

# Montana Healthcare Programs Outpatient Prospective Payment System Procedure Fee Schedule Explanation

Effective July 1, 2025

Montana Medicaid Conversion Factor \$62.54

## 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

<b>R</b>	Blood and blood products
<b>S</b>	Significant procedures that are paid under OPPS but to which the multiple surgery reduction does not apply
<b>T</b>	Significant services that are paid under the OPPS and to which the multiple procedure payment discount under OPPS applies
<b>U</b>	Brachytherapy Sources
<b>V</b>	Medical visits (including clinic or emergency department visits) that are paid under OPPS
<b>X</b>	Ancillary services that are paid under OPPS
<b>Y</b>	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:**

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