

Medicaid Mental Health and Mental Health Services Plan Individuals under 18 years of age Fee Schedule September 1st, 2011

I. Practitioner Services

Mental health practitioners include physicians, physician assistants, nurse practitioners, psychologists, social workers, and professional counselors. Practitioners bill using standard Current Procedural Terminology (CPT) procedure codes and are reimbursed according to the Department's RBRVS system. Interactive psychotherapy codes are restricted to individuals 12 years of age and younger. (The conversion factor for psychologists, social workers, and professional counselors in calculating reimbursement rates is \$22.23.)

The RBRVS fee schedule is available at <http://medicaidprovider.hhs.mt.gov/>.

This link replaces the previous table containing some CPT code rates.

Youth may receive a combined total of 24 sessions per state fiscal year (July 1 thru June 30), without having a Serious Emotional Disturbance (SED). Additional sessions must be prior authorized, and youth must be SED.

To obtain a description of Outpatient therapy services that do not count towards the 24 session limit please refer to the current *Children's Mental Health Bureau's Provider Manual and Clinical guidelines for Utilization Management*.

II. Acute Inpatient Services

Acute care hospital services will be reimbursed for Medicaid beneficiaries under the Montana Medicaid program's All Patient Refined Diagnosis Related Groups (APR -DRG) reimbursement system. All admissions of Medicaid recipients require prior authorization.

Acute care inpatient treatment is not a benefit under the Mental Health Services Plan.

III. Mental Health Center Services (in addition to practitioner services):

The following table summarizes services available through licensed mental health centers.

| Service | Procedure | Modifier | | Unit | Reimbursement | Co-pay | Limits | Management |
|---|-----------|----------|---|---------|---------------|--------|----------------------------------|------------------|
| | | 1 | 2 | | | | | |
| Respite Care – Youth | S5150 | HA | | 15 min | \$2.57 | None | 24 units/24 hours 48 units/mo | Retrospective |
| Youth Day Treatment | H2012 | HA | | Hour | \$10.46 | None | 6 hours/day | Retrospective |
| Community-based psychiatric rehabilitation & support – individual | H2019 | | | 15 min. | \$6.49 | None | None | Retrospective ** |
| Community-based psychiatric rehabilitation & support – group | H2019 | HQ | | 15 min. | \$1.94 | None | None | Retrospective |

** Prior Authorization required when used in day treatment for youth in the PRTF Waiver.

IV. Targeted Case Management Services

Targeted case management (TCM) services for youth are available through the Medicaid program when provided by a licensed mental health center with a case management area of endorsement.

| Service | Procedure | Modifier | | Unit | Reimbursement | Co-pay | Limits | Management |
|------------------------------------|-----------|----------|---|---------|---------------|--------|--------|------------|
| | | 1 | 2 | | | | | |
| Targeted Case Management - Youth** | T1016 | HA | | 15 min. | \$12.61 | None | None | Prior Auth |

** TCM services for SED youth require prior authorization (PA). PA on intake is a pass through and youth must be SED. A medical necessity PA is required after 120 units in a state fiscal year.

V. Therapeutic Youth Group Home Services

The following table summarizes services available by therapeutic youth group homes for Medicaid beneficiaries.

| Service | Procedure | Modifier | | Unit | Reimbursement | Co-pay | Limits | Management |
|---|-----------|----------|----|------|---------------|--------|--------------|--------------------|
| | | 1 | 2 | | | | | |
| Therapeutic Youth Group Home | S5145 | | | Day | \$180.37 | None | None | Prior auth. CON |
| Therapeutic Youth Group Home Therapeutic home leave | S5145 | | U5 | Day | \$180.37 | None | 14 days/year | Retrospective |
| Extraordinary Needs Aide Services | S5145 | UD | | Hour | \$14.56 | None | None | Prior auth. |

VI. Therapeutic Family Care and Therapeutic Foster Care Services

This table summarizes the services available to Medicaid beneficiaries through the therapeutic family (foster) care program.

| Service | Procedure | Modifier | | Unit | Reimbursement | Co-pay | Limits | Management |
|--|-----------|----------|----|------|---------------|--------|--------------|--------------------|
| | | 1 | 2 | | | | | |
| Moderate level Therapeutic Family Care | H2020 | | | Day | \$45.50 | None | None | Prior auth. CON |
| Moderate level Therapeutic Foster Care | S5145 | HR | | Day | \$45.50 | None | None | Prior auth. CON |
| Moderate level Therapeutic Foster Care –Therapeutic home leave | S5145 | HR | U5 | Day | \$45.50 | None | 14 days/year | Retrospective |
| Permanency Therapeutic Foster Care | S5145 | HE | | Day | \$125.92 | None | None | Prior auth. CON |

VII. Partial Hospitalization

Partial hospitalization services are available to Medicaid beneficiaries according to the following schedule:

| Service | Procedure | Modifier | | Unit | Reimbursement | Co-pay | Limits | Management |
|---|-----------|----------|---|----------|---------------|--------|----------|-----------------|
| | | 1 | 2 | | | | | |
| Acute Partial Hospitalization Full day | H0035 | U8 | | Full Day | \$158.75 | None | 15 days* | Prior auth. CON |
| Acute Partial Hospitalization Half day | H0035 | U7 | | Half Day | \$119.06 | None | 15 days* | Prior auth. CON |
| Sub-acute Partial Hospitalization Full day | H0035 | U6 | | Full Day | \$100.82 | None | 60 days* | Prior auth. CON |
| Sub-acute Partial Hospitalization Half day | H0035 | | | Half Day | \$75.62 | None | 60 days* | Prior auth. CON |

* Maximum recommended to utilization review agency; may be extended if medically necessary.

VIII. In-State Psychiatric Residential Treatment Facility (PRTF) Services

This table summarizes PRTF services, which are reimbursed for Medicaid beneficiaries.

| Service | Procedure | Unit | Reimbursement | Co-pay | Limits | Management |
|-----------------------------|------------------|------|---------------|--------|--------------|--------------------------|
| PRTF | Revenue Code 124 | Day | \$303.76 | None | None | Prior auth. CON |
| PRTF Therapeutic Home Visit | Revenue Code 183 | Day | \$303.76 | None | 14 days/year | Prior auth if > 72 hours |
| PRTF Assessment Services | Revenue Code 220 | Day | \$349.32 | None | None | Prior auth. CON |

** In addition to this rate, a facility –specific ancillary rate is paid.

