Priority Health	BILLING POLICY No. 058
PORTABLE RADIOLOGY SERVICES	
Date of origin: Nov. 12, 2024	**Review dates: 2/2025. 2/2026**

APPLIES TO

- Commercial
- Medicare follows CMS NCD/LCD policies unless otherwise noted
- Medicaid follows MDHHS/CHAMPS unless otherwise noted

DEFINITION

Portable radiology services are radiologic procedures performed in the member's residence. The member's residence could be their private home, assisted living facility, nursing facility or intermediate care facility.

POLICY SPECIFIC INFORMATION

We'll reimburse for portable radiology when your claim has the following:

- Place of service 31,32,33,12,13,14 representing the members primary residence.
- Transportation codes:
  - **R0070**: Used when one member is seen at this location.
  - **R0075**: Used when more than one member is seen at this location.
- HCPC code Q0092 – portable x-ray set up is reimbursed for each radiology procedure (other than retakes of the same procedure) during both single patient and multiple patient trips.
- A CPT code from the radiology range (70010-76499)

When billing for multiple members seen at the same location please use the following modifiers:

- **Modifier UN**: Two patients
- **Modifier UP**: Three patients
- **Modifier UQ**: Four patients
- **Modifier UR**: Five patients
- **Modifier US**: Six or more patients

Documentation requirements within the medical record.

- Name of beneficiary and date of service on all documentation
- Documentation legible and complete (including signature(s)
- Signed physician's order
- Diagnosis that supports the reason for the test.
- Name of the radiology technician.

RESOURCES

- Improperly claimed Medicare Part B reimbursement for portable X-ray services (OIG)
- Medicare Claims Processing Manual – Chapter 13 (Radiology services and other diagnostic procedures) (CMS)

DISCLAIMER

Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for

coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements are appropriate to procedure, diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS) and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standards, compliant codes defined by CPT, HCPCS and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document services rendered or items supplied will result in denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align to these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made
2	Added "Disclaimer" section
Feb. 17, 2026	Updated Q0092 information