

PART II

**PORTABLE X-RAY AND CT SCAN SERVICES
MANUAL**



**GEORGIA DEPARTMENT OF COMMUNITY HEALTH
DIVISION OF MEDICAID
July 1, 2019**

Policy Revisions Record

Part II

Manual for Portable X-ray and CT Scan Services

Revision Date	Section	Revision Description	Revision Type	Citation
			A=Added D=Deleted M=Modified	(Revision required by Regulation, Legislation, etc.)
01/01/2019		Revised language stating 'only pay for single transportation payments, per trip to a facility or location for a single date of service'	M	NA
4/1/2019		No changes		NA
7/1/2019		Appendix A – CMS 1500 Claim Form	A	NA

Table of Contents

Overview.....	4
Covered Services.....	5
Reimbursement Policy	6
Billing Requirements	7
Provider Requirements	8
Provider Responsibilities.....	9
Limitations.....	10
Fee Schedule	11
Appendix A: CMS 1500 Form	12

Overview

The Department of Community Health (DCH) portable diagnostic x-ray and computed tomography scan services will provide portable radiological services to eligible members who are unable to travel to a physician's office or outpatient radiology facility. Portable x-rays and computed tomography scans will allow DCH to meet the needs of members and providers, while complying with all applicable Federal and State statutes and regulations.

The purpose of this manual is to set forth the conditions and requirements that portable x-ray providers must meet in-order to qualify for reimbursement under the Georgia Medicaid program. The manual is intended to make available to portable x-ray suppliers a ready reference of information and procedural material needed for the prompt and accurate submission of claims. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis. Providers are required to use industry medical billing standards and compliant codes on all claim submissions. The codes should denote the services and/or radiological procedures performed. The billed procedures are required to be fully supported with documented medical necessity by treating physician.

Covered Services

Specific diagnostic radiology services for an eligible member may be performed in the following places of service: Home and Community Based Services, Skilled Nursing Facility, Home Health and Hospice (Place of Service: 31, 32, 33 or 34) to include the member's place of residence (Place of Service: 12). Portable X-ray services may be provided to a member in his or her place of residence. The member place of residence is defined by the Division of Georgia Medicaid as the member's own dwelling, a residential care facility, or nursing facility. Portable X-ray services are not covered in hospital settings.

The portable x-ray and computed tomography scan services are only considered for payment when medically necessary and ordered by the member's physician.

Covered radiographs are limited to:

- Skeletal x-rays of a member's arm, legs, pelvis, vertebral column or skull,
- Chest x-rays which do not involve the use of contrast media, and
- Abdominal x-rays which do not involve the use of contrast media.

Note: The portable x-ray and computed tomography scan fee schedule reimbursement rate is the same basis as modifier TC services generally used.

Reimbursement Policy

Transportation of portable x-ray equipment is reimbursable only when the equipment used is actually transported to the location where x-ray services are provided. Georgia Medicaid will not reimburse for the transportation of the portable x-ray equipment when the x-ray equipment is stored at a facility for use as needed.

Georgia Medicaid pays for the transportation component once for each trip to a facility or particular location. Therefore, providers should make every effort to schedule all members at a single location during a single trip to that location. If more than one member at the same location is x-rayed, the portable x-ray transportation fee is allocated among the members who receive portable x-ray services in a single trip.

The physician's order must clearly state the following:

- Suspected diagnosis or reason the x-ray is required,
- Area of the body to be x-rayed or scan,
- Number of radiographs ordered, and
- Precise views needed.

The member's place of residence is defined as:

- The member's private residence,
- Hospice, or
- Skilled nursing facility.

Billing Requirements

Georgia Medicaid reimburses the Healthcare Common Procedure Coding System (HCPCS) codes R0070 and R0075. The Division reimburse HCPCS code R0070 (transportation of portable x-ray equipment), per trip to facility or location, as one member seen. HCPCS code R0075 (transportation of portable x-ray equipment), per trip to facility or location for portable x-ray providers, of more than one member seen.

When submitting a claim for procedure code R0075, the provider is required to use a modifier to indicate the total number of Georgia Medicaid members served at the location. The provider is also required to submit a separate claim for each Georgia Medicaid member. A claim with procedure code R0075 will be denied if it is submitted without an appropriate modifier. Each claim for a single location and date of service must indicate the same x-ray transportation procedure code and modifier for all members seen during that visit.

- R0070 - Portable x-ray equipment and personnel to the member's home or nursing home, per trip to a facility or other location.
- R0075 - Transportation of portable x-ray equipment and personnel to home or nursing home, per trip to facility or location, of more than one member seen, per trip to facility or location. R0075 must be billed in conjunction with the CPT radiology codes (70000 series) and only when the x-ray equipment used was actually transported to the location where x-ray and computed tomography scan services were performed for use as needed.

Below are the definitions for each modifier that must be reported with R0075. Only one of these five modifiers should be reported with R0075.

Note: If only one member is served, R0070 should be reported with no modifier since the description for this code reflects only one member seen.

(no modifier if one patient served)

UN - Two patients served

UP - Three patients served

UQ - Four patients served

UR - Five patients served

US - Six or more patients served

Payment for the above modifiers must be consistent with the definition of the modifiers. Provider must append modifiers, UN, UP, UQ, UR and US with code R0075, the total payment for the service shall be divided by 2, 3, 4, 5 and 6 respectively. For example, modifier US, the total payment for the service shall be divided by 6 regardless of the number of members served. If provider served 8 patients, R0075 would be reported with modifier US and the total payment for this service would be divided by 6.

Provider Requirements

In order to bill Georgia Medicaid for portable x-ray and computed tomography scan services, providers must:

- Comply with all Medicare and Medicaid guidelines for portable x-ray providers,
- Maintain certification to practice radiology in the state of Georgia,
- Enroll with Georgia Medicaid as a portable x-ray provider, and
- Exist independently of any hospital, clinic or physician's office.

The physician order must be written and ordered by the member's physician before any portable x-rays and /or computed tomography scan services are provided. The claim for reimbursement must indicate the name of the physician who ordered the service before payment.

Provider Responsibilities

The portable x-ray provider is responsible for determining that a member is Medicaid eligible on the date of service. Providers must maintain complete, individual, accurate and legible records. Records must include documentation of services provided to members and billed to Georgia Medicaid. Records must include a written order, original signature of the member's treating physician, date test was ordered, member's diagnosis, and the specific x-ray(s) requested. These records must be available upon request to the Office of Inspector General for investigation by the Medicaid Fraud Control Unit or for any audit purpose.

Portable x-ray providers must keep the following records for each member for a period of at least 7 years:

- A copy of the written, signed and dated order by the member's physician,
- The date of the portable x-ray examination,
- The name of the physician who performed the professional interpretation of the procedure, and
- The date the radiograph was sent to the physician.

Portable x-ray providers will **not** be reimbursed for the following services:

- Procedures involving fluoroscopy.
- Procedures involving the use of contrast media.

- Procedures requiring the administration of a substance to the member the injection of a substance, or the spinal manipulation of the member.
- Procedures requiring special technical competency and/or special equipment or materials.
- Routine screening procedures such as annual physicals
- Procedures which are not of a diagnostic nature, e.g., therapeutic x-ray treatments.
- Setup of portable x-ray and equipment at the site of service, and transportation and/or set up charges for portable radiological services, (Level II HCPCS code Q0092) are not reimbursable.
- Portable x-ray services are not covered in hospital settings.
- Annual x-rays.

Limitations

These services are limited to true medical necessity radiological services that substantiate the need for portable x-rays and computed tomography scans to members who are unable to travel to a physician's office or outpatient radiology facility.

Portable providers must use the most appropriate Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) codes representing the service performed when submitting portable x-ray claims to Georgia Medicaid. Guidelines indicated in the CPT manual are to be followed when billing for these services unless specifically directed otherwise by Georgia Medicaid.

Only the codes that are included in the Portable X-Ray and CT Scan Fee Schedule may be billed to Georgia Medicaid for reimbursement. Portable radiology services should not be performed for routine purposes or for reasons of convenience. Reimbursement is limited to the applicable portable x-ray and computed tomography scan services fee schedule rates for the radiological service and transportation with use of applicable modifiers.

Georgia Medicaid reserves the right to review and revise periodically when necessary. If appropriate coding/billing guidelines and/or current reimbursement policies are not followed, Georgia Medicaid may:

- Reject or deny the claim, and
- Recover and/or recoup claim payment.

Fee Schedule

For further Information regarding the Portable X-rays and CT Scans Fee Schedule can be obtained on www.gammis.com following the links under “Provider Manual”, “Provider Information”, “Fee Schedules”, and “Portable X-Rays and CT Scans Fee Schedule”.

APPENDIX A



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

☐ PICA ☐												☐ PICA ☐																																			
1. MEDICARE ☐ MEDICAID ☐ TRICARE ☐ CHAMPVA ☐ GROUP HEALTH PLAN ☐ FECA BLK LUNG ☐ OTHER ☐ (Medicare#) (Medicaid#) (ID#/DoD#) (Member ID#) (ID#) (ID#)												1a. INSURED'S LD. NUMBER (For Program in Item 1)																																			
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)												3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐												4. INSURED'S NAME (Last Name, First Name, Middle Initial)																							
5. PATIENT'S ADDRESS (No., Street)												6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐												7. INSURED'S ADDRESS (No., Street)																							
CITY												8. RESERVED FOR NUCC USE												CITY																							
STATE												9. RESERVED FOR NUCC USE												STATE																							
ZIP CODE												TELEPHONE (Include Area Code) ()												ZIP CODE																							
TELEPHONE (Include Area Code) ()												10. IS PATIENT'S CONDITION RELATED TO:												11. INSURED'S POLICY GROUP OR FECA NUMBER																							
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)												a. EMPLOYMENT? (Current or Previous) YES ☐ NO ☐												a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐																							
a. OTHER INSURED'S POLICY OR GROUP NUMBER												b. AUTO ACCIDENT? YES ☐ NO ☐ PLACE (State)												b. OTHER CLAIM ID (Designated by NUCC)																							
b. RESERVED FOR NUCC USE												c. OTHER ACCIDENT? YES ☐ NO ☐												c. INSURANCE PLAN NAME OR PROGRAM NAME																							
c. RESERVED FOR NUCC USE												10d. CLAIM CODES (Designated by NUCC)												d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐ <i>If yes, complete items 9, 9a, and 9d.</i>																							
d. INSURANCE PLAN NAME OR PROGRAM NAME												12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.												13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.																							
SIGNED _____ DATE _____												SIGNED _____																																			
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.												15. OTHER DATE MM DD YY QUAL.												16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY																							
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE												17a. NPI												18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																							
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? YES ☐ NO ☐ \$ CHARGES												22. RESUBMISSION CODE ORIGINAL REF. NO.																							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)												ICD Ind.												23. PRIOR AUTHORIZATION NUMBER																							
A. _____ B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____												24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS F. \$ CHARGES G. DAYS OR UNITS H. ICD-9-CM I. ID. QUAL. J. REFERRING PROVIDER ID, #																																			
1																																															
2																																															
3																																															
4																																															
5																																															
6																																															
25. FEDERAL TAX ID. NUMBER SSN EIN ☐ ☐												26. PATIENT'S ACCOUNT NO.												27. ACCEPT ASSIGNMENT? (For gov't claims, see back) YES ☐ NO ☐												28. TOTAL CHARGE \$ 29. AMOUNT PAID \$ 30. Rsvd for NUCC Use											
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)												32. SERVICE FACILITY LOCATION INFORMATION												33. BILLING PROVIDER INFO & PH # ()																							
SIGNED _____ DATE _____												a. NPI b. NPI																																			

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

New 1500 CMS Claim Form

The following table outlines the **revised changes** on the above CMS 1500 claim form version 02/12:

FLD Location	NEW Change
Header	Replaced 1500 rectangular symbol with black and white two-dimensional QR Code (Quick Response Code)
Header	Added “(NUCC)” after “APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE.”
Header	Replaced “08/05” with “02/12”
Item Number 1	Changed “TRICARE CHAMPUS” to “TRICARE” and changed “(Sponsor’s SSN)” to “(ID#/DoD#).”
Item Number 1	Changed “(SSN or ID)” to “(ID#)” under “GROUP HEALTH PLAN”
Item Number 1	Changed “(SSN)” to “(ID#)” under “FECA BLK LUNG.”
Item Number 1	Changed “(ID)” to “(ID#)” under “OTHER.”
Item Number 8	Deleted “PATIENT STATUS” and content of field. Changed title to “RESERVED FOR NUCC USE.”
Item Number 9b	Deleted “OTHER INSURED’S DATE OF BIRTH, SEX.” Changed title to “RESERVED FOR NUCC USE.”
Item Number 9c	Deleted “EMPLOYER’S NAME OR SCHOOL.” Changed title to “RESERVED FOR NUCC USE.”
Item Number 10d	Changed title from “RESERVED FOR LOCAL USE” to “CLAIM CODES (Designated by NUCC).” Field 10d is being changed to receive Worker's Compensation codes or Condition codes approved by NUCC. FOR DCH/DXC: FLD 10d on the OLD Form CMS 1500 Claim (08/05) will no longer support receiving the Medicare provider ID.
Item Number 11b	Deleted “EMPLOYER’S NAME OR SCHOOL.” Changed title to “OTHER CLAIM ID (Designated by NUCC).” Added dotted line in the left-hand side of the field to accommodate a 2-byte qualifier
Item Number 11d	Changed “If yes, return to and complete Item 9 a-d” to “If yes, complete items 9, 9a, and 9d.” (Is there another Health Benefit Plan?)
Item Number 14	Changed title to “DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP).” Removed the arrow and text in the right-hand side of the field. Added “QUAL.” with a dotted line to accommodate a 3-byte qualifier.”

	FOR DCH/ DXC Technology: Use Qualifiers: 431 (onset of current illness); 484 (LMP); or 453 (Estimated Delivery Date).
Item Number 15	Changed title from 'IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE' to "OTHER DATE." Added "QUALIFIER." with two dotted lines to accommodate a 3-byte qualifier: 454 (Initial Treatment); 304 (Latest Visit or Consultation); 453 (Acute Manifestation of a Chronic Condition); 439 (Accident); 455 (Last X-ray); 471 (Prescription); 090 (Report Start [Assumed Care Date]); 091 (Report End [Relinquished Care Date]); 444 (First Visit or Consultation).
Item Number 17	Added a dotted line in the left-hand side of the field to accommodate a 2-byte qualifier – Used by Medicare for identifiers for provider roles: Ordering, Referring and Supervising. FOR DCH/ DXC Technology: Use the following Ordering Provider, Referring, Supervising Qualifiers (effective 4/01/2014): Ordering = DK; Referring = DN or Supervising = DQ.
Item Number 19	Changed title from "RESERVED FOR LOCAL USE" to "ADDITIONAL CLAIM INFORMATION (Designated by NUCC)." FOR DCH/ DXC Technology: Remove the Health Check logic from field 19 and add it in field 24H.
Item Number 21	Changed instruction after title (Diagnosis or Nature of Illness or Injury) from "(Relate Items 1, 2, 3 or 4 to Item 24E by Line)" to "Relate A-L to service line below (24E)."
Item Number 21	Removed arrow pointing to 24E (Diagnosis Pointer).
Item Number 21	Added "ICD Indicator." and two dotted lines in the upper right-hand corner of the field to accommodate a 1-byte indicator. <u>Use the highest level of code specificity in FLD Locator 21.</u> Diagnosis Code ICD Indicator - new logic to validate acceptable values (0, 9) ICD -10 diagnoses (CM) codes = value 0.
Item Number 21	Added 8 additional lines for diagnosis codes. Evenly space the diagnosis code lines within the field.
Item Number 21	Changed labels of the diagnosis code lines to alpha characters (A-L).

Item Number 21	Removed the period within the diagnosis code lines
Item Number 22	Changed title from “MEDICAID RESUBMISSION” to “RESUBMISSION.” The submission codes are: 7 (Replacement of prior claim) 8 (Void/cancel of prior claim)
Item Numbers 24A – 24 G (Supplemental Information)	The supplemental information is to be placed in the shaded section of 24A through 24G as defined in each Item Number. For DCH/ DXC Technology : Item numbers 24A & 24G are used to capture Hemophilia drug units. 24H (EPSDT/Family Planning).
Item Number 30	Deleted “BALANCED DUE.” Changed title to “RESERVED FOR NUCC USE.”
Footer	Changed “APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)” to “APPROVED OMB-0938-1197 FORM 1500 (02/12).”