

Facility Fee Schedule Instruction Set Effective July 1, 2015

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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 non-labor 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. These 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)—A CCR is simply a ratio of the cost divided by the charges and is generally used with acute inpatient or outpatient services. Operating and capital cost-to-charge ratios are computed annually for each hospital based on the latest available settled cost report for the hospital. These ratios can be obtained for the entire facility and broken down by outpatient and inpatient services.

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.

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 centers, skilled nursing facilities) and at non-facilities (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—The geometric mean length of stay (GMLOS) is the national mean length of stay for each diagnostic related grouper (DRG) as determined and published by CMS(Bolt Super Coder).

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.

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*.

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.

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. The total number of units that may be billed at each visit is listed in the MUE Values column. 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 non-facility or facility setting.

Non-facility—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.

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 (U&C)—“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.

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

The Montana Hospital Outpatient and ASC Fee Schedule Organized by APC was combined with C below as of July 1, 2015.

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

APC

The list of APC codes that correlate with the HCPCS codes

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.

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.

C.1 Organized by Code on Dental Procedures and Nomenclature (CDT)

The reimbursement for facility charges for dental procedures.

D. The Montana Ambulance Fee Schedule

HCPCS

The list of HCPCS codes for correct calculation of reimbursement.

Descriptors

The descriptions of the HCPCS codes for ambulance services.

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.

Rural Ground Miles

The rate of reimbursement for ground or air mileage.

E. The Montana CCI Code Edits Listing

CMS codes that assist in correct coding and billing procedures. If a code descriptor of a HCPCS/CPT code includes the phrase “separate procedure,” the procedure is subject to CCI edits.

Column 1

CPT code

Column 2

CPT code

Column 3

Effective date of Column 1/Column 2 CPT code combination

Column 4

Termination date of Column 1/Column 2 CPT code combination. An asterisk indicates no termination date.

Column 5

A code indicating the applicability: 0= not allowed; 1=allowed; 9=not applicable.

F. Medically Unlikely Edits (MUEs)

CMS codes that assist in correct coding and billing procedures. This lists the total number of units that are possible for each visit.

G. The Montana CCR and other Montana CCR-based Calculations

A list of the cost to charge ratios (CCR), formerly Ratio of Cost to Charge (RCC), for the regulated hospitals in Montana as determined by CMS.

H. The Montana Status Indicator Codes

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

I. Place of Service Codes

CMS codes indicating where the service was provided.

J. Modifiers

CMS codes indicating different services provided by the medical provider.

Facility Fee Schedule Archives

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

Clarifications

Department clarifications regarding the facility fee schedule and the professional fee schedule currently in place.

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 point of pickup determines whether rural mileage is applied to the ambulance transport services.

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.

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.

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.

Immunoassay (qualitative) 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 one unit. Laboratories billing G0431 must not append the QW modifier to the claim lines.

The following chart reflects Medicare’s interpretation of the terms for type of drug test.

TERM	GENERAL PURPOSE IN CLINICAL DRUGS OF ABUSE TESTING
Qualitative Drug Testing	Used to determine the presence or absence of drug or drug metabolite (drug class) in the sample. The test result may be expressed as negative or positive (non-numerical) or as a semi-quantitative result.
Quantitative Drug Testing	Used when it is medically necessary to determine the specific quantity of drug or drug metabolite present in the sample. The test result is expressed in concentration. Medicare considers this definitive testing.
Confirmation Testing	Used to confirm the presence of illicit drug(s) following an initial, presumptive positive, screening result. This confirmation prevents a clinician from relying on a false positive result.

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 the 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 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 ARM for the additional details.

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 the most current version of the CMS 1500.

Exception to this is PT, OT, ST providers may bill on the UB04 for outpatient services provided in a hospital outpatient setting. Providers may not bill on the CMS 1500 for additional professional reimbursement under the Montana Professional Fee Schedule.

A total of eight units of active and passive therapy may be billed in each session. If active therapy and/or passive therapy is being applied, only one unit of a passive modality may be included in the eight units.

Passive modalities are a variety of treatment tools used by therapists to decrease pain, inflammation, and treat muscle strains. For example, hot/cold packs, electrical stimulation, iontophoresis, etc., are considered passive modalities. However, joint mobilization is a passive therapy and is not considered a passive modality and is not limited to the one unit for a passive modality.

If passive therapy which includes passive modalities as listed in the MT Guidelines is the only treatment being provided, the provider may bill up to -four units in one session.

CPT code 97750 for the Functional Capacity Exam which is a special report is not considered an active therapy, passive therapy or a passive modality.

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. 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.

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

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%

The multiple procedure reduction for other services in the outpatient fee schedules applies to multiple services furnished by the same provider to the same patient in the same session on the same day.

First subsequent procedure	50%
Second subsequent procedure	25%

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.

Outliers

Payment made to hospitals in addition to the basic prospective payments for inpatient cases incurring extraordinarily high costs. This additional payment known as an “Outlier” is designed to protect the hospital from large financial losses due to unusually expensive cases. Implants are excluded from outlier calculations.

Status Code Indicators (SI)

SI codes will be used to calculate reimbursements for services and supplies. The codes are listed on the ERD website. Refer to Section Four: Outpatient Reimbursement for payment of new J1 code.

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, 2015 is \$8,076. 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.

MS-DRG Grouper

A MS-DRG grouper takes five clinical and demographic data elements as input and generates a corresponding MS-DRG classification code.

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 time 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. $\$25,000 \times 3 = \$75,000$

CCR 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.
2. Implants totaling more than \$10,000 may be reimbursed at cost plus 15%
 - a. A copy of the implant invoice 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

Non-patient Hospital Outpatient Clinical Diagnostic Laboratory Test Payment and Billing

Using Medicare's directives, there are limited circumstances described below in which hospitals can separately bill for outpatient diagnostic laboratory tests. For those specific situations hospitals should use the UB04 claim form and for the bill type in field 4 use the new bill type 14X (141 original bill, 147

corrected claim). This will allow reimbursement for these services using the professional fee schedule in which RVU values are still available.

Laboratory tests using the above bill type must be for a non-patient specimen billed in the following circumstances:

- (1) Non-patient laboratory specimen tests; non-patient continues to be defined as an injured worker that is neither an inpatient nor an outpatient of a hospital, but that has a specimen that is submitted for analysis to a hospital and the injured work is not physically present at the hospital;
- (2) When the hospital only provides laboratory tests to the injured worker (directly or under arrangement) and the injured worker does not also receive other hospital outpatient services during that same encounter; and
- (3) When the hospital provides a laboratory test (directly or under arrangement) during the same encounter as other hospital outpatient services that is clinically unrelated to the other hospital outpatient services, and the laboratory test is ordered by a different practitioner than the practitioner who ordered the other hospital outpatient services provided in the hospital outpatient setting.

In addition, laboratory tests for molecular pathology tests described by CPT codes in the ranges of 81200 through 81383, 81400 through 81408, and 81479 are not packaged and should be billed using bill type 13X.

Outpatient Fee Schedule J1 Modifier

Using Medicare's guidelines a new modifier has been added to the HCPCS/CPT Outpatient Fee Schedule. The new J1 modifier provides a single payment for a primary service, and payment for all adjunctive services reported on the same claim are packaged into the payment for the primary service.

Claims reporting at least one J1 procedure code will package the following items and services that are not typically packaged under the OPSS:

- Major OPSS procedure codes (status indicators P, S, T, V);
- Lower ranked comprehensive procedure codes (status indicator J1);
- Non-pass-through drugs and biologicals (status indicator K);
- Blood products (status indicator R);
- DME (status indicator Y); and
- Therapy services (HCPCS codes with status indicator A reported on therapy revenue centers)

The following services are excluded from comprehensive APC packaging:

- Brachytherapy sources (status indicator U);
- Pass-through drugs, biologicals and devices (status indicators G or H);
- Corneal tissue, CRNA services, and Hepatitis B vaccinations (status indicator F);
- Influenza and pneumococcal pneumonia vaccine services (status indicator L);
- Ambulance services;
- Mammography; and
- Certain preventive services

The single payment for a comprehensive claim is based on the rate associated with the J1 service. When multiple J1 services are reported on the same claim, the single payment is based on the rate associated with the highest ranking J1 service within the same clinical family. When certain pairs of J1 services (or in certain cases a J1 service and an add-on code) are reported on the same claim, the claim is eligible for a complexity adjustment, which provides a single payment for the claim based on the rate of the next higher comprehensive APC within the same clinical family.

Outpatient Reimbursement

Outpatient services are payable under CPT/HCPCS codes.

Physical Therapy, Occupational Therapy, Speech Therapy: Visits, examinations, consultations, and similar services listed in this section reflect wide variations required in time and skill. Providers should not bill for services performed for less than 8 minutes when only one service is administered in a day. Time intervals are assigned in increments of 15 minutes, beginning with a base of at least 8 minutes (1 unit is ≥ 8 –22 minutes; 2 units are ≥ 23 –37 minutes; 3 units are ≥ 38 –52 minutes, etc.). When more than one service represented by 15-minute timed codes is performed in a single day, the total minutes of service determines the number of timed units billed. Documentation for each aspect of the service performed should be included in the patient record to substantiate the level of service. A total of eight units of active or passive may be billed in each session. Only one unit of the eight may be a passive modality. Passive modalities are a variety of treatment tools used by therapists to decrease pain, inflammation, and treat muscle strains. For example, hot/cold packs, electrical stimulation, iontophoresis, etc., are considered passive modalities.

Joint mobilization is a passive therapy. It is not considered a passive modality and therefore does not fall under the one unit limitation for a passive modality.

If passive therapy includes passive modalities as listed in the MT Guidelines and is the only treatment being provided, the provider may bill up to -four units in one session.

CPT code 97750 for the Functional Capacity Exam which is a special report is not considered an active therapy, passive therapy or a passive modality.

These services when billed on a UB04 are paid at 100% of usual and customary for CAHS and 100% of the facility fee schedule for acute care hospitals regardless of whether there is a designated treating physician or not. They are still subject to the multiple procedures discount.

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, 2014	\$111.00
ASC base rate effective July 1, 2014	\$83.00

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 totaling more than \$500 may be reimbursed at cost plus 15%
 - a. A copy of the implant invoice 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.