How Payment Is Calculated

Overview

Although providers do not need the information in this chapter in order to submit claims to Montana Medicaid, the information allows providers to understand how payment is calculated and to predict approximate payment for particular claims.

The RBRVS Fee Schedule

Most services by provider types covered in this manual are reimbursed for using the Department's Resource-Based Relative Value Scale (RBRVS). The fee schedule includes several thousand CPT codes and HCPCS codes. Within the CPT coding structure, only anesthesia services (00100–01999) and clinical lab services (almost the entire 80000–89999 range) are not reimbursed for using the RBRVS fee schedule.

RBRVS was developed for the Medicare program, which first implemented it in 1992. Medicare does a major update annually, with smaller updates performed quarterly. Montana Medicaid implemented its RBRVS-based fee schedule in 1997. It is based largely on the Medicare model, with a few differences that will be described below. By adapting the Medicare model to the needs of the Montana Medicaid program, the Department was able to take advantage of the research performed by the federal government and national associations of physicians and other healthcare professionals. RBRVS-based payment methods are widely used across the U.S. by Medicaid programs, Blue Cross and Blue Shield Plans, workers' compensation plans and commercial insurers.

Many Medicaid payment methods are based on Medicare, but there are differences. In these cases, the Medicaid method prevails.

Fee Calculation

Each fee is the product of a relative value times a conversion factor.

Basis of Relative Values

For almost all services, Medicaid uses the same relative values as Medicare in Montana. Nationally, Medicare adjusts the relative values for differences in practice costs between localities, but Montana is considered a single locality.

For fewer than 1% of codes, relative values are not available from Medicare. For these codes, the Department has set the relative values.

When Medicaid payment differs from the fee schedule, consider the following:

- The Department pays the lower of the established Medicaid fee or the provider's charge.
- Modifiers. (See Other Modifiers in this chapter;)
- Provider type. (See Professional Differentials in this chapter.)
- Place of service. (See Site of Service Differential in this chapter.)
- Date of service. (Fees for services may change over time.)
- Check for cost sharing and Medicare or TPL payments, which are shown on the remittance advice.

Composition of Relative Values

For each code, the relative value is the sum of a relative value for the work effort (including time, stress, and difficulty), the associated transitional practice expense, and the associated malpractice expense.

Site of Service Differential

The Medicare program has calculated two sets of relative values for each code: one reflects the practitioner's practice cost of performing the service in an office and one reflects the practitioner's practice cost of performing the service in a facility.

Medicaid typically pays a lower fee if the service is provided in a facility because Medicaid typically also pays the facility.

Conversion Factor

The Department sets the conversion factor for the state fiscal year (July through June) and it is listed on the fee schedule.

Policy Adjuster

To encourage access to maternity services and family planning services, the Department increases fees for these codes using a policy adjuster that increases the fee. The fee listed on the fee schedule includes the policy adjuster.

Payment for Audiology Services

Medicaid payment for audiology services will be the lower of the provider's usual and customary charge for the service or 100% of the published RBRVS fee schedule.

Payment for Hearing Aid Services

Medicaid payment for covered hearing aid services and items will be the lower of the provider's usual and customary charge for the service or item, the submitted price on the invoice, or the Department's fee schedule.

How Cost Sharing Is Calculated on Medicaid Claims

Member cost sharing for services provided by audiology services and hearing aid services providers is $4.00/day per visit. The member's cost sharing amount is shown on the remittance advice and deducted from the Medicaid allowed amount. (See the Remittance Advices and Adjustments chapter in the *General Information for Providers Manual).*

How Payment Is Calculated on TPL Claims

When a member has coverage from both Medicaid and another insurance company, the other insurance company is often referred to as third party liability (TPL). In these cases, the other insurance is the primary payer and Medicaid makes a payment as the secondary payer. For example, a Medicaid member who also has insurance through her job receives a monaural hearing aid to wear behind her right ear (V5060RT). The invoice amount is $375.00. The member's other insurance is billed first and pays $200.00. The Medicaid allowed amount for this item is the invoice amount up to $400.00. The amount the other insurance paid ($200.00) is subtracted from the Medicaid allowed amount ($375), leaving a balance of $175.00.

How Payment Is Calculated on Medicare Crossover Claims

When a member has coverage from both Medicare and Medicaid, Medicare is the primary payer. Medicaid will pay the Medicare co-insurance and deductible amounts not to exceed the Medicaid fee for the service for these dually eligible individuals. See the How Payment Is Calculated chapter in the *Physician-Related Services* manual for details on how payment is calculated on Medicare crossover claims.

Professional Differentials

For some services within the scope of RBRVS payment methods, mid-level practitioners are paid differently. Audiologists are paid at 100% of the fee schedule.

Charge Cap

For the services covered in this manual, Medicaid pays the lower of the established Medicaid fee or the provider's charge.

Payment by MSRP

About 4% of services covered by the RBRVS fee schedule do not have fees set for them; these services are typically rare or vaguely specified in the coding guidelines. For these services, payment is set at 75% of the amount submitted, which is the manufacturers suggested retail price (MSRP) or, when no MSRP is available, the provider's acquisition cost.