

Reimbursement for TB Chest X-Rays

OHA-TB will reimburse chest x-rays at the rate of \$22.15 for taking a chest x-ray and \$11.45 for the radiologist interpretation. Chest x-ray reimbursement is limited to one view (PA) unless prior authorization is received from OHA-TB. NO prior authorization is needed for PA and lateral chest x-ray if the patient is a child 5 years old or younger. Funds should be reserved for patients being evaluated for tuberculosis (TB) without other means of payment.

The LHD will pay their locally selected providers for TB chest x-ray services and submit an invoice to OHA-TB for reimbursement on a monthly basis. OHA-TB will then reimburse LHDs.

The Local Health Department (LHD) is responsible for:

1. Identifying who to screen for TB.
2. Ensuring the chest x-ray is for TB related follow-up.
3. Ensuring the person has no other means of payment. Chest x-rays for inmates or employee/healthcare worker screening (including LHD staff) cannot be reimbursed.
4. Requesting prior verbal approval from OHA-TB if additional or special views are needed and documenting verbal authorization on the "Authorization for Tuberculosis Chest X-Ray" form. Include this form with the invoice.
Prior authorization is NOT needed for a PA and lateral chest x-ray if the patient is a child 5 years old or younger.
5. Submitting the invoice for reimbursement to OHA-TB within 60 days of date of service. If the submission is delayed, payment may not occur.

What to submit for reimbursement: 1) Invoice; 2) Patient List; and 3) "Authorization for Tuberculosis Chest X-Ray" form (if needed)

1. Invoice

Use the template on page three to create an invoice. A word document of the invoice is available on the web site under *TB Program Forms* for easier formatting. The invoice must contain the following information:

Note: Do not put patient names on the invoice.

A) Description of service *(See invoice template on page three)*

- List the number of one view PA chest x-rays being billed and total \$ amount
- List the number of two view chest x-rays being billed and total \$ amount
- List the number of special view chest x-rays being billed and total \$ amount

B) Reimbursement amount

- **\$33.60** is the maximum reimbursement for a take and read on a one view chest x-ray
- **\$67.20** is the maximum reimbursement for a take and read on a two view chest x-ray

C) Signature of LHD representative authorizing the service

Type or print the name of the authorizer below the signature line

D) Invoice number

Creating an invoice number will help us track the reimbursement in our accounting system. If you don't have an invoice numbering system, create an invoice number by using the first four letters of the county name and the reimbursement submission date. Example: **MULT 010814**. (For **Multnomah County**: **MULT**; **two digit month**: **01**; **two digit day**: **08**; **two digit year**: **14**)

2. List with patient information

On a document **separate** from the invoice include:

- Date of Service
- Patient Last Name, Patient First Name
- Patient DOB
- Type of x-ray: one view PA CXR, two view CXR, special view CXR

3. "Authorization for Tuberculosis Chest X-Ray" form.

Attach this form only if additional or special views were required. Documentation of verbal approval for the additional views should be on this form.

Within 60 days of date of service, mail a paper copy or e-mail a secure electronic copy of the: 1) invoice; 2) the list of patient information; and 3) the "Authorization for Tuberculosis Chest X-Ray" form (when needed) to:

Gayle Wainwright
Oregon Health Authority
Tuberculosis Control Program
800 NE Oregon Street, Ste. 1105
Portland, OR 97232
gayle.wainwright@state.or.us

Questions: 971-673-0174

From:

Local Health Department Name

Remit to:

Local Health Department Address

Email the Invoice and Patient List to:

gayle.wainwright@state.or.us

If mailing a paper copy send to:

Oregon Health Authority
Tuberculosis Control Program
800 NE Oregon Street, Ste 1105
Portland, OR 97232

TUBERCULOSIS CHEST X-RAY INVOICE

Date:

Invoice#:

Patient List Dated:

# CXRs Billed	Description	Reimbursement	Total \$ amount
	One view PA chest x-ray(s)	\$33.60 each	
	Two view chest x-ray(s)	\$67.20 each	
	Special view chest x-ray(s)	\$33.60 each	
		Invoice Total:	

Authorization for the Chest X-Rays Given By: _____

Local Health Dept. Representative Signature

Type or print name of authorizing individual

OHA-PHD fiscal program use only - do not write below this line