Montana Healthcare Programs IDTF Fee Schedule Explanation

Effective January 1, 2025

Definitions:

Modifier:

When a modifier is present, this indicates system may have different reimbursement or code edits for that procedure code/modifier combination.
For example:

26 = professional component
TC = technical component

Description:

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

Effective

This is the first date of service for which the listed fee is applicable. Fees for drugs, radiopharmaceuticals, blood products, immune globin's, vaccines, And toxoids are reviewed and updated quarterly -- effective dates that are greater than three months old indicate that there has been no fee change since that date.

Method – Source of Fee Determination:

Note: If a valid, current code is not present, that code may be a non-covered service

Fee Sched: Medicaid fee; not determined using RBRVS payment schedule
Medicare: Medicare-prevailing fee.
MSRP: Manufacturers Suggested Retail Price (MSRP): Equals a percentage of billed charges based on MSRP or the provider acquisition cost (when no MSRP is available)
AAC: Average Acquisition Cost
Anes Value: Number of anesthesia base value units. This is added to the 15 min. time increment units and multiplied by the anesthesia conversion factor of $31.78
RBRVS: Based on Medicare Relative Value Units (RVU's) x Montana Medicaid conversion factor x policy adjuster. Conversion factor for fiscal year 2025 is $43.96

Fees:

The facility rate is paid to physicians/practitioners providing services in the following sites: hospitals, emergency rooms, ambulatory surgery centers, IHS provider based and IHS 638 free standing facilities, skilled nursing and nursing facilities, hospice, ambulance, inpatient psychiatric and partial psychiatric hospitals, psychiatric residential treatment centers, comprehensive inpatient rehab facilities, birthing centers and military treatment facilities. All other sites of service receive the office

rate. Procedures not normally done in the office are shown with the same facility rate, while those done in both locations have different rates. Bundled services, which are covered but paid as part of a related service, are shown with an RBRVS method and a fee of $0.00. Policy adjustments are applied to certain codes to increase or decrease reimbursement for the service. Vaccines covered by the Vaccines for Children (VFC) program are not reimbursable for individuals under 19. Please refer to the Medicaid Provider website for the list of VFC vaccines.

Global Days

Global surgery indicator

Global surgery periods are pre- and post-operative time frames assigned to surgical procedures.

000: Same day as procedure
010: Same day and ten days following procedure Indicators
090: One day prior to and ninety days following procedure
MMM: In maternity cases, the global period is per the CPT-4 code description
ZZZ: Add-on code, global period does not apply. An add-on code must be billed with its associated primary code

Indicators:

Mult: Multiple surgery guidelines do apply
Bilat: Bilateral. The procedure can be done bilaterally
Assist: Assistant. An assistant is allowed for this procedure
Co-Surg: A co-surgeon is allowed for this procedure
Team: A team of surgeons is allowed for this procedure
Y: Indicator is applicable to this code
Policy Adjust: M= Maternity, F= Family Planning

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

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