Select Health

CODING/REIMBURSEMENT POLICY

COMPARISON FILMS

Policy # 53
Implementation Date: 7/1/09
Review Date:
Revision Date: 6/1/10, 7/8/14

Disclaimer:
1. Policies are subject to change without notice.
2. Policies outline coverage determinations for Select Health Commercial, Select Health Advantage (Medicare/CMS), and Select Health Community Care (Medicaid/CHIP) plans. Refer to the "Policy" section for more information.

Description

Radiography is a proven and useful procedure for evaluation of the bones, joints, and soft tissues, to establish the presence, absence, and/or nature of disease. These procedures should be performed for valid medical reasons, using the minimum amount of radiation necessary to obtain a quality examination. Comparison films (i.e., x-rays, ultrasounds, etc.) are usually minimal views of contralateral (bilateral) bones, joints, or soft tissue, that are used to verify or exclude specific pathology of the symptomatic bone, joint, or soft tissue.

COMMERCIAL PLAN POLICY AND CHIP (CHILDREN'S HEALTH INSURANCE PROGRAM)

Select Health **will not reimburse for any comparison film(s) (e.g., bilateral) regardless of diagnosis, modifier, and/or separate interpretation and report. These will be denied as inclusive to the medically necessary procedure.**

In addition, no reimbursement will be made for a comparison film when it is done as part of an internal protocol (e.g., when the patient presents for an E/M service) or any research project. This type of film will be considered an essential part of the medical decision-making component of an evaluation and management E/M service. As such, the documentation should include the visualization and interpretation of the comparison image(s).

SELECT HEALTH ADVANTAGE (MEDICARE/CMS)

Select Health Advantage **will follow the commercial plan policy.**

SELECT HEALTH COMMUNITY CARE (MEDICAID)

Select Health Community Care **will follow the commercial plan policy.**

Applicable Codes

Codes	Descriptions
Multiple	Multiple joint and/or soft tissue films

Sources
1. *Current Procedural Terminology (CPT®)*, (2014) – American Medical Association

2. ICD-9-CM Coding Guidelines. (2013, January 1). Retrieved July 8, 2014, from https://www.encoderpro.com/epro/physicianDoc/pdf/i9v1/i9_guidelines.pdf

Disclaimer

This document is for informational purposes only and should not be relied on in the diagnosis and care of individual patients. Medical and Coding/Reimbursement policies do not constitute medical advice, plan preauthorization, certification, an explanation of benefits, or a contract. Members should consult with appropriate healthcare providers to obtain needed medical advice, care, and treatment. Benefits and eligibility are determined before medical guidelines and payment guidelines are applied. Benefits are determined by the member's individual benefit plan that is in effect at the time services are rendered.

The codes for treatments and procedures applicable to this policy are included for informational purposes. Inclusion or exclusion of a procedure, diagnosis or device code(s) does not constitute or imply member coverage or provider reimbursement policy. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

Select Health® makes no representations and accepts no liability with respect to the content of any external information cited or relied upon in this policy. Select Health updates its Coverage Policies regularly, and reserves the right to amend these policies without notice to healthcare providers or Select Health members.

Members may contact Customer Service at the phone number listed on their member identification card to discuss their benefits more specifically. Providers with questions about this Coverage Policy may call Select Health Provider Relations at (801) 442-3692.