Washington State Department of
Labor & Industries

Chapter 11: Impairment Ratings and Independent Medical Exams (IMEs)

Payment Policies for Healthcare Services

Provided to Injured Workers and Crime Victims

Effective July 1, 2025

How to navigate this document

Use the keyboard command **CTRL+F** on Windows (**Command+F** on Mac) to search for specific topics. If you can't find what you're looking for, try different keywords or combinations of words.

The Table of Contents lists each policy. To jump to a policy, click on the page number.

Links to appendices

For definitions of terms used throughout these payment policies, see Appendix A: Definitions.

For explanations of modifiers referenced throughout these payment policies, see Appendix B: Modifiers.

For information about place of service codes, see Appendix C: Place of Service (POS).

Updates and corrections

An annual update of the entire payment policies and fee schedules (MARFS) is published routinely to coincide with the beginning of each state fiscal year (July 1).

Throughout the year, updates and corrections may be needed to modify existing policies and fees or create new ones. Updated and corrected information supersedes the policies in MARFS. Look for possible updates and corrections to these payment policies and fee schedules on L&I's website.

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Payment policy: Impairment ratings

Prior authorization

Prior authorization is only required when:

- A psychiatric impairment rating is needed, *or*
- An **Independent Medical Exam** (**IME**) is scheduled.

Only the claim manager may request and authorize local billing code **1198M** **(Impairment rating, addendum report)**.

When and how to perform an impairment rating

When to rate impairment

When the worker has reached maximum medical improvement (MMI) or when requested by the insurer. Impairment rating should occur during the closing exam.

Rate impairment only for medical conditions accepted under the claim.

Body areas and organ systems

For purposes of this chapter, the following body areas are recognized:

- Head, including the face,
- Neck,
- Chest, including breasts and axilla,
- Genitalia, groin, buttock,
- Back,
- Abdomen, *and*
- Each extremity.

Each extremity is counted once per extremity examined when determining standard or complex codes.

The following organ systems are recognized:

- Eyes,
- Ears, nose, mouth, and throat,
- Cardiovascular,
- Gastrointestinal,

- Respiratory,
- Genitourinary,
- Musculoskeletal,
- Skin,
- Neurologic,
- Psychiatric, *and*
- Hematologic/lymphatic/immunologic.

These definitions of body areas and organ systems must be used to distinguish between standard and complex impairment rating.

How to rate impairment

Use the appropriate rating system.

Link: For an overview of systems for rating impairment, see the Medical Examiners' Handbook.

Include the objective findings to support the impairment rating. The objective medical information is required if a worker requests the claim be reopened. **If there isn't an impairment, document that in the report.**

Impairment rating reports must include all of the following elements:

- **MMI**: Statement that the patient has reached maximum medical improvement (MMI) and that no further curative or rehabilitative treatment is recommended, *and*
- **Examination**: Pertinent details of the physical examination performed (both positive and negative findings). The report must include pertinent measurements (such as range of motion) even if they are within normal limits. This is important to document for comparison with potential reopening applications, *and*
- **Diagnostic tests**: Results of any pertinent diagnostic tests performed (both positive and negative findings). Include copies of any pertinent tests or studies ordered as part of the exam, *and*
- **Rating**: An impairment rating consistent with the findings and a statement of the system on which the rating was based. For example:
    - The AMA Guidelines to the Evaluation of Permanent Impairment Fifth Edition, *or*
    - The Washington State Category Rating System.
- **Rationale**: The rationale for the rating, supported by specific references to the clinical findings, especially objective findings and supporting documentation including

the specific rating system, tables, figures and page numbers on which the rating was based.

Links: Refer to WAC 296-20-19000 through WAC 296-20-19030 and WAC 296-20-200 through WAC 296-20-690, and for amputations refer to RCW 51.32.080.

Who must perform these services to qualify for payment

Qualified **Attending Providers (APs)** (see table below) may rate impairment of their own patients.

APs who are permitted to rate their own patients, with exception of chiropractors, don't need a separate provider account number and may use their existing provider account number. In order to perform impairment ratings, chiropractors must be an approved **IME** examiner, which requires a separate provider account. Chiropractors must bill using their **IME** examiner provider account number. Providers may only give ratings for areas of the body or conditions within their scope of practice.

If the **AP** is unable or unwilling to perform the rating examination, the **AP** can ask a **consultant** to perform the rating examination in accordance with table below.

Psychologists can't rate impairment for injured workers but may rate impairment for victims of crime.

Providers qualified to provide impairment ratings include the following:

Provider Type Code	Provider type	Can you rate impairment as an AP or consultant?
20	Medicine and surgery (MD)	Yes
21	Physicians' Assistant (PA/PA-C)	No
22	Osteopathic medicine and surgery (DO)	Yes
27	Dentistry (DDS/DMD)	Yes
28	Optometry (OD)	No
30	Chiropractic (DC)	Yes, if L&I-approved **IME** examiner
31	Psychology (PsyD/PhD)	No
32	Podiatric medicine and surgery (DPM)	Yes
40	Advanced Registered Nurse Practitioners (ARNP), including Psychiatric ARNPs	No
92	Naturopathy (ND)	No

Links: To see how these qualifications are set in state law, see WAC 296-20-2010.

For more details on the topic of impairment ratings, refer to the Medical Examiners' Handbook.

For more information, see L&I's Become a Chiropractic Consultant webpage.

For information on becoming an **IME** webage, see L&I's Independent Medical Exams and Impairment Rating Information.

Services that can be billed

When an impairment rating exam is requested by the insurer, it must be sufficient to achieve the purpose and reason per the request.

Choose the local billing code based on the number of body areas or organ systems that need to be examined to fully evaluate the accepted condition(s) or the condition(s) contended as work related (see fee schedule, below).

The report must document the relationship of the areas examined to the accepted work related injury(s) or contended condition(s).

Local billing code	Description	Maximum fee
1190M	**Comprehensive Hearing loss exam** Use this code for comprehensive examination of the hearing system. The hearing system is comprised of 2 organ systems that need to be thoroughly examined for evaluation of the contended or accepted condition(s). Use of this code requires: • This specialty exam is directed only toward the affected body area or organ system. • Familiarity with the history of the industrial injury, exposure or condition through worker interview and medical and work records if available. • Appropriate diagnostic tests needed, including audiograms, are ordered and interpreted by the physician. • The degree of impairment is based on the audiogram and is interpreted by a physician. • The report must contain the required elements noted in the Medical Examiners' Handbook. • Report conclusions address how the examined body areas or organ systems relate to the accepted or contended work related injury(s) or conditions(s). • A statement regarding eligibility for permanent partial impairment. Note: Per RCW 51.28.055, workers aren't eligible for a disability payment if they don't file a claim within 2 years of last injurious exposure. Office visits are considered a **bundled** service and are included in the impairment rating fee.	**$728.06**

Local billing code	Description	Maximum fee
1191M	**Impairment rating by attending physician, standard, 1-3 body areas or organ systems.** Use this code if there are 1-3 body areas or organ systems examined for sufficient evaluation of the accepted condition(s). Use of this code requires: • Familiarity with the history of the industrial injury or condition. • Physical exam is directed only toward the affected body area(s) or organ system(s). • Appropriate diagnostic tests needed are ordered and interpreted. • Impairment rating is performed. • Impairment rating report must contain the required elements noted in the Medical Examiners' Handbook. • Report conclusions address how the examined body areas or organ systems relate to the accepted or contended work related injury(s) or condition(s). Office visits are considered a **bundled** service and are included in the impairment rating fee.	**$728.06**

Local billing code	Description	Maximum fee
1192M	**Impairment rating by attending physician, complex, 4 or more body areas, or organ systems.** Use this code if there are 4 or more body areas or organ systems examined for sufficient evaluation of the accepted condition(s). • Familiarity with the history of the industrial injury or condition. • Physical exam is directed only toward the affected body areas or organ systems. • Appropriate diagnostic tests needed are ordered and interpreted. • Impairment rating is performed. • Impairment rating report must contain the required elements noted in the Medical Examiners' Handbook. • Report conclusions address how the examined body areas or organ systems relate to the accepted or contended work related injury(s) or condition(s). Office visits are considered a **bundled** service and are included in the impairment rating fee.	**$910.07**

Local billing code	Description	Maximum fee
1194M	**Impairment rating by consultant, standard, 1-3 body areas or organ systems.** Use this code if there are 1-3 body areas or organ systems examined for sufficient evaluation of the accepted condition(s). Use of this code requires: • Records are reviewed. • Physical exam is directed only toward the affected body area(s) or organ systems. • Appropriate diagnostic tests needed are ordered and interpreted. • Impairment rating is performed. • Impairment rating report must contain the required elements noted in the Medical Examiners' Handbook. • Report conclusions address how the examined body areas or organ systems relate to the accepted or contended work related injury(s) or condition(s). Office visits are considered a **bundled** service and are included in the impairment rating fee.	**$728.06**

Local billing code	Description	Maximum fee
1195M	**Impairment rating by consultant, complex, 4 or more body areas or organ systems.** Use this code if there are 4 or more body areas or organ systems examined for sufficient evaluation of the accepted condition(s). Use of this code requires: • Records are reviewed. • Physical exam is directed only toward the affected body areas or organ systems. • Appropriate diagnostic tests needed are ordered and interpreted. • Impairment rating is performed. • Impairment rating report must contain the required elements noted in the Medical Examiners' Handbook. • The report conclusions address how the examined body areas or organ systems relate to the accepted or contended work related injury(s) or condition(s). Office visits are considered a **bundled** service and are included in the impairment rating fee.	**$910.07**
1198M	**Impairment rating, addendum report.** Must be requested and authorized by the claim manager. Addendum report for additional information which necessitates review of new records. Payable to attending physician or **consultant**. This code isn't billable when the impairment rating report didn't contain all the required elements. (See the Medical Examiners' Handbook for the required elements.)	**$139.29**

Rating hearing loss

When performing a comprehensive exam for hearing loss, the report must include a statement regarding eligibility for permanent partial impairment. Per RCW 51.28.055, workers aren't eligible for a disability payment if they don't file a claim within 2 years of last injurious exposure.

Additional information: How to find out if an IME is scheduled

To see if an **IME** is scheduled for a claim:

- **State Fund**, use our secure online Claim & Account Center.
- **Self-insured**, contact the self-insured employer (SIE) or their third party administrator (TPA).
- **Crime Victims**, call **1-800-762-3716**.

Payment policy: Independent medical exams (IMEs)

General information

Independent medical exams (IMEs) are medical examinations requested by the department or self-insured employers to answer medical and legal questions about the claim. Performing IMEs or impairment ratings requires considerable judgement and understanding of specialized terms and a mastery of skills that aren't always part of a doctor's original training. **IME** providers must be familiar with and follow the Medical Examiners' Handbook.

Per RCW 51.36.070(2), the department or self-insurer shall provide the physician performing the exam all relevant **medical records** from the worker's claim file.

Who must perform services to qualify for payment

Only **department-approved IME** Providers with an **IME** provider account number can bill **IME** codes. Applications are available on our website. **Attending providers** eligible to become an **IME** examiner include:

- Medical physicians and surgeons,
- Osteopathic physicians and surgeons,
- Podiatric physicians and surgeons,
- Chiropractic physicians , *and*
- Dentists.

For more information on **becoming an approved IME provider** or to perform impairment ratings, see the Medical Examiners' Handbook.

To receive email updates on IMEs, subscribe to the ListServ.

Prior authorization

Prior authorization is only required when an **IME** is scheduled. To get prior authorization for claims that are:

- **State Fund**, use L&I's secure, online Claim & Account Center to see if an **IME** is scheduled.
- **Self-Insured**, contact the self-insured employer (SIE) or their third party administrator (TPA).
- **Crime Victims**, call **1-800-762-3716**.

Services that can be billed

Interpretation services during IMEs

Interpreter services are covered during IMEs. All interpreter requests must be scheduled through the scheduling system. For additional information regarding interpreter services, see Chapter 14: Language Access Services. For Sign Language interpretation, see Chapter 18: Other Services.

IME fee schedule

Local code	Description and notes	Maximum fee
1104M	**IME, addendum report** Must be requested and authorized by claim manager. Addendum report is for additional information that isn't requested in original assignment, which necessitates review of records. Not to be used in place of a new **IME**, if requested by the insurer. Fee already includes additional reimbursement for file review of 50 pages or less of records not previously provided by the insurer during the initial exam. For addendums over 50 pages, use **1129M**. To bill for review of **job analysis**, only use when records are reviewed and a report attesting to that review is submitted with the **job analysis**. The review of diagnostic testing or study results ordered by the examiner isn't separately payable or billable under this code. When diagnostics weren't ordered by the examiner originally, an addendum may be payable to account for review of the records. Not payable with **1066M**.	**$169.88**
1105M	**IME Physical Capacities Estimate** (F242-387-000) Must be requested by the insurer. If an exam is performed by multiple examiners, bill under only one of the performing examiner's provider account number. (Bill once per exam.)	**$37.18**

Local code	Description and notes	Maximum fee
1108M	**IME, standard exam – 1-3 body areas or organ systems** Use this code if there are only 1-3 body areas or organ systems examined for sufficient evaluation of the accepted condition(s). L&I expects that these exams will typically involve at least 30 minutes of face-to-face time with the worker. Use of this code requires: • Records reviewed by examiner and a report included with detailed chronology of the injury or condition as described in the Medical Examiners' Handbook. • Physical exam is directed only towards the affected **body area(s)** or **organ system(s)**. • Appropriate diagnostic tests needed are ordered and interpreted. • Impairment rating performed if requested. • The **IME** report containing the required elements noted in the Medical Examiners' Handbook. • Report conclusions address how the examined body areas or organ systems relate to the accepted or contended work related injury(s) or condition(s). • Review of up to 2 job analyses. **Note**: Additional examiners use **1112M**. **Note**: Compensation for downloading, printing and sorting files is **bundled** into the reimbursement for the examination fees.	**$728.06**

Local code	Description and notes	Maximum fee
1109M	**IME, complex exam – 4 or more body areas or organ systems** Use this code if there are 4 or more body areas or organ systems examined for sufficient evaluation of the accepted condition(s) or contended conditions. L&I expects that these exams will typically involve at least 45 minutes of face-to-face time with the worker. Use of this code requires: • Records reviewed by examiner and a report included with detailed chronology of the injury or condition as described in the Medical Examiners' Handbook. • Physical exam is directed only toward the affected body areas or organ systems. • Appropriate diagnostic tests needed are ordered and interpreted. • Impairment rating performed if requested. • The **IME** report containing the required elements noted in the Medical Examiners' Handbook. • Report conclusions address how the examined body areas or organ systems relate to the accepted or contended work related injury(s) or condition(s). • Review of up to 2 job analyses. **Note**: Additional complex examiners use **1126M**. **Note**: Compensation for downloading, printing and sorting files is **bundled** into the reimbursement for the examination fees.	**$910.07**

Local code	Description and notes	Maximum fee
1112M	**IME, additional examiner for Standard IME** Use where input from more than 1 examiner is combined into 1 report. Includes: • Record review, • Exam, *and* • Contribution to combined report. L&I expects these exams will typically involve at least 30 minutes of face-to-face time with the worker. **Note**: 1 examiner on IMEs with a combined report should bill a standard (**1108M**). **Note**: Compensation for downloading, printing and sorting files is **bundled** into the reimbursement for the examination fees.	**$728.06**
1118M	**IME by psychiatrist** Psychiatric diagnostic interview with or without direct observation of a physical exam. L&I expects these exams will typically involve at least 60 minutes of face-to-face time with the worker. Includes: • Review of records, other specialist's or provider's exam results, if any. • **Consultation** with other examiners and submission of a joint report if scheduled as part of a panel. • The **IME** report containing the required elements noted in the Medical Examiners' Handbook. • Impairment rating performed if requested. • Review of up to 2 job analyses. Also includes impairment rating, if applicable. **Note**: Compensation for downloading, printing and sorting files is **bundled** into the reimbursement for the examination fees.	**$1,319.61**

Local code	Description and notes	Maximum fee
1123M	**IME, communication issues** Exam was unusually difficult due to a worker's expressive problems, such as a stutter, aphasia or need for an interpreter in a case that required an extensive history as described in the report. If an interpreter is needed, verify and record name of interpreter in report. Bill once per examiner per exam. Isn't payable with a no show fee (1144M).	**$243.78**
1124M	**IME, other, by report** Requires prior authorization and prepay review: • For State Fund claims, contact the claims manager, or • For self-insured claims, contact the self-insured employer or third party administrator. Billable services under this code are limited to: • Research and review for chemically related illness (CRI) claims to be billed only by contracted providers authorized to perform CRI IMEs, • Security services for potentially violent workers, or • Guard services for incarcerated workers.	**By report**
1125M	**Physician travel per mile** Allowed when roundtrip exceeds 14 miles using Personally Owned Vehicles. Code usage is limited to extremely rare circumstances, such as IMEs in correctional facilities. Requires prior authorization and prepay review: • For State Fund claims, call Provider Quality and Compliance at **800-468-7870**, or • For self-insured claims, contact the self-insured employer or third party administrator.	**$5.96**

Local code	Description and notes	Maximum fee
1126M	**IME, additional examiner for Complex IME** Use where input from more than 1 examiner is combined into 1 report. Includes: • Record review, • Exam, and • Contribution to combined report. L&I expects these exams will typically involve at least 45 minutes of face-to-face time with the worker. **Note**: One examiner on an **IME** with a combined report should bill a complex **IME** (1109M). The **IME** report must meet the criteria required for a complex **IME** (**1109M**). **Note**: Compensation for downloading, printing and sorting files is **bundled** into the reimbursement for the examination fees.	**$910.07**
1128M	**Occupational disease report** (Doctor's Assessment of Work Relatedness for Occupational Diseases) Must be requested by insurer. Examples of conditions which L&I considers occupational diseases are: • Occupational carpal tunnel syndrome, • Noise-induced hearing loss, • Occupational dermatitis, and • Occupational asthma. The legal standard is different for occupational diseases from occupational injuries. Refer to RCW 51.080.140 on the definition for occupational disease. This is a detailed assessment of work relatedness, with the exact content presented in the Medical Examiners' Handbook. An examiner may bill this code **only once for each worker.** **Note:** An examiner can't use **1055M**. **1055M** is used by **attending providers** and **consultants**.	**$225.44**

Local code	Description and notes	Maximum fee
1129M	**IME, extensive file review by examiner** Units of service are based on the number of hardcopy pages reviewed by the **IME** examiner on microfiche, paper, Claim and Account Center, or other medium. Review of the **first 400 hardcopy pages** is included in the base exam fee (**1104M***, **1108M**, **1109M**, **1112M**, **1118M**, **1126M, 1130M, 1141M, 1142M, 1146M** or **1147M**). * Please see **1104M** description for specific information regarding billing **1104M** with **1129M**. Review of the first 50 hardcopy pages is included in the fee for **1104M**. Bill for each additional page reviewed beyond the first 400 hardcopy pages (for **1104M**, bill for each additional page beyond the first 50 hardcopy pages). Isn't payable with **IME** late cancellations (**1143M**) or **IME** no show fee (**1144M**). Only the following document categories will be paid for **unless** the authorizing letter requests a review of **all** documents: • Medical files, • History, • Report of Accident, • Reopen Application, *and* • Other documents specified by claim manager or requestor. Bill per examiner. Not payable for review of duplicate documents. **Note**: To be eligible for payment, a detailed chronology of the injury or condition must be included in the report as defined by the Medical Examiners' Handbook.	**$1.23**

Local code	Description and notes	Maximum fee
1130M	**IME, terminated exam** Bill for exam ended prior to completion. Requires file review, partial exam by the examiner and report (including reasons for early termination of exam). Bill per examiner. Terminated exams don't include failure to obtain an interpreter. Terminated exams are payable when the worker is uncooperative, becomes obstructive (for example, the exam starts and the worker insists on recording but hadn't provided required notice), or becomes ill in the middle of the exam. **Note**: A partial exam is face-to-face time between the examiner and the worker where, at a minimum, the worker's history is obtained. **Note**: **1130M** or **1143M** can't be billed together. Only one code can be billed per the determination on whether it was a termination or cancellation.	**$431.85**
1139M	**No show fee for missed neuropsychological testing.** Must be scheduled or approved by department or self-insurer in conjunction with an **independent medical examination**. (For more information, see: WAC 296-20-010(5).) This code is payable only once per **independent medical examination** assignment. Must notify department or self-insurer of no-show as soon as possible. Bill only if worker fails to show and appointment can't be filled.	**$1,084.03**

Local code	Description and notes	Maximum fee
1140M	**No show fee for missed Functional Capacity Evaluation (FCE).** Must be scheduled or approved by department or self-insurer in conjunction with an **independent medical examination**. (For more information, see: WAC 296-20-010(5).) This code is payable only once per **independent medical examination** assignment. The code is only payable to the rendering provider performing the FCE in conjunction with the exam. Must notify department or self-insurer of no show as soon as possible. Bill only if worker fails to show and appointment can't be filled.	**$346.77**

Local code	Description and notes	Maximum fee
1141M	**IME, rare specialty exam – 1-4 or more body areas or organ systems** Use this code in lieu of **1108M** or **1109M** when exam is performed by 1 of the following rare provider specialties: • Allergy and Immunology • Cardiology • Dermatology • Endocrinology • Gastroenterology • Hematology • Obstetrics and Gynecology • Oncology • Ophthalmology • Pain Medicine/Dolorology • Pulmonology • Thoracic surgery • Urology • Vascular surgery L&I expects these exams will typically involve at least 30 minutes of face-to-face time with the worker. **Note**: Follow the exam requirements for either **1108M** or **1109M** depending on number of body areas or organ systems involved. This specialty list may be updated depending on the number of examiners available. For additional rare specialty examiners use **1142M**. **1108M** or **1109M** may be billed with an **1141M** if 1 of the examiners is completing a standard or complex exam, and the other is completing a rare specialty exam. Only the rare specialty examiner may bill **1141M**. **Note**: Compensation for downloading, printing and sorting files is **bundled** into the reimbursement for the examination fees.	**$1,319.61**

Local code	Description and notes	Maximum fee
1142M	**IME, additional examiner for Rare Specialty IME** Use where input from more than 1 rare specialty examiner is combined into 1 report. Includes: • Record review, • Exam, *and* • Contribution to combined report. L&I expects these exams will typically involve at least 30 minutes of face-to-face time with the worker. **Note**: 1 rare specialty examiner on IMEs with a combined report should bill a rare specialty **IME** exam (**1141M**). **Note**: Compensation for downloading, printing and sorting files is **bundled** into the reimbursement for the examination fees.	**$1,319.61**
1143M	**IME late cancellation fee, per examiner** Bill only if worker cancels the appointment within 5 business days prior to exam. May be billed if worker arrives for exam but the exam can't start due to obstructive behavior (for example, worker insists on recording exam but didn't provide required notice). Billable if appointment time can't be filled. (Business days are Monday through Friday.) Isn't payable for no shows of **IME** related services (for example, neuropsychological evaluations) or when **IME** provider cancels exam (for example, provider wants to co-record and worker doesn't allow) **IME** providers must notify department or self-insurer of no show as soon as possible. **Note**: **1130M** and **1143M** can't be billed together. Only one code can be billed per the determination on whether it was a termination or cancellation.	**$399.88**

Local code	Description and notes	Maximum fee
1144M	**IME no show fee, per examiner** Bill only if worker fails to show, and appointment time can't be filled. Isn't payable for no shows of **IME** related services (for example, neuropsychological evaluations). **IME** providers must notify department or self-insurer of no show as soon as possible. For more information, see WAC 296-20-010.	**$399.88**
1145M	**IME, for multiple claims**. Requires prior authorization Bill by unit (1 unit = 1 additional claim). This code is used in addition to the primary **IME** exam code (**1108M, 1109M, 1112M, 1118M, 1126M, 1130M, 1141M, 1142M, 1146M** or **1147M**) only. This can't be reported as a stand-alone code A maximum of 5 additional claims (units) are billable with this code. Anytime 6 or more additional claims are included, special review and authorization is required by the insurer. Not payable when only 1 claim is examined. Bill per examiner. **Note:** Don't bill a unit for the first claim. The first claim must be billed using a base exam code (such as **1108M**).	**$140.54 per unit**
1146M	**Forensic IME** Requires prior authorization Bill only if the worker is unavailable for the physical portion of the **IME** exam. Isn't payable for no shows of **IME** related services (for example, neuropsychological evaluations). **Note**: Compensation for downloading, printing and sorting files is **bundled** into the reimbursement for the examination fees.	**$431.85**

Local code	Description and notes	Maximum fee
1147M	**Correctional facility IME** Bill for IMEs conducted at a correctional facility, if the examiner travels to the facility. This code requires prior authorization. Examiners may also bill for travel to conduct anr **IME** conducted at a correctional facility; bill using **1125M**, which requires prior authorization.	**$2,730.22**

Requirements for billing

State Fund (L&I) provider account number requirements for IMEs

For IMEs, examiners working through a firm need 1 **IME** provider account number for each payee.

An **IME** examiner who isn't working through an **IME** firm will need 1 **IME** provider account number, which will also serve as their payee number.

Bills for testing or other services performed in conjunction with an **IME** must be submitted by the provider who rendered the service (WAC 296-20-125(3)(o)). These services include:

- X-ray, diagnostic laboratory tests in conjunction with **IME** (append modifier **–26** and **–7N**).
- Psychological/neurological testing CPT® codes – **90791**, **96136, 96137, 96138, 96139.** Automated testing and results for psychological/neurological CPT® code **96146**. (For more detailed information on psychological/neurological services, refer to Chapter 17: Mental Health and Behavioral Health Interventions (BHI).)
- Functional Capacity Evaluations (FCE) – **1045M.**
    - **IME** examiners may only review and comment on an FCE as part of the exam. Please see Medical Examiners' Handbook.

Body areas and organ systems

For billing purposes, the following body areas are recognized:

- Head, including the face,
- Neck,
- Chest, including breasts and axilla,
- Genitalia, groin, buttock,
- Back,

- Abdomen, *and*
- Each extremity.

Each extremity is counted once per extremity examined when determining standard or complex codes.

The following organ systems are recognized:

- Eyes,
- Ears, nose, mouth, and throat,
- Cardiovascular,
- Gastrointestinal,
- Respiratory,
- Genitourinary,
- Musculoskeletal,
- Skin,
- Neurologic,
- Psychiatric, *and*
- Hematologic/lymphatic/immunologic.

Standard and complex coding

The exam should be sufficient to achieve the purpose and reason the exam was requested.

Choose the code based on the number of body area(s) or organ system(s) that are examined to fully evaluate the accepted condition(s) or the condition(s) contended as work related.

The report must documentsthe relationship of the areas examined to the accepted work related injury(s) or contended condition(s).

The definitions of body area(s) and organ system(s) above must be used to distinguish between standard and complex IMEs.

Payment limits

Limit on total scheduled exams per day

L&I has placed a limit of 12 **independent medical examination**s scheduled per examiner per day. For psychiatrist examiners, the limit is 8 per day.

This limit includes IMEs scheduled for State Fund and self-insured claims. The applicable codes include:

- **1108M IME**, standard exam – 1-3 body areas or organ systems,
- **1109M IME**, complex exam – 4 or more body areas or organ systems,
- **1112M IME**, additional examiner for Standard **IME**,
- **1118M IME** by psychiatrist,
- **1126M IME** additional examiner for Complex **IME**,
- **1130M IME**, terminated exam,
- **1141M IME,** rare specialty exam,
- **1142M IME,** additional examiner for Rare Specialty **IME**,
- **1143M IME,** late cancellation fee,
- **1144M IME,** no show fee,
- **1146M IME,** forensic exam,
- **1147M IME,** correctional facility exam

Payment policy: Radiology reporting requirements for IMEs

Requirements for billing

Documentation for the professional interpretation of radiology procedures is required for all professional component billing.

Documentation includes:

- Charting of justification,
- Findings,
- Diagnoses, *and*
- Test result integration, including a comparison between repeat radiology studies where applicable.

When billing for the professional component of radiology services, bill using modifier **–26** and modifier **–7N**.

IME providers who read imaging studies they order in relation to an **IME**, or reinterpret imaging studies previously performed, are required to document their findings within the **IME** report. Each imaging study must be separately documented in its own section and include all of the following:

- Patient's name, age, sex, *and*
- Date the imaging study was performed, *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*
- When ordering imaging studies, a brief sentence describing the 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 **IME** report. If the same imaging study was performed on multiple dates of service, the provider must document a comparison between the studies, in sequential order, noting any significant changes that occurred. For example:
  - For a neck comparison where there is a difference between the original imaging study and the most recent findings, the impression could be: “A comparison of this recent study from 7/1/2019 is made to the study of 5/1/2018. 5/1/2018 which noted narrowing of the disc space at C-5 with bony protuberance at right facet causing impingement. New image from 7/1/2019 shows bony protuberance has grown 5mm and is contributing to increased impingement of the nerve root. This appears to be a continuation of a natural growth process.”

In addition to the above information, when reinterpreting imaging studies, the **IME** provider must document whether they are or aren’t in agreement with original interpretation of the imaging study.

Note: Documentation such as "X-rays are negative" or "X-rays are normal", or documentation that just restates the notes/recommendations of the radiologist doesn’t fulfill the reporting requirements described in this section and the insurer **won’t pay** for the professional component in these circumstances. The provider reviewing the radiologist’s report must document their own interpretation of the diagnostic service.

Payment limits

Reinterpretation of imaging studies

Reinterpretation of imaging studies may only be billed once per panel exam. The reinterpretation is only payable for studies related to the accepted or contended condition.

In addition, services must be billed with the correct CPT® code for the specific imaging study reinterpreted, along with modifier **-26** and modifier **-7N**.

Example of how to bill for IME services including reinterpretation of imaging studies

The following example demonstrates how to bill when **IME** providers perform a reinterpretation of imaging studies. This example isn't reflective of the documentation requirements for an **IME**.

Example: A panel **IME** is performed on 7/1/21 meeting the documentation criteria for a complex **IME**. The **IME** providers review and appropriately document the review of the following imaging studies, all related to the accepted conditions:

- 1 – 3 view knee x-ray performed 6/1/19
- 2 – 2 view shoulder x-rays performed 6/1/19 and 8/2/20
- 1 – Shoulder MRI without contrast

The correct billing for the services is:

Examiner 1

Line item	Procedure code (and modifiers)	Number of Units
1	**1109M**	1
2	CPT® **73562-26-7N**	1
3	CPT® **73030-26-7N**	2
4	CPT® **73221-26-7N**	1

Examiner 2

Line item	Procedure code (and modifiers)	Number of Units
1	**1126M**	1

Note: Reinterpretation is only payable once per panel exam.

Links to related topics

If you're looking for more information about…	Then see…
Administrative rules and other Washington state laws for impairment ratings	Washington Administrative Code (WAC) 296-20-19000 WAC 296-20-19030 WAC 296-20-200 WAC 296-20-2010 WAC 296-20-690 Revised Code of Washington (RCW) 51.32.080
Administrative rules for Billing procedures	Washington Administrative Code (WAC 296-20-125)
Administrative rules for IME no shows	WAC 296-20-010
Application to become an IME provider	F245-046-000
Becoming an L&I IME provider	Become an IME Provider on L&I's website
Becoming an L&I provider	Become A Provider on L&I's website
Billing instructions and forms	Chapter 2: Information for All Providers
Fee schedules for all healthcare services (including impairment ratings)	Fee schedules on L&I's website
How to perform an impairment rating	Medical Examiner's Handbook
Laws for Medical Aid	RCW 51.28.055
Mental Health and Behavioral Health Interventions (BHI)	Chapter 17: Mental Health and Behavioral Health Interventions (BHI)
Performing **impairment ratings**	Medical Examiner's Handbook
Receiving **email updates on IMEs**	Subscribe to L&I's ListServ

Need more help?

Contact Provider Hotline with billing and authorization questions by emailing PHL@Lni.wa.gov or calling **1-800-848-0811** between 8 am and 12 pm PT Monday through Friday.

