

Montana Healthcare Programs Outpatient Prospective Payment System Procedure Fee Schedule Explanation

Proposed Effective July 1, 2024

Montana Medicaid Conversion Factor \$60.72

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 62% of listed fee for sole community hospitals and at 60% 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 OPPTS
- 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. CPT codes, descriptors, and other data only are copyright American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS Apply.