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# *Therapy Services*

*Physical Therapy, Occupational Therapy, and Speech Therapy*



*Medicaid and Other Medical Assistance Programs*

*This publication supersedes all previous Physical Therapy, Occupational Therapy, and Speech Therapy handbooks. Published by the Montana Department of Public Health & Human Services, August 2004.*

*Updated April 2005, August 2005, September 2015, and January 2016.*

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**My NPI/API:**

**My HMK/CHIP Provider ID Number:**

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# Key Contacts and Websites

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See the Contact Us link in the menu on the Montana Healthcare Programs Provider Information [website](http://medicaidprovider.mt.gov/), <http://medicaidprovider.mt.gov/>, for a list of contacts and websites.



# Introduction

Thank you for your willingness to serve members of the Montana Medicaid program and other medical assistance programs administered by the Department of Public Health and Human Services.

## Manual Organization and Maintenance

This manual provides information specifically for **physical, occupational, and speech therapy providers**. Other essential information for providers is contained in the separate *General Information for Providers* manual. Providers are responsible for reviewing both manuals.

A table of contents and an index allow you to quickly find answers to most questions. The margins contain important notes with extra space for writing notes. There is a list of contacts and websites on the Contact Us page of the Provider Information [website](#). There is space on the inside of the front cover of this manual to record your NPI/API and CHIP/HMK numbers for quick reference when calling Provider Relations.

Changes to manuals are provided through provider notices and replacement pages. When replacing a page in a manual, file the old pages and provider notices in the back of the manual for use with claims that originated under the old policy. Manual replacement pages and provider notices are posted on the Provider Information [website](#).

## Rule References

Providers must be familiar with all current rules and regulations governing the Montana Medicaid program. Provider manuals are to assist providers in billing Medicaid; they do not contain all Medicaid rules and regulations. Rule citations in the text are a reference tool; they are not a summary of the entire rule. **In the event that a manual conflicts with a rule, the rule prevails.** Links to rule references are available on the Provider Information [website](#). Paper copies of rules are available through the Secretary of State's office. (See the Contact Us link in the left menu on the Provider Information [website](#).) The following rules and regulations are specific to physical, occupational, and speech therapy programs. Additional Medicaid rule references are available in the *General Information for Providers* manual.

- Administrative Rules of Montana (ARM)
  - ARM 37.86.601 – ARM 37.86.610 Therapy Services
- Montana Codes Annotated (MCA)
  - MCA Title 37, Chapter 11 Physical Therapy
  - MCA Title 37, Chapter 15 Speech-Language Pathologists and Audiologists
  - MCA Title 37, Chapter 24 Occupational Therapy
- Code of Federal Regulations (CFR) 42 CFR 440.110



Providers are responsible for knowing and following current Medicaid rules and regulations.

## Claims Review (MCA 53-6-111, ARM 37.85.406)

The Department is committed to paying Medicaid providers' claims as quickly as possible. Medicaid claims are electronically processed and usually are not reviewed by medical experts prior to payment to determine if the services provided were appropriately billed. Although the computerized system can detect and deny some erroneous claims, there are many erroneous claims which it cannot detect. For this reason, payment of a claim does not mean that the service was correctly billed or the payment made to the provider was correct. Periodic retrospective reviews are performed which may lead to the discovery of incorrect billing or incorrect payment. If a claim is paid and the Department later discovers that the service was incorrectly billed or paid or the claim was erroneous in some other way, the Department is required by federal regulation to recover any overpayment, regardless of whether the incorrect payment was the result of Department or provider error or other cause.

## Getting Questions Answered

The provider manuals are designed to answer most questions; however, questions may arise that require a call to a specific group (such as a program officer, Provider Relations, or a prior authorization unit). The list of contacts on the [website](#) has important telephone numbers and addresses. Medicaid manuals, provider notices, replacement pages, fee schedules, forms, and more are available on the Provider Information [website](#).

# Covered Services

## General Coverage Principles

This chapter provides covered services information that applies specifically to services performed by independent physical, occupational, and speech therapists. Therapists that are employed by a facility (e.g., hospitals, nursing facilities, home health agencies) should refer to their corresponding provider manual for requirements and billing procedures, which may vary. Like all healthcare services received by Medicaid members, services rendered by these providers must also meet the general requirements listed in the Provider Requirements chapter of the *General Information for Providers* manual.

### ***Services within Scope of Practice (ARM 37.86.606)***

Services are covered only when they are within the scope of the provider's license as permitted by state law.

### ***Services Provided by Therapists (ARM 37.86.601–605 and ARM 37.85.402)***

Therapy includes speech, occupational, and physical therapy services. Services may be performed by a therapy assistant or therapy aide but must be billed to Medicaid under the supervising licensed therapist's NPI. (See the Billing Procedures chapter in this manual.)

Therapy providers must maintain current licensure to practice from the state in which they are practicing. Providers must also be enrolled as Montana Medicaid providers. An assistant or aide may not enroll as a Medicaid provider. Providers cannot submit claims for services they did not provide, except for services provided by therapy assistants or aides. Services performed by an assistant or aide in accordance with Title 37 MCA must have their services billed to Medicaid under the licensed supervising therapist's Medicaid provider number. The levels of supervision for occupational and physical therapy aides and assistants are as follows:

- ***Direct.*** The licensed provider must be present in the office and immediately available to furnish assistance and direction throughout the performance of the procedure. The licensed provider must be in the direct treatment area of the member-related procedure being performed.
- ***Routine.*** The licensed provider must provide direct contact at least daily at the site of work, within interim supervision occurring by other methods, such as telephonic, electronic or written communication.
- ***General.*** Procedure is furnished under the licensed provider's direction and control, but the licensed provider's presence is not required during the performance of the procedure.

- **Temporary Practice Permit Holders.** New graduates from occupational therapy school who are waiting for their national exam results **must work under routine** supervision of the licensed therapist. **If the exam is failed, the Temporary Practice Permit immediately becomes void.** Routine supervision requires direct contact at least daily at the site of work.
- **Occupational Therapy Assistants.** Require **general** supervision, meaning the licensed provider does not have to be physically on the premises at the time of the service. However, the licensed therapist must provide face-to-face supervision at least monthly.
- **Occupational Therapy Aides.** Require **direct** supervision by a licensed occupational therapist or a certified occupational therapy assistant. This means the licensed provider must be present in the office and immediately available to the aide.
- **Physical Therapy Aides/Assistants.** Require **general** supervision, meaning that the licensed provider must be on the premises.
- **Temporarily Licensed Therapists.** Can never supervise anyone.

#### **Services Included**

Covered therapy services include the following:

- Restorative therapy services when the particular services are reasonable and necessary to the treatment of the member's condition and subsequent improvement of function. The amount and frequency of services provided must be indicated on the member's IEP.
- Assessment services to determine member medical needs and/or to establish an IEP, as long as the assessment results in health-related services documented in the IEP.

#### **Service Requirements**

For all therapies being billed, they must be included in the student's IEP.

#### **Services Restricted**

- Montana Medicaid does not cover therapy services that are intended to maintain a member's current condition but only covers services to improve member functions.

***Non-Covered Services (ARM 37.85.207 and ARM 37.86.606)***

Some services not covered by Medicaid include, but are not limited to, the following:

- Maintenance therapy services may be covered under the Home and Community-Based Services (HCBS) program; refer to the HCBS manual.
- Services that do not require the performance or supervision of a licensed therapist, even if the services are performed by the therapist.
- A therapist's time for the following:
  - Attending member care meetings.
  - Member-related meetings with other medical professionals or family members.
  - Completion of paperwork or reports.
- Observation
- Acupuncture
- Naturopath services
- Masseur or masseuse services
- Services considered experimental or investigational
- Services provided to Medicaid members who are absent from the state, with the following exceptions:
  - Medical emergency
  - Required medical services are not available in Montana. Prior authorization may be required.
  - If the Department has determined that the general practice for members in a particular area of Montana is to use providers in another state.
  - When out-of-state medical services and all related expenses are less costly than in-state services
  - When Montana makes adoption assistance or foster care maintenance payments for a member who is a child residing in another state.
- Medicaid does not cover services that are not direct patient care such as the following:
  - Missed or canceled appointments
  - Mileage and travel expenses for providers
  - Preparation of medical or insurance reports
  - Service charges or delinquent payment fees
  - Telephone services in home
  - Remodeling of home
  - Plumbing service
  - Car repair and/or modification of automobile



Use the fee schedule for your provider type to verify coverage for specific services.



An order/referral is valid for 180 days from the day the therapist receives it.

### ***Verifying Coverage***

The easiest way to verify coverage for a specific service is to check the Department's fee schedule for your provider type. In addition to being listed on the fee schedule, all services provided must also meet the coverage criteria listed in the Provider Requirements chapter of the *General Information for Providers* manual and in this chapter. Use the fee schedule in conjunction with the more detailed coding descriptions listed in the CPT and HCPCS coding books. **Use the fee schedule and coding books that pertain to the date of service.** Fee schedules are available on the Provider Information website.

## **Therapy Service Requirements (ARM 37.86.606)**

Medicaid covers restorative therapy services when they are reasonable and necessary to the treatment of the member's condition and result in improved function. The amount and frequency of services provided must be within the therapy's generally accepted standard of practice. Therapy services are not restorative if the member's expected restoration potential is insignificant in relation to the extent and duration of services required. Therapy services are no longer restorative when it is determined that function will not improve. All therapy services require an order or referral from the member's physician or mid-level practitioner and documentation on the member's progress. Some services may also require prior authorization or Passport to Health provider approval before they are provided. See the Prior Authorization chapter in this manual and the *Passport to Health* manual.

### ***Order/Referral***

Therapy services may be provided to a member when a current written or verbal order/referral has been received from the member's physician or mid-level practitioner. The therapy provider is responsible for obtaining the order/referral before providing services. Medicaid does not cover services provided before obtaining an order/referral. When the order/referral is verbal, the member's physician or mid-level practitioner must supply the therapist with the same order/referral in writing within 30 days of the verbal order/referral. The therapist should document in his/her records a verbal order/referral was provided by the member's physician or mid-level practitioner. The written order/referral must be signed and dated by the referring physician or mid-level practitioner. The Department considers an order/referral valid for no more than 180 days from the time the therapist receives the order/referral from the physician or mid-level practitioner. When a member is enrolled in the Passport to Health program, a Passport approval is required and the referral number must be included on the claim. See the *Passport to Health* manual.

***Documentation***

Providers must maintain records that demonstrate compliance with Medicaid requirements. General record keeping requirements are described in the *General Information for Providers* manual, Provider Requirements chapter. All therapy case records must be current and available upon request from the Department. Case records must contain at least the following:

- Signed and dated order/referral from the member's physician or mid-level practitioner.
- Member's name on each page of documentation.
- Diagnosis, duration and time, course of treatment, and expected outcomes.
- Therapist treatment for each session.
- Member's progress in meeting therapy goals to ensure therapy services are still restorative and not maintenance.
- Support time spent for each procedure billed. Time should be indicated in the record, whether a start/end time documented at each visit or total time spent with the member at the visit.
- Documentation must be complete and representative of what the therapist has provided each time a member is seen and must support the procedures that are billed to Medicaid.
- Records signed and dated by the treating therapist.

**Coverage of Specific Services**

The following are coverage rules for specific services provided by physical, occupational, and speech therapists. The Medicaid payment includes all related supplies and items used when providing therapy services, except for splints, braces, and slings, which are discussed later.

***Augmentative Communications Devices***

Medicaid covers augmentative communications devices when they are prior authorized. The Department's policy is to rent the communications device for eight weeks prior to purchase. For instructions on obtaining prior authorization, see the Prior Authorization chapter in this manual.

***Maintenance Therapy Plan***

Medicaid covers the development of a maintenance therapy plan by a licensed therapist. The maintenance plan must include all of the following:

- The member's initial evaluation.
- Development of a plan that incorporates the prescribing physician's or mid-level practitioner's treatment objectives and is appropriate for the member's capacity and tolerance.
- Instructions for others in carrying out the plan and further evaluations by a licensed therapist as required.

***Occupational, Physical, and Speech Therapy***

Medicaid covers reimburses covered therapies that are ordered by a physician or mid-level practitioner. The order is valid for 180 days. If services are needed past 180 days, a new order must be received and a new care plan must be established.

The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services program (EPSDT) covers all medically necessary services for children age 20 and under. Therapy services for children are not restricted to a specific number of hours or units as long as the therapy services are restorative, not maintenance. All other applicable requirements apply (e.g., current order/referral, provider requirements, prior authorization requirements, and Passport approval). See the Prior Authorization chapter in this manual and the *Passport to Health* manual, available on applicable provider type pages on the [website](#).

***Splints, Braces, and Slings***

Medicaid covers the design, fabrication, fitting, and instruction by a licensed therapist in the use of splints, braces, and slings under the Durable Medical Equipment (DME) program. Therapists must be enrolled with Medicaid as DME providers to bill for these services, and he/she must abide by the rules/policies set forth by the DME program.

**Other Department Programs**

This is how the information in this manual applies to Department programs other than Medicaid.

***Mental Health Services Plan (MHSP)***

The information in this manual does not apply to the Mental Health Services Plan (MHSP). For more information on the MHSP program, see the mental health manual available on the Provider Information website.

***Healthy Montana Kids (HMK)***

The information in this manual does not apply to HMK members. For an HMK medical manual, contact Blue Cross and Blue Shield of Montana at 1-800-447-7828. Additional information regarding HMK is available on the [HMK website](#).

# Prior Authorization

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Therapy services do not require prior authorization. For general information about Prior Authorization, see the *General Information for Providers* manual.



# Coordination of Benefits

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The following is specific to therapy services. In addition, providers should refer to the section on Third Party Liability in the Member Eligibility and Responsibilities chapter in the *General Information for Providers* manual.

Occupational and physical therapy services provided by independent occupational and physical therapists are covered under Medicare Part B,



# Billing Procedures

## Claim Forms

Services provided by the healthcare professionals covered in this manual must be billed either electronically or on a CMS-1500 claim form. CMS-1500 forms are available from various publishing companies; they are not available from the Department or Provider Relations.

## Member Cost Sharing (ARM 37.85.204 and ARM 37.85.402)

Cost sharing fees are a set dollar amount per visit based on the average Medicaid allowed amount for the provider type and rounded to the nearest dollar. There is no cost sharing cap. Do not show cost sharing as a credit on the claim; it is automatically deducted during claims processing and is shown on the remittance advice. Cost sharing for the following services is shown below.

Cost Sharing	
Service	Amount
Occupational therapy	\$2.00 per visit
Physical therapy	\$2.00 per visit
Speech therapy	\$3.00 per visit

The following members are exempt from cost sharing:

- American Indians or Alaska Natives who has ever been treated at an Indian Health Service (IHS), Tribal, or Urban facility or through referral under contract health services with appropriate documentation.
- Members under 21 years of age (i.e., EPSDT services).
- Pregnant women until end of postpartum, which begins on the last day of pregnancy and ends at the end of the month in which 60 days have passed.
- Inpatients in a hospital, skilled nursing facility, intermediate care facility or other medical institution if the individual is required to spend all but their personal needs allowance on the cost of care.
- Medicaid members who also have Medicare or another insurance are exempt from cost sharing only when the service is allowed by Medicare or paid by the other insurance, and Medicaid is the secondary payer.

A provider cannot deny services to a Medicaid member because the member cannot pay cost sharing fees at the time services are rendered. However, the member's inability to pay cost sharing fees when services are rendered does not lessen the member's obligation. If a provider has a policy on collecting delinquent payment from non-Medicaid members, that same policy must be used for

Medicaid members. A provider may sever the relationship with a member who has unpaid cost sharing obligations, as long as a consistent policy is followed with Medicaid and non-Medicaid members. Once the relationship is severed, with prior notice to the member either verbally or in writing, the provider may refuse to serve the member.

## When Members Have Other Insurance

If a Medicaid member is also covered by Medicare, has other insurance, or some other third party is responsible for the cost of the member's healthcare, see the Coordination of Benefits chapter in this manual.

## Passport Billing Tips

- If you are not the member's Passport provider, include the Passport provider's Passport number on the claim.
- The member's Passport provider must be contacted for approval for therapy services to be provided. Using another provider's Passport number without approval is considered fraud.
- For more information on Passport to Health, see the *Passport to Health* manual.
- For claims questions, contact Provider Relations.

## Billing for Retroactively Eligible Members

When a member becomes retroactively eligible for Medicaid, the provider has 12 months from the date retroactive eligibility was determined to bill for those services. When submitting claims for retroactively eligible members, attach a copy of the 160-M to the claim if the date of service is more than 12 months earlier than the date the claim is submitted.

When a provider chooses to accept the member from the date retroactive eligibility was effective, and the member has made a full or partial payment for services, the provider must refund the member's payment for the services before billing Medicaid for the services.

For more information on retroactive eligibility, see the Member Eligibility and Responsibilities chapter in the *General Information for Providers* manual.

## Place of Service

Place of service must be entered correctly on each line. Medicaid typically reduces payment for services provided in hospitals and ambulatory surgical centers since these facilities typically bill Medicaid separately for facility charges. See the Place of Service Code Set on the CMS website, [https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place\\_of\\_Service\\_Code\\_Set.html](https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set.html).

## Therapists Employed by Nursing Facilities, Hospitals, or Home Health Agencies

The billing instructions in this chapter apply to independent therapists who bill on professional or CMS-1500 claims. Independent therapists must be individually enrolled Medicaid providers to bill for services. Therapists who are employed by nursing facilities do not need to be individually enrolled in the Medicaid program when their services are to be billed by the nursing facility directly to Medicaid. The nursing facility provider will be responsible for meeting the enrollment and billing requirements under the therapy provider number. Therapists that are employed by hospitals or home health agencies should refer to the corresponding provider manual for requirements and billing procedures, which may vary.

### Billing for Evaluations

Evaluations are considered an encounter and should be reported as one unit; do not bill with multiple units. If the evaluation spans more than one day, providers should report the day of completion as the date of service when billing.

### Coding Tips

Standard use of medical coding conventions is required when billing Medicaid. Provider Relations or the Department cannot suggest specific codes to be used in billing for services. See the Coding Resources table in the *General Information for Providers* manual. The following suggestions may reduce coding errors and unnecessary claim denials:

- Use current CPT, HCPCS, and ICD diagnosis coding books.
- Always read the complete description and guidelines in the coding books. Relying on short descriptions can result in inappropriate billing.
- Attend classes on coding offered by certified coding specialists.
- Use the correct “units” measurement on CMS-1500 claims. In general, Medicaid follows the definitions in the CPT and HCPCS billing manuals. One unit may equal *one visit* or *each 15 minutes*. Always check the long text of the code description.
- When billing for *each 15 minutes*, one unit of service is equal to 8 minutes but less than 23 minutes. If a single modality or procedure is greater than 23 minutes, then time for more units of service should be counted as follows:

Units Over 23 Minutes	
Units	Time
2	Greater than or equal to 23 minutes, but less than 38 minutes
3	Greater than or equal to 38 minutes, but less than 53 minutes
4	Greater than or equal to 53 minutes, but less than 68 minutes
5	Greater than or equal to 68 minutes, but less than 83 minutes
6	Greater than or equal to 83 minutes, but less than 98 minutes
7	Greater than or equal to 98 minutes, but less than 113 minutes
8	Greater than or equal to 113 minutes, but less than 128 minutes

Count only the time spent treating a member. When counting time, if three modalities are provided and 20 total minutes are spent with the member in providing these services, bill only one unit using the code that best defines the greater amount of the service provided.

## Using the Medicaid Fee Schedule

When billing Medicaid, it is important to use the Department's fee schedule for your provider type in conjunction with the detailed coding descriptions listed in the CPT and HCPCS coding books. In addition to covered services and payment rates, fee schedules often contain helpful information such as appropriate modifiers. Department fee schedules are updated each January and July. Fee schedules are available on the Provider Information [website](#).

## Using Modifiers

- Review the guidelines for using modifiers in the CPT, HCPCS, or other helpful resources.
- Always read the complete description for each modifier; some modifiers are described in the CPT manual while others are in the HCPCS book.
- The Medicaid claims processing system recognizes three pricing modifiers and one informational modifier per claim line on the CMS-1500. Providers are asked to place any modifiers that affect pricing in the first two modifier fields.
- Use modifier 52 when a service or procedure is partially reduced or eliminated. This occurs when a code includes a procedure or service that was not completed, but the code most closely describes the service provided.
- Use modifier 22 when a service is more extensive than usual. This modifier can be used when a service is more difficult than usual or when there is an increased risk to the member. Slight extension of the procedure beyond the usual time does not validate the use of this modifier.
- The TC modifier is used when only the technical portion of the service is provided. The provider who interprets the results uses modifier 26. When both technical and professional services are performed by the same provider, no modifier is required.

 Always refer to the long description in coding books.

### ***Bundled Services***

Certain services are covered by Medicaid but have a fee of zero. This means that the service is typically bundled with an office visit or other service (e.g., hot or cold packs). Since the bundled service is covered by Medicaid, providers may not bill the member separately for it.

# Submitting a Claim

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See the Billing Procedures chapter in the *General Information for Providers* manual.



# Remittance Advices and Adjustments

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For information on remittance advices and adjustments, see the *General Information for Providers* manual.



# 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 therapists, physicians, mid-level practitioners, and other providers are paid for using the Department's Resource-Based Relative Value Scale (RBRVS) fee schedule. The fee schedule includes CPT codes and HCPCS codes. Within the CPT coding structure, only anesthesia services and clinical lab services are not paid for using the RBRVS fee schedule.

RBRVS was developed for the Medicare program. Medicare does a major update annually, with smaller updates performed quarterly. Montana Medicaid's RBRVS-based fee schedule is based largely on the Medicare model, with a few differences as described below. By adapting the Medicare model to the needs of the Montana Medicaid program, the Department was able to take advantage of the millions of dollars of 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, workers' compensation plans, and commercial insurers.

The following paragraphs elaborate on aspects of the RBRVS fee schedule used by the Department.

### ***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 does 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.



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

When Medicaid payment differs from the fee schedule, consider the following:
<ul style="list-style-type: none"> <li>• The Department pays the lower of the established Medicaid fee or the provider's charge</li> <li>• Modifiers. (See Other Modifiers in this chapter.)</li> <li>• Place of service. (See Site of Service Differential in this chapter.)</li> <li>• Date of service. (Fees for services may change over time.)</li> <li>• Also check for cost sharing and Medicare or TPL payments shown on the remittance advice.</li> </ul>

***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 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 that reflects the practitioner's practice cost of performing the service in an office and one that reflects the practitioner's practice cost of performing the service in a facility.

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

***Professional and Technical Components***

Many imaging services and some other diagnostic services are divided into the technical component (performing the test) and the professional component (interpreting the test). A practitioner who only performs the test would bill the service with Modifier TC; a practitioner who only interprets the test would bill with Modifier 26; and a practitioner who performs both components would bill the code without a modifier. Performance of both components is called the global service. The fee schedule has separate fees for each component and for the global service.

***Other Modifiers***

Under the RBRVS fee schedule, certain other modifiers also affect payment.

***How Modifiers Change Pricing***

The table below shows summary modifier descriptions of modifiers that affect pricing for therapy services. See the CPT and HCPCS coding books for the full text.

<b>Modifiers That Affect Pricing</b>		
<b>Modifier</b>	<b>Definition</b>	<b>How Payment Is Affected</b>
26	Professional component	For services paid via the RBRVS fee schedule, see the specific service. For other services, payment equals 40% of the fee.
52	Reduced service	The service is paid at 50% of the fee.
59	Distinct procedural service	The service is separate and distinct from another service on the same day. Medicaid will pay both if the modifier is used on one of the codes.

***Charge Cap***

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

***Bundled Codes***

A few services are covered by the Department but have a fee of zero, meaning that payment for the service is considered bundled into the payment for services that are usually provided with it. Because these services are covered by Medicaid, providers may not bill members for them on a private-pay basis.

**Status Codes**

The RBRVS fee schedule includes status codes that show how each service is paid. The list of status codes is based on that used by Medicare, as shown in the table.

**Medicare and Medicaid RBRVS Status Values**

Medicare Status		Medicaid Status	
A	Active code paid using RVUs	A	Active code paid using RVUs set by Medicare
B	Bundled code	B	Bundled code
C	Carrier determines coverage and payment	C	Pay by report
D	Deleted code	D	Discontinued code
E	Excluded from fee schedule by regulation		[Medicaid reviews each code and usually assigns A, K, or X status]
F	Deleted/discontinued code; no grace period	D	[Assigned to D status]
G	Use another code; grace period allowed	G	Use another code; grace period set code-by-code
H	Modifier deleted		[Assigned to D status]
I	Use another code; no grace period		[Assigned to G status]
		J	Anesthesia code
		K	Active code paid using RVUs set by Medicaid
		L	Not paid via RBRVS. See lab fee schedule.
		M	Not paid via RBRVS. See non-RBRVS fee schedule.
N	Excluded from fee schedule by policy		[Medicaid reviews each code and usually assigns A, K, or X status]
P	Bundled or excluded		[Medicaid reviews each code and usually assigns B or X status]
R	Restricted coverage		[Medicaid reviews each code and usually assigns A or K status]
T	Injections		[Medicaid reviews each code and usually assigns A status]
X	Excluded from fee schedule by statute	X	Not covered

Medicare publishes RVUs for codes that have Medicare status values of R and sometimes publishes RVUs for codes with status values of E, N, or X. Medicare uses the label “injections” for status T but now uses the code for other situations (e.g., pulse oximetry) where Medicare pays for the service only if no other service is performed on the same day.

## **How Cost Sharing is Calculated on Medicaid Claims**

Member cost sharing fees are a set dollar amount per visit. For services provided by physical and occupational therapists is \$2.00 per visit and \$3.00 per visit for speech therapy. The member's cost sharing amount is shown on the remittance advice and deducted from the Medicaid allowed amount.

## **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 (as described in the Coordination of Benefits chapter of this manual), and Medicaid makes a payment as the secondary payer.

## **How Payment is Calculated on Medicare Crossover Claims**

When a member has coverage from both Medicaid and Medicare, Medicare is the primary payer as described in the Coordination of Benefits chapter of this manual. Medicaid then makes a payment as the secondary payer. For the provider types covered in this manual, Medicaid's payment is calculated so that the total payment to the provider is either the Medicaid allowed amount less the Medicare paid amount or the sum of the Medicare coinsurance and deductible, whichever is lower. This method is sometimes called lower of pricing.



# Appendix A: Forms

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For these forms and others, see the Forms link in the left menu on the Provider Information [website](#).

- Montana Healthcare Programs Individual Adjustment Request
- Paperwork Attachment Cover Sheet



# Appendix B: Place of Service Codes

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For a list of place of service (POS) codes, corresponding names, and a brief description of each, see the CMS [website](#).



# Definitions and Acronyms

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Below are definitions and acronyms that pertain to therapy providers. See the Definitions and Acronyms page of the [website](#) for general terms.

## **Assistant/Aide**

A person who assists in the provision of therapy services. The assistant/aide must be under supervision and authorized to assist according to Montana law.

## **Maintenance Therapy**

Maintenance therapy is repetitive therapy services used to maintain functions with no expectation of progress. Maintenance therapy does not require licensed therapist evaluation or skills.

## **Modalities**

Any physical agent applied to produce therapeutic changes to biologic tissue; includes but not limited to thermal, acoustic, light, mechanical, or electric energy.

## **Restorative Therapy**

Therapy services are restorative when the member's function is expected to improve significantly in a reasonable and predictable period of time. Assessment of the member's restorative potential is completed by the member's physician or mid-level practitioner in consultation with the licensed therapist. Therapy services are not restorative if the member's expected restoration potential is insignificant in relation to the extent and duration of services required. Therapy services are no longer restorative when it is determined that function will not improve.



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