nephrostogram	21.70	9.00
X138	Percutaneous antegrade pyelogram	21.70	9.00
X139	Percutaneous nephrostogram	21.70	11.10
X134	Retrograde urethrogram	17.95	6.80
X136	Vasogram	17.95	6.80
X141	Cavernosography	20.65	8.30

OBSTETRICS AND GYNAECOLOGY

		H	P
X147	Hysterosalpingogram	29.80	11.35

DIAGNOSTIC RADIOLOGY

FLUOROSCOPY - BY PHYSICIAN WITH OR WITHOUT SPOT FILMS

		H	P
X195	Chest	9.25	14.20
X196	Skeleton	9.25	14.20
X197	Abdomen	9.25	14.20
X189	Fluoroscopic control of clinical procedures done by another physician per ¼ hour	7.30	23.75

DIAGNOSTIC RADIOLOGY

SPECIAL EXAMINATIONS

		H	P
	Abdominal, thoracic, cervical or cranial angiogram by catheterization		
	Using single films		
X179	- non-selective	29.60	15.85
X180	- selective (per vessel, to a maximum of 4)	38.95	31.35
	Using film changer, cine or multiformat camera		
X181	- non-selective	59.65	30.90
X182	- selective (per vessel, to a maximum of 4)	79.30	37.45
X140	- selective (5 or more vessels)	317.35	185.60
	Carotid angiogram by direct puncture		
X160	- unilateral	48.90	34.00
X161	- bilateral	78.60	69.65
	Peripheral angiogram		
X174	- unilateral	29.80	15.50
X175	- bilateral	39.35	30.90
X198	Splenoportogram	59.10	22.60
X199	Translumbar aortogram	59.10	22.60
	Vertebral angiogram - direct puncture or retrograde brachial injection		
X132	- unilateral	48.90	34.00
X133	- bilateral	79.90	51.05
X156	Arthrogram, tenogram or bursogram	26.25	27.50
X200	- with fluoroscopy and complete positioning throughout by physician	36.70	45.55
	Bronchogram		
X158	- unilateral	28.95	23.00
X159	- bilateral	38.40	34.60
X162	Cerebral stereotaxis	59.20	23.10
X122	Cholangiogram, percutaneous trans-hepatic	29.50	23.15
X121	Stereotactic core breast biopsy	-	83.15

BONE MINERAL DENSITY (BMD) MEASUREMENT

H P

Dual-energy X-ray Absorptiometry (DXA) - by axial technique only

Definition:

For the purpose of second and subsequent testing,

"high risk patient" means a patient:

1. at risk for accelerated bone loss (in the absence of other risk factors, patient age is deemed not to place a patient at high risk for accelerated bone loss);
2. with osteopenia or osteoporosis on any previous BMD testing; or
3. with bone loss in excess of 1% per year as demonstrated by previous BMD testing.

"low risk patient" means a patient who is not a high risk patient.

Definition/Required elements of service:

BMD measurement by DXA is an insured service only when all the following conditions have been met:

1. the service is rendered for the prevention and management of osteoporosis or osteopenia;
2. when more than one site is measured, the sites include both hip and spine and where measurement of both hip and spine is not technically feasible the site measured consists of either hip or spine.

[Commentary:
Measurement of hip and spine would be considered not technically feasible due to prosthesis or deformity.]

Baseline test

X145	- one site	42.85	40.15
X146	- two or more sites	55.20	48.00

Second test - low risk patient

X152	- one site	42.85	40.15
X153	- two or more sites	55.20	48.00

Subsequent test - low risk patient

X142	- one site	42.85	40.15
X148	- two or more sites	55.20	48.00

Subsequent test - high risk patient

X149	- one site	42.85	40.15
X155	- two or more sites	55.20	48.00

Payment rules:

1. Patients are limited to one baseline test (X145 or X146) in their lifetime.
2. Second test - low risk patient (X152/X153) is limited to a maximum of one test rendered not earlier than 36 months following the baseline test (X145/X146).
3. Subsequent test - low risk patient (X142/X148) is *not eligible for payment* when rendered earlier than 60 months following the second or any subsequent test.
4. Any combination of services described by X152 or X153 that were rendered to a patient between July 1, 2007 and April 1, 2008 for which claims were submitted and paid as insured services under the *Health Insurance Act* constitutes, a "second test – low risk patient" for the purpose of determining service maximums for a second or subsequent test - low risk patient, and is deemed to have been rendered on July 1, 2010.

BONE MINERAL DENSITY (BMD) MEASUREMENT

H P

5. Any service described by X152 or X153 rendered between April 1, 2008 and July 1, 2010 for which a claim was submitted and paid as an insured service under the *Health Insurance Act* constitutes a subsequent test - low risk patient for the purpose of determining service maximums for second or subsequent test – low risk patient and is deemed to have been rendered on July 1, 2010.
6. Subsequent test - high risk patients (X149/X155) is limited to a maximum of one test every 12 months unless the ordering physician obtains written prior authorization from a *medical consultant*.

[Commentary:
Authorization will be dependent on the ordering physician demonstrating that the test is generally accepted as necessary for the patient under the circumstances.]

[Commentary:
1. Baseline, second test and subsequent tests should be ordered only in accordance with current practice guidelines. In those situations where testing is ordered on a particular patient for reasons that vary from the guidelines, the ordering physician should ensure that the patient's medical record sufficiently explains the justification for the test in this particular case.
2. In the event a patient with a previous normal baseline test (X145/X146) or second test (X152/X153) or normal subsequent test – low risk patient (X142/X148) meets any of the criteria listed for high risk patients as stated above, the patient would be eligible for subsequent test – high risk patient services (X149/X155) subject to the restriction stated in payment rule #6.
3. The 2002 Clinical Practice Guidelines for the Diagnosis and Management of Osteoporosis in Canada (reviewed in 2006) can be found at http://www.cmaj.ca/cgi/reprint/167/10_suppl/s1.pdf.
4. Individuals under age 65 without one major or two minor risk factors typically do not benefit from BMD measurement.]

COMPUTED TOMOGRAPHY (CT)

		H	P
	Head		
X400	- without IV contrast	-	43.25
X401	- with IV contrast	-	64.95
X188	- with and without IV contrast	-	75.85
E874	- with CT perfusion study, to X188, X400, X401, X402, X405, or X408	add	64.00

Note:

1. E874 is *only eligible for payment* when the study is rendered as part of the investigation of acute stroke and the interpretation is rendered within the limited period of time following acute stroke during which the treating physician must render therapeutic decisions.

2. E874 includes the administration of contrast necessary to complete the CT perfusion study.

3. E874 includes creation and interpretation of post-imaging colour mapping of cerebral perfusion maps for regional cerebral blood flow, cerebral blood volume, and mean blood transit time.

[Commentary:
For example, when a CT perfusion study is only performed in conjunction with a non-contrast CT head scan, the appropriate claim is E874 and the non-contrast CT head service (e.g. X400, X402). In this example, a claim for E874 with a contrast enhanced CT head service (e.g. X401, X405) would not be appropriate.]

	Complex head		
X402	- without IV contrast	-	64.95
X405	- with IV contrast	-	75.85
X408	- with and without IV contrast	-	86.60

Note:
Complex head (see Diagnostic Radiology Preamble, paragraph 9).

	Neck		
X403	- without IV contrast	-	86.60
X404	- with IV contrast	-	97.50
X124	- with and without IV contrast	-	108.30
	Thorax		
X406	- without IV contrast	-	64.95
X407	- with IV contrast	-	75.85
X125	- with and without IV contrast	-	86.60

COMPUTED TOMOGRAPHY (CT)

	H	P

Cardio-thoracic

Cardio-thoracic CT is an imaging service of the cardio-thoracic structures including cardiac gating and 3D imaging post-processing, cardiac structure and morphology and computed tomographic angiography of coronary arteries (including native and anomalous coronary arteries, coronary bypass grafts) and requires imaging without contrast material followed by contrast material(s).

X235 Cardio-thoracic ..... - 147.50

Note:

1. The service described by X235 includes the supervision of oral beta blockers and/or IV injection where clinically indicated.

2. X235 is *only eligible for payment* when the service is performed using a minimum of a 64-detector CT scanner.

3. X235 is *only eligible for payment* when:

a. one or more of the following indications are present:

i. arterial and venous aneurysms;

ii. traumatic injuries of arteries and veins;

iii. arterial dissection and intramural hematoma;

iv. arterial thromboembolism;

v. vascular congenital anomalies and variants;

vi. percutaneous and surgical, vascular interventions;

vii. vascular infection, vasculitis, and collagen vascular disease;

viii. sequelae of ischemic coronary disease (i.e. myocardial scarring, ventricular aneurysms, thrombi);

ix. cardiac tumours and thrombi;

x. pericardial diseases;

xi. cardiac function evaluation, especially in patients in whom cardiac function may not be assessed by magnetic resonance imaging or echocardiography; or

b. conventional coronary angiography is technically infeasible, or contraindicated for:

i. a clinically stable symptomatic patient with low to intermediate probability of obstructive coronary disease;

ii. a clinically stable symptomatic patient who has planned surgery for valvular or structural heart disease;

iii. a patient has low to intermediate probability of stent stenosis where the stent has a diameter > 3mm; or

iv. a patient with suspected clinically relevant congenital coronary artery anomalies.

Payment rules:

1. X417, X406, X407, and X125 are *not eligible for payment* with X235.

2. X235 includes all elements required to perform the study, including additional CT acquisition sequencing and/or post-processing, two or three dimensional reconstruction(s), and administration of contrast.

Medical record requirements:

X235 is *only eligible for payment* when the patient's permanent medical record includes all of the following:

1. An interpretation is provided by a physician who must meet the current American College of Radiology's minimum training standards for thorax and cardiac CT imaging.

2. A record of a detailed relevant patient history and demographics to determine the scan protocol is maintained.

3. A diagnosis of the entire detailed field of view is provided including the lymph nodes, pleura, lungs, mediastinum, airways, bony thorax, spine and heart, and veins, arteries and other related anatomical structure.

4. A quantitative evaluation of coronary calcium for risk stratification is documented when clinically appropriate.

COMPUTED TOMOGRAPHY (CT)

H P

[Commentary:

1. For services where the heart vasculature and structures are not being visualized for the indications above, CT thorax (X406, X407 and/or X125) may be payable instead of X235.

2. Examples where CT coronary angiography is not insured include:

a. for a patient with a high pre-test probability of obstructive coronary artery disease or ECG or cardiac enzyme evidence of an acute coronary syndrome;

b. for purposes of screening, risk stratification, or calcium scoring in asymptomatic patients.

3. The maintenance of radiation dose should be consistent with the As Low As Responsibly Achievable principle and current standards under the direction of the radiologist Radiation Protection Officer.]

Abdomen

X409	- without IV contrast	-	86.60
X410	- with IV contrast	-	97.50
X126	- with and without IV contrast	-	108.30

Pelvis

X231	- without IV contrast	-	86.60
X232	- with IV contrast	-	97.50
X233	- with and without IV contrast	-	108.30
X234	CT colonography	-	235.30

Note:

1. X234 includes all elements required to perform the study, including additional CT acquisition sequencing and/or post processing, two or three dimensional reconstruction(s), administration of contrast, and faecal tagging, if rendered.

2. X417, X409, X410, X126, X231, X232, X233 are *not eligible for payment* with X234.

Payment rules:

1. CT colonography is an insured service only in the following circumstances:

a. individuals who are at moderate risk for colorectal cancer based on family history and the patient refuses colonoscopy or where the patient has been advised of the relative risks and benefits of CT colonography and colonoscopy and the patient refuses colonoscopy;

b. for surveillance examination in patients with a history of previous colonic neoplasm, where clinically appropriate;

c. for diagnostic examination in symptomatic patients;

[Commentary:
Examples of relevant symptomatology include unexplained abdominal pain, diarrhea, constipation, gastrointestinal bleeding, anemia, intestinal obstruction, or weight loss.]

1. when rendered for a patient for whom colonoscopy is technically infeasible, has been difficult in the past, or contraindicated;

2. for patients who are at increased risk for complications during endoscopy such as, advanced age, sedation or anti-coagulation therapy, prior incomplete or difficult colonoscopy;

3. when double contrast barium enema services are unavailable or regarded as inadequate for clinical or diagnostic reasons.]

2. CT colonography is *only eligible for payment* if:

a. the study is interpreted using standard 2D and 3D rendering consistent with current practice guidelines;

b. the study is performed on a minimum 16-detector CT scanner; and

c. the interpretation is provided by a physician who must meet minimum training standards.

Medical record requirements:
X234 is *only eligible for payment* when the reporting radiologist:

1. documents a detailed relevant patient history and demographics to determine the scan protocol; and

2. provides a diagnosis of the entire detailed field of view including colonic and extra-colonic structures.

[Commentary:

1. CT colonography also refers to and includes “virtual colonoscopy”.

2. The maintenance of radiation dose should be consistent with the As Low As Responsibly Achievable principle and current standards under the direction of the radiologist Radiation Protection Officer.]

COMPUTED TOMOGRAPHY (CT)

		H	P
	Extremities (one or more)		
X412	- without IV contrast	-	43.25
X413	- with IV contrast	-	64.95
X127	- with and without IV contrast	-	75.85
	Spine(s)		
X415	- without IV contrast	-	86.60
X416	- with IV contrast	-	97.50
X128	- with and without IV contrast	-	108.30
X168	CT guidance of biopsy	-	42.50
X417	Three dimensional CT acquisition sequencing, including post-processing (minimum of 60 slices; maximum 1 scan per patient per day)	-	32.70

DIAGNOSTIC RADIOLOGY

MISCELLANEOUS EXAMINATIONS

		H	P
X151	Cordotomy, percutaneous	48.40	34.85
X163	Dacrocystogram	29.60	11.60
	Discogram(s)		
X164	- one or more levels	28.95	23.00
X167	Fistula or sinus	21.50	11.45
X169	Laminogram, planigram, tomogram	39.90	11.35
X170	Laryngogram	28.95	23.00
X171	Lymphangiogram	49.00	23.05
X192	Mammary ductography	25.05	10.65
	Mammogram - Signs or Symptoms		
	[Commentary: For individuals with identified signs or symptoms or follow-up of established disease.]		
	Dedicated equipment		
X184	- unilateral	28.05	16.90
X185	- bilateral	37.15	27.00
	Mammogram - No Signs or Symptoms		
	[Commentary: Where the sole reason for the request for a mammogram is for an individual with identified risk factors in accordance with clinical practice guidelines.]		
	Dedicated equipment		
X172	- unilateral	28.05	16.90
X178	- bilateral	37.15	27.00
X194	Additional coned views with or without magnification (limit of two per breast) per film	5.95	5.20
X201	Breast biopsy specimen x-ray, per specimen	5.95	5.20
X150	Mechanical evaluation of knee	25.45	15.85
X193	Microradioscopy of the hands	14.50	11.60
X173	Myelogram - spine and/or posterior fossa	34.95	27.30
X190	Pantomography	17.75	6.90
X154	Penis	15.95	4.70
X165	Photographic subtraction	-	11.35
X176	Sialogram	29.80	11.35
X177	Skin thickness measurement	15.60	9.20
X183	Ventriculogram	48.40	34.70
X166	Examination using portable machine “in home” add to first examination only	-	-

Note:
X166 does not apply to the use of a portable machine in a hospital. Can only be claimed once per *day* regardless of the number of people x-rayed in the same “*home*” including “nursing *home*”. The facility fee for X166 is listed in the *Schedule* of Facility Fees for Independent Health Facilities.

DIAGNOSTIC RADIOLOGY

NOT ALLOCATED