Montana Healthcare Programs Outpatient Prospective Payment System Procedure Fee Schedule Explanation

Effective April 1, 2025

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 OPPS
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 OPPS but to which the multiple surgery reduction does not apply
T Significant services that are paid under the OPPS and to which the multiple procedure payment discount under OPPS applies
U Brachytherapy Sources
V Medical visits (including clinic or emergency department visits) that are paid under OPPS
X Ancillary services that are paid under OPPS
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: