wisconsin Medicaid update
and BadgerCare
April 2004 • No. 2004-31
Wisconsin Medicaid and BadgerCare Information for Providers

To:
Federally Qualified Health Centers
Portable X-ray Providers
HMOs and Other Managed Care Programs

Wisconsin Medicaid Covers Transportation and Set-up for Portable X-ray Providers

This *Wisconsin Medicaid and BadgerCare Update* provides information to providers for billing transportation and set-up of portable X-ray equipment. Effective for dates of service on and after January 1, 2004, Wisconsin Medicaid reimburses portable X-ray providers for procedure code R0075.

Transportation of Portable X-ray Equipment

Wisconsin Medicaid Reimburses Additional Procedure Code

Effective for dates of service (DOS) on and after January 1, 2004, Wisconsin Medicaid reimburses procedure code R0075 (Transportation of portable X-ray equipment and personnel to home or nursing home, per trip to facility or location, more than one patient seen) for portable X-ray providers. In addition to procedure code R0075, Wisconsin Medicaid will continue to reimburse procedure code R0070 (Transportation of portable X-ray equipment and personnel to home or nursing home, per trip to facility or location, one patient seen).

When billing procedure code R0075, the provider is required to use a modifier to indicate the total number of Medicaid recipients served at the location. The provider is required to submit a separate claim for each Medicaid recipient. Procedure code R0075 will be denied if it is submitted without an appropriate modifier in Element 24D of the CMS 1500 claim form. Refer to Attachment 1 of this *Wisconsin Medicaid and BadgerCare Update* for a list of appropriate modifiers. Each claim for a single location and DOS must indicate the same X-ray transportation procedure code and modifier for all recipients seen during that visit.

Wisconsin Medicaid prorates the transportation reimbursement according to the number of Medicaid recipients served at the location. Do not include non-Medicaid recipients when determining the appropriate modifier to use with procedure code R0075. For example, if the provider provides X-ray services to five nursing home residents and only two are Medicaid recipients, the provider would use modifier "UN" in Element 24D of the CMS 1500 claim form. Refer to Attachment 2 for a sample of a claim for portable X-ray provider services.

Transportation Coverage Criteria

The following criteria apply to both transportation procedure codes:

- Portable X-ray services are allowable only in a nursing home (place of service [POS] codes "31," "32," or "33") or in a home setting (POS code "12") as medically necessary and appropriate, under the supervision of a physician.

- 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. Wisconsin Medicaid will not reimburse for the transportation of the portable X-ray equipment when the X-ray equipment is stored at a nursing home for use as needed.
- Only a single transportation payment is allowed per trip to a facility or location for a single DOS. Therefore, Wisconsin Medicaid will not reimburse both R0070 and R0075 to a provider for the same location on the same DOS unless there is a medically necessary reason for multiple trips. Providers are required to document the medical necessity of repeat trips. Providers should make every effort to schedule all patients at a single location during a single trip to that location.

Note: Wisconsin Medicaid does not reimburse procedure code R0076 (Transportation of portable EKG to facility or location, per patient). The cost of transporting EKG equipment is included in Medicaid's reimbursement for the EKG.

Set-up of Portable X-ray Equipment

Wisconsin Medicaid will continue to reimburse portable X-ray providers for services necessary to place the recipient into position in preparation for taking the X-ray (procedure code Q0092 [Set-up portable X-ray equipment]). The following criteria apply to this procedure code:

- Portable X-ray services are allowable only in a nursing home (POS codes "31," "32," or "33") or in a home setting (POS code "12") as medically necessary and appropriate, and under the supervision of a physician.
- Charges for this set-up code may be submitted in addition to the X-ray service when the service is provided in the recipient's home or a nursing facility. This applies to each recipient receiving X-ray services during both single-patient and multiple-patient trips. A set-up component is allowed for each radiologic procedure performed, other than retakes of the same procedure.
- Q0092 is not reimbursable for the set-up of portable EKG equipment.

Information Regarding Medicaid HMOs

This *Update* contains Medicaid fee-for-service policy and applies to providers of services to recipients on fee-for-service Medicaid only. For Medicaid HMO or managed care policy, contact the appropriate managed care organization. Wisconsin Medicaid HMOs are required to provide at least the same benefits as those provided under fee-for-service arrangements.

The *Wisconsin Medicaid and BadgerCare Update* is the first source of program policy and billing information for providers.

Although the *Update* refers to Medicaid recipients, all information applies to BadgerCare recipients also.

Wisconsin Medicaid and BadgerCare are administered by the Division of Health Care Financing, Wisconsin Department of Health and Family Services, P.O. Box 309, Madison, WI 53701-0309.

For questions, call Provider Services at (800) 947-9627 or (608) 221-9883 or visit our Web site at *dhfs.wisconsin.gov/medicaid/*.

PHC 1250

ATTACHMENT 1
Modifiers for Transportation of Portable X-ray Equipment and Personnel to Home or Nursing Home, More Than One Patient Seen

Effective for dates of service on and after January 1, 2004, the appropriate modifier must be used with procedure code R0075 (Transportation of portable X-ray equipment and personnel to home or nursing home, per trip to facility or location, more than one patient seen).

Modifier	Description	Maximum Fee
UN	Mobile X-ray, two patients served	$26.05
UP	Mobile X-ray, three patients served	$17.37
UQ	Mobile X-ray, four patients served	$13.03
UR	Mobile X-ray, five patients served	$10.42
US	Mobile X-ray, six or more patients served	$8.69

ATTACHMENT 2
Sample CMS 1500 Claim Form:
Transportation, Set-up, and X-ray Services
When Two Medicaid Recipients Were Served

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE ☐ (Medicare #) | MEDICAID ☐ (Medicaid #) P | CHAMPUS ☐ (Sponsor's SSN) | CHAMPVA ☐ (VA File #) | GROUP HEALTH PLAN ☐ (SSN or ID) | FECA BLK LUNG ☐ (SSN) | OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 1234567890

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Recipient, Im A.

3. PATIENT'S BIRTH DATE MM DD YY: MM DD YY | SEX M ☐ F X

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 609 Willow St

6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street):

CITY: Anytown | STATE: WI

8. PATIENT STATUS: Single ☐ Married ☐ Other ☐

CITY | STATE

ZIP CODE: 55555 | TELEPHONE (Include Area Code): (XXX) XXX-XXXX

Employed ☐ Full-Time Student ☐ Part-Time Student ☐

ZIP CODE | TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): OI-P

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: M-7

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) ☐ YES ☐ NO

a. INSURED'S DATE OF BIRTH MM DD YY | SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY | SEX M ☐ F ☐

b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? ☐ YES ☐ NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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.

SIGNED _____ DATE _____

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 _____

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: I. M. Referring

17a. I.D. NUMBER OF REFERRING PHYSICIAN: 12345678

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. V72.5 3. ____.__

2. ____.__ 4. ____.__

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 05 01 04		31		R0075	UN	1	XXX XX	1.0				
2 05 01 04		31		Q0092		1	XXX XX	1.0				
3 05 01 04		31		72010	TC	1	XXX XX	1.0				
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.: 1234JED

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO

28. TOTAL CHARGE $ XXX XX

29. AMOUNT PAID $ XX XX

30. BALANCE DUE $ XX XX

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.)

J.M. Authorized MM/DD/YY

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

12341234

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

I.M. Physician
1 W. Williams
Anytown, WI 55555 87654321

PIN# GRP#

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) *PLEASE PRINT OR TYPE*

APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)