



ADMINISTRATIVE RULES OF MONTANA



24.29.1433 FACILITY SERVICE RULES AND RATES

- (1) The department adopts the fee schedules provided by this rule to determine the reimbursement for medical services provided by a facility when a person is discharged on or after July 1, 2013. An insurer is obligated to pay the fee provided by the fee schedules for a service, even if the billed charge is less, unless the facility and insurer have a managed care organization (MCO) or preferred provider organization (PPO) arrangement that provides for a different payment amount. The fee schedules are available online at the department's web site and are updated as soon as is reasonably feasible relative to the effective dates of the medical codes as described below. The fee schedules are comprised of the elements listed in 39-71-704, MCA, and the following:
 - (a) The Montana Status Indicator (SI) Codes;
 - (b) The Montana unique code, MT003, described in (11)(e) and (12)(f); and
 - (c) The base rates and conversion formulas are established by the department.
 - (d) All current and prior instruction sets for services provided starting July 1, 2013, are available on the department's website.
- (2) The application of the base rate depends on the date the medical services are provided.
- (3) Critical access hospitals (CAH) are reimbursed at 100 percent of that facility's usual and customary charges. CAH is a designation for a facility only. The reimbursement rate for CAH set by this rule applies to facility charges.
 - (a) Regarding professional services provided at a physical therapy (PT), occupational therapy (OT), and speech therapy (ST) services provided on an outpatient basis must be billed on a UB04 and reimbursed 100 percent of usual and customary. PT, OT, and ST outpatient services may not be billed on the CMS 1500.
 - (b) All other professional services provided at a CAH must be billed on a CMS 1500 and reimbursed according to the professional fee schedule pursuant to ARM 24.29.1534.
- (4) Any services provided by a type of facility not explicitly addressed by this rule or any services using new codes not yet adopted by this rule must be paid at 75 percent of the facility's usual and customary charges.
- (5) Any inpatient rehabilitation services, including services provided at a long-term inpatient rehabilitation facility must be paid at 75 percent of that facility's usual and customary charges. All CMS rehabilitation MS-DRGs are excluded from the Montana MS-DRG payment system and instead are paid at 75 percent of the facility's usual and customary charges regardless of the place of service.

- (6) DME, prosthetics, and orthotics, excluding implantables, will be paid according to the professional fee schedule pursuant to ARM 24.29.1534 or, if no reimbursement value, ARM 24.29.1523.
- (7) Facility billing must be submitted on a CMS Uniform Billing (UB04) form, including the 837-I form when submitting electronically.
- (8) Hospitals and ASCs must, on an annual basis, submit to the department data reporting Medicare, Medicaid, commercial, unrecovered, and workers' compensation claims reimbursement in a standard form supplied by the department. The department may in its discretion conduct audits of any facility's financial records to confirm the accuracy of submitted information.
- (9) Medical provider services furnished in an acute care hospital, ASC, or other facility setting, whether those professional services are furnished as an employee or as an independent professional, must be billed separately using the CMS 1500 and must be reimbursed using the professional fee schedule pursuant to ARM 24.29.1534, except as provided in (a).
 - (a) PT, OT, and ST services provided on an outpatient basis must be billed on a UB04 and reimbursed according to the facility fee schedule. These reimbursements are excluded from any calculation of outlier payments. PT, OT, and ST outpatient services may not be billed on the CMS 1500.
- (10) Facility pharmacy reimbursements are made as follows:
 - (a) If a facility pharmacy dispenses prescription drugs to an individual during the course of treatment in the facility, reimbursement is part of the MS-DRG or APC reimbursement.
 - (b) If a patient's medications are not included in the MS-DRG or APC service bundle, the reimbursement will be according to ARM 24.29.1529.
- (11) The following applies to inpatient services provided at an acute care hospital:
 - (a) The department may establish the base rate annually.
 - (i) The base rate effective July 1, 2025, is \$10,384.
 - (ii) All prior base rates for services provided starting July 1, 2013, are available on the department's website.
 - (b) Payments for inpatient acute care hospital services must be calculated using the base rate multiplied by the Montana MS-DRG weight.
 - (c) If a service falls outside of the scope of the MS-DRG and is not otherwise listed on a Montana fee schedule, including new codes not yet adopted, reimbursement for that service must be 75 percent of that facility's usual and customary charges.
 - (d) The threshold for outlier payments is three times the Montana MS-DRG payment amount. If the outlier threshold is met, the outlier payment must be the MS-DRG reimbursement amount plus an amount that is determined by multiplying the charges above the threshold by the sum of 15 percent and the individual hospital's Montana CCR.
 - (i) For example, if the hospital submits total charges of \$100,000, the MS-DRG reimbursement amount is \$25,000, and the CCR is 0.50, then the resultant calculation for reimbursement is as follows: The DRG reimbursement amount (\$25,000) is multiplied by 3 to set the threshold trigger (\$75,000). The threshold trigger (\$75,000) is subtracted from the total charges (\$100,000) resulting in the amount above the

trigger (\$25,000). The amount above the trigger (\$25,000) is then multiplied by .65 (which is the CCR of .5 plus .15) to obtain the outlier payment (\$16,250). The total payment to the hospital in this example would be the DRG reimbursement amount (\$25,000) plus the outlier payment (\$16,250) = \$41,250.

- (ii) The department may establish the inpatient outlier amount annually.
- (e) Where an implantable exceeds \$10,000 in cost, hospitals may seek additional reimbursement beyond the normal MS-DRG payment. Hospitals may seek additional reimbursement by using Montana unique code MT003. Any implantable that costs less than \$10,000 is bundled in the implantable charge included in the MS-DRG payment.
 - (i) Any reimbursement for implantables pursuant to this subsection must be documented by a copy of the invoice for the implantable (or purchase order if it lists the number of items, the wholesale price, and the shipping costs) and the operative report. Insurers are subject to privacy laws concerning disclosure of health or proprietary information.
 - (ii) Reimbursement is set at a total amount that is determined by adding the actual amount paid for the implantable on the invoice or purchase order for the implantable, plus 15 percent of the actual amount paid for the implantable, plus the handling and freight cost for the implantable. Handling and freight charges must be included in the implantable reimbursement and are not to be reimbursed separately.
 - (iii) When a hospital seeks additional reimbursement pursuant to this subsection, the implantable charge is excluded from any calculation for an outlier payment.
 - (iv) Because the decision regarding an implantable is a complex medical analysis, this rule defers to the judgment of the individual physician and facility to determine the appropriate implantable. A payer may not reduce the reimbursement when the medical decision is to use a higher cost implantable.
- (f) All facility services provided during an uninterrupted patient encounter leading to an inpatient admission must be included in the inpatient stay, except air and ground ambulance services which are paid separately pursuant to the Montana Ambulance Fee schedule. Air ambulances whose charter and certification is through the federal Department of Transportation will be paid at 100 percent of their usual and customary charges pursuant to federal law.
- (g) The following applies to facility transfers when a patient is transferred for continuation of medical treatment between two acute care hospitals:
 - (i) A hospital receiving a patient is paid the full MS-DRG payment plus any appropriate outliers and add-ons.
 - (ii) Facility transfers do not include costs related to transportation of a patient to initially obtain medical care. Such reimbursements are covered by ARM 24.29.1409.
- (12) The following applies to outpatient services provided at an acute care hospital or an ASC:
 - (a) The department may establish a base rate annually.
 - (i) The base rate effective July 1, 2025, is \$133.
 - (ii) All prior base rates for services provided starting July 1, 2013, are available on the department's website.

- (b) The department may establish a base rate annually for ASCs at 75 percent of the hospital outpatient base rate.
 - (i) The base rate effective July 1, 2025, is \$100.
 - (ii) All prior base rates for services provided starting July 1, 2013, are available on the department's website.
- (c) Payments for outpatient services in a hospital or an ASC are based on the Montana APC system. A single outpatient visit may result in more than one APC for that claim. The payment must be calculated by multiplying the base rate times the APC weight. If an APC code is available, the services must be billed using the APC code. If the APC weight is not listed or if the APC weight is listed as null, reimbursement for that service must be paid at 75 percent of the facility's usual and customary charges. Examples of such services include but are not limited to laboratory tests and radiology. If a service falls outside of the scope of the APC and is not otherwise listed on a Montana fee schedule, reimbursement for that service must be 75 percent of that facility's usual and customary charges.
- (d) CCI and MUE code edits must be used to determine bundling and unbundling of charges.
- (e) Outpatient medical services include observation in an outpatient status.
- (f) Where an outpatient implantable exceeds \$500 in cost, hospitals or ASCs may seek additional reimbursement beyond the normal APC payment. In such an instance, the provider may bill using Montana unique code MT003. Any implantable that costs less than \$500 is bundled in the APC payment.
 - (i) Any reimbursement for implantables pursuant to this subsection must be documented by a copy of the invoice for the implantable (or purchase order if it lists the number of items, the wholesale price, and the shipping cost) and the operative report. Insurers are subject to privacy laws concerning disclosure of health or proprietary information.
 - (ii) Reimbursement is set at a total amount that is determined by adding the actual amount paid for the implantable on the invoice or purchase order for the implantable, plus 15 percent of the actual amount paid for the implantable, plus the handling and freight cost for the implantable. Handling and freight charges must be included in the implantable reimbursement and are not to be reimbursed separately.
- (g) The following applies to patient transfers from an ASC to an acute care hospital:
 - (i) An ASC transferring a patient is paid the APC reimbursement.
 - (ii) The acute care hospital is paid the MS-DRG or the APC reimbursement, whichever is applicable.
 - (iii) Facility transfers do not include costs related to transportation of a patient to initially obtain medical care. Such reimbursements are covered by ARM 24.29.1409.

Authorizing statute(s): 39-71-203, MCA

Implementing statute(s): 39-71-704, MCA

History: NEW, 2013 MAR p. 1185, Eff. 7/12/13; AMD, 2014 MAR p. 1513, Eff. 7/11/14; AMD, 2015 MAR p. 818, Eff. 6/26/15; AMD, 2016 MAR p. 1055, Eff. 6/18/16; AMD, 2017 MAR p. 784, Eff. 6/10/17; AMD, 2018 MAR p. 1036, Eff. 5/26/18; AMD, 2019 MAR p. 848, Eff. 6/22/19; AMD, 2020 MAR p. 1021, Eff. 6/13/20; AMD, 2021 MAR p. 716, Eff. 6/12/21; AMD, 2022 MAR p. 1075, Eff. 6/25/22; AMD, 2023 MAR p. 522, Eff. 6/10/23; AMD, 2024 MAR p. 1457, Eff. 7/1/24; AMD, 2025 MAR, Notice No. 2025-30, Eff. 7/1/25.