



**Payment Policies for Healthcare Services
 Provided to Injured Workers and Crime Victims**

Chapter 26: Radiology Services

Effective October 1, 2020



Link: Look for possible **updates and corrections** to these payment policies at:

<https://lni.wa.gov/patient-care/billing-payments/fee-schedules-and-payment-policies/policy-2020>



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Definitions

- ▶ **CPT® and HCPCS code modifiers mentioned in this chapter:**

- 7N **X-rays and laboratory services in conjunction with an IME**

- When X-rays, laboratory, and other diagnostic tests are provided with an exam, identify the service(s) by adding the modifier – 7N to the usual procedure number.

- 26 **Professional component**

- Certain procedures are a combination of the professional (–26) and technical (–TC) components. This modifier should be used when only the professional component is performed. When a global service is performed, neither the –26 nor the –TC modifier should be used. (See above for information on the use of the –TC modifier.)

- 52 **Reduced services**

- Payments are made at the fee schedule level or billed charge, whichever is less.

- LT **Left side**

- Although this modifier doesn't affect payment, it should be used when billing for bilateral services. This will help reduce duplicate bills and minimize payment delays.

- RT **Right side**

- Although this modifier doesn't affect payment, it should be used when billing for bilateral services. This will help reduce duplicate bills and minimize payment delays.

- TC **Technical component**

- Certain procedures are a combination of the professional (–26) and technical (–TC) components. This modifier should be used when only the technical component is performed. When a global service is performed, neither the –26 nor the –TC modifier should be used. (See above for information on the use of the –26 modifier.)

- UN **Two patients served**

- UP **Three patients served**

- UQ **Four patients served**

- UR **Five patients served**

- US **Six or more patients served**

- ▶ **Full spine study:** A full spine study is a radiologic exam of the entire spine: anteroposterior (AP) and lateral views. Depending on the size of the film and the size of the patient, the study may require up to 6 films (the AP and lateral views of the cervical, thoracic, and lumbar spine). (See definition of **incomplete full spine study**, below.)

- ▶ **Incomplete full spine study:** An incomplete full spine study is one in which the entire AP or lateral view is taken, but not both. For example, a study is performed in which all AP and lateral views are obtained except for the lateral thoracic. (See definition of **full spine study**, above.)



Payment policy: Contrast material

► Requirements for billing

Use the following HCPCS codes to bill for contrast material:

- Low osmolar contrast material (LOCM): **Q9951, Q9965 - Q9967**
- High contrast osmolar material (HOCM): **Q9958 - Q9964**

For LOCM, bill one unit per ml.

Providers may use either HOCM or LOCM. The use of either type of contrast material must be based on medical necessity.

The brand name of the contrast material and the dosage must be documented in the patient's chart.



Note: Separate payment will be made for contrast material for imaging studies.

► Payment limits

HCPCS codes for LOCM are paid at a flat rate based on the AWP per ml.



Payment policy: Nuclear medicine

▶ Payment limits

The standard multiple surgery policy applies to the following radiology CPT® codes for nuclear medicine services:

- 78306,
- 78802,
- 78803,

The multiple procedures reduction will be applied when these codes are billed:

- With other codes subject to the standard multiple surgery policy, *and*
- For the same patient:
 - On the same day by the same physician, *or*
 - By more than one physician of the same specialty in the same group practice.



Link: For more information about the standard multiple surgery payment policies, refer to [Chapter 29: Surgery Services](#).



Payment policy: Radiology consultation services

▶ Services that aren't covered

CPT® code **76140** isn't covered.

▶ Requirements for billing

For radiology codes where a consultation service is performed, providers who perform the service must bill the specific X-ray code with **modifier –26**.

Attending health care providers who request second opinion consulting services are responsible for determining the necessity for the second opinion and must briefly document that justification in their chart notes. Examples include:

- Confirm or deny hypermobility at C5/C6,
- Does this T12 compression fracture look old or new?
- Evaluate stability of L5 spondylolisthesis,
- What is soft tissue opacity overlying sacrum? Will it affect case management for this injury?
- Is opacity in lung field anything to be concerned about?, *and*
- Does this disc protrusion shown on MRI look new or preexisting?

▶ Payment limits

The insurer won't pay separately for review of films taken previously or elsewhere if a face to face service is performed on the same date as the X-ray review.

Review of records and diagnostic studies is bundled into the E/M, chiropractic care visit, or other procedure(s) performed.

Payment for a radiological consultation will be made at the established professional component (**modifier –26**) rate for each specific radiology service. A written report of the consultation is required.



Note: For specific reporting requirements, see the next section of this chapter.



Payment policy: Radiology reporting requirements

► Requirements for billing

Documentation for the professional interpretation of radiology procedures is required for all professional component billing whether billed with **modifier –26** or as part of the global service.



Note: Documentation refers to charting of justification, findings, diagnoses, and test result integration.

Any provider who produces and interprets his/her own imaging studies, and any radiologist who over reads imaging studies must produce a report of radiology findings to bill for the professional component. The radiology report of findings must be in written form and must include all of the following:

- Patient's name, age, sex, and date of procedure, *and*
- The anatomic location of the procedure and type of procedure (lumbar spine plain films, abdomen CT, cervical spine MRI, etc.), *and*
- Specific views (AP, lateral, oblique, weight bearing, axial, sagittal, coronal, with or without contrast, etc., as applicable), *and*
- Brief sentence summarizing history and/or reason for the study, such as:
 - "Lower back pain; evaluate for degenerative changes and rule out leg length inequality."
 - "Neck pain radiating to upper extremity; rule out disc protrusion," *and*
- Description of, or listing of, imaging findings:
 - **Advanced imaging reports** should follow generally accepted standards to include relevant findings related to the particular type of study, *and*
 - Radiology **reports on plain films of skeletal structures** should include evaluation of osseous density and contours, important postural/mechanical considerations, assessment of any joint space abnormalities, and assessment of any important abnormal soft tissue findings, *and*

- Radiology **reports on chest plain films** should include assessment of lung fields, bronchovascular markings, apices, tracheal air shadow, mediastinal and hilar contours, cardiovascular contours, costophrenic recesses, any abnormalities below the diaphragm, and assessment of any important osseous abnormalities shown incidentally (ribs, clavicles, scapulae, proximal humeri, spine), *and*



Note: Chart notes such as "X-rays are negative" or "X-rays are normal" don't fulfill the reporting requirements described in this section and the insurer **won't pay** for the professional component in these circumstances (see Payment limits, below).

- Imaging impressions, which summarize and provide significance for the imaging findings described in the body of the report. For example:
 - For a skeletal plain film report with imaging findings of normal osseous density and contours and no joint abnormalities, the impression could be: "No evidence of fracture, dislocation, or gross osseous pathology."
 - For a skeletal plain film report with imaging findings of reduced bone density and thinned cortices, the impression could be: "Osteoporosis, compatible with the patient's age."
 - For a chest report with imaging findings of vertically elongated and radiolucent lung fields, low diaphragm, and long vertical heart, the impression could be: "Emphysema."

Attending providers who produce or order diagnostic imaging studies are responsible for acknowledging and integrating the imaging findings into their case management.

Providers must include brief documentation in their chart notes. Examples include:

- "Imaging rules out fracture, so rehab can proceed."
- "Flexion/extension plain films indicate hypermobility at C5/C6, and spinal manipulation will avoid that region."

▶ Payment limits

Chart notes such as "X-rays are negative" or "X-rays are normal" don't fulfill the reporting requirements described in this section and the insurer **won't pay** for the professional component in these circumstances.



Payment policy: Use of office-based ultrasound

Ultrasounds (76881 and 76882) used for evaluation and diagnosis are considered bundled into the evaluation and management E/M service and shouldn't be billed separately. No separate payment will be made for these services when performed during an office visit.

The use of ultrasounds for treatment such as guided needle placement and for quick assessments in emergency departments are separately reimbursable services.



Link: For more information on the use of ultrasound for treatment refer to [Chapter 25: Physical Medicine Services](#).



Note: Separate payment will not be made for portable ultrasound during an office visit.



Payment policy: X-ray services

▸ Requirements for diagnostic imaging studies

Documentation

Attending health care providers who produce or order diagnostic imaging studies are responsible for determining the necessity for the study and must briefly document that justification in their chart notes. Examples include:

- Plain films of the cervical spine to include obliques to rule out foraminal encroachment as possible cause for radiating arm pain, *or*
- PA and lateral chest films to determine cause for dyspnea.

Technical quality

All imaging studies must be of adequate technical quality to rule out radiologically detectable pathology.

Custody

X-rays must be retained for 10 years.



Link: For more information on custody requirements, see [WAC 296-20-121](#) and [WAC 296-23-140\(1\)](#).

▸ Requirements for billing

Billing code modifiers –RT and –LT

HCPCS modifiers –RT (right side) and –LT (left side) don't affect payment. They may be used with CPT® radiology codes **70010-79999** to identify duplicate procedures performed on opposite sides of the body.

Global radiology services

Global radiology services include both a technical component (producing the study) and a professional component (interpreting the study). If only the:

- **Technical component** of a radiology service is performed, then **modifier –TC** must be used, and only the technical component fees are allowable, *and*
- **Professional component** of a radiology service is performed, then **modifier –26** must be used, and only the professional component fees are allowable.

Incomplete full spine studies

(See definitions of **full spine study** and **incomplete full spine study** in Definitions at the beginning of this chapter.)

For a single view bill **72081**.

For 2 or 3 views bill **72082**.

For 4 or 5 views bill **72083**.

For 6 or more views bill **72084**.

Portable X-rays

Radiology services furnished in the patient's place of residence are limited to the following tests, which must be performed under the general supervision of a physician:

- Skeletal films involving:
 - Extremities,
 - Pelvis,
 - Vertebral column, *or*
 - Skull,
- Chest or abdominal films that don't involve the use of contrast media, *and*
- Diagnostic mammograms.

HCPCS codes for transportation of portable X-ray equipment **R0070** (one patient) or **R0075** (multiple patients) may be paid in addition to the appropriate radiology code(s).

R0075 will pay based on the number of patients served and the modifier billed. Payment is outlined in the following table.

For transport portable X-ray services:

If the number of patients served is...	Then the appropriate HCPSC code to bill is...	Along with this billing code modifier :	The maximum fee , effective July 1, 2020 is:
1	R0070	—	\$184.31
2	R0075	-UN	\$92.16
3	R0075	-UP	\$61.45
4	R0075	-UQ	\$46.06
5	R0075	-UR	\$36.86
6 or more	R0075	-US	\$30.72

► **Payment limits**

Number of views

There isn't a specific code for additional views for radiology services. Therefore, the number of X-ray views that may be paid is determined by the CPT® description for that service.

For example, the following CPT® codes for radiologic exams of the spine are payable as outlined below:

If the CPT® code is...	Then it is payable :
72020	Once for a single view
72040	Once for 2 to 3 cervical views
72050	Once for 4 or more cervical views
72052	Once, regardless of the number of cervical views it takes to complete the series

Repeat X-rays

The insurer won't pay for excessive or unnecessary X-rays.

Repeat or serial X-rays may be performed only upon adequate clinical justification to confirm changes in the accepted condition(s). Documented changes in objective findings or subjective complaints must support the need.

Dynamic Spinal Visualization

Dynamic Spinal Visualization (DSV) refers to several imaging technologies for the purpose of assessing spinal motion, including videofluoroscopy, cineradiology, digital motion x-ray, vertebral motion analysis and spinal x-ray digitization.

DSV isn't a covered benefit. Procedure code 76496 shouldn't be used to bill the insurer for these services.



Link: For more information about DSV, see the [Dynamic Spinal Visualization coverage decision](#).



Links: Related topics

If you're looking for more information about...	Then go here:
Administrative rules for X-ray custody requirements	Washington Administrative Code (WAC) 296-20-121: http://apps.leg.wa.gov/WAC/default.aspx?cite=296-20-121 WAC 296-23-140(1): http://apps.leg.wa.gov/WAC/default.aspx?cite=296-23-140
Becoming an L&I Provider	L&I's website: https://lni.wa.gov/patient-care/provider-accounts/become-a-provider/
Billing instructions and forms	Chapter 2: Information for All Providers
Payment policies for physical medicine services	Chapter 25: Physical Medicine Services
Payment policies for surgery	Chapter 29: Surgery Services
Professional Services Fee Schedules	L&I's website: http://www.lni.wa.gov/FeeSchedules
Dynamic Spinal Visualization coverage decision	L&I's website: https://lni.wa.gov/patient-care/treating-patients/conditions-and-treatments/?query=Dynamic+Spinal+Visualization

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