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, 2024

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

Table of Contents

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).

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.

Modifiers

The following CPT®, HCPCS, and/or local code modifiers appear in this chapter:

Use	Payment Information
–7N (Services in conjunction with an IME)	
Use this modifier to indicate when services are requested for an IME.	This modifier doesn't affect payment but is necessary to describe the service performed.
–26 (Professional component)	
Use this modifier to indicate when only the professional component of a service is performed and reported separately. Certain procedures are a combination of a provider's professional component (**–26**) and a technical component (**–TC**). When the provider's professional component is reported separately, the service may be identified by adding this modifier. When a global service is performed, the **–26** or the **–TC** modifier can't be used. **Note**: Procedure codes that are applicable to these components are listed in the L&I Professional Services Fee Schedules.	These services are represented by their own line on the professional services fee schedule. Payment will be made at **100%** of the professional component (**–26**) rate for each specific radiology service performed or billed charge, whichever is less.
–LT (Left side)	
Use this modifier to indicate when a procedure or service was performed on the left side of the body. Specifically for procedures or services that can be performed on contralateral sites, paired organs, or extremities.	This modifier doesn't affect payment but is necessary to describe the service. Its use will help reduce duplicate bills and minimize payment delays.
–RT (Right side)	
Use this modifier to indicate when a procedure or service was performed on the right side of the body. Specifically for procedures or services that can be performed on contralateral sites, paired organs, or extremities.	This modifier doesn't affect payment but is necessary to describe the service. Its use will help reduce duplicate bills and minimize payment delays.

Use	Payment Information
–TC (Technical component)	
Use this modifier to indicate when only the technical component of a service is performed and reported separately. Certain procedures are a combination of a provider's professional component (**–26**) and a technical component (**–TC**). When the provider's technical component is reported separately, the service may be identified by adding this modifier. When a global service is performed, the **–26** or the **–TC** modifier can't be used. **Note**: Procedure codes that are applicable to these components are listed in the L&I Professional Services Fee Schedules.	These services are represented by their own line on the professional services fee schedule. Payment will be made at **100%** of the technical component (**–TC**) rate for each specific radiology service performed or billed charge, whichever is less.
–UN (2 patients served)	
Use this modifier to indicate when 2 patients are served using portable radiology equipment.	This modifier doesn't affect payment but is necessary to describe the service.
–UP (3 patients served)	
Use this modifier to indicate when 3 patients are served using portable radiology equipment.	This modifier doesn't affect payment but is necessary to describe the service.
–UQ (4 patients served)	
Use this modifier to indicate when 4 patients are served using portable radiology equipment.	This modifier doesn't affect payment but is necessary to describe the service.
–UR (5 patients served)	
Use this modifier to indicate when 5 patients are served using portable radiology equipment.	This modifier doesn't affect payment but is necessary to describe the service.
–US (6 or more patients served)	
Use this modifier to indicate when 6 or more patients are served using portable radiology equipment.	This modifier doesn't affect payment but is necessary to describe the service.

Note: Many factors contribute to the resulting allowed amount. Therefore, there may be other factors aside from modifier usage that reduce or affect payment. Refer to the applicable payment policies and fee schedules for the service(s) being provided for more information.

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 and HOCM, 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 and HOCM 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: Portable radiology services

Services that can be billed

Portable X-ray services are only payable when furnished in the worker's place of residence, which includes:

- The workers' home,
- Assisted living, adult family, or boarding home, *and*
- Skilled Nursing Facilities.

All tests must be performed under the general supervision of a physician and are limited to:

- 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** (1 patient) or **R0075** (multiple patients), and set up of portable X-ray equipment **Q0092**, may be paid in addition to the appropriate CPT® radiology code(s).

Link: For more information on service and documentation requirements for X-rays see the X-ray services policy in this chapter.

Services that aren't covered

Don't bill **R0070**, **R0075**, **R0076** or **Q0092** for portable X-rays or EKGs performed in a location other than the workers' place of residence.

There are no codes for transportation of portable ultrasound equipment. This is not a covered benefit.

Payment limits

Set up of portable X-ray equipment using HCPCS code **Q0092** is only payable when performed in a workers' place of residence and not for routine purposes or the convenience of the provider or worker. Refer to the HCPCS code book for more details.

Use HCPCS code **R0070** or **R0075** only when the equipment was not stored in the location the service was performed. **R0075** will pay based on the number of patients served and the modifier billed. Payment is outlined in the following table. For transportation of 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**	—	**$200.47**
2	**R0075**	**–UN**	**$100.24**
3	**R0075**	**–UP**	**$66.83**
4	**R0075**	**–UQ**	**$50.10**
5	**R0075**	**–UR**	**$40.09**
6 or more	**R0075**	**–US**	**$32.92**

Payment policy: Radiology consultation services

General Information

Radiology consultation services include requests for secondary interpretive opinions by a different radiologist. These are performed at the request of the attending provider or insurer.

Who must perform these services to qualify for payment

Second opinion radiology consultations must be performed by:

- Radiologists, *or*
- Approved chiropractic radiology consultants who are a Diplomat of the American Chiropractic Board of Radiology.

Services that aren't covered

CPT® code **76140** isn't covered.

Requirements for billing

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

Documentation requirements

Attending 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?

The consulting provider must follow all reporting and documentation requirements for the professional service, including justification of the level, type, and extent of the services billed. See the reporting requirements policy in this chapter for more details.

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 limits

Payment for radiology consultation services will be made at the professional component (modifier **–26**) rate for each specific radiology service performed.

Payment policy: Radiology reporting requirements

General information

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 quality

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

Documentation requirements

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, *and*
- Date of study, *and*
- Name of ordering provider, *and*
- The name of the location of where the service was performed (e.g., the provider's office, a hospital, etc.), *and*
- The anatomic location of the procedure, including laterality as applicable, and type of procedure (lumbar spine plain films, abdomen CT, cervical spine MRI, etc.), *and*
- A description of any contrast media or pharmaceutical used, including route of administration and dose, when applicable, *and*
- Specific views (AP, lateral, oblique, weight bearing, axial, sagittal, coronal, with or without contrast, etc., as applicable).

Note: The technical component (modifier **—TC**) must be billed by the provider who actually performed the service or the provider who supervised the technician performing the service. Copying an imaging report into the chart note isn't enough to support billing the technical component (modifier **—TC**) or a global imaging service.

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 study, *and*
- The anatomic location of the procedure, including laterality as applicable, 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 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.”

Requirements for billing

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.

Use modifier **–TC** when only the **technical component** of a radiology service is performed.

Use modifier **–26** when only the **professional component** of a radiology service is performed.

Do not use modifier **–TC** or **–26** for **global radiology services** when both the technical and professional components are performed by the same provider.

Note: All professional interpretations (modifier –**26**) must be billed by the provider who actually performed the service.

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.

The technical component (**–TC**) or global radiology service is only payable once per study.

The professional component (**–26**) may be billed, under their individual provider number, only when a provider has performed an independent interpretation of the study.

Payment policy: Ultrasound

Who must perform these services to qualify for payment

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

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.

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

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.

Transportation of portable equipment

HCPCS codes **Q0092**, **R0070** and **R0075** aren’t payable for mobile ultrasound services.

Requirements for billing

Technical component (modifier –TC)

The following documentation is required for the technical component of an ultrasound study:

- Patient name, age, sex,
- Date and time of ultrasound exam,
- Name of ordering provider,
- The anatomic location of the procedure, including laterality as applicable, and type of procedure,

- A description of any contrast media or pharmaceutical used, including route of administration and dose when applicable,
- Specific ultrasound examination performed, including all joint spaces and structures examined,
- Output display standard (thermal index & mechanical),
- Address where study took place (for mobile providers).

Professional component (modifier –26)

The following documentation is required for the professional component of an ultrasound study:

- Patient's name, age, sex, *and*
- Date of study, *and*
- Indication for exam, *and*
- Relevant clinical information, including indication for the exam and/or relevant ICD-10 code, *and*
- The specific method use for endocavity techniques, if performed, *and*
- A description of the studies and/or procedures performed, *and*
- A description of any contrast media or pharmaceutical used, including route of administration and dose when applicable, *and*
- Anatomic measurements, if taken, *and*
- A description of examination findings, *and*
- Impression, conclusion, or summary statement, *and*
- Specific diagnosis, if appropriate, *and*
- Recommendation for follow-up, if necessary, *and*
- Accounting of any failure to include standard views or other necessary components, if necessary, *and*
- 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

General Information

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

Incomplete full spine studies

- 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**.

Link: See definitions of **fully spine study** and **incomplete full spine study** at the beginning of this chapter.

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. Don't bill CPT® code **76496** for these services.

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

Requirements for billing

Most radiology services include both a technical component (**–TC**) for producing the study and a professional component (**–26**) for interpreting the imaging study. When billing for radiology services, the reporting requirements for the component(s) billed must be met. See the Radiology reporting requirements policy in this chapter for more information.

Attending provider documentation

Attending 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.

Repeat X-rays

Per WAC 296-20-121, 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. Use these modifiers with CPT® radiology codes **70010**-**79999** to identify duplicate procedures performed on opposite sides of the body.

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 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?

Email L&I's Provider Hotline at PHL@Lni.wa.gov. If you would prefer a phone call, please email us your name and contact number.

