



ADMINISTRATIVE RULES OF MONTANA



24.29.1401A DEFINITIONS

As used in subchapters 14 and 15, the following definitions apply:

- (1) "Acute care hospital" or "hospital" means a health care facility appropriately licensed by the Department of Public Health and Human Services that provides inpatient and outpatient medical services to injured workers experiencing acute illness or trauma. Acute care hospitals are sometimes referred to as regulated hospitals.
- (2) "Ambulatory Payment Classification (APC)" means the reimbursement system adopted by the department for outpatient services.
- (3) "Ambulatory surgery center (ASC)" means a health care facility that operates primarily for the purpose of furnishing outpatient surgical services to patients.
- (4) "Base rate" means the dollar value which is multiplied by the relative weight of the MS-DRG or APC to determine payment.
- (5) "Bundling" means the practice of grouping multiple services, procedures, and supplies into one charge item instead of billing each separately.
- (6) "CCR," formerly known as "RCC," means the cost-to-charge ratio computed by using the hospital's Medicare cost report and charges.
- (7) "CMS" means the Centers for Medicare and Medicaid Services.
- (8) "Correct Coding Initiative (CCI)" means the code edits adopted by the department that are used to correct contradictory billing information.
- (9) "Current Procedural Terminology (CPT)" codes means codes and descriptors of procedures owned, copyrighted, and published by the American Medical Association.
- (10) "Designated Treating Physician" has the same meaning as a "treating physician," defined in 39-71-116, MCA, who is designated or formally approved by the insurer as the physician who will be coordinating the injured worker's care, according to the criteria in 39-71-1101, MCA.
- (11) "Documentation" means written information that is complete, clear, and legible, which describes the service provided and substantiates the charge for the service.
- (12) "Durable medical equipment (DME)" means durable medical appliances or devices used in the treatment or management of a condition or complaint, along with associated nondurable materials and supplies required for use in conjunction with the appliance or device. The term does not include an implantable object or device.
- (13) "Evidence-based" means use of the best evidence available in making decisions about the care of the individual patient, gained from the scientific method of medical decision-making and includes

use of techniques from science, engineering, and statistics, such as randomized controlled trials (RCTs), meta-analysis of medical literature, integration of individual clinical expertise with the best available external clinical evidence from systematic research, and a risk-benefit analysis of treatment (including lack of treatment).

- (14) "Facility" or "health care facility" means all or a portion of an institution, building, or agency, private or public, excluding federal facilities, whether organized for profit or not, that is used, operated, or designed to provide health services, medical treatment, or nursing, rehabilitative, or preventive care to any individual. The term includes chemical dependency facilities, critical access hospitals, end-stage renal dialysis facilities, home health agencies, home infusion therapy agencies, hospices, hospitals, long-term care facilities, intermediate care facilities for the developmentally disabled, medical assistance facilities, mental health centers, outpatient centers for surgical services, rehabilitation facilities, residential care facilities, and residential treatment facilities. The above facilities are defined in 50-5-101, MCA. The term does not include outpatient centers for primary care, infirmaries, provider-based clinics, offices of private physicians, dentists or other physical or mental health care workers, including licensed addiction counselors.
- (15) "Functional status" means written information that is complete, clear, and legible, that identifies objective findings indicating the claimant's physical capabilities and provides information about the change in the status as a result of treatment.
- (16) "Healthcare Common Procedure Coding System (HCPCS)" means the identification system for health care matters developed by the federal government, and includes level one codes, known as CPT codes, and level two codes that were developed to use for supplies, procedures, or services that do not have a CPT code. These codes also include successor codes for CPT and HCPCS established by the American Medical Association and CMS.
- (17) "Implantable" means a system of objects or devices that is made either to replace and act as a missing biological structure, to repair or support a biological structure, or to manage chronic disease processes and that is surgically implanted, embedded, inserted, or otherwise applied. The term also includes any related equipment necessary to install, operate, program, and recharge the implantable.
- (18) "Improvement status" means written information that is complete, clear, and legible, which identifies objective medical findings of the claimant's medical status with respect to the treatment plan.
- (19) "Inpatient services" means services rendered to a person who has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services. Generally, a patient is considered an inpatient if formally admitted as inpatient with the expectation that the patient will remain at least overnight and occupy a bed even though it later develops that the patient can be discharged or transferred to another hospital and not actually use the hospital bed overnight. The physician or other practitioner responsible for a patient's care at the hospital is also responsible for deciding whether the patient should be admitted as an inpatient.
- (20) "Interested party" means:
 - (a) the "physician" or "provider" as defined by this rule;
 - (b) the "claimant" or "injured worker"; or
 - (c) the representative of the injured worker.

- (21) "Medicare-Severity Diagnosis Related Group (MS-DRG or DRG)" means the inpatient diagnosis classifications of circumstances where patients demonstrate similar resource consumption, length of stay patterns, and medical severity status that are adopted by the department and are used for billing purposes.
- (22) "Nonfacility" means any place not included in this rule's definition of "facility."
- (23) "Objective medical findings" means medical evidence that is substantiated by clinical findings. Clinical findings include, but are not limited to, range of motion, atrophy, muscle strength, muscle spasm, and diagnostic evidence. Complaints of pain in the absence of clinical findings are not considered objective medical findings.
- (24) "Outpatient" means a patient who is not admitted for inpatient or residential care.
- (25) "Physician" means a healthcare provider who meets the licensure requirements of a "treating physician" as defined by 39-71-116, MCA.
- (26) "Prior authorization" means that for those matters identified by ARM 24.29.1621 the provider receives (either verbally or in writing) authorization from the insurer to perform a specific procedure or series of related procedures, prior to performing that procedure.
- (27) "Provider" means any health care provider, unless the context in another rule clearly indicates otherwise. "Provider" does not include pharmacists nor does it include a supplier of medical equipment who is not a health care provider.
- (28) "Relative Value Unit" or "RVU" represents a unit of measure for medical services, procedures, or supplies. RVU is used in the fee schedule formulas to calculate reimbursement fees and is expressed in numeric units. Those services that have greater costs or value have higher RVUs than those services with lower costs or value.
- (29) "Resource-Based Relative Value Scale" or "RBRVS" means the publication titled "Essential RBRVS," published by OptumInsight, Inc.
- (30) "Service or services" means treatment including procedures and supplies provided in a facility or nonfacility that is billable under these rules.
- (31) "Status indicator (SI)" codes mean CPT codes treated in the same fashion or category, such as packaged services, and apply to outpatient services only.
- (32) "Treatment plan" means a written outline of how the provider intends to treat a specific condition or complaint. The treatment plan must include a diagnosis of the condition, the specific type(s) of treatment, procedure, or modalities that will be employed, a timetable for the implementation and duration of the treatment, and the goal(s) or expected outcome of the treatment. Treatment, as used in this definition, may consist of diagnostic procedures that are reasonably necessary to refine or confirm a diagnosis. The treating physician may indicate that treatment is to be performed by a provider in a different field or specialty, and defer to the professional judgment of that provider in the selection of the most appropriate method of treatment; however, the treating physician must identify the scope of the referral in the treatment plan and provide guidance to the provider concerning the nature of the injury or occupational disease.

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

Implementing statute(s): 39-71-116, 39-71-704, MCA

History: NEW, 1993 MAR p. 404, Eff. 4/1/93; AMD, 1993 MAR p. 2809, Eff. 12/1/93; AMD, 2002 MAR p. 1758, Eff. 7/1/02; AMD, 2007 MAR p. 1670, Eff. 10/26/07; TRANS from ARM 24.29.1504 and AMD, 2008 MAR p. 2490, Eff. 12/1/08; AMD, 2011 MAR p. 1137, Eff. 6/24/11; AMD, 2013 MAR p. 1185, Eff. 7/12/13; AMD, 2014 MAR p. 1513, Eff. 7/11/14; AMD, 2018 MAR p. 2531, Eff. 1/1/19; AMD, 2024 MAR p. 1457, Eff. 7/1/24; AMD, 2025 MAR, Notice No. 2025-30, Eff. 7/1/25.