

# Professional Fee Schedule

## Instruction Set Effective July 1, 2018

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## Section One: Introduction

### ***Background***

Montana has adopted some of the codes and processes of the Centers for Medicare and Medicaid Services (CMS), but the Montana Codes Annotated (MCA) and Administrative Rules of Montana (ARM) govern the application of these codes and processes in Montana for Workers' Compensation (WC) reimbursement.

### ***Conversion Factors***

There are two conversion factors (CF) for the Professional Fee Schedule. Montana mirrors the two-tier CF system of the national RBRVS, one for anesthesiology, and one for all other services, procedures, and supplies. Details on calculating the anesthesiology fee can be found in the Anesthesia section below.

The standard conversion for the Professional Fee Schedule is \$63.50. The anesthesiology conversion factor for the Professional Fee Schedule is \$66.97. The new schedule is effective July 1, 2018.

If insurers have a contract through a managed care or preferred provider organization, the insurers will reimburse the contracted medical provider using the reimbursement agreed upon in the contract. However, the Utilization and Treatment Guidelines, NCCI edits, and instruction sets must be followed by all payers.

### ***Related Terminology***

**American Medical Association (AMA)** --- The association that develops, updates and publishes the *Physicians Current Procedural Terminology* (CPT) coding system for effective, consistent language for nationwide communication among physicians, insurance payers, and patients.

**Category II Codes**---Temporary sets of codes used for tracking performance measurement on emerging technologies, services, and procedures. The temporary codes are used to document use levels for future setting of RVUs if a given code is converted into a permanent CPT or HCPCS.

**Centers for Medicare and Medicaid Services (CMS)** —The government agency responsible for overseeing and administering the Medicare and Medicaid programs. CMS annually publishes the relative value units (RVUs) known as RBRVS for the reimbursement of medical services. The RBRVS is the basis for reimbursement in Montana for WC medical services and procedures.

**Correct Coding Initiative Edits (CCI Edits)**—CMS codes that assist in correct coding and billing procedures. CCI Edits are posted on the ERD website.

**Conversion Factor (CF)** — The conversion factor represents the dollar value of each relative value unit. When this dollar amount is multiplied by the total relative value units (RVU) assigned to a specific service or procedure, it will yield the allowed reimbursement

for that specific service or procedure.

**Customary, Prevailing, and Reasonable Charge (CPR)** — The basis for Medicare’s reimbursement rates prior to the RBRVS. CPR reimbursement rates were based on historical medical provider charges rather than relative values, which allowed for wide variation in Medicare payments among medical providers and specialties. See Usual and Customary Charge, which is the Montana variation on this terminology.

**CPT** — Current Procedural Terminology is a listing of descriptive terms and identifying codes for reporting medical services and procedures performed by providers. CPT is copyrighted by The American Medical Association.

**Employment Relations Division (ERD)** – The division within the Montana Department of Labor and Industry responsible for regulation of the Montana workers’ compensation system.

**Evaluation and Management Services (E&M)** — Medical services provided to patients that involve visits, examinations and consultations, both in facilities (e.g., hospitals, ambulatory surgery center, skilled nursing facilities) and at non-facilities (e.g., physician offices, patient’s home).

**Facility**—The term as used here is defined in ARM 24.29.1401A.

**Facility Reimbursement**—The allowed reimbursement for each professional service when that service or procedure is provided in a facility.

**Gap**— Services not covered by Medicare and/or not assigned a relative value in the RBRVS system.

**Gap Code** — Any Level I (CPT) or Level II (HCPCS) code that is not given an RVU by CMS.

**Global Period**—Global Period is a period of time starting with a surgical procedure and ending some period of time after the procedure. Most major surgeries have a 90-day global period and minor surgeries have a 10-day global period.

**HCPCS** — HCPCS is an acronym for Healthcare Common Procedure Coding System. It is a two-tier medical coding system composed of HCPCS Level I (CPT) codes and HCPCS Level II national codes.

**Level I Codes** — the first level of the HCPCS system is the American Medical Association’s *Current Procedural Terminology* (CPT) codes. This code set, known universally as CPT, reports a broad spectrum of medical procedures and services.

**Level II Codes** — this is the second level of the HCPCS system and is developed by CMS to report services and supplies not found in the CPT system. These Level II national codes are commonly referred to collectively as HCPCS.

**Independent Medical Review (IMR)**—A formal request to the department for a review of medical records or available evidence-based documentation that support treatment

recommendations. The IMR request form is posted on the ERD website.

**Medical Severity Diagnosis Related Groups (MS-DRG)** — This system classifies facility admissions based on their illness (diagnosis) and the treatment provided. It is assumed that patients with similar illnesses undergoing similar procedures will require similar resources. This payment methodology, therefore, reimburses facilities on a flat-rate basis based on the patient’s diagnosis and treatment.

**Medically Unlikely Edits (MUE)**—CMS codes that assist in correct coding and billing procedures. The total number of units that may be billed at each visit is listed in the MUE Values column. MUEs are posted on the ERD website.

**Montana Professional Fee Schedule (MPFS)** — The allowed reimbursement paid to a professional provider for services and procedures provided in a non-facility or facility setting.

**Non-facility**—The term as used here is defined in ARM 24.29.1401A.

**Professional Reimbursement** — The allowed reimbursement paid for each professional service when that service is provided in a non-facility setting, such as a physician office or patient’s home.

**Relative Value (RV)** — RBRVS ranks each service or procedure based on the relative costs required to provide them. A relative value reflects the cost of providing a specific medical provider’s service as compared to the cost of providing all other services and procedures.

**Relative Value Unit (RVU)** — Relative values are expressed in numeric units that represent the unit of measure of the cost of providing a medical service. Those services that have greater costs have greater relative value units than those services with lower costs.

**Resource Based Relative Value Scale (RBRVS)** —Payment schedule based on the relative values of services provided. The RBRVS system ranks services according to the relative costs required to provide them. These costs are defined in terms of units, with more complex, more time-consuming services having higher unit values than less complex, less time-consuming services. Furthermore, each service is compared to all other medical services so that each service is given a value that reflects its cost when compared to all other medical services.

**Status Indicator Codes (SI)**

CMS codes which assist in the calculation of reimbursements for services and supplies. The codes are listed on the ERD website.

**Usual and Customary Charge (U&C)** — “Usual and Customary Charge” means the regular medical charge that a facility or individual medical provider bills for the service or procedure provided to any non-workers’ compensation patient.

**Workers’ Compensation (WC)** — A system that provides wage-loss and medical benefits to a worker suffering from a work-related injury or disease.

## ***Description of Columns in Montana WC Professional Fee Schedule***

### **Year Column/Quarter Column**

These columns indicate the applicable time periods for the displayed values in the fee schedule.

### **Code Column**

The code column lists the current five character numeric or alphanumeric codes designated in the Montana Professional Fee Schedule corresponding to the description in *Current Procedural Terminology* (CPT), the HCPCS Level II description for the alphanumeric codes, Montana specific codes, or Category II and III codes.

### **Modifier Column**

The modifier column is used to further describe the services rendered. Modifier codes are listed on the ERD website.

### **Professional and Facility Reimbursement Columns**

The reimbursement amount(s) in these two columns are based on the definitions for these terms in the Related Terminology section above.

### **Gap Code Column**

A \* symbol in this column indicates that the relative value was established by Optum.

### **Modifier 51 Exempt Column**

Codes with the numeric 1 (one) or 2 (two) in this column are exempt from modifier 51.

### **Add-On Code Column**

Codes with the numeric unit 1 (one) in this column are considered add-on codes by the AMA.

### **Utilization (and Treatment) Rules Column (prior to July 1, 2013)**

Utilization and treatment rules in this column are based on ARM 24.29.1574, 24.29.1575, 24.29.1585, and 24.29.1586, and are primarily limited to descriptions for Physical Medicine services and procedures. The following abbreviations are used: PA (Prior Authorization is required); C (Chiropractic); OT (Occupational Therapy); N/A (Not Allowed); and PT (Physical Therapy).

## **Section Two: General Instructions**

### ***Facility Reimbursement***

Reimbursement for facility charges are to be billed on the UB04. Reimbursement will be made using the Facility Fee Schedule with the exception of Critical Access Hospitals which are reimbursed at 100% of the facility's usual and customary charges. Professional services provided at facilities including Critical Access Hospitals are reimbursed using the Professional Fee Schedule under the facility column. Outpatient PT, OT, ST may be billed on the UB04 for services provided in the outpatient hospital setting. Those providers may not bill on the CMS 1500 for additional reimbursement under the Montana Professional Fee Schedule. Provider based provider clinics will be reimbursed only under

the Professional Fee Schedule non-facility column. All professional provider claims are to be billed on the CMS1500 with the exception of outpatient hospital PT, OT, ST which may be billed on the UB04.

### ***Medical Review and Utilization and Treatment Review by Insurers***

Insurers may initiate a medical review and/or utilization and treatment review for services provided. However, if the claim is not paid within 30 days of receipt of the claim by the insurer, the provider may assess a 1% interest payment penalty per month using the Montana unique code **MT005**. Refer to 24.29.1402 for procedures.

### ***Billing Procedures***

The following billing procedures apply to Sections Three through Eight.

**Bilateral Procedures:** Some procedures which are performed on both left and right (bilateral procedures) warrant the use of modifier 50 for the second procedure. Follow appropriate rules of valuation listed under Multiple Procedures. Providers may not unbundle procedures by not using modifier 50 for bilateral procedures.

**By Report (BR):** The value of a procedure should be established for any “by report” circumstance by identifying a similar service and justifying value difference. When a report is indicated, the report should include the following:

- Accurate procedure definition or description
- Operative report
- Justification for procedural variance, when appropriate
- Similar procedure and value comparisons
- Justification for value difference

**Consultation:** There are two categories for consultation: outpatient and inpatient. Any medical provider may use an appropriate consultation code on any patient for any problem including one which has been previously evaluated by the consulting medical provider provided the following criteria are met:

- The attending medical provider or appropriate source requests that the medical provider render advice or opinion regarding the evaluation and/or management of a specific problem
- The need for the consultation, the consultant’s opinion, and any services ordered or performed must be well documented in the patient’s record
- The information is communicated to the requesting medical provider or appropriate source

If the consulting medical provider upon completion of the consultation assumes care of the patient, the services subsequent to the consultation are reported with the appropriate office/outpatient, inpatient, or other E/M service codes.

When a consultation is initiated by the patient or family without a request by a medical provider or other appropriate source, the service is not reported with consultation codes. The service is instead reported using the appropriate office visit, home service or domiciliary/rest home care codes.

**Counseling:** A discussion with the patient and/or family concerning one or more of the following:

- Diagnostic results, impressions, and/or recommended diagnostic studies
- Prognosis
- Risks and benefits of management options
- Instructions for management and/or follow-up
- Importance of compliance with chosen management
- Risk factor reduction
- Patient and family education

See Key Components and Time (pg. # 20, 22)

**Multiple Procedures:** When multiple services are rendered by the same **provider** to the same patient, in the same session on the same day, those services will be subject to multiple procedure reduction. The reimbursement will be in order of the RBRVU values with the highest paid at 100% of the fee schedule with the following reductions in order of descending value. Bilateral procedures with modifier 50 are paid at 150% of the fee schedule with subsequent procedure reductions in order of descending RBRVU value. With the exception of diagnostic imaging services, the reduction will be as follows:

- First subsequent procedure 75%
- Second subsequent procedure 50%
- Third and all additional subsequent procedures 25%

The multiple payment reduction for **diagnostic imaging services** applies to multiple services furnished by the same provider to the same patient, in the same session on the same day. See April 14, 2016, guidance on the Facility Fee Schedule page for those services subject to multiple procedure discount.

- Professional Component
  - First subsequent procedure 75%
  - Second subsequent procedure 50%
  - Third and all subsequent procedures 25%
- Technical Component
  - First subsequent procedure 50%
  - Second and all subsequent procedures 25%

**Assistant Surgeon:** This group of physicians is reimbursed at 20% of the fee schedule value. The provider must bill using modifier 80 to designate the assistant surgeon.

**Bilateral Services:** If a medical provider performs a bilateral procedure, the modifier 50 must be added to the CPT code for billing purposes. If providers bill incorrectly for a bilateral procedure, the insurers or TPA may reimburse using the bilateral procedure reimbursement. This is payable at 150% of the fee schedule reimbursement. For multiple procedures, see clarification above.

**Minimum Assistant Surgeon:** Minimum assistant surgeons are for non-physician surgical assistants. The assistants are identified using the modifier 81 and reimbursed at

15% of the value listed on the fee schedule.

**Reduced Services:** If a medical provider elects to reduce the value of a procedure, the correct modifier must be used.

**Separate Procedure:** Procedures identified as “separate procedure” are frequently included in the global value of other procedures. Listing of separate codes is not appropriate when a procedure is included in the global value of another (e.g., code 29870 is not appropriate to list in conjunction with 29874 when performed on the same side).

**Services or Procedures Listed in Other Sections:** Services or procedures provided by a pathologist may be listed in an alternate section of the CPT manual (e.g., consultations listed in Medicine). The pathologist should use these procedure codes following the coding/billing guidelines appropriate to that section.

**Unlisted Service or Procedure:** When a service or procedure provided is not adequately identified, use of the unlisted procedure code for the related anatomical area is appropriate. However, if there is a code available for the procedure, it must be used. Service must be substantiated in the documentation for unlisted procedure codes.

**Unusual Procedural Services:** A service may necessitate skills and time of the medical provider over and above listed services and values. If substantiated by report BR, additional values may be warranted. Use the appropriate modifier to indicate these procedures. See By Report.

## ***Drug Screens***

Drug screens that are presumptive (Screening and confirmation, qualitative or semi-quantitative) are billed using one of the three presumptive codes 80305-80307.

1. 80305– Used to test any number of drug classes by any number of devices or procedures capable of being ready direct optical observation only (e.g. dipsticks, cups, cards, cartridges, etc.), and includes sample validation when performed per date of service.
2. 80306—Used to test any number of drug classes by any number of devices or procedures read by instrument-assisted direct optical observation (e.g. dipsticks, cups, cards, cartridges, etc.), and includes sample validation when performed per date of service.
3. 80307– Used to test any number of drug classes by any number of devices or procedures by instrumented chemistry analyzers (e.g., immunoassay, enzyme assay, TOF, ALDI, LDTD, DESI, DART, GHPC, GC mass spectrometry), and includes sample validation when performed, per date of service.

For drug screens that are definitive (quantitative) in nature and utilize drug identification methods able to identify individual drugs and distinguish between structural isomers (including but not limited to single or tandem GC/MS, single or tandem LC/MS excluding immunoassay, any enzymatic method, etc.) that are billed using the following tiers based on the number of drug classes tested, including metabolite(s) if performed:

1. G0480—1-7 drug classes
2. G0481 – 8-14 drug classes
3. G0482 – 15-21 drug classes
4. G0483 – 22 or more drug classes

At maximum, only one code from each category (presumptive and definitive) is to be utilized per date of service or patient encounter resulting in no more than 2 billing codes per bill.

TERM	GENERAL PURPOSE IN CLINICAL DRUGS OF ABUSE TESTING
<b>Qualitative Drug Testing</b>	Used to determine the presence or absence of drug or drug metabolite (drug class) in the sample. The test result may be expressed as negative or positive (non-numerical) or as a semi-quantitative result.
<b>Quantitative Drug Testing</b>	Used when it is medically necessary to determine the specific quantity of drug or drug metabolite present in the sample. The test result is expressed in concentration. Medicare considers this definitive testing.
<b>Confirmation Testing</b>	Used to confirm the presence of illicit drug(s) following an initial, presumptive positive, screening result. This confirmation prevents a clinician from relying on a false positive result.

### ***Durable Medical Equipment (DME)***

These modifiers should be used by all medical providers when additional medical equipment is needed. DME will be paid under the professional fee schedule. If there is no value use ARM 24.29.1523 for reimbursement. For implant reimbursement, see the Facility Fee Schedule Instructions.

**DME Rentals:** Reimbursement for rentals shall follow the 13-month calculation set up by Medicare. Repairs are allowed using the appropriate HCPCS code.

- The Level II modifiers included in this section are:
  - NU New Equipment
  - RR Rental Equipment
  - UE Used Durable Medical Equipment (DME)

### ***Global Period***

Services **not** included in the global surgical package are as follows:

- The initial consultation or evaluation of the problem by the surgeon to determine the need for surgery;
- Services of other physicians except where the surgeon and the other physician(s) agree on the transfer of care. This agreement may be in the form of a letter or an annotation in the discharge summary, hospital record, or ASC record;
- Visits unrelated to the diagnosis for which the surgical procedure is performed, unless the visits occur due to complications of the surgery.
- Treatment for the underlying condition or an added course of treatment which is not part of normal recovery from surgery;

- Diagnostic tests and procedures, including diagnostic radiological procedures;
- Clearly distinct surgical procedures during the postoperative period which are not reoperations or treatment for complications. This includes procedures done in 2 or more parts for which the decision to stage the procedure is made prospectively or at the time of the first procedure.
- Treatment for postoperative complications which requires a return trip to the operating room (OR). An OR for this purpose is defined as a place of service specifically equipped and staffed for the sole purpose of performing procedures. The term includes a cardiac catheterization suite, a laser suite, and an endoscopy suite. It does not include a patient's room, a minor treatment room, a recovery room, or an intensive care unit (unless the patient's condition was so critical there would be insufficient time for transportation to an OR).

## ***Modifiers***

Codes may be modified under certain circumstances. When applicable, the modifying circumstance should be identified by the addition of the appropriate modifier code after the usual procedure number (e.g., 47600 22). Modifier descriptions should be carefully reviewed because in recent years, significant revisions have been made to modifier descriptions. Providers shall use the modifiers listed on the ERD website.

Some modifiers are specific to certain types of services.

- **Total:** When no modifier is listed, the unit value represents the global value of the procedure. The five-digit code is used to represent a global service inclusive of the professional services and technical value of providing that service. The following sections, professional and technical, provide additional definitions for each component. Providers who are not employees of a facility may bill using code without a modifier if both the professional and technical component are performed in the providers office. Facilities must bill using the appropriate modifiers if services for the technical component is provided
- **Professional:** Modifier 26 is used to designate professional services. The professional component includes examination of the patient, when indicated, performance and/or supervision of the procedure, interpretation and written report of the examination, and consultation with referring medical providers. Providers must bill for these services using the CMS1500.
- **Technical:** Modifier TC is used to designate the technical value of providing the service. The technical component includes personnel, materials, space, equipment, and other allocated facility overhead normally included in providing the service.
- Modifier 59 has 4 subsets of modifiers. The following four subsets will be recognized by Montana Worker's Compensation for billing. Modifier 59 should not be used when a more descriptive modifier is available.

**XE** (Separate Encounter), A service that is distinct because it occurred during a separate encounter

**XS** (Separate Structure), A service that is distinct because it was performed on a separate organ/structure

**XP** (Separate Practitioner), A Service that is distinct because it was performed

by a different practitioner

**XU** (Unusual Non-Overlapping Service), The use of a service that is distinct because it does not overlap usual components of the main service.

- **PLACE OF SERVICE**

The following Place of Service (POS) Codes for E & M services will be paid under the Professional Fee Schedule, Professional Reimbursement Column if no reimbursement is requested that is allowed under the Outpatient Fee Schedule. POS codes that could be affected are 17, 19, 20, 22, 49, 52, 71, 72. This list is not all-inclusive.

- **HCPCS Level II Modifiers:** HCPCS Level II modifiers differ from Level I (CPT), and are more specific and limited in their application. Three Level II modifiers are used in the HCPCS section. Reporting of HCPCS services and supplies may require the use of additional modifiers. Modifiers for the specific digits of the hand and foot have been added to the modifier list.

### ***Workers' Compensation Reports***

The following codes are recommended for the following specific reports being generated by providers:

- 99455- Impairment rating by the treating physician, paid at 100% U & C
- 99456- Impairment rating or Independent Medical Exam not by the treating physician, paid at 100% U & C
- 97750- Functional Capacity Exam (Not limited to 8 units) (15-minute increments)

## **Section Three: Anesthesia**

**I. General:** Values for anesthesia services are listed by CPT code in the Anesthesia section.

These values are to be used only when the anesthesia is legally administered by or under the responsible supervision of a licensed medical provider. These values include usual pre- and post-operative visits, the administration of anesthetic and administration of fluids and/or blood incident to the anesthesia or surgery. Calculated values are derived from the base unit and time increments are discussed under calculations of total anesthesia values.

**II. Unlisted Service or Procedure/New Service or Procedure:** When an unlisted/new service or procedure is provided, the value should be substantiated by report (BR). Reimbursement is 75% of the providers usual and customary.

**III. Materials Supplied By Medical Provider:** Identify as 99070 or by specific HCPCS Level II code(s). The codes identify supplies and materials provided by the medical provider (e.g., dressings, casting supplies, drugs, etc.) over and above those usually included with the office visit or other services and are not excluded above. For codes such as 99070 without a listed value in RBRVS, please refer to ARM 24.29.1523. Use HCPCS codes for identifying supplies.

**IV. Stand-by Anesthesia:** When an anesthesiologist is requested by the attending medical provider to be present in the operating room to monitor vital signs and manage the patient from an anesthesia standpoint, even though the actual surgery is being done under local anesthesia, calculation will be the same as if general anesthesia had been administered (time + base value). If not properly documented, insurers may not pay for stand-by anesthesia. Stand-by anesthesia is generally accepted without justifying documentation for the following:

- Deliveries
- Subdural hematomas
- Femoral or brachial arterial embolectomies
- Patients with physical status 4 or 5—the medical provider must document the patient’s condition (e.g., severe systemic disease, moribund patient). See below for the section on Physical Status Modifiers.
- Insertion of a cardiac pacemaker
- Cataract extraction and/or lens implant
- Stand-by anesthesia for other than the above generally requires documentation

**V. More Than One Anesthesiologist:** When it is necessary to have a second anesthesiologist, the necessity should be substantiated by report (BR). The second anesthesiologist receives 5.0 base units plus time units (calculation of total anesthesia value). If not properly documented, insurers may not pay for more than one anesthesiologist.

**VI. Modifiers:** All anesthesia services are reported by using the anesthesia five-digit procedure code (00100-01999) plus the addition of a physical status modifier. These modifying units may be added to the basic values and documentation must support the Physical Status modifier used. The use of other modifiers may be appropriate.

**VII. Physical Status Modifiers:** These modifiers are represented by the letter P followed by a single digit as shown below:

Modifier	Physical Status	Unit Values
P1	*	0
P2	*	0
P3	*	1
P4	*	2
P5	*	3
P6	*	0

- Example: 00100 P1
- Please refer to CPT for a complete description

**VIII. Qualifying Circumstances:** Some circumstances warrant additional value due to unusual events. The following list of CPT codes and the corresponding anesthesia unit values may be listed if appropriate. More than one code may be necessary. The value listed is added to the existing anesthesia base.

CPT	Description	Unit Values
99100	*	1
99116	*	5
99135	*	5
99140	*	2

- Please refer to CPT for a complete description.
- For CPT code 99140, an emergency is determined to exist when delay in treatment of a patient would lead to a significant increase in the threat to life or body part.

**IX. Reporting Anesthesia Base Units When Two or More Surgical Procedures are Performed:** Typically, only a single anesthesia base unit is reported when multiple surgical procedures are performed. The base unit for anesthesia, when multiple surgical procedures are performed during a single anesthetic administration, is the basic value for the procedure with the highest unit value. The appropriate base units, modifying units, and time units may be applied to each anesthesia administration. The exception is when an add-on anesthesia code is available for reporting an additional service or procedure. Add-on anesthesia codes are services that may be carried out in addition to the primary procedure. The CPT code for the add-on service and any associated base units may be reported in addition to the primary anesthesia service.

**X. Status Code:** The Introduction in *The Essential RBRVS* publication provides a complete description for the status code column (abbreviated as S). The Anesthesia section contains the following status code: J for Anesthesia Services.

**XI. Calculations of Total Anesthesia Values:** The total anesthesia value is calculated by adding the separately listed basic value and time value. A basic value is listed for most procedures. This includes the value of all anesthesia services except the value of the actual time spent administering the anesthesia or in unusual detention with the patient. When multiple surgical procedures are performed during the same period of anesthesia, only the greater basic anesthesia value of the various surgical procedures should be used as the base. An exception is when an add-on anesthesia code is available for reporting the additional service. When an add-on code applies, the add-on code and any associated base units are reported in addition to the primary anesthesia service.

**XII. Time Value:** This is computed by allowing 1.0 RVU for each 15 minutes of anesthesia time, and should be calculated on a minute-by-minute basis. Because the conversion factor for anesthesiology for each additional time value of one 15-minute period is \$65.98, the per-minute reimbursement amount is \$4.40.

Anesthesia time begins when the anesthesiologist physically starts to prepare the patient for the induction of anesthesia in the operating room (or its equivalent) and ends when the anesthesiologist is no longer in constant attendance (when the patient may be safely placed under postoperative supervision).

- **The following examples illustrate the calculation of total anesthesia values if**

**you are using the Montana CF with the values in the *Essential RBRVS*:**

- Procedure Number + Anesthesia Modifier or Anesthesia Code Basic Value + Time Value = Total Anesthesia Value (sum of basic value and time value)
- For a needle thyroid biopsy performed in 48 minutes (three whole time units [45 minutes] plus three partial time units [3 minutes]): 00322 Basic Value of 3 + Time Value of 3 = Subtotal of 6 (total whole unit's anesthesia value)
- Subtotal Whole Units Conversion \$395.88 (six units x \$65.98) + Partial Time Value \$13.20 (three minutes x \$4.40) = Full Reimbursement \$409.08

**• The following examples illustrate the calculation of total anesthesia reimbursements if you are using the allowed amounts already calculated in the Montana Professional Fee Schedule (MPFS):**

- Procedure Number + Anesthesia Modifier or Anesthesia Code Basic Allowed Amount listed in the MNFS Time Value = Total Anesthesia Reimbursement (sum of basic allowed reimbursement amount and time value)
- For a needle thyroid biopsy performed in 48 minutes (three whole time units [45 minutes] plus three partial time units [3 minutes]): 00322 Basic Allowed Amount \$197.94 + Time Value of \$197.94 (three whole time units [ $\$65.98 \times 3$ ]) = Subtotal \$395.88 (total whole units anesthesia value) + Partial Time Value of \$13.20 (three minutes x \$4.40) = Full Reimbursement \$409.08.
- **Note:** Modifiers and additional or reduced values should be used when appropriate.

## **Section Four: Surgery**

**I. General:** If a relative value is not available for a procedure, it is indicated with a "0.00" in the total units column. When no total relative value unit has been established, the value should be substantiated BR. Individual units columns may also have a "0.00" when one or more of the components do not apply to the listed service or supply. For example, some surgery codes, such as cystometrograms (51725TC, 51726TC), have technical components so the medical provider work component does not apply and this is indicated with "0.00."

**II. Operating Microscope:** When an operating microscope is used to perform a procedure, the use of code 69990 is appropriate. This code is an add-on-code and is in addition to the code for the primary procedure. Do not report 69990 in addition to procedures where the use of the operating microscope is an inclusive component as indicated in the NCCI manual available on CMS's website.

**III. Anesthesia By Surgeon:** For anesthesia administered by a surgeon, use the appropriate modifier. The surgeon may receive a value for the procedure equal to the base anesthesia value listed in the anesthesia section. It is important to remember that anesthesia and surgery relative value units are based on different scales and conversion factors are different.

**IV. Pre-operative, Surgery, and/or Post-operative Care Provided By Different Medical Providers:** Montana workers' compensation utilizes the following rules for post-operative and surgical care modifiers to determine the pre-operative and post-operative percentages on an individual code basis. For inpatient services, post-operative care percentages represent the percentage applied after hospital discharge.

**V. Two Surgeons:** The appropriate modifier must be used when two surgeons with different skills are required in the management of a specific surgical problem (e.g., a urologist and a general surgeon in the creation of an ideal conduit).

**VI. Surgical Assistants:** When an assistant at surgery service is required, use the following numeric codes: surgical procedures for which an assistant at surgery may be allowed with supporting documentation (0), assistant at surgery never allowed (1), assistant at surgery allowed (2), and assistant at surgery concept does not apply (9). Appendix A of *The Essential RBRVS* lists the CPT code and the related numeric codes for the assistant at surgery designation. Providers must bill using the appropriate modifier. Refer to the modifiers table on the ERD website for correct reimbursement calculations.

**VII. Materials Supplied By Medical Provider:** The specific HCPCS Level II code may be used to identify materials provided by the medical provider (e.g., dressings, casting supplies, drugs, etc.) over and above those usually indicated with the office visit.

## Section Five: Radiology

**I. General:** If a relative value is not available for a radiology code, it is indicated with a "0.00" in the total units columns. When no total relative value unit has been established the value should be substantiated (BR). Individual units columns may also have a "0.00" when one or more of the components do not apply to the listed service or supply. Listed values for radiology procedures apply only when these services are performed by or under the supervision of a medical provider.

**II. Supervision and Interpretation Only:** A code designated as "supervision and interpretation only" is used to indicate the radiological component of a service that has both a radiological and procedural component (e.g., injection, insertion of catheter, etc.). These two-component services may be performed by a single medical provider or two medical providers, usually a radiologist and another medical provider (e.g., surgeon, cardiologist, urologist, etc.). When a single medical provider performs both components of the service, current CPT guidelines require the medical provider to report both the radiological supervision and interpretation component (70000 series code) and the procedural component (surgical or medicine code). When two medical providers perform

the procedure, each medical provider reports only the component provided either the radiological supervision and interpretation component or the procedural component.

## **Section Six: Pathology and Laboratory**

**I. General:** If a relative value is not available for a code, it is indicated with a “0.00” in the total units columns. When no total relative value unit has been established the value should be substantiated BR. Individual units columns may also have a “0.00” when one or more of the components do not apply to the listed service. The total non- facility and total facility units for those services having only a practice expense component will be the same as the listed practice expense component.

**II. Repeat Clinical Diagnostic Laboratory Test:** Tests repeated the same day for the same patient to obtain multiple results require use of the appropriate modifier.

**III. Collection and Handling:** Collection and handling of laboratory and pathology specimens may be reported. Providers may only bill one unit for the collection and handling. The provider performing the analysis of the specimen may bill for laboratory services.

For Drug Screens refer to that section starting on pg. 8.

## **Section Seven: Medicine**

**I. General:** If a relative value is not available for a Medicine code, it is indicated with a “0.00” in the total units column. When no total relative value unit has been established, the value should be substantiated (BR). Individual units column may also have a “0.00” when one or more of the components do not apply to the listed service or supply.

Listed values for Medicine procedures apply when these services are performed by or under the supervision of a medical provider.

**II. Materials Supplied By Medical Provider:** Use the appropriate code to identify materials provided by the medical provider (e.g., sterile trays, drugs) over and above those usually indicated with the office visit.

**Physical Therapy, Occupational Therapy:** Visits, examinations, consultations, and similar services listed in this section reflect wide variations required in time and skill. Providers should not bill for services performed for less than 8 minutes when only one service is administered in a day. Time intervals are assigned in increments of 15 minutes, beginning with a base of at least 8 minutes (1 unit is  $\geq$  8–22 minutes; 2 units are  $\geq$  23–37 minutes; 3 units are  $\geq$  38–52 minutes, etc.). When more than one service represented by 15-minute timed codes is performed in a single day, the total minutes of service determines the number of timed units billed. Documentation for each aspect of the service performed should be included in the patient record to substantiate the level of service. A total of 8 units of active and passive therapy may be billed in each session. If active therapy is being applied, only two units of a passive therapy may be included in the 8 units. Passive modalities are a variety of treatment tools used by therapists to

decrease pain, inflammation, and treat muscle strains. For example, hot/cold packs, electrical stimulation, iontophoresis, etc. are considered passive modalities. Joint mobilization, for example, is a passive therapy and but is not considered a passive modality.

CPT code 97750 for the Functional Capacity Exam which is a special report is not considered an active therapy, passive therapy or a passive modality.

Documentation must include the following for each type of visit:

- Initial Examination/Evaluation
  - Examination
  - Assessment
  - Diagnosis
  - Prognosis
  - Plan of Care
  - Units of time
  
- Visit/Encounter
  - Patient/client Self-Report
  - Identification of specific interventions provided, including frequency, intensity, and duration as appropriate
    - e.g., knee extension, three sets, ten repetitions, 10# weight, 15 min
  - Equipment provided
  - Changes in patient/client impairment, activity limitation and participation restriction status as it relates to plan of care
  - Response to interventions
  - Communication/consultation with providers/patient/client/family etc.
  - Document ongoing provision of services for the visit
    - Interventions with objectives
    - Progression parameters
    - Precautions, if indicated
  - Units of time
  
- Reexamination
  - Documentation of selected components of examination to update patient's/client's function and or disability status
  - Interpretation of findings and when indicated, revision or goals
  - Where needed revision of plan of care as it is directly correlated with goals as documented
  - Units of time
  
- Discharge/Discontinuation Summary
  - Current physical/function status
  - Degree of goals achieved and reasons for goals not being achieved
  - Discharge/discontinuation plan related to the patient/client's continuing care
    - Home Program
    - Referrals for additional services
    - Recommendations for follow-up physical therapy care
    - Family and caregiver training

- Equipment Provided
- Units of time

**III. Passive Therapy:** Passive therapies and/or passive modalities as listed in the MT Guidelines will be limited to 4 units per visit, if only passive therapy and/or passive modalities are being applied. Each unit will consist of 15 minutes.

Chiropractic care is a passive therapy per the Montana Utilization and Treatment Guidelines. The codes 98940-98943 are adjustment codes which will be given a 15-minute value for ease of calculating the total number of units. If there is a need for additional treatment beyond the manipulation code, the provider must append modifier 59 to 97140 and indicate the number of units. Documentation must be very clear on the additional treatment(s) and the expected outcomes. Code 97140-59 will be reviewed for appropriate usage when used on the same visit and code set 98940-98943.

If there is a need for additional treatment beyond the manipulation code, the provider must append modifier 59 to 97140 and indicate the number of units. Documentation must be very clear on the additional treatment(s) and the expected outcomes.

## Section Eight: Evaluation and Management

**I. General:** If a relative value is not available for a procedure, it is indicated with a “0.00” in the total units columns. When no total relative value unit has been established, the value should be substantiated BR or documentation. At the completion of every visit, a medical status form must be completed by the physician (see Medical Status Form in the Glossary below).

**II. Glossary:** Visits, examinations, consultations, and similar services listed in this section reflect wide variations required in time and skill. The following alphabetical listing of definitions is included to aid in the determination of the correct code for the service provided. Documentation for each aspect of the service performed should be included in the patient record to substantiate the level of service. Listed values for each code group apply only when these services are performed by, or under the supervision of, a medical provider.

**Chief Complaint**—A concise statement describing the symptom, problem, condition, diagnosis or other factor that is the reason for the encounter.

**Classification of Service**—Each code in this section is grouped into a category. The groupings are defined by place (e.g., office, hospital, nursing home, etc.) and type of service (e.g., consultation, preventive, etc.). Some of the codes are grouped into subcategories (e.g., new patient, established patient, initial, etc.). Each code in the group represents a different level of service defined by the clinical components of a patient encounter for E/M. See Levels of Service.

**Components**—Each level of service recognizes seven components. The components include history, physical examination, medical decision making, counseling, coordination of care, nature of presenting problem, and time. See Levels of Service, Key Components, History, Physical Examination, Medical Decision Making, Counseling, Problem, and Time.

**Concurrent Care**—The provision of similar services (e.g., hospital visits) to the

same patient by more than one medical provider on the same day.

**Consultation**—There are two categories for consultation: outpatient and inpatient. Any medical provider may use an appropriate consultation code on any patient for any problem including one which has been previously evaluated by the consulting medical provider provided the following criteria are met:

- The attending medical provider or appropriate source requests that the medical provider render advice or opinion regarding the evaluation and/or management of a specific problem.
- The need for the consultation, the consultant's opinion, and any services ordered or performed must be well documented in the patient's record.

The information is communicated to the requesting medical provider or appropriate source.

If the consulting medical provider upon completion of the consultation assumes care of the patient, the services subsequent to the consultation are reported with the appropriate office/outpatient, inpatient, or other E/M service codes.

When a consultation is initiated by the patient or family without a request by a medical provider or other appropriate source, the service is not reported with consultation codes. The service is instead reported using the appropriate office visit, home service or domiciliary/rest home care codes.

**Counseling**—A discussion with the patient and/or family concerning one or more of the following:

- Diagnostic results, impressions, and/or recommended diagnostic studies
- Prognosis
- Risks and benefits of management options
- Instructions for management and/or follow-up
- Importance of compliance with chosen management
- Risk factor reduction
- Patient and family education

See Key Components and Time.

**Established Patient**—A patient who has received professional services from a medical provider or another medical provider in the same specialty within the same group within the last three years. In the instance a medical provider is covering for or on call for another medical provider, the patient is classified as an established patient if the other medical provider or a member of the providing medical provider specialty group has provided services for the patient within the last three years.

**Family History**—A review of medical events in the patient's family that includes significant information about:

- Health status or cause of death of parents, siblings, and children
- Specific diseases related to problems identified in Chief Complaint, History of the Present Illness, and/or System Review
- Diseases of family members that may be hereditary or place the patient at risk

**History**—This key component relates to the type of history obtained during a patient encounter. The four types of history are defined as follows:

- Problem focused. brief history of present illness or problem as related to the chief complaint
- Expanded problem focused. brief history of present illness relating to chief complaint and pertinent system review

- Detailed: extended history of present illness related to chief complaint, an extended system review, and pertinent past, family and/or social history
- Comprehensive: extended history of present illness related to chief complaint, complete system review and complete past, family and social history

**History of Present Illness**—A chronological description of the development of the patient's present illness from the first sign and/or symptom to the present. This includes a description of location, quality, severity, timing, context, modifying factors, associated signs, and symptoms significantly related to the presenting problem(s).

**Key Components**—Those components that are used primarily to determine the appropriate code level. These components are history, medical decision making, and physical examination. Time is not considered a key component unless counseling constitutes more than 50 percent of the face-to-face patient/medical provider encounter. See also History, Medical Decision Making, Physical Examination, Time, and Counseling.

**Levels of Service**—Each category and subcategory contains three to five levels of service indicated by code. The services include examinations, evaluations, treatments, conferences with or concerning patients, preventative pediatric and adult health supervision, and similar services. Each level of service recognizes seven clinical components. Three of these components are considered key components, including history, medical decision making, and physical examination. All medical providers may use each level of service.

**Medical Decision Making**—The complexity of establishing a diagnosis or selecting a management option. Medical decision making is divided into four categories. The level of medical decision making is determined using documentation in the patient record for three subcategories including: number of possible diagnoses and or the number of management options considered; the amount and/or complexity of medical records, diagnostic tests, and/ or other information that must be obtained, reviewed, and analyzed; and the risk of significant complications, morbidity and/or mortality, as well as co-morbidities, associated with the patient's presenting problem(s), the diagnostic procedure(s), and/or the possible management options. The following four classifications for level of medical decision making are used in determining the proper code:

- Straightforward: minimal number of possible diagnoses or management options, minimal or no amount and/or complexity of data to be reviewed, and minimal risk of complications and/or morbidity or mortality
- Low Complexity. limited number of possible diagnoses or management options, limited amount and/or complexity of data to be reviewed, and low risk of complications and/or morbidity or mortality
- Moderate Complexity. multiple number of possible diagnoses or management options, moderate amount and/or complexity of data to be reviewed, and moderate risk of complications and/or morbidity or mortality
- High Complexity. extensive number of possible diagnoses or management options, extensive amount and/or complexity of data to be reviewed, and high risk of complications and/or morbidity or mortality.

**Medical Status Form**—Completed at each visit with a copy to the injured worker at the conclusion of each visit and a copy to the insurer within 48 hours. The form is designed to assist the injured worker and their employer in returning the injured worker to work in either a modified job or their time of injury job. Contact

the Department when an injured worker may return to work either part time or full time. The Department's Stay-at-Work/Return-to-Work program manager will coordinate with the injured worker and insurer or employer for a safe return to work using the information provided on the Medical Status Form. Contact information: [sawrtwrquest@mt.gov](mailto:sawrtwrquest@mt.gov) or call (406) 444-1752.

**Nature of Presenting Problem**—A presenting problem is a disease, condition, illness, injury, symptom, sign, finding, complaint, or other reason for encounter, with or without a diagnosis being established at the time of the encounter. The E/M codes recognize five types of presenting problems that are defined as follows:

- Minimal: a problem that may not require the presence of the medical provider, but service is provided under the medical provider's supervision
- Self-limited or minor: a problem that runs a definite and prescribed course, is transient in nature, and is not likely to permanently alter health status OR has a good prognosis with management/compliance
- Low severity: a problem where the risk of morbidity without treatment is low; there is little to no risk of mortality without treatment; full recovery without functional impairment is expected
- Moderate severity: a problem where the risk of morbidity without treatment is moderate; there is moderate risk of mortality without treatment; uncertain prognosis OR increased probability of prolonged functional impairment
- High severity: a problem where the risk of morbidity without treatment is high to extreme; there is a moderate to high risk of mortality without treatment OR high probability of severe, prolonged functional impairment

**New Patient**—A patient who has not received any professional services from a medical provider or another medical provider in the same specialty within the same group within the past three years. In the instance where a medical provider is on call for or covering for another medical provider, the patient is classified as a new patient if the other medical provider is a member of the providing medical providers specialty group has not provided any professional service for the patient within three years. See also Established Patient.

**Past History**—A review of the patient's past experiences with illnesses, injuries, and treatments that include significant information about:

- Prior major illnesses and injuries
- Prior operations
- Prior hospitalizations
- Current medications
- Allergies (e.g., drug, food)
- Age appropriate immunization status
- Age appropriate feeding/dietary status

**Physical Examination**—This key component relates to the type of physical examination performed during a patient encounter. The four defined types of physical examination are:

- Problem focused: an examination limited to the affected body area or organ system
- Expanded problem focused: an examination of the affected body area or organ system and other symptomatic or related organ systems
- Detailed: an extended examination of the affected body area(s) and other symptomatic or related organ system(s)

- Comprehensive: a complete single system specialty examination or a complete multi-system examination

**Problem**—Describes the nature of the issue presented as the reason for the encounter. The problem is considered to be a contributing factor and therefore is not used as a primary factor in determining level of service. The problem includes the same five categories as Nature of Presenting Problem.

**Review of Systems**—An inventory of body systems obtained through a series of questions seeking to identify signs and/or symptoms, which the patient may be experiencing or has experienced. For the purposes of these CPT definitions, the following elements of a system review have been identified:

- Constitutional symptoms (fever, weight loss, etc.)
- Eyes
- Ears, Nose, Mouth, Throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Integumentary (skin and/or breast)
- Neurological
- Psychiatric
- Endocrine
- Hematologic/Lymphatic
- Allergic/immunologic

**Social History**—an age appropriate review of past and current activities that includes significant information about:

- Marital status and/or living arrangements
- Current employment
- Occupational history
- Use of drugs, alcohol, and tobacco
- Level of education
- Sexual history
- Other relevant social factors

**Time**—Time for an outpatient is considered to be face-to-face time spent with the patient and does not include time spent in such activities as record review or dictation. The time for an inpatient is considered to be the time spent “on the floor” and does include record review, dictation, and other services rendered while in the facility unit of the patient. Times given are considered to be an average and should not be used to determine the length of time spent in the encounter. Time is considered to be a contributory factor and as such is not used to define the level of service unless 50 percent or more of the service performed is spent in counseling or coordinating care. In cases where 50 percent of the service is counseling or coordinating care, time is used as the primary component for defining the level of service. Careful documentation of time is essential in cases where time is the defining component.

**III. Prolonged Evaluation and Management Service:** When a service provided is prolonged or otherwise greater than that usually required for the E/M service, use the

appropriate modifier or prolonged service codes. Time must be documented.

**IV. Unrelated E/M Service by the Same Medical Provider During a Post-operative Period:** If a service which is not related to the original procedure and is performed during the follow-up period for that period, the service may be identified by the appropriate modifier to indicate this service is unrelated.

**V. Significant, Separately Identifiable E/M Service by the Same Medical Provider on the Same Day of a Procedure or Other Service:** When an E/M service is performed on the same day of a procedure, separate reporting of the E/M service may be allowed.

The E&M service must be for a condition that required services above and beyond the normal pre- and postoperative care associated with the procedure that are noted in the HCPCS/CPT manual. Use the appropriate modifier to indicate this type of service.

**VI. Materials Supplied by Medical Provider:** The specific HCPCS Level II code may be used to identify materials provided by the medical provider (e.g., dressings, casting supplies, drugs, etc.) over and above those usually indicated with the office visit if indicated in the HCPCS code.

## Section Nine: HCPCS

If a relative value is not available for a HCPCS code, it is indicated with a “0.00” in the total units columns. Individual units columns may also have a “0.00” when one or more of the components do not apply to the listed service or supply. For example, many codes in the HCPCS section have only nonfacility and facility practice expense components listed because supplies do not contain work or malpractice cost components. The total nonfacility and total facility units for those supplies and services having only a practice expense component will be the same as the listed practice expense component.

Since HCPCS Level I codes (CPT) do not contain all the codes needed to report medical services and supplies HCPCS Level II codes were developed. Level II codes begin with a single letter (A through V, though not all the letters are used) followed by four numeric digits. They are grouped by the type of service or supply they represent and are updated annually. Check the current HCPCS Level II publication for the groupings as well as additional reporting guidelines related to the use of these codes.

## Section Ten: Gap Values

**I. Gap Values: Valuation of CPT Level I and HCPCS Level II Codes:** Wherever possible, the Montana WC Professional Fee Schedule relies on The Essential RBRVS publication for CPT and HCPCS gap code RVU values.

**II. Valuation of Drugs and Biologicals:** If no codes are available, see our separate Administrative Rules of Montana section (24.29.1529) for prescription drug reimbursement information

**III. Gap Values for Relative Values less than 0.01:** Some CPT Level I and HCPCS Level II codes are valued with a relative value less than 0.01. The relative value for these codes has been rounded up to 0.01 in order to distinguish them from codes with no

established value.

## **Section Eleven: Return to Work/Stay at Work**

If the treating physician has safety concerns about returning an injured worker to the workplace, the department recommends that the treating physician consult with a certified rehabilitation counselor. At times, the treating provider might be hesitant to return an individual to the workplace if they are uncertain about potential hazards. By obtaining this consultation, the treating provider will have access to additional information about workplace hazards or conditions that affect the designation of work restrictions, ideally facilitating a safer and more efficient return to work.

MT009 is a new reimbursement code available to treating physicians who recommend a certified rehabilitation counselor (CRC) perform an onsite job evaluation with the injured worker with the goal of returning the injured worker to their time-of-injury employer or a new employer (part time or full time). This code is only reimbursable for time loss work injuries and on one occasion per injured worker per injury, unless an exacerbation occurs. When the physician determines that the individual can return to work after an exacerbation, the treating physician may request a CRC consultation to return the injured worker to a safe working environment if the injured worker is returning to a different position.

The treating physician's recommendation must be made on the completed Medical Status Form. The physician may bill the insurer \$25.00 using the MT009 code for the CRC recommendation **and** subsequent discussion of the findings with the patient. The treating physician would follow normal procedures for distribution of the form.