Washington State Department of Labor & Industries

Payment Policies for Healthcare Services

Provided to Injured Workers and Crime Victims

Chapter 26: Radiology Services

Effective July 1, 2023

Link: Look for possible **updates and corrections** to these payment policies on L&I's website.

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Definitions

The following terms are utilized in this chapter and are defined as follows:

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.)

Modifiers

The following CPT®, HCPCS, and/or local code modifiers apply to 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 below for information on the use of the **–TC** modifier.)

–52 (Reduced services)

Under certain circumstances, a service or procedure is partially reduced or eliminated at the discretion of the provider. Under these circumstances the service can be identified by its usual procedure number and the addition of modifier 52, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service.

–76 (Repeat procedure or service by same physician or other qualified health care professional)

It may be necessary to indicate that a procedure or service was repeated by the same provider subsequent to the original procedure or service. This circumstance may be reported by adding modifier **–76** to the repeated procedure or service. **Note:** This modifier should not be appended to and E/M service.

–77 (Repeat procedure by another physician or other qualified health care professional)

It may be necessary to indicate that a basic procedure or service was repeated by another provider subsequent to the original procedure or service. This circumstance may be reported by adding modifier **–77** to the repeated procedure or service. **Note:** This modifier should not be appended to and E/M service.

–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 (2 patients served)

–UP (3 patients served)

–UQ (4 patients served)

–UR (5 patients served)

–US (6 or more patients served)

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 1 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.

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: Noninvasive cardiac imaging for coronary artery disease

Services that can be billed

Certain noninvasive cardiac imaging technologies for coronary artery disease are covered with conditions. See L&I's coverage decision for details.

Cardiac magnetic resonance angiography (CMRA)

Cardiac magnetic resonance angiography is covered with conditions. See L&I's coverage decision for details.

Payment policy: Nuclear medicine

Payment limits

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

- **78306**,
- **78802**, *and*
- **78803**.

The multiple procedure 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 provider, *or*
    - By more than 1 provider of the same specialty in the same group practice.

Link: For more information about the standard multiple surgery payment policy, 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

Providers who perform radiology consultation services must bill the specific X-ray CPT® code with modifier **–26**.

Attending health care providers who request second opinion radiology consultation 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 service, chiropractic care visit, or other procedure(s) performed. For more information about E/M services, see Chapter 10: Evaluation and Management Services.

Payment for radiology consultation services will be made at the professional component (modifier **–26**) rate for each specific radiology service performed. A written report of the consultation is required. The written report must justify the level, type, and extent of the services billed.

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

Payment policy: Radiology reporting requirements

Global radiology services

Global radiology services include both a technical component (producing the study) and a professional component (interpreting the imaging study). When billing for radiology services globally the reporting requirements for both the technical (–TC) and professional (–26) components must be met.

Technical component (modifier–TC)

Any provider who is billing separately for the technical component (–TC) is required to submit documentation to the insurer. The documentation must include the following:

- Patient name, age, sex, date of service,
- Name of ordering provider,
- 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).

Professional component (modifier –26)

Documentation (charting of justification, findings, diagnoses, and test result integration) 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.

Any provider who produces and interprets their 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*
- 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.”

Note: Providers performing the professional component (modifier **—26**) must bill under their individual L&I provider account number.

Requirements for billing

Billing code modifiers

- Use HCPCS modifiers **–RT** (right side) and **–LT** (left side) with CPT® codes **70010-79999** to identify duplicate procedures performed on opposite sides of the body.
- **Global radiology services** include both a technical component and professional component
- **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.

Note: Providers performing the professional component (modifier ─26) must bill under their individual L&I provider account number.

Payment limits

Documentation 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 ultrasounds

Who must perform these services to qualify for payment

Facilities billing for the technical component must have an L&I provider ID and provide documentation to support the service rendered.

Providers performing the professional component (modifier **–26**) must bill under their individual L&I provider ID.

Providers and/or technicians performing ultrasounds must have the appropriate licensure per Department of Health requirements.

Services that can be billed

Refer to the fee schedule for codes covered by the insurer. Refer to CPT® for additional guidelines.

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

Services that aren’t covered

Office based ultrasounds used for evaluation and diagnosis are considered bundled into the evaluation and management (E/M) service and can’t be billed separately. No separate payment will be made for these services.

HCPCS codes R0070 and R0075 are not payable for mobile ultrasound services.

Requirements for billing

Technical component (modifier –TC)

In addition to the requirements in the radiology reporting documentation policy above, for the technical component, the following documentation is required:

- Patient name, age, sex,
- Date and time of ultrasound exam,
- Output display standard (thermal index & mechanical),
- Name of ordering provider,
- Label of the anatomic location and laterality, when appropriate,
- A description of any contrast media or pharmaceutical used, including route of administration and dose when applicable,
- Indication for exam,

- Specific ultrasound examination performed, including all joint spaces and structures examined, *and*
- Address where exam took place (for mobile providers)

Professional component (modifier –26)

In addition to the requirements in the radiology reporting documentation policy above, for the professional component, the following documentation is required:

- Patient's name, age, sex, and date of procedure,
- Relevant clinical information, including indication for the exam and/or relevant ICD-10 code,
- The specific method use for endocavity techniques, if performed,
- A description of the studies and/or procedures performed,
- A description of any contrast media or pharmaceutical used, including route of administration and dose when applicable,
- Anatomic measurements, if taken,
- A description of examination findings,
- Impression, conclusion, or summary statement,
- Specific diagnosis, if appropriate,
- Recommendation for follow-up, if necessary,
- Accounting of any failure to include standard views or other necessary components, if necessary,
- Statement of comparison of relevant imaging studies if reviewed, *and*
- Details on any provider-to-provider communication if there are delays which may have an adverse effect on the patient's outcome.

Payment limits

CPT® codes **76881** and **76882** are limited to **1 unit per extremity per day.**

76881 and **76882** aren't payable in conjunction with each other when performed on the same anatomical region on the same date of service. Refer to CPT® for additional restrictions and requirements.

Payment policy: X-ray services

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.

Links: For more information on custody requirements, see WAC 296-20-121 and WAC 296-23-140.

Services that can be billed

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.

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**.

Services that aren't covered

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. CPT® code 76496 shouldn't be used to the bill the insurer for these services.

Link: For more information about DSV, see the L&I's coverage decision.

Requirements for billing

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.

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.

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.

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.

Payment limits

HCPCS codes for transportation of portable X-ray equipment **R0070** (1 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 **HCPCS code** to bill is…	Along with this billing code **modifier**:	The **maximum fee**, effective July 1, 2023 is:
1	**R0070**	—	**$197.51**
2	**R0075**	**–UN**	**$98.76**
3	**R0075**	**–UP**	**$65.85**
4	**R0075**	**–UQ**	**$49.36**
5	**R0075**	**–UR**	**$39.50**
6 or more	**R0075**	**–US**	**$32.92**

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 exam of the cervical 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 5 cervical views
72052	Once, 6 or more views, regardless of the number of cervical views it takes to complete the series

Links to related topics

If you're looking for more information about…	Then see…
Administrative rules for X-ray custody requirements	Washington Administrative Code (WAC) 296-20-121 WAC 296-23-140
Becoming an L&I Provider	Become A Provider on L&I's website
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: Surgical Services
Professional Services **Fee Schedules**	Fee schedules on L&I's website
Dynamic Spinal Visualization coverage decision	Dynamic spinal visualization coverage decision

Need more help?

Call L&I's Provider Hotline at **1-800-848-0811** or email **PHL@lni.wa.gov**

