

## PRCs: What Radiology and IR Practices Need To Know

### Understanding Patient Relationship Codes

Patient Relationship Codes (PRCs) are HCPCS Level II modifiers (X1–X5) that identify a clinician’s role and level of responsibility at the time of service. When reported on Medicare Part B claims, they provide the context needed to link patients and episodes of care to the appropriate providers for cost measurement under the Merit-based Incentive Payment System (MIPS). The Centers for Medicare & Medicaid Services (CMS) uses this data to better understand how care is delivered and refine its cost attribution methodologies.

### The 5 PRC Modifiers

Each modifier captures two key dimensions:

- ▶ **Duration:** Continuous vs. Episodic
- ▶ **Scope of Responsibility:** Broad vs. Focused

HCPCS Modifier	Patient Relationship Category	Description
X1	Continuous/Broad	Principal responsibility for the full scope of a patient's problems with no planned endpoint, either directly or in a care coordination role
X2	Continuous/Focused	Ongoing management of a chronic disease or condition requiring long-term specialty care
X3	Episodic/Broad	Broad responsibility for a patient’s comprehensive needs during a defined period, such as a hospitalization
X4	Episodic/Focused	Time-limited, specialty-focused services for a specific problem treated through surgery, radiation, or intervention, spanning that episode
X5	Only as Ordered by Another Clinician	Services furnished solely at the direction of another clinician, without responsibility for ongoing or comprehensive care

Reporting is currently voluntary and does not impact Medicare reimbursement. However, CMS has signaled it will formalize these requirements through future rulemaking.

## Diagnostic Radiology

Report modifier X5 when a radiologist provides services as ordered by another clinician, without assuming responsibility for the patient's treatment planning or ongoing care.

- ▶ **Examples:** X-ray, CT, MRI, ultrasound, nuclear medicine, PET, mammography
- ▶ **Additional scenarios:** Teleradiology, overreads, and outside film interpretations

## Interventional Radiology

Modifier selection for interventional radiology (IR) requires more judgment than diagnostic radiology, as it depends on whether the physician's role extends beyond the procedure itself.

### X4 — Episodic/Focused

Use X4 when the IR physician provides time-limited, focused care, including post-procedure follow-up:

- ▶ Transjugular intrahepatic portosystemic shunt (TIPS)
- ▶ Hepatic chemoembolization
- ▶ Abscess or fluid drainage
- ▶ Biliary drain placement and subsequent exchanges
- ▶ Tumor ablation with post-ablation imaging review

### X5 — Only as Ordered by Another Clinician

Use X5 when the IR physician performs a procedure at the direction of another provider who continues to manage the patient's care and follow-up:

- ▶ Central venous access or port placement ordered by an oncologist
- ▶ Diagnostic angiography ordered by a vascular surgeon
- ▶ Kyphoplasty or vertebroplasty ordered by an orthopedic surgeon
- ▶ Uterine fibroid embolization ordered by a gynecologist

### Additional IR Modifiers

X2 and X3 are rare in IR. They apply only when the IR physician assumes ongoing specialty-focused care (X2) or comprehensive inpatient responsibility during a defined episode (X3).

### How to Decide: X4 or X5?

To determine the correct modifier, ask: Who manages the patient's clinical course after the procedure?

- IR physician directs post-procedure care → Use X4 (Episodic/Focused)
- Care transitions back to the referring clinician → Use X5 (Only as Ordered)

### Documentation and Reporting

These modifiers do not require additional documentation. They are claim-level designations supported by the existing medical record, including the imaging order, radiology report, and any relevant procedure notes.

For practices that have opted in, Ventra applies the appropriate modifier during the submission process, with no additional steps required on your end.

### PRC Submission Overview:

- ▶ **Confirm Payer:** Limit reporting to Medicare Part B claims unless a payer specifically instructs otherwise.
- ▶ **Select Modifier:** Choose the appropriate X1–X5 based on the clinician’s role for that specific service.
- ▶ **Enter on Claim:** Add the modifier to Item 24D on the CMS-1500 (or the electronic equivalent) for the applicable service line.
- ▶ **Determine Sequencing:** Apply the PRC in any order relative to other modifiers (e.g., -26 or -TC).
- ▶ **Verify Ordering NPI:** Ensure the ordering or referring provider’s NPI is present in the appropriate claim field.
- ▶ **Review Line Items:** Assign PRCs at the line-item level, as different services on the same claim may require different relationship types.

### Resources:

[Patient Relationship Categories and Codes \(PRCs\) – CMS](#)  
[MLN Matters MM11259 – Reporting HCPCS Level II PRC Modifiers](#)  
[MACRA Patient Relationship Categories and Codes FAQ](#)