

Montana Healthcare Programs **Proposed** Outpatient Procedure Fee Schedule Explanation –

Effective March 1, 2018

Definitions:

Description:

Procedure code short description. You must refer to the appropriate official CPT-4, HCPCS or CDT-5 coding manual for complete definitions in order to assure correct coding.

Method:

Source of fee determination

APC: Based on APC assigned weight x Montana's conversion factor. Pricing is affected by modifiers as listed in the provider manual. Procedures paid by APC method that have a zero fee are either bundled or not covered services. (See the Status Indicator)

APC/Charge Ratio: Based on APC designation as pass-through. Paid at the provider specific Medicaid cost to charge ratio for outpatient services.

Fee Schedule: Medicaid fee for listed code. Codes noted as "not allowed" will cause the claim line to deny.

Medicare: Medicare-prevailing fee for listed code. Laboratory services are paid at 60.1462% of listed fee for sole community hospitals and at 58.206% for others.

Charge Ratio: Equals a percentage of billed charges; percentage depends on provider type and service/supply. For outpatient hospital services, providers are paid their current Medicaid cost to charge ratio for outpatient services.

Inpatient Only: These services are not payable in an outpatient setting

Not Allowed: These services are not payable

Bundled/subject to separate payment criteria: Services may be packaged in certain instances. These services will have a fee listed but may only be payable if specific criteria are met.

*If a valid, current code is not present on the fee schedule(s) that code may be a non-covered service

Indicators:

- C** Inpatient services that is not payable under OPSS
- E** Not allowed under Outpatient
- G** Pass through drugs and biologicals
- H** Pass through devices that are paid by report
- K** Drugs and biologicals paid by APC
- M** Montana Medicaid specific fee
- N** Services for which payment is packaged into another service or APC
- Q** Montana Medicaid Laboratory service
- R** Blood and blood products
- S** Significant procedures that are paid under OPSS but to which the multiple surgery reduction does not apply

- T** Significant services that are paid under the OPSS and to which the multiple procedure payment discount under OPSS applies
- U** Brachytherapy Sources
- V** Medical visits (including clinic or emergency department visits) that are paid under OPSS
- X** Ancillary services that are paid under OPSS
- Y** Montana Medicaid fee for Physical Therapy, Occupational Therapy or Speech and Language Therapy services

Some procedures may have a variable status dependent on if they are provided with other billable services. These codes are listed on the fee schedule as status N (bundled) but will have an APC and price shown.

PA:

Prior Authorization

- Y:** Prior authorization is required by this code
- NA:** Prior authorization not required for this code

Pass:

Passport Referral - Not all provider specialties require passport, please refer to your program manual for specifics.

- Y:** Passport referral is required
- NA:** Passport not required for this code

Note:

Effective January 01, 2016 CMS changed the way lab codes need to be billed. If all codes on the claim are Status Q lab codes, the L1 modifier is not needed. In all other cases, continue to use the L1 modifier as previously directed in the Provider Notice below.

<http://medicaidprovider.mt.gov/Portals/68/docs/providernotices/2014/medicaidoutpatientlabbilling02192014.pdf>

Note:

This fee schedule is used by OPSS and non-OPSS facilities. Not all codes listed are appropriate for use by all facilities

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