Washington State Department of
Labor & Industries

Chapter 8: Electrodiagnostics and Radiology

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: All 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.

For billing purposes, the **technical component** (modifier **–TC**) accounts for equipment costs, supplies, and clinical staff (technicians) involved in producing the test or procedure. The **professional component** (modifier **–26**) accounts for the interpretation of the study.

Technical quality

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

Requirements for billing

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.

Modifiers

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.

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

Component eligibility

The **technical component** (modifier **–TC**) can only be billed by the facility or provider's practice where the radiology service was actually performed. For example, an X-ray was taken by an ordering provider or a technician in their practice, then the ordering provider may bill for the technical component. However, if the X-ray was taken at a facility outside the ordering provider's practice, then the ordering provider can't bill for the technical component. Only 1 technical component is allowed per study.

The **professional component** (modifier **–26**) can only be billed by the provider who personally performed an interpretation and has met all reporting requirements.

If a provider is billing for a **global radiology service**, the provider must meet each component eligibility for both modifier **–TC** and modifier **–26**.

Documentation requirements

Documentation for each component of radiology services is required, whether billed separately or as part of a **global service**.

Technical component (modifier–TC)

Any provider who is billing separately for the **technical component** (**–TC**) is required to submit documentation to the insurer to support that a radiology service was performed. The documentation must include the following:

- Patient name, age, sex, *and*
- Date of study, *and*
- Name of ordering provider, *and*
- 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: Documentation for the **technical component** may be included within the ordering provider's chart note for the office visit where the radiology service was ordered and performed.

Professional component (modifier –26)

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.”

Note: Documentation for the **professional component** may be included within the provider’s chart note or as a separate report. Copying an imaging report with interpretation from another provider into a chart note isn’t enough to support billing of the **professional component** or a global service.

Attending provider (AP) documentation

APs who 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.
- Acknowledging and integrating the imaging findings into their case management. **APs** 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

Documentation such as "X-rays are negative" or "X-rays are normal" don’t fulfill the reporting requirements described in this policy and the insurer **won’t pay** for the professional component (**–26**) separately or as part of a global service in these circumstances.

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

The **professional component** (**–26**) must be billed by the provider who performed an independent interpretation the study, under their individual provider number.

Payment policy: Biofeedback

Who must perform these services to qualify for payment

Practitioners must submit a copy of their biofeedback certification or supply evidence of their qualifications to the department or self-insurer to administer biofeedback treatment to workers. Administration of biofeedback treatment is limited to practitioners who:

- Are certified by the Biofeedback Certification Institute of America (BCIA), *or*
- Meet the minimum education, experience, and training qualifications to be certified.

Paraprofessionals who aren't independently licensed must practice under the direct supervision of a qualified, licensed practitioner:

- Whose scope of practice includes biofeedback, *and*
- Who is BCIA certified or meets the certification qualifications.

A qualified or certified biofeedback provider who isn't licensed as a practitioner may not receive direct payment for biofeedback services.

Link: For more information and a legal definition of licensed practitioner, see WAC 296-21-280 and WAC 296-20-01002.

Prior authorization

Biofeedback treatment requires an **attending provider**'s order and prior authorization.

When the condition is accepted under the industrial insurance claim, the insurer will authorize biofeedback treatment for:

- Idiopathic Raynaud's disease,
- Temporomandibular joint dysfunction,
- Myofascial pain dysfunction syndrome (MPD),
- Tension headaches,
- Migraine headaches,
- Tinnitus,
- Torticollis,
- Neuromuscular reeducation as result of neurological damage in a stroke (also known as "CVA") or spinal cord injury,
- Inflammatory and/or musculoskeletal disorders causally related to the accepted condition.

Link: For more information, see WAC 296-21-280.

12 biofeedback treatments in a 90 day period will be authorized for the conditions listed above when an evaluation report is submitted documenting all the following:

- The basis for the worker's condition, *and*
- The condition's relationship to the industrial injury, *and*
- An evaluation of the worker's current functional measurable modalities (for example, range of motion, up time, walking tolerance, medication intake), *and*
- An outline of the proposed treatment program, *and*
- An outline of the expected restoration goals.

No further biofeedback treatments will be authorized or paid for without substantiation of evidence of improvement in measurable, functional modalities (for example, range of motion, up time, walking tolerance, medication intake). Also:

- Only 1 additional treatment block of **12 treatments per 90 days** will be authorized, *and*
- Requests for biofeedback treatment beyond **24 treatments or 180 days** will be granted only after file review by and on the advice of the department's medical **consultant**.

In addition to treatment, pretreatment and periodic evaluation will be authorized. Follow-up evaluation can be authorized at 1, 3, 6, and 12 months post treatment.

Home biofeedback device rentals are time limited and require prior authorization.

Link: Refer to WAC 296-20-1102 for the insurers' policy on rental equipment.

Services that can be billed

CPT® codes **90875** and **90876** are payable to L&I approved biofeedback providers who are clinical psychologists or psychiatrists (MD or DO).

CPT® codes **90901**, **90912**, and **90913** are payable to any L&I approved biofeedback provider.

HCPCS code **E0746** is payable to **DME** or pharmacy providers (for rental or purchase).

Requirements for billing

The supervising licensed practitioner must bill the biofeedback services for paraprofessionals.

When biofeedback is performed along with individual psychotherapy, bill using either CPT® code **90875** or **90876**.

Don't bill CPT® codes **90901**, **90912**, or **90913** with the individual psychotherapy codes.

Use evaluation and management codes for diagnostic evaluation services.

Payment limits

CPT® code **90901** is limited to **1 unit of service per day**, **90912** is limited to **1 unit per day** and **90913** is limited to **3 units per day** regardless of the number of modalities.

For HCPCS code **E0746**, use of the device in the office isn't separately payable.

Payment policy: Contrast material

General information

The Average Wholesale Price (AWP) is a pharmacy reimbursement formula by which the pharmacist is reimbursed for the cost of the product plus a mark-up. The AWP is an industry benchmark, which is developed independently by companies that specifically monitor drug pricing.

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: Electrocardiograms (EKG)

Service that can be billed

Separate payment is allowed for electrocardiograms (CPT® codes **93000**, **93010**, **93040**, and **93042**) when an interpretation and report is included. These services may be paid along with office services.

Services that aren't covered

EKG tracings without interpretation and report (CPT® codes **93005** and **93041**) aren't payable with office services.

Payment limits

Transportation of portable EKG equipment to a facility or other patient location (HCPCS code **R0076**) is **bundled** into the EKG procedure and isn't separately payable.

Note: For more information on portable radiology services, including mobile EKG, see Chapter 23: Telehealth, Remote, and Mobile Services.

Payment policy: Electrodiagnostic services

Who must perform these services to qualify for payment

Prior to performing and billing for these services, physical therapists (PTs) performing electrodiagnostic testing must provide documentation of proper Department of Health (DOH) licensure to L&I's Provider Credentialing.

PTs who meet the requirements of DOH rules may provide electroneuromyographic tests.

Links: For information on where to send proper license documentation, contact L&I's Provider Credentialing at PACMail@Lni.Wa.Gov.

To see the DOH rules, refer to WAC 246-915-370.

Services that can be billed

The insurer covers the use of electrodiagnostic testing, including nerve conduction studies and needle electromyography only when:

- Proper and necessary, *and*
- Testing meets the requirements described in L&I's Electrodiagnostic testing coverage decision.

Performance and billing of NCS (including SSEP and H-reflex testing) and EMG that consistently falls outside of the American Association of Neuromuscular & Electrodiagnostic Medicine (AANEM) recommended number of tests may be reviewed for quality and whether it is "proper and necessary."

Qualified PT providers may bill for the technical and professional portion of the nerve conduction and electromyography tests performed.

Services that aren't covered

Electrodiagnostic testing isn't covered when:

- It isn't proper and necessary (see Note and Link, below this list), *or*
- Performed in a mobile diagnostic lab in which the specialist physician isn't present to examine and test the patient, *or*
- Performed with noncovered devices, including:
    - Portable, *and*
    - Automated, *and*

- “Virtual” devices not demonstrated equivalent to traditional lab based equipment (for example, NC-stat®, Brevio), *or*

- Determined to be outside of AANEM recommended guidelines without proper documentation supporting that the testing is proper and necessary.

In general, repetitive testing isn’t considered proper and necessary except if:

- Documenting ongoing nerve injury (for example, following surgery), *or*
- Required to provide an impairment rating, *or*
- Documenting significant changes in clinical condition.

Link: The legal definition of “proper and necessary” is available in WAC 296-20-01002.

Requirements for billing

Billing of electrodiagnostic medicine codes must be in accordance with CPT® code definitions and supervision levels.

Link: The complete requirements for appropriate electrodiagnostic testing are available online.

Billing of the technical and professional portions of the codes may be separated. However, the physician billing for interpretation and diagnosis (professional component) must have direct contact with the patient at the time of testing.

Note: The insurer may recoup payments made to a provider, plus interest, for NCS and EMG tests paid inappropriately.

Example: Reasonable limits on units required to determine a diagnosis

The table below was developed by the AANEM and summarizes reasonable limits on units required, per diagnostic category, to determine a diagnosis 90% of the time.

Note: Review of the quality and appropriateness (whether the test is “proper and necessary”) may occur when testing repeatedly exceeds AANEM recommendations.

Recommended maximum number of studies by indication (from “AANEM Table 1”; recreated and adapted with written permission from AANEM):

Indication	Needle EMG CPT® 95860-95864, 95867-95870	NCS CPT® 95907-95913	Other EMG studies CPT® 95907-95913		
	# of tests	Motor NCS with and without Fwave	Sensory NCS	H-Reflex	Neuromuscular Junction Testing (repetitive stimulation)
Carpal tunnel (unilateral)	1	3	4	—	—
Carpal tunnel (bilateral)	2	4	6	—	—
Radiculopathy	2	3	2	2	—
Mononeuropathy	1	3	3	2	—
Poly/ mononeuropathy multiplex	3	4	4	2	—
Myopathy	2	2	2	—	2
Motor neuronopathy (for example, ALS)	4	4	2	—	2
Plexopathy	2	4	6	2	—
Neuromuscular Junction	2	2	2	—	3
Tarsal tunnel (unilateral)	1	4	4	—	—
Tarsal tunnel (bilateral)	2	5	6	—	—
Weakness, fatigue, cramps, or twitching (focal)	2	3	4	—	2

Indication	Needle EMG CPT® 95860-95864, 95867-95870	NCS CPT® 95907-95913	Other EMG studies CPT® 95907-95913		
	# of tests	**Motor NCS with and without Fwave**	**Sensory NCS**	**H-Reflex**	**Neuromuscular Junction Testing** (repetitive stimulation)
Weakness, fatigue, cramps, or twitching (general)	4	4	4	—	2
Pain, numbness, or tingling (unilateral)	1	3	4	2	—
Pain, numbness or tingling (bilateral)	2	4	6	2	—

Payment policy: Extracorporeal shockwave therapy (ESWT)

Services that aren’t covered

The insurer doesn’t cover extracorporeal shockwave therapy because there is insufficient evidence of effectiveness of ESWT in the medical literature. See L&I’s coverage decision for details.

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 22: Surgery.

Payment policy: Ultrasound

General information

For more information on reporting requirements, see the All radiology services policy in this chapter.

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 account number and provide documentation to support the service rendered.

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

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.

Documentation requirements

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.

For more information on reporting requirements, see the All radiology services policy in this chapter.

Services that can be billed

Full spine studies

Radiologic exams of the entire spine (also known as full spine studies) must always include the entire thoracic and lumbar regions. These studies also may include the skull, cervical and sacral regions, if performed. Depending on the size of the film and size of the patient, the study may require 6 or more views. Providers must bill the correct code, based on the number of views taken to complete the study.

- 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**.

For studies that do not include radiographs of the entire thoracic and/or lumbar spine, the applicable spinal region radiograph CPT® code(s) must be billed.

Transportation of portable equipment

HCPCS codes **Q0092**, **R0070** and **R0075** may be payable for mobile X-ray services. See the Portable Radiology Services policy in Chapter 23: Telehealth, Remote, and Mobile Services.

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 All radiology reporting requirements policy in this chapter for more information, including documentation requirements for the ordering and performing providers.

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 biofeedback	Washington Administrative Code (WAC) 296-21-280
Administrative rules for the definitions of "licensed practitioner" and "proper and necessary"	WAC 296-20-01002
Administrative rules for the policy on rental equipment	WAC 296-20-1102
Administrative rules for the requirements on who may provide electroneuromyographic tests	WAC 246-915-370
Administrative rules for X-ray custody requirements	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
Coverage decision for **electrodiagnostic testing**	Electrodiagnostic testing coverage decision
Coverage decision for extracorporeal shockwave therapy	Extracorporeal shockwave therapy coverage decision
Dynamic Spinal Visualization coverage decision	Dynamic spinal visualization coverage decision
Fee schedules for all healthcare professional services (including chiropractic)	Fee schedules on L&I's website
Payment policies for **physical medicine services**	Chapter 20: Physical Medicine
Payment policies for **surgery**	Chapter 22: Surgery

If you're looking for more information about…	Then see…
Submission of proper license documentation to perform electrodiagnostic services	PACMail@Lni.wa.gov

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.