



ADMINISTRATIVE RULES OF MONTANA

37.86.3020 OUTPATIENT HOSPITAL SERVICES, OUTPATIENT PROSPECTIVE PAYMENT SYSTEM (OPPS) METHODOLOGY, AMBULATORY PAYMENT CLASSIFICATION

- (1) Outpatient hospital or birthing center services that are not provided by critical access hospitals will be reimbursed on a rate-per-service basis using the Outpatient Prospective Payment System (OPPS) schedules. The provider reimbursement rates for outpatient hospital services is stated in the department's Outpatient Prospective Payment System (OPPS) Fee Schedule as provided in ARM 37.85.105(3). Under this system, Medicaid payment for outpatient services included in the OPPS is made at a predetermined, specific rate. These outpatient services are classified according to a list of APCs published annually in the Code of Federal Regulations (CFR). The rates for OPPS are determined as follows:
 - (a) The department uses a conversion factor for each APC group as defined in ARM 37.86.3001(5). The conversion factor is as provided in ARM 37.85.105(3). The APC-based fee equals the Medicare specific relative weight for the APC times the conversion factor that is the same for all APCs with the exceptions of services in ARM 37.86.3025. APCs are based on classification assignment of CPT/HCPCS codes.
 - (b) At the claim level, payment will be the lower of the provider's charge or the payment as calculated using OPPS. There will be no charge cap at the line level.
 - (c) APCs are an all-inclusive bundled payment per visit which covers all outpatient services provided to the patient, including but not limited to nursing, pharmacy, laboratory, imaging services, other diagnostic services, supplies and equipment, and other outpatient services. For purposes of OPPS, a visit includes all outpatient hospital or birthing center services related or incident to the outpatient visit that are provided the day before or the day of the outpatient visit.
 - (d) If two or more surgical procedures are performed at the same hospital on the same patient on the same day, payment for the most expensive procedure will be made at 100% of the APC for that service and payment for all other procedures will be made at 50% of the APC for those services.
 - (e) If the OPPS does not assign a Medicare fee or APC for a particular procedure code, a Medicaid fee will be assigned in accordance with the resource based relative value scale (RBRVS) methodology found at ARM 37.85.212. If there is not a Medicaid fee, the service will be reimbursed at hospital-specific outpatient cost-to-charge ratio as in ARM 37.86.2803. Birthing centers and out-of-state hospitals will be reimbursed the statewide outpatient cost-to-charge ratio:
 - (i) The Medicaid statewide average outpatient cost-to-charge ratio is as provided at ARM 37.85.105(3).

- (f) The department will make separate payment for observation care procedure codes for Medicare qualifying conditions or obstetric complications. If an observation service does not meet these criteria for these services, payment for observation care will be considered bundled into the APC for other services.
 - (i) The diagnosis used to define a potential obstetric qualification will be taken from diagnosis-related groups 565 (false labor) and 566 (other antepartum diagnosis with medical complications).
 - (ii) The department will make separate payment for observation care procedure codes when billed as a direct admit or have a high level clinic visit, high level critical care, or high level emergency room visit.
 - (iii) The department will make separate payment for observation care procedure codes if billed using a qualifying diagnosis as per the CMS Claims Processing Manual.
- (g) The department follows Medicare guidelines for procedures defined as "inpatient only". When these procedures are performed in the outpatient hospital or birthing center setting, the claim will be denied.
- (h) Procedures started on patients but discontinued before completion will be reimbursed at 50% of the APC for those services.
- (2) The department adopts and incorporates by reference the OPPS Schedules published by the Centers for Medicare and Medicaid Services (CMS) as provided in ARM 37.85.105(3).
- (3) All outpatient hospitals including birthing centers are subject to the requirements in ARM 37.86.2801(9).

Authorizing statute(s): 53-2-201, 53-6-113, MCA

Implementing statute(s): 53-2-201, 53-6-101, 53-6-111, 53-6-113, MCA

History: NEW, 2001 MAR p. 27, Eff. 1/12/01; AMD, 2001 MAR p. 1119, Eff. 6/22/01; EMERG, AMD, 2002 MAR p. 2665, Eff. 9/27/02; AMD, 2003 MAR p. 1652, Eff. 8/1/03; AMD, 2005 MAR p. 265, Eff. 2/11/05; AMD, 2006 MAR p. 2849, Eff. 11/10/06; AMD, 2006 MAR p. 3078, Eff. 1/1/07; AMD, 2007 MAR p. 1680, Eff. 10/26/07; AMD, 2012 MAR p. 1382, Eff. 7/13/12; AMD, 2013 MAR p. 1111, Eff. 7/1/13; AMD, 2014 MAR p. 1415, Eff. 7/1/14.