

Medicaid Youth Mental Health Fee Schedule

July 1, 2013

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 can be found at 37.85.212(1)(c)(i).

A copy of the RBRVS fee schedule is available at

<http://medicaidprovider.hhs.mt.gov/providerpages/providertype/45.shtml#feeschedules>.

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 medically necessary, and youth must be SED.

To obtain a description of Children's Mental Health services refer to the *Children's Mental Health Bureau's Provider Manual and Clinical Guidelines for Utilization Management*, referenced in ARM 37.87.903(9).

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.

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 | Copay | Limits | Management |
|---|-----------|----------|---|--------|---------------|-------|---|----------------|
| | | 1 | 2 | | | | | |
| Respite Care – Youth | S5150 | HA | | 15 min | \$2.62 | None | Up to 24 units/ 24 hours and 48 units/month | Retrospective |
| Youth Day Treatment | H2012 | HA | | Hour | \$10.67 | None | 6 hours/day | Retrospective |
| Community-based psychiatric rehabilitation & support – individual | H2019 | | | 15 min | \$6.62 | None | None | Retrospective* |
| Community-based psychiatric rehabilitation & support – group | H2019 | HQ | | 15 min | \$1.98 | None | None | Retrospective* |
| Comprehensive School and Community Treatment | H0036 | | | 15 min | \$25.11** | None | 720 units/ month per team | Retrospective |
| CSCT Intervention Assessment and Referral (IAR) | H2027 | | | 15 min | \$25.11** | None | 20 units/ month per SFY*** | Retrospective |

* Prior authorization required when used in day treatment for youth in the Montana i-home.

**See <http://medicaidprovider.hhs.mt.gov/providerpages/providertype/45.shtml#feeschedules>

*** CSCT and CSCT IAR combined are limited to 720 units/month per team.

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 endorsement.

| Service | Procedure | Modifier | | Unit | Reimbursement | Copay | Limits | Management |
|----------------------------------|-----------|----------|---|--------|---------------|-------|--------|---------------|
| | | 1 | 2 | | | | | |
| Targeted Case Management – Youth | T1016 | HA | | 15 min | \$12.86 | None | None | Retrospective |

V. Therapeutic Youth Group Home Services

This table summarizes Therapeutic Group Home services available to Medicaid beneficiaries.

| Service | Procedure | Modifier | | Unit | Reimbursement | Copay | Limits | Management |
|--|-----------|----------|----|------|---------------|-------|--------------|-----------------|
| | | 1 | 2 | | | | | |
| Therapeutic Youth Group Home | S5145 | | | Day | \$183.98 | None | None | Prior auth. CON |
| Therapeutic Youth Group Home Therapeutic home leave | S5145 | | U5 | Day | \$183.98 | None | 14 days/year | Retrospective |
| Extraordinary Needs Aide Services | S5145 | UD | | Hour | \$14.85 | None | None | Prior auth. |

VI. Home Support Services and Therapeutic Foster Care Services

This table summarizes the services available to Medicaid beneficiaries through the Home Support Services (formally therapeutic family care) and Therapeutic Foster Care Services.

| Service | Procedure | Modifier | | Unit | Reimbursement | Copay | Limits | Management |
|------------------------------------|-----------|----------|---|------|---------------|-------|--------|-----------------|
| | | 1 | 2 | | | | | |
| Home Support Services | H2020 | | | Day | \$46.41 | None | None | Retrospective |
| Therapeutic Foster Care | S5145 | HR | | Day | \$46.41 | None | None | Retrospective |
| Permanency Therapeutic Foster Care | S5145 | HE | | Day | \$128.44 | None | None | Prior auth. CON |

VII. Partial Hospitalization

This table summarizes partial hospitalization services available to Medicaid beneficiaries.

| Service | Procedure | Modifier | | Unit | Reimbursement | Copay | Limits | Management |
|---|-----------|----------|---|----------|---------------|-------|----------|-----------------|
| | | 1 | 2 | | | | | |
| Acute Partial Hospitalization Full day | H0035 | U8 | | Full Day | \$161.93 | None | 15 days* | Prior auth. CON |
| Acute Partial Hospitalization Half day | H0035 | U7 | | Half Day | \$121.44 | None | 15 days* | Prior auth. CON |
| Sub-acute Partial Hospitalization Full day | H0035 | U6 | | Full Day | \$102.84 | None | 60 days* | Prior auth. CON |
| Sub-acute Partial Hospitalization Half day | H0035 | | | Half Day | \$77.13 | 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 available to Medicaid beneficiaries.

| Service | Procedure | Unit | Reimbursement | Copay | Limits | Management |
|-----------------------------|------------------|------|---------------|-------|--------------|--------------------------|
| PRTF | Revenue Code 124 | Day | \$309.84** | None | None | Prior auth. CON |
| PRTF Therapeutic Home Visit | Revenue Code 183 | Day | \$309.84** | None | 14 days/year | Prior auth if > 72 hours |
| PRTF Assessment Services | Revenue Code 220 | Day | \$356.31** | None | None | Prior auth. CON |

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

Reimbursement for out-of-state PRTF Services is 50% of their usual and customary charges.