

# Facility Fee Schedule Instruction Set for 2013

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## Section One: Introduction

### ***Background***

Montana has adopted some of the codes and processes of the Centers for Medicare and Medicaid Services (CMS), but the Montana Codes Annotated (MCA) and Administrative Rules of Montana (ARM) govern the application of these codes and processes in Montana for Workers' Compensation (WC) reimbursement.

The Montana Facility Fee Schedule is intended to guide the direct reimbursement for two specific types of Montana facilities, namely Acute Care Hospitals and Ambulatory Surgery Centers (ASCs), for WC services provided on and after July 1, 2013.

### ***Related Terminology***

**American Medical Association (AMA)** —The association that develops, updates and publishes the *Physicians Current Procedural Terminology* (CPT) coding system for medical services and procedures (HCPCS Level I codes). CPT codes provide an effective, consistent language for nationwide communication among physicians, insurance payers, and patients.

**Ambulatory Procedure Codes (APC)** —Ambulatory Payment Classification developed by CMS.

**Base Rate**—The base payment rate is divided into a labor-related and nonlabor share. The labor-related share is adjusted by the wage index applicable to the area where the hospital is located.

**Category II Codes**—Temporary sets of codes used for tracking performance measurement on emerging technologies, services, and procedures. The temporary codes are used to document use levels for future setting of RVUs if a given code is converted into a permanent CPT or HCPCS.

**Centers for Medicare and Medicaid Services (CMS)** —The government agency responsible for overseeing and administering the Medicare and Medicaid programs. CMS annually publishes the relative value units (RVUs) known as RBRVS for the reimbursement of medical services. The RBRVS is the basis for reimbursement in Montana for WC medical services and procedures.

**Correct Coding Initiative Edits (CCI Edits)**—CMS codes that assist in correct coding and billing procedures. CCI Edits are posted on the ERD website.

**Cost to Charge Ratio (CCR)**—Operating and capital cost-to-charge ratios are computed annually for each hospital based on the latest available settled cost report for that hospital

**CPT** — Current Procedural Terminology is a listing of descriptive terms and identifying codes for reporting medical services and procedures performed by providers. CPT is copyrighted by The American Medical Association.

**Employment Relations Division (ERD)** —The division within the Montana Department of Labor and Industry responsible for regulation of the Montana workers' compensation system.

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**Evaluation and Management Services (E/M)** — Medical services provided to patients that involve visits, examinations and consultations, both in facilities (e.g., hospitals, ambulatory surgery center, skilled nursing facilities) and at nonfacilities (e.g., physician offices, patient’s home).

**Facility**—The term as used here is defined in 24.29.1401A, ARM.

**Facility Reimbursement**—The allowed reimbursement for each professional service when that service or procedure is provided in a facility.

**Gap**—Services not covered by Medicare and/or not assigned a relative value in the RBRVS system.

**Gap Code**—Any Level I (CPT) or Level II (HCPCS) code that is not given an RVU by CMS.

**Geometric Mean LOS**—Geometric Mean Length of Stay in a hospital

**HCPCS**—HCPCS is an acronym for Healthcare Common Procedure Coding System. It is a two-tier medical coding system composed of HCPCS Level I (CPT) codes and HCPCS Level II national codes.

**Independent Medical Review (IMR):** A request by an interested party for the medical director to review medical records for the medical necessity of a denied service.

**Level I Codes** — The first level of the HCPCS system is the American Medical Association’s *Current Procedural Terminology* (CPT) codes. This code set, known universally as CPT, reports a broad spectrum of medical procedures and services.

**Level II Codes** — this is the second level of the HCPCS system and is developed by CMS to report services and supplies not found in the CPT system. These Level II national codes are commonly referred to collectively as HCPCS.

**Medical Severity Diagnosis Related Groups (MS-DRG)**—This system classifies facility admissions based on their illness (diagnosis) and the treatment provided. It is assumed that patients with similar illnesses undergoing similar procedures will require similar resources. This payment methodology, therefore, reimburses facilities on a flat-rate basis based on the patient’s diagnosis and treatment.

**Medically Unlikely Edits (MUE)**—CMS codes that assist in correct coding and billing procedures. MUEs are posted on the ERD website.

**Montana Professional Fee Schedule (MPFS)**—The allowed reimbursement paid to a professional provider for services and procedures provided in a nonfacility or facility setting.

**Nonfacility**—The term as used here is defined in 24.29.1401A, ARM.

**Relative Value (RV)** — RBRVS ranks each service or procedure based on the relative costs required to provide them. A relative value reflects the cost of providing a specific medical provider’s service as compared to the cost of providing all other services and procedures.

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**Relative Value Unit (RVU)** — Relative values are expressed in numeric units that represent the unit of measure of the cost of providing a medical service. Those services that have greater costs have greater relative value units than those services with lower costs.

**Relative Weight**— The weight assigned by Medicare to APC codes which measure the resource requirements of the service and is based on the median cost of services

**Resource Based Relative Value Scale (RBRVS)** —Payment schedule based on the relative values of services provided. The RBRVS system ranks services according to the relative costs required to provide them. These costs are defined in terms of units, with more complex, more time-consuming services having higher unit values than less complex, less time-consuming services. Furthermore, each service is compared to all other medical services so that each service is given a value that reflects its cost when compared to all other medical services.

**Status Indicator Codes**— CMS codes which assist in the calculation of reimbursements for services and supplies. The codes are listed on the ERD website.

**Usual and Customary Charge**—“Usual and Customary Charge” means the regular medical charge that a facility or individual medical provider bills for the service or procedure provided to any non-WC patient.

**Weight**—A relative weight reflects the expected relative costliness of inpatient treatment for patients in a MS-DRG group

**Workers' Compensation (WC)** — A system that provides wage-loss and medical benefits to a worker suffering from a work-related injury or disease.

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### *Components in Montana WC Facility Fee Schedule*

#### **A. The Montana Hospital Inpatient Services MS-DRG Reimbursement Fee Schedule**

##### **MS-DRG**

The list of MS-DRG codes for inpatient reimbursement.

##### **MS-DRG Title**

Code descriptors

##### **Geometric**

Geometric Mean Length of Stay

##### **Weights**

The factor used to multiply by the base rate to determine reimbursement.

##### **Montana Reimbursement Amount**

The reimbursement for each MS-DRG billed by the facility.

#### **B. The Montana Hospital Outpatient and ASC Fee Schedule Organized by APC**

##### **APC**

The list of APC codes for outpatient reimbursement

##### **Group Title**

Code descriptors

##### **SI**

The related Status Indicator code for correct calculation of reimbursement

##### **Relative Weight**

The factor used to multiply by the base rate to determine reimbursement.

##### **Hospital APC Reimbursement Amount**

The reimbursement for services provided in an outpatient hospital setting

##### **Ambulatory Surgical Center (ASC) Reimbursement Amount**

The reimbursement for services provided in an ambulatory surgical center.

#### **C. The Montana Hospital Outpatient and ASC Fee Schedule Organized by CPT/HCPCS**

##### **HCPCS Code**

The list of HCPCS codes for correct calculation of reimbursement

##### **SI**

The related Status Indicator code for correct calculation of reimbursement

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### APC

The list of APC codes that correlate with the HCPCS codes

### Relative Weight

The factor used to multiply by the base rate to determine reimbursement.

### MT Hospital Rate

The reimbursement for services provided in an outpatient hospital setting

### MT ASC Rate

The reimbursement for services provided in an ambulatory surgical center.

## **D. The Montana Ambulance Fee Schedule**

### HCPCS

The list of HCPCS codes for correct calculation of reimbursement

WC Urban Base Rate The rates for Missoula, Great Falls and Billings, excluding air ambulance

### WC Rural Base Rate

The rates for the remainder of the state, excluding air ambulance

### WC Miles

The rate of reimbursement for ground or air mileage

### Explanation of Service Mode

Descriptors

## **E. The Montana CCR and other Montana CCR-based Calculations**

A list of the cost to charge ratios (CCR) for the regulated hospitals in Montana as determined by CMS.

## **F. The Montana Status Indicator Codes**

A list of the status indicator codes that apply to the Montana WC Facility Fee Schedule

## **G. The Base Rates and Conversion Formulas Established by the Department**

The current base rates for inpatient, outpatient and ambulatory surgery center facility services

## ***Facility Fee Schedule Archives***

Past facility fee schedules and instruction sets are posted on the ERD website.

## Facility Fee Schedule Instruction Set for 2013

### Section Two: General Instructions

#### ***Ambulance Services***

The Montana Ambulance Fee Schedule can be found within the Montana Facility Fee Schedule. “Urban areas” in Montana are defined as Billings, Great Falls, and Missoula.

The State of Montana does not have the authority to set a fee schedule rate for Air Ambulances on workers’ compensation patients who have their operating authority through the Federal Department of Transportation (Airline Deregulation Act of 1978 (ADA)). State of Montana administrative rules are preempted by federal law 49 USC 41713(b). Air ambulances that are regulated by federal law will be paid at the usual and customary charge for the carrier.

#### ***Drug Screens***

Drug screens performed by a provider that is a CLIA waived test or of moderate complexity per patient encounter must bill using G0434 for one unit. This includes tests such as dipsticks, cups, cassettes, and cards that are interpreted visually, with the assistance of a scanner, or are read utilizing a moderately complex reader device outside the instrumented laboratory setting.

Drug screens performed by a provider that is a CLIA test in an instrumented laboratory setting and is a high complexity method per patient encounter must bill using G0431 for each unit. Laboratories billing G0431 must not append the QW modifier to the claim lines.

#### ***Facility Billing***

The nationally utilized medical billing form UB04 will be used by providers for facility charges when requesting reimbursement.

#### ***Independent Medical Review by the Department***

A form for the Independent Medical Review (IMR) must be filled out and sent to the department along with the medical records or available evidence-based documentation that support treatment recommendations. The IMR request form is posted on the ERD website.

#### ***Medical Review and Utilization and Treatment Review by Insurers***

Insurers will conduct any reviews on a post-payment basis only. Insurer may request providers to submit supporting documentation for services provided. However, if the claim is not paid within 30 days of receipt of the undisputed medical claim by the insurer, the provider may assess a 1% interest payment penalty per month or portion of the month using the Montana unique code MT005. Refer to 24.29.1402 for the procedure.

#### ***Medical Services Rendered in a Facility by a Professional Provider***

Professional medical procedures, services and supplies provided by a facility are to be reimbursed under the professional fee schedule rate under the **facility reimbursement** column. The medical bills for these providers will be billed on a CMS 1500.

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### ***Medical Services Rendered Outside a Facility by a Professional Provider***

Medical professionals providing services, supplies and procedures in their offices and clinics are to be reimbursed at the rate for those services listed in the Montana Professional Fee Schedule in the column labeled **nonfacility reimbursement**. These services will be billed on a CMS1500.

### ***Medically Unlikely Edits (MUEs)***

These edits will further assist providers and insurers in determining acceptable units of service. MUEs are posted on the ERD website.

### ***Modifiers***

Codes may be modified under certain circumstances. When applicable, the modifying circumstance should be identified by the addition of the appropriate modifier code after the usual procedure number (e.g., 47600 22). Modifier descriptions should be carefully reviewed because in recent years, significant revisions have been made to modifier descriptions. Providers shall use the modifiers listed on the ERD website.

Some modifiers are specific to certain types of services.

- **Total:** When no modifier is listed, the unit value represents the global value of the procedure. The five-digit code is used to represent a global service inclusive of the professional services and technical value of providing that service. The following sections, professional and technical, provide additional definitions for each component. Providers who are not employees of a facility may bill using code without a modifier if both the professional and technical component are performed in the providers office. Facilities must bill using the appropriate modifiers if services for the technical component is provided
- **Professional:** Modifier 26 is used to designate professional services. The professional component includes examination of the patient, when indicated, performance and/or supervision of the procedure, interpretation and written report of the examination, and consultation with referring medical providers. Providers must bill for these services using the CMS1500.
- **Technical:** Modifier TC is used to designate the technical value of providing the service. The technical component includes personnel, materials, space, equipment, and other allocated facility overhead normally included in providing the service.
- **HCPCS Level II Modifiers:** HCPCS Level II modifiers differ from Level I (CPT), and are more specific and limited in their application. Three Level II modifiers are used in the HCPCS section. Reporting of HCPCS services and supplies may require the use of additional modifiers
- **DME Rentals:** Reimbursement for rentals follow the 13-month calculation set up by Medicare. The Level II modifiers included in this section are:
  - NU New Equipment
  - RR Rental Equipment
  - UE Used Durable Medical Equipment (DME)

### ***Montana CCI (Correct Coding Initiative) Edits***

These will assist providers and insurers to understand how to reimburse when multiple codes are involved. CCI edits are on the ERD website.

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### ***Multiple Procedures***

The multiple payment reduction for diagnostic imaging services applies to multiple services furnished by the same provider to the same patient in the same session on the same day.

Professional Component—to be reimbursed under the Montana Professional Fee Schedule

First subsequent procedure 75%

Second subsequent procedure 50%

Third and all additional subsequent procedures 25%

Technical Component

First subsequent procedure 50%

Second and all subsequent procedures 25%

For all other multiple procedures, the discount is the same as the technical multiple procedure discount.

### ***New Codes***

If no rate is listed and the facility code is not otherwise included in the Montana Facility Fee Schedule or the administrative rules, the service will be paid at 75% of the provider's usual and customary charge.

New codes will be paid at 75% usual and customary until the new code is incorporated into the fee schedule.

### ***Status Code Indicators (SI)***

SI codes will be used to calculate reimbursements for services and supplies. The codes are listed on the ERD website.

For SI code "P," any length of stay under 24 hours for patient observation is considered outpatient. Also if there is no value, pay at 75% usual and customary.

### ***Usual and Customary***

In Montana, Usual and Customary means the provider's normal charges for service, and does not include state or regional database information purporting to be usual and customary.

## **Section Three: Inpatient (MS-DRG) Reimbursement**

### ***MS-DRG Reimbursement***

MS-DRGs in Montana are reimbursed at the same rate for all Acute Care Hospitals for workers' compensation medical services. Each MS-DRG is given a relative weight based on its relative complexity and use of resources. The Montana base rate effective July 1, 2013 is \$7,944. The payment formula is the relative weight multiplied by the base rate.

Unbundling of a grouper code is not allowed. If a provider bills a CPT or HCPCS code and there is a DRG code available, the insurer may pay the reimbursement under the DRG code. All facility charges must be billed on the UB04.

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### ***MS-DRG Grouper***

A MS-DRG grouper takes five clinical and demographic data elements as input and generates a corresponding MS-DRG classification code. One software program available is [www.hospitalbenchmarks.com](http://www.hospitalbenchmarks.com).

### ***Outliers***

Occasionally very high medical costs associated with a particular case, known as outlier costs, may require additional reimbursement to the facility. The threshold for outlier payments is **three times the Montana MS-DRG reimbursement**.

To calculate outliers, use the following formula:

$$[\text{Charges} - (\text{MS-DRG reimbursement} \times 3)] \times (\text{CCR plus 15\%}) = \text{outlier reimbursement}$$

There is a different CCR (Cost-to-Charge Ratio) for each acute care hospital in Montana. The CCR is listed on the ERD website for each acute care hospital.

Example:

Charges are \$100,000 from ABC Hospital

MS-DRG reimbursement per the fee schedule is \$25,000

Outlier threshold is \$75,000.  $\$25,000 \times 3 = \$75,000$

RCC is 0.50

$$(\$100,000 - \$75,000) \times (0.50 + .15) = \$16,250.00$$

The total reimbursement to ABC Hospital would be  $\$25,000 + \$16,250 = \$41,250$

### ***Inpatient Implants***

The administrative rules have a special reimbursement process to ensure that injured workers receive the appropriate implant and the hospital or ASC implant costs are appropriately reimbursed.

An implant is an object or device that is made to replace and act as a missing biological structure that is surgically implanted, embedded, inserted, or otherwise applied. The term also includes any related equipment necessary to operate, program, and recharge the implantable.

Implant cost refers to the total cost of all components for a patient. Providers must use the code MT003 to request implant reimbursements separate from the DRG reimbursement.

Inpatient Implant Reimbursement:

1. Implants costing less than \$10,000 are considered to be bundled into the MS-DRG reimbursement.
  - a. Implants which exceed \$10,000 in cost may be reimbursed at cost plus 15%. A copy of the implant invoice (or purchase order if it lists the number of items, the wholesale price, and the shipping costs) is required with the medical bill for reimbursement.
  - b. A copy of the surgical notes with the items implanted must be included in the documentation.
  - c. Shipping and handling costs may be reimbursed at cost only and are not included in the 15% calculation.
  - d. Implant costs from the invoice are excluded from outlier calculations.

## Section Four: Outpatient Reimbursement

### *Outpatient Reimbursement*

Outpatient services are payable under APC or CPT codes. There may be several APCs per medical bill. If the provider bills under a CPT code that has a corresponding APC code, the insurer may pay using the APC code. However, there may be services that do not have an APC code and will only be payable under the CPT or HCPCS code. The insurer will pay these codes separately from the APC code. All outpatient or ASC facility charges must be billed on the UB04.

### *APC Reimbursement Levels*

Levels of APC reimbursement are different for ASCs than for hospitals. The basic formula for outpatient reimbursement is the base rate times the APC relative weight.

Hospital outpatient base rate effective July 1, 2013	\$107
ASC base rate effective July 1, 2013	\$80

### *Outpatient Implants*

Implant cost refers to the total cost of all components for a patient. Providers must use the code MT003 to request implant reimbursements separate from the DRG reimbursement.

1. Implants costing less than \$500 are considered to be bundled into the APC reimbursement.
2. Implants which exceed \$500 in cost may be reimbursed at cost plus 15%
  - a. A copy of the implant invoice (or purchase order if it lists the number of items, the wholesale price, and the shipping costs) is required with the medical bill for reimbursement.
  - b. A copy of the surgical notes with the items implanted must be included in the documentation.
  - c. Shipping and handling costs may be reimbursed at cost only and are not included in the 15% calculation.
  - d. Implant costs from the invoice are excluded from outlier calculations.