



ADMINISTRATIVE RULES OF MONTANA

37.86.105 PHYSICIAN SERVICES, REIMBURSEMENT/GENERAL REQUIREMENTS AND MODIFIERS

- (1) Providers must bill for services using the procedure codes and modifiers set forth, and according to the definitions contained, in the Centers for Medicare and Medicaid Services' (CMS) Healthcare Common Procedure Coding System (HCPCS). Information regarding billing codes, modifiers, and HCPCS is available upon request from the Health Resources Division at the address stated in ARM 37.86.101(3).
- (2) Reimbursement for physician services, except as otherwise provided in this rule, is the lower of:
 - (a) the provider's usual and customary charges (billed charges); or
 - (b) the department's fee schedule maintained in accordance with the methodologies described in ARM 37.85.212.
- (3) Reimbursement for services of a psychiatrist, except as otherwise provided in this rule, is the lower of:
 - (a) the provider's usual and customary charges (billed charges); or
 - (b) to address problems of access to mental health services, subject to funding, mental health services performed by a psychiatrist are reimbursed using a provider rate of reimbursement which is a percentage of the reimbursement for physicians provided in accordance with the methodologies described in ARM 37.85.212. The effective date and percentage are as provided in ARM 37.85.105(2).
- (4) Reimbursement to physicians for physician-administered drugs billed under HCPCS "A", "J", "Q", or "S" codes will be paid according to the department's fee schedule or the provider's usual and customary charge, whichever is lower. The department's fee schedule is updated at least annually based upon:
 - (a) the effective date and citation for the Medicare Average Sale Price (ASP) as provided in ARM 37.85.105(2);
 - (b) the RBRVS fee as defined in ARM 37.85.212 if there is an RBRVS fee;
 - (c) the Average Acquisition Cost (AAC) methodology as defined in ARM 37.86.1101; or
 - (d) the Medicaid fee as determined in (9).
- (5) Physician administered compound drugs must be billed with the associated HCPCS; an invoice is required to be attached. The invoice must list each ingredient in the compound with the associated NDCs, and the quantity of each ingredient. Physician administered compound drugs are paid by invoice.

- (6) The maximum allowable cost limitation does not apply in those cases where the physician certifies in their own handwriting that in their medical judgment a specific brand name drug is medically necessary for a particular patient. Acceptable certification statements are "brand necessary" or "brand required." A check-off box on a form or a rubber stamp is not acceptable.
- (7) Reimbursement rates for adult and children vaccines are extracted from the Private/Sector Cost/Dose fee schedule maintained by the Center for Disease Control (CDC). Private sector vaccine pricing are reported by vaccine manufacturers annually to the CDC.
- (8) A Medicaid fee for services without fees is determined for physician services and anesthesia services as defined at ARM 37.85.212 and licensed direct-entry midwife services as defined at ARM 37.86.1201.
 - (a) The Medicaid fee is determined for procedure codes:
 - (i) that are new, less than one year in existence;
 - (ii) that have no or low utilization;
 - (iii) that have inconsistent charges by reviewing cost information for the service if available; or
 - (iv) by reviewing the reimbursement of similar services if cost information is not available.
 - (b) Otherwise, the Medicaid fee in this section is determined by multiplying the average charge for the service by the payment-to-charge ratio.
- (9) Claims for child delivery must have one of the following line procedure code modifiers or the line will be denied:
 - (a) CG-cesarean section/induction prior to 39 weeks;
 - (b) GK-spontaneous vaginal delivery prior to 39 weeks (noninduced);
 - (c) KX-vaginal delivery at or after 39 weeks (induced or not induced; or
 - (d) SC - cesarean section at or after 39 weeks.
- (10) The maternity policy adjustor is not applied to early elective delivery.
- (11) Gestational age must be determined and documented in medical records. The department accepts the following American Congress of Obstetricians and Gynecologists guidelines for determining gestational age:
 - (a) fetal heart tones documented for 20 weeks by nonelectronic fetoscope or 30 weeks by Doppler;
 - (b) a positive serum or urine pregnancy test by a reliable laboratory at least 36 weeks prior to delivery;
 - (c) an ultrasound prior to 20 weeks gestation that confirms the gestational age of at least 39 weeks at delivery; or
 - (d) when pregnancy care is not initiated within 20 weeks of gestation, the gestational age may be documented from the first day of the last menstrual period (LMP).

Authorizing statute(s): 53-6-101, 53-6-113, MCA

Implementing statute(s): 53-6-101, 53-6-113, MCA

History: NEW, 1980 MAR p. 1808, Eff. 6/27/80; AMD, 1981 MAR p. 559, Eff. 6/12/81; AMD, 1981 MAR p. 1976, Eff. 1/1/82; AMD, 1982 MAR p. 1289, Eff. 7/1/82; AMD, 1987 MAR p. 1496, Eff. 8/28/87; AMD, 1988 MAR p. 1255, Eff. 7/1/88; AMD, 1989 MAR p. 881, Eff. 6/30/89; AMD, 1989 MAR p. 880, Eff. 7/1/89; AMD, 1990 MAR p. 1179, Eff. 6/15/90; AMD, 1990 MAR p. 1608, Eff. 8/17/90; AMD, 1990 MAR p. 2305, Eff. 12/28/90; AMD, 1991 MAR p. 824, Eff. 5/31/91; AMD, 1991 MAR p. 1030, Eff. 7/1/91; AMD, 1997 MAR p. 1269, Eff. 7/22/97; AMD, 1998 MAR p. 676, Eff. 3/13/98; TRANS, from SRS, 2000 MAR p. 481; AMD, 2001 MAR p. 27, Eff. 1/12/01; AMD, 2001 MAR p. 1476, Eff. 8/10/01; AMD, 2001 MAR p. 2156, Eff. 10/26/01; AMD, 2007 MAR p. 206, Eff. 1/1/07; AMD, 2009 MAR p. 1012, Eff. 7/1/09; AMD, 2010 MAR p. 433, Eff. 3/1/10; AMD, 2011 MAR p. 1700, Eff. 8/26/11; AMD, 2012 MAR p. 1266, Eff. 6/22/12; AMD, 2012 MAR p. 2625, Eff. 1/1/13; AMD, 2013 MAR p. 1111, Eff. 7/1/13; AMD, 2014 MAR p. 1407, Eff. 7/1/14; AMD, 2014 MAR p. 2171, Eff. 10/1/14; AMD, 2015 MAR p. 145, Eff. 2/13/15; AMD, 2016 MAR p. 1065, Eff. 7/1/16; AMD, 2017 MAR p. 1522, Eff. 9/9/17; AMD, 2018 MAR p. 458, Eff. 3/1/18.