

Understanding Montana Workers' Compensation (WC) Facility Fee Schedule: Unit One

New updates of information, similar to FAQ, will be added to this educational module on a regular basis, so please check the date at the bottom of this page regularly to keep up with added fee schedule information.

A Power Point educational module initially created by the Montana Department of Labor (DLI) in February, 2009. Actual regulations in the Montana Code Annotated and Administrative Rules of Montana, of course, take precedence in case of any misstatements in this educational module.

April 24, 2009

***Unit One: Introduction
to the Montana MS-DRG
(inpatient)
and
APC (outpatient)
Facility Fee Schedule***

**For use with the Montana Facility Fee Schedule for Workers'
Compensation (WC) Reimbursement**

Educational Module Organization

- **Section One: General Concepts & Rules**
- **Section Two: Inpatient (MS-DRG) System System, Outliers, Implants**
- **Section Three: Outpatient (APC) System Hospitals, ASCs, Status Indicator (SI) Codes, Implants**

Section One: General Concepts

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.

Section One: General Concepts (continued)

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 12/01/08. Based on recent legislative decisions, a number of additional changes in how WC services are managed have been made for the time period beginning with 4/1/09 and going forward.

Section One: General Concepts (continued)

Facility-based Medical Services

Reimbursement:

The Montana Facility Fee Schedule is intended to be used in coordination with the Montana Nonfacility Fee Schedule, which in contrast is intended to reimburse for professional medical procedures, services and supplies. For example, an anesthesiologist providing

Section One: General Concepts (continued)

independent professional services at a hospital would be reimbursed at the rate for those services listed in the Montana Nonfacility Fee Schedule in the column labeled “facility reimbursement” for those services.

Section One: General Concepts (continued)

Nonfacility-based Medical Services

Reimbursement:

As a final contrast, medical professionals providing services, supplies and procedures in their offices and clinics, however, are to be reimbursed at the rate for those services listed in the Montana Nonfacility Fee Schedule in the column labeled “nonfacility reimbursement.”

Section One: General Concepts & Rules (continued)

- Inpatient rehabilitation services are paid at 75% of the usual and customary charges*
 - DME, prosthetics & orthotics (not implantables) are paid at 75% of the usual and customary charges*
 - Ambulance services are to be reimbursed based on the “(d) Montana Ambulance Fee Schedule” within the Montana Facility Fee Schedule. “Urban areas” in Montana are defined as Billings, Great Falls, and Missoula. Only Status Indicator (SI) “A” codes for Ambulance-related services are to be reimbursed.
- *In Montana “usual and customary” means the provider’s normal charges for a service, and does not include state or regional database information purporting to be usual and customary

Section One: General Concepts and Rules (continued)

- **Use of nationally utilized medical billing forms such as the UB-04 or CMS 1500 are required**
- **Insurer payment is due within 30 days of receipt of the bill from the provider facility, or a 1% interest payment penalty per month is charged**
- **Audits are conducted on a post-payment basis only**
- **Facilities do not need to submit medical records initially except when there are no other supporting documents, for example labs or PT**
- **In the past the Montana WC reimbursement system was not automatically updated with CMS quarterly updates. Based on statutory changes beginning April 1, 2009, however, we are in the process catching up with recent CMS updates and making them applicable to the Montana WC reimbursement system**

Section Two: The MS-DRG System

What are MS-DRGs?

A payment system that classifies hospital inpatient cases into one of approximately 750 groups that are expected to have a similar hospital resource use. MS-DRGs in Montana are reimbursed at the same rate for all Acute Care Hospitals for WC medical services.

Section Two: The MS-DRG System (continued)

Where did the MS-DRG system come from?

The system was developed initially for CMS as part of its Medicare prospective payment system beginning in 2007, and many state Workers' Compensation (WC) programs, including Montana, now also use MS-DRGs for inpatient reimbursement.

Section Two: The MS-DRG System (continued)

**What are the five data elements used
to classify a MS-DRG?**

- **ICD-9 Procedures**
- **ICD-9 Diagnoses**
- **Gender**
- **Age**
- **Discharge Status**

Section Two: The MS-DRG System (continued)

Why were MS-DRGs created?

Medical bills can be complex, and MS-DRGs can help simplify billing by grouping multiple diagnosis, procedure, and other codes into one service grouping---the MS-DRG---for payment.

Section Two: The MS-DRG System (continued)

MS-DRG Calculations

- **Each MS-DRG is given a Relative Weight based on its relative complexity and use of resources**
- **Montana's Conversion Factor (CF) is \$7,735 for the period beginning 12/01/08**
- **The payment formula is the Relative Weight multiplied by the CF (\$7,735)**

Section Two: The MS-DRG System (continued)

What is an MS-DRG Grouper?

A computer program or software module which takes five clinical and demographic data elements as input and generates a corresponding Medicare Severity-Diagnosis Related Group (MS-DRG) classification code as output. One free Grouper you can use is located on the internet at

www.hospitalbenchmarks.com

Section Two: The MS-DRG System (continued)

Where can I obtain an MS-DRG Grouper?

CMS makes available a \$500 CD or \$660 magnetic tape-based inpatient Grouper/Pricer software program for versions 25 or 26 at

<http://www.ntis.gov/products/grouper.aspx>

The use of Montana WC reimbursement weights and conversion factors are required to customize the software so that it can generate Montana-related WC reimbursement calculations.

Section Two: The MS-DRG System (continued)

How can I customize---or get a customized--Grouper/Pricer software for the Montana Facility Fee Schedule?

Montana weights and conversion factors are on the Montana Facility Fee Schedule, listed on the “(a) Montana Hospital Inpatient Services MS-DRG Reimbursement Fee Schedule” and “(h) The Base Rates and Conversion Formulas Established By The Department” which are located at <http://erd.dli.mt.gov/wcstudyproject/MFFS%20pdf/a%20MSDRG%20V26.pdf> In addition, TPAs provide a customized Grouper/Pricer as a part of their services if they manage this reimbursement system for insurers.

Section Two: The MS-DRG System (continued)

Using an MS-DRG Grouper/Pricer with a UB-04

(see a portion of a sample UB-04 form on the next slide):

- 1) Identify the Diagnosis (D) and Procedure (P) Codes on the UB-04, & proceed if Block 4 includes code 0111 (which equates to inpatient services)
- 2) Insert the D & P Codes into the correct cells on the Grouper/Pricer and press the “Group & Compare” button (see sample Grouper on subsequent two slides below)
- 3) Confirm the reimbursement amount cited with the Grouper-generated MS-DRG code with the Montana Facility Fee Schedule section listing that MS-DRG code

Section Two: The MS-DRG System (continued) Sample UB-04

63 TREATMENT AUTHORIZATION CODES						64 DOCUMENT CONTROL NUMBER						
A												
B												
C												
66 DX	75612	3051	e8889	4019	25000	41400						
	7806	7850	2859	L	M	N						
69 ADMIT DX			70 PATIENT REASON DX	a	b	c	71 PPS CODE			72 ECI		
74	PRINCIPAL PROCEDURE CODE DATE					b. OTHER PROCEDURE CODE DATE				75		
	8108	082809	8162	082809	8451	082809						
			d. OTHER PROCEDURE CODE DATE									
80 REMARKS				81CC a								
				b								

Grouper Example (page 1 of 2)

INGENIX. Hospital

financial benchmarks participating hospitals »

Username:

Password:

Login

Web Based MS-DRG
Grouper →

Online a
clinical i
hospital i

To compete i
industry, it is
care organiz
information. I
is customizal
service that
to reliable an
you can mak
that improve

Age: Sex: F ▼ Discharge Status: 01 - Home, Self Care ▼

Diagnosis Codes (Do not enter with decimal points):

Procedure Codes (Do not enter with decimal points):

GROUP & COMPARE

Reset

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Grouping Example (page 2 of 2)

Diagnosis Codes (Do not enter with decimal points):

75612 3051 e8889 4019 25000 41400 7806 7850 2859

Procedure Codes (Do not enter with decimal points):

8108 8162 8451

GROUP & COMPARE

Reset

Grouping Results:

CMS v24 DRG Assignment:	498 (SPINAL FUSION EXCEPT CERVICAL W/O CC)
CMS v25 (MS) DRG Assignment:	460 (SPIN FUS EXC CERV WO MCC)
CMS v26 (MS FY2009) DRG Assignment:	460 (SPIN FUS EXC CERV WO MCC)
MDC:	08 (Diseases & Disorders Of The Musculoskeletal System & Conn Tissue)
CMS v24 DRG Weight:	2.9896
CMS v25 (MS) DRG Weight:	3.4870
CMS v26 (MS FY2009) DRG Weight:	3.5607
CC Diagnosis:	None
MCC Diagnosis:	None
*	Updated to CMS final rule.

Section Two: The MS-DRG System (continued)

Is It An Inpatient or Outpatient Bill?

Remember that a bill from a hospital facility can be for either inpatient or outpatient services, so be sure to confirm that the code entered into Block 4 on the UB-04 is either

- 0111 (inpatient services, use a MS-DRG Grouper) or
- 0131 (outpatient services, use the APC codes and process)

Pay the Bill based on the Fee Schedule

MS-DRG rates are based on a “case mix” formula, so Insurers should pay the actual fee schedule reimbursement amount, instead of the higher or lower reimbursement amount the medical provider might inadvertently bill

Section Two: The MS-DRG System (continued)

Inpatient Outliers

**The MS-DRG system is intended to meet
the majority of all inpatient
reimbursement needs**

**Occasionally very high medical costs
associated with a particular case, known
as outlier costs, may require additional
reimbursement to the facility**

Section Two: The MS-DRG System (continued)

Calculating Outlier Payments

- Charges must meet the outlier threshold formula established by the Administrative Rules of Montana (ARM) for inpatient outlier costs
- The threshold formula is the MS-DRG payment multiplied by 3
- $[\text{Charges} - (\text{MS-DRG payment} \times 3)] \times (\text{RCC plus } 15\%)$
- There is a different RCC (Ratio of Cost-to-Charge) for each Montana Hospital (for the RCCs, see “(f) The Montana RCC and other Montana RCC-based Calculations” section of the Montana Facility Fee Schedule)

Section Two: The MS-DRG System (continued)

An example of calculating an outlier:

- **Assume that the medical charges total \$100,000,**
- **And the MS-DRG Payment is \$25,000,**
- **And the outlier threshold is \$75,000,**
- **And the RCC (Ratio of Cost-to-Charge) is 0.50,**
- **Then the outlier payment = $(\$100,000 - \$75,000) \times (0.50 + .15) = \$16,250$ to be added to the regular reimbursement**
- **Therefore total payment is $\$25,000 + \$16,250 = \$41,250$**

Section Two: The MS-DRG System (continued)

Implants: Another Major Cost Factor

Implants can be a substantial cost element in WC medical expenses, so in the Administrative Rules of Montana we have set up a special reimbursement process to ensure that injured workers receive the appropriate implant and the hospital's implant costs are appropriately reimbursed.

Section Two: The MS-DRG System (continued)

Implants Defined

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.

It is important to note that “implant cost,” as used in the Montana WC reimbursement system, refers to the total implant costs for all implant components combined for a patient.

Section Two: The MS-DRG System (continued)

Inpatient Implant Reimbursement System

- **Implants costing less than \$10,000 are considered to be bundled into the MS-DRG reimbursement**
- **Implants costing more than \$10,000 can be separately reimbursed at cost plus 15%**
- **Copies of Implant invoices are required for this separate reimbursement process**
- **Implant costs include shipping and handling**
- **Implant costs are excluded from outlier calculations**

Section Three: Outpatient (APC) Reimbursement System

**The Montana WC system reimburses
both Acute Care Hospitals and
Ambulatory Surgery Centers (ASCs)
for outpatient medical services
using the Montana Facility Fee
Schedule 's APC system**

Section Three: Outpatient (APC) Reimbursement System

What is the APC?

- On December 1, 2008, the APC reimbursement system was adopted through the Administrative Rules of Montana process for outpatient services provided by Hospitals and Ambulatory Surgery Centers (ASCs)
- The Ambulatory Payment Classification (APC) system was developed by CMS to group outpatient services into classifications that are expected to have a similar outpatient resource use

Section Three: Outpatient (APC) Reimbursement System

Montana Outpatient services that might be in an APC:

- Surgery
- Clinic visits
- Emergency Room (ER) visits
- Psychological services
- X-rays
- Diagnostic tests
- Pathology
- Use of recovery room
- Use of observation bed
- Drugs, supplies, and dressings
- Anesthesia supplies & equipment
- Implants (sometimes)

Example of Montana APC Fee Schedule reimbursement page

APC Description **Status** **Hosp\$** **ASC\$**
Indicator

0041	Level I Arthroscopy	T	3,021.93	2,273.64
0042	Level II Arthroscopy	T	4,799.26	3,610.87
0043	Closed Treatment Fracture Finger/Toe/Trunk	T	185.66	139.69
0045	Bone/Joint Manipulation Under Anesthesia	T	1,550.41	1,166.50
0047	Arthroplasty without Prosthesis	T	3,769.92	2,836.42
0048	Level I Arthroplasty with Prosthesis	T	5,343.20	4,020.12
0049	Level I Musculoskeletal Procedures Except Hand and Foot	T	2,233.23	1,680.24
0050	Level II Musculoskeletal Procedures Except Hand and Foot	T	3,064.95	2,306.01
0051	Level III Musculoskeletal Procedures Except Hand and Foot	T	4,513.43	3,395.82
0052	Level IV Musculoskeletal Procedures Except Hand and Foot	T	8,339.56	6,274.53
0053	Level I Hand Musculoskeletal Procedures	T	1,728.69	1,300.63
0054	Level II Hand Musculoskeletal Procedures	T	2,762.60	2,078.53
0055	Level I Foot Musculoskeletal Procedures	T	2,186.98	1,645.44
0056	Level II Foot Musculoskeletal Procedures	T	4,648.21	3,497.23
0057	Bunion Procedures	T	3,088.75	2,323.92
0058	Level I Strapping and Cast Application	S	114.78	86.35

Section Three: Outpatient (APC) Reimbursement System

APC System Components

Outpatient services are grouped into APCs

- **There may be several APCs per patient per day**
- **There may be discounts for multiple APCs**
- **There may be separately payable CPT and HCPCS services**
- **Montana CCI (Correct Coding Initiative) edits further assist insurers to understand how to reimburse when multiple codes are involved**

Section Three: Outpatient (APC) Reimbursement System

Montana Status Indicator (SI) codes

- Apply to outpatient services only
- Also help identify how APCs and other codes are reimbursed

Only Montana Status Indicator codes can be used to calculate reimbursements for services and supplies

Do not use status indicator codes other than A, B, D, F, G, H, K, L, N, P, S, T and X, and pay the amount listed on the fee schedule

Please note that:

- SI “A” should only be reimbursed for ambulance-related services, for example stand-by waiting and other services listed on “(d) The Montana Ambulance Fee Schedule” within the Montana Facility Fee Schedule
- SI “K” on the “(g) Status Indicator (SI)” portion of our fee schedule is mislabeled and should instead state “not a pass-through drug or device, and needs to be paid separately from the APC”

(g) The Montana Status Indicator (SI) Codes

Each APC, CPT and HCPCS code has been assigned a letter that signifies whether the Montana Facility Fee Schedule will reimburse the service and how it will be reimbursed. The indicator also helps in determining whether policy rules, such as packaging and discounting, apply. Only Montana Status Indicator codes can be used to calculate reimbursements for services and supplies. Do not use status indicator codes other than A, B, D, F, G, H, K, L, N, P, S, T and X and pay at the fee scheduled amount listed.

SI Code	SI (Status Indicator) Description
A	Fee Schedules:[reimburse] Ambulance[-related codes only].
B	Non-allowed item or service. Not a hospital service.
D	Discontinued code.
F	Acquisition costs paid for Corneal tissue acquisition; certain CRNA services and hepatitis B vaccines.
G	Additional payment for Drug/Biological pass-through.
H	Additional payment for Pass-through device categories, brachytherapy sources, and radiopharmaceutical agents.
K	[Not a] Pass-through [for] drugs [, devices] and biologicals [These are to be paid separately from the APC].
L	Flu and other vaccines.
N	No additional payment, payment included in line items with APCs for incidental service. (Packaged codes not paid separately).
P	Paid Partial hospitalization per diem payment.
S	Significant procedure not subject to multiple procedure discounting.
T	Significant procedure, subject to 50% discount on second procedure if present.
X	Ancillary services.
1) Please note the misprint for SI "K" corrected hereon with bracketed text	
2) Please note the clarification for SI "A" corrected hereon with bracketed text	

Section Three: Outpatient (APC) Reimbursement System

APC reimbursement levels are different for ASCs and Hospitals

- **The basic formula for outpatient reimbursement is the Montana Base Rate times the APC relative weight of a given APC**
- **For hospitals, the Montana Base Rate is \$105 beginning 12/01/08**
- **For ASCs, the Montana Base Rate is \$79 beginning 12/01/08**
- **If no rate is listed and the code is not otherwise included in the Montana Facility Fee Schedule or the Administrative Rules of Montana, the service is to be paid at 75% of the Montana usual & customary charge***
- **Additional codes may be used on billing documents to help identify service categories (see the next slide for Revenue Code examples)**

***In Montana “usual and customary” means the provider’s normal charges for a service, and does not include state or regional database information purporting to be usual and customary**

Other reference codes

TABLE 2.—CY 2008 PACKAGED REVENUE CODES		622	SUPPLIES INCIDENT TO OTHER DIAGNOSTIC
Revenue	Description	624	INVESTIGATIONAL DEVICE (IDE)
250	PHARMACY	630	DRUGS REQUIRING SPECIFIC IDENTIFICATION, GENERAL CLASS
251	GENERIC	631	SINGLE SOURCE
252	NONGENERIC	632	MULTIPLE
254	PHARMACY INCIDENT TO OTHER DIAGNOSTIC	633	RESTRICTIVE PRESCRIPTION
255	PHARMACY INCIDENT TO RADIOLOGY	681	TRAUMA RESPONSE, LEVEL I
257	NONPRESCRIPTION DRUGS	682	TRAUMA RESPONSE, LEVEL II
258	IV SOLUTIONS	683	TRAUMA RESPONSE, LEVEL III
259	OTHER PHARMACY	684	TRAUMA RESPONSE, LEVEL IV
260	IV THERAPY, GENERAL CLASS	689	TRAUMA RESPONSE, OTHER
262	IV THERAPY/PHARMACY SERVICES	700	CAST ROOM
263	SUPPLY/DELIVERY	709	OTHER CAST ROOM
264	IV THERAPY/SUPPLIES	710	RECOVERY ROOM
269	OTHER IV THERAPY	719	OTHER RECOVERY ROOM
270	M&S SUPPLIES	720	LABOR ROOM
271	NONSTERILE SUPPLIES	721	LABOR
272	STERILE SUPPLIES	732	TELEMETRY
273	TAKE HOME SUPPLIES	762	OBSERVATION ROOM
275	PACEMAKER DRUG	801	HEMODIALYSIS
276	INTRAOCULAR LENS SOURCE DRUG	802	PERITONEAL DIALYSIS
278	OTHER IMPLANTS	803	CAPD
279	OTHER M&S SUPPLIES	804	CCPD
280	ONCOLOGY	809	OTHER INPATIENT DIALYSIS
289	OTHER ONCOLOGY	810	ORGAN ACQUISITION
343	DIAGNOSTIC RADIOPHARMS	819	OTHER ORGAN ACQUISITION
344	THERAPEUTIC RADIOPHARMS	821	HEMODIALYSIS COMP OR OTHER RATE
370	ANESTHESIA	824	MAINTENANCE 100%
371	ANESTHESIA INCIDENT TO RADIOLOGY	825	SUPPORT SERVICES
372	ANESTHESIA INCIDENT TO OTHER DIAGNOSTIC	829	OTHER HEMO OUTPATIENT
379	OTHER ANESTHESIA	942	EDUCATION/TRAINING
390	BLOOD STORAGE AND PROCESSING		
399	OTHER BLOOD STORAGE AND PROCESSING		
560	MEDICAL SOCIAL SERVICES		
569	OTHER MEDICAL SOCIAL SERVICES		
621	SUPPLIES INCIDENT TO RADIOLOGY		

Section Three: Outpatient (APC) Reimbursement System

Outpatient Grouper/Pricer Options

CMS has created Integrated Outpatient Code Editor (IOCE)

software that is available for \$130 per issue

(see <http://www.ntis.gov/products/oceapc.aspx> for details)

The IOCE software:

- identifies data errors and creates edit flags
- Assigns an APC number for each service for hospitals, and provides information that can be passed to a Pricer program
- Assigns an APC number for each service for ASCs

The user can then apply specific Montana reimbursement rates to the grouping information created by the IOCE

TPAs provide a customized Grouper/Pricer as a part of their services if they manage this reimbursement system for insurers

Section Three: Outpatient (APC) Reimbursement System

Implants: Another Major Cost Factor

Implants can be a substantial cost element in WC medical expenses, so language in the Administrative Rules of Montana establishes a special reimbursement process to ensure that injured workers receive the appropriate implant and the ASC or hospital's outlier implant costs are appropriately reimbursed.

Section Three: Outpatient (APC) Reimbursement System

Outpatient Implant Reimbursement System

- **Implants costing less than \$500 are considered to be bundled into the APC reimbursement**
- **Implants costing more than \$500* can, separately from the APC system, be reimbursed at cost plus 15 percent; use Code L8699**
- **Copies of Implant invoices are required for this separate reimbursement process**
- **Implant costs include shipping and handling**
- * **It is important to note that “implant cost” as used in the Montana WC system refers to the total implant costs for all implants combined for a patient.**

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DLI wishes to thank Betty Osborne of Corvel for her contributions to a prototype of this presentation done in September, 2008.

The End