



Adult Mental Health Services

This publication supersedes all previous Adult Mental Health handbooks. Published by the Montana Department of Public Health & Human Services, October 2003.

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The purpose of this manual is to assist Medicaid enrolled providers who serve adults with mental health needs. The manual contains information intended to assist the reader in understanding Medicaid funded mental health services for adults, and to explain billing and other requirements for services provided. Because this is a general guide, it was written to serve as an aid to enrolled providers in understanding processes important to the provision of adult mental health services. This manual does not substitute for state or federal rule, manuals incorporated in Administrative Rule (ARM), or other professional resources.

NPI/API:

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Key Contacts

Hours for Key Contacts are 8 a.m. to 5 p.m. Monday through Friday (Mountain Standard Time), unless otherwise stated. The telephone numbers designated **only** “In state” will not work outside Montana.

Claims

Send paper claims to:
 Claims Processing Unit
 P.O. Box 8000
 Helena, MT 59604

Member Eligibility

Provider Relations

800-624-3958

FaxBack

800-714-0075 (24 hours)

Integrated Voice Response (IVR)

800-714-0060 (24 hours)

Montana Access to Health Web Portal

<https://mtaccesstohealth.acs-shc.com>

Emdeon (Must have an account)

877-469-3263

Electronic Funds Transfer/ Electronic Remittance Advice

Direct deposit is another term for EFT. To enroll in electronic funds transfer (EFT) and register for the Montana Access to Health (MATH) web portal to receive electronic remittance advices (ERAs), contact Provider Relations.

Completed documentation should be mailed or faxed to:

Provider Relations
 P.O. Box 4936
 Helena, MT 59604
406-442-4402

EDI Support Unit

For questions regarding electronic claims submission:

800-987-6719 In/Out of state
406-442-1837 Helena

Xerox EDI Solutions – Montana
 P.O. Box 4936
 Helena, MT 59604
MTEDIHelpdesk@Xerox.com

Passport Help Line

Members who have Passport and general Medicaid questions may call the Help Line:
800-362-8312

Send written inquiries to:

Passport to Health
 P.O. Box 254
 Helena, MT 59624-0254

Prior Authorization

See the Prior Authorization and Continued Care Review section in this manual.

For prior authorization for certain services, contact:

Magellan Medicaid Administration (previously dba First Health)

For questions regarding prior authorization and continued stay review for selected mental health services:

800-770-3084 Phone
800-639-8982/800-247-3844 Fax
<https://montana.fhsc.com>

Magellan Medicaid Administration
 4300 Cox Road
 Glen Allen, VA 23060

For prior authorization of pharmacy services, contact Mountain-Pacific Quality Health.

Mountain-Pacific Quality Health

The prescriber (e.g., physician) or pharmacy provider may submit requests to the Drug Prior Authorization Unit by mail, telephone, or fax to:

- 406-443-6002** Phone
- 800-395-7961** Phone
- 406-513-1928** Fax
- 800-294-1350** Fax

Drug Prior Authorization Unit
Mountain-Pacific Quality Health
3404 Cooney Drive
Helena, MT 59602

Provider’s Policy Questions

For policy questions, contact the appropriate division of the Department of Public Health and Human Services. See the Introduction chapter in the *General Information for Providers* manual found on each provider type page.

Provider Relations

For general claims questions and questions about enrollment, eligibility, payments, or denials:

- 800-624-3958** In/Out of state
- 406-442-1837** Helena
- 406-442-4402** Fax

Send e-mail inquiries to:
MTPRHelpdesk@Xerox.com

Send written inquiries to:
Provider Relations Unit
P.O. Box 4936
Helena, MT 59604

Secretary of State

The Secretary of State’s office publishes the Administrative Rules of Montana (ARM):

406-444-2055 Phone

Secretary of State
P.O. Box 202801
Helena, MT 59620-2801

Third Party Liability

For questions about private insurance, Medicare, or other third party liability:

- 800-624-3958** In/ Out-of State
- 406-442-1837** Helena
- 406-442-0357** Fax

Send written inquiries to:
Third Party Liability Unit
P.O. Box 5838
Helena, MT 59604

Key Websites

Web Address	Information Available
<p>Xerox EDI Solutions (formerly ACS EDI Gateway) http://www.acs-gcro.com/gcro/</p>	<p>The Xerox HIPAA clearinghouse. From the <i>EDI Gateway Clients</i> tab, select the <i>Montana Department of Public Health and Human Services</i> link for information on:</p> <ul style="list-style-type: none"> • EDI enrollment/support • HIPAA guides • Manuals • Provider services • Related links • Software
<p>Centers for Disease Control and Prevention (CDC) http://www.cdc.gov/</p>	<p>Immunization and other health information</p>
<p>Healthy Montana Kids (HMK) http://hmk.mt.gov</p>	<p>Information on Healthy Montana Kids (HMK)</p>
<p>Provider Information Website www.medicaprovider.hhs.mt.gov</p> <p>Montana Access to Health (MATH) Web Portal https://mtaccesstohealth.acs-shc.com/</p>	<ul style="list-style-type: none"> • Claim instructions • Definitions and acronyms • Enrollment (web portal) • Fee schedules • Forms • Frequently asked questions (FAQs) • HIPAA information • ICD information • Key contacts • Medicaid news • Newsletters (Claim Jumper) • Other website links • Passport and Team Care information • Provider manuals and manual replacement pages • Provider notices • Remittance advice notices (web portal) • Training resources • Upcoming events
<p>Public Assistance Toolkit https://dphhs.mt.gov/</p>	<p>Under Human Services is information on:</p> <ul style="list-style-type: none"> • Medicaid: <ul style="list-style-type: none"> ○ Member information ○ Eligibility information ○ Provider information • Montana Access Card
<p>Secretary of State www.sos.mt.gov</p> <p>ARM Home Page www.mtrules.org</p>	<p>Secretary of State website</p> <p>Administrative Rules of Montana</p>
<p>Washington Publishing Company www.wpc-edi.com</p> <p>There is a fee for documents; however, code lists are viewable online at no cost.</p>	<ul style="list-style-type: none"> • HIPAA tools • HIPAA and EDI education

Enrollment Provider Numbers

Reimbursement for mental health services through Medicaid requires enrollment as a Medicaid provider prior to services being provided. Xerox will enroll mental health providers. Information concerning enrollment is available on the Montana Medicaid Provider Information website at <http://medicaidprovider.hhs.mt.gov/>. Providers without Internet access may contact Provider Relations at 1-800-624-3958 (in/out of state) or 406-442-1837 (Helena). A provider must have an active provider number in order to submit a claim for reimbursement. Mental health providers must use their National Provider Identifier (NPI) and taxonomy number to bill for services unless they are an atypical mental health provider type. Atypical mental health provider types include group homes and adult foster care. Atypical mental health providers may bill using their NPI and taxonomy number or the Atypical Provider Identifier (API) number assigned to them by Xerox upon enrollment.

Pharmacy providers and prescribers should also enroll as Mental Health Service Plan (MHSP) providers to be eligible for reimbursement for services provided under the MHSP program. Call Provider Relations for information.

Some providers may have different provider numbers assigned for different types of mental health services they are providing. If you do have multiple provider numbers, be sure to use the correct provider number for the services being billed.

Coding Requirements

When coding for Montana Medicaid, be aware that Current Procedural Terminology (CPT) codes and modifiers, including their respective definitions, are developed by the American Medical Association for providers to describe their services numerically for claim submission to insurers.

Montana DPHHS requires the use of uniform procedure and diagnosis coding on all claims. The procedure code must accurately reflect the time spent with the patient.

Fees and covered codes for each provider type are available on the Montana Medicaid Provider Information [website](#).

The Department's goal is to pay claims as quickly and efficiently as possible. To attain this goal, a computer processes claims. This automated method does not include review by medical personnel or detailed evaluation for appropriate billing procedures.

The automated system detects many billing errors and denies claims accordingly. However, this process is not conclusive. **Providers are responsible for billing their services correctly.** Standard use of coding conventions, particularly those established in the most current editions of the ICD diagnosis, CPT, and HCPCS Level II manuals are required of the provider when billing Medicaid. Providers should become familiar with these manuals because DPHHS relies on them when setting its coding policies.

ARM 37.85.413 states that employees of the Department, or of any contractor or agent of the Department, may give a provider general information as to what codes are available for billing under Medicaid for a particular service or item being provided. However, the provider retains responsibility for selecting and submitting the proper code to describe the service or item provided. If an employee of

the Department or of a contractor or agent of the Department suggests, recommends, or directs the provider to use a particular code from the choices available or gives other specific coding advice, the provider may not rely on such advice unless the advice is provided in writing before the provider submits a claim for the service or item.

Do not assume that payment of a claim means the service was billed or paid correctly. All claims are subject to post-payment review and possible recovery of overpayments.

Provider Manuals

Detailed information on billing, reimbursement, limitations, and other requirements are contained in the provider manuals available for each provider type through the Montana Medicaid Provider Information website, and those provider manuals take precedence over this manual where conflicts may exist for Montana Medicaid services. All providers also have access to the *General Information for Providers* manual through their provider type page on the Montana Medicaid Provider Information [website](#).

If you bill for services on the CMS-1500 and need assistance, call Provider Relations or refer to <http://medicaidprovider.hhs.mt.gov/pdf/npionlyclaiminstructions1500.pdf>.

If you bill for services on the UB-04 claim form and need assistance, call Provider Relations or refer to <http://medicaidprovider.hhs.mt.gov/pdf/npionlyclaiminstructions1500.pdf>.

Providers are required to provide services in accordance with federal regulations, Montana state law, Administrative Rules, and any applicable licensure standards. **In the event of a conflict between federal regulations, Montana state law, Administrative Rules, or any applicable licensure standards and this manual, the federal regulations will prevail.**

The Department only makes payment for services which are medically necessary as determined by the Department or by the designated review organization.

For medical necessity information, refer to the current Adult Mental Health's *Provider Manual and Clinical Guidelines for Utilization Management* at <http://www.dphhs.mt.gov/publications>.

Third Party Coverage and Medicare

When they exist, other financial resources must be identified on the claim form. The other resource must be billed before the provider files a claim with Xerox. When billing Xerox secondary, the provider must report the amount paid by the other resource or submit a photocopy of the statement of denial from the other resource. The denial must list the insurance company name, patient name, date of service, amount billed and complete reason for denial. Refer to your provider manual or the *General Information for Providers* available on your provider type page on the Montana Medicaid Provider Information website at <http://medicaidprovider.hhs.mt.gov/>.

Claims for individuals who are dually Medicare/Medicaid eligible will be paid taking into consideration the psychiatric reduction from Medicare. Medicare mental health crossovers will price at the lower of the Medicare allowed minus what Medicare has paid or the Medicaid allowed minus what Medicare paid.

Surveillance/Utilization Review

Payment of a claim does not mean it was paid correctly. Periodic retrospective reviews are performed which may lead to the discovery of incorrect billing or incorrect payment. The Department is charged by federal and state law to identify, investigate, and refer to the Medicaid Fraud Control Unit of the Department of Justice all cases of suspected fraud or abuse in Medicaid by either providers or members. Refer to the *General Information for Providers* manual for additional information and requirements regarding surveillance/utilization review.

Coverage

Mental health services delivered by the provider types listed below are covered under Montana Medicaid. For detailed information on reimbursed services, see the appropriate provider category under the Services section of this manual.

Program	Coverage	Prior Authorization	Billing Form
Inpatient Hospital	Y	Y	UB-04
Hospital Outpatient/Emergency Room	Y	N	UB-04
Partial Hospitalization	Y	Y	UB-04
Mental Health Centers	Y	Some	CMS-1500
Physicians	Y	N	CMS-1500
Psychiatrists	Y	N	CMS-1500
Psychologists	Y	N	CMS-1500
Related Laboratory and X-Ray	Y	N	CMS-1500
Mid-Level Practitioners	Y	N	CMS-1500
Social Workers	Y	N	CMS-1500
Licensed Professional Counselors	Y	N	CMS-1500
Pharmacy & Related Lab Services	Y	Some*	Point-of-sale or MA-5
Case Management	Y	N	CMS-1500
Institution for Mental Disease	Y	N	MA-3/TAD
Home Health Services	Y	N	UB-04
Personal Care	Y	N	CMS-1500
Indian Health Services	Y	N	UB-04
Federally Qualified Health Centers	Y	N	UB-04
Rural Health Clinics	Y	N	UB-04

*Some prescriptions require prior authorization.

Covered Diagnoses

The definition of Severe Disabling Mental Illness (SDMI) can be found in ARM 37.86.3503. All mental health services must be medically necessary for the treatment of the mental health diagnosis entered on the claim form. For medical necessity criteria, refer to the Adult Mental Health Services Bureau at the Magellan Medicaid Administration website, <https://montana.fhsc.com>.

Prior Authorization and Continued Care Review

Certain mental health services listed in this manual always require prior authorization. Claims for those services rendered to Medicaid beneficiaries will be denied payment without prior authorization. All inpatient psychiatric admissions require request for prior authorizations within 3 days of the admission.

All requests for prior authorization and continued stay authorization must be sent to:

Magellan Medicaid Administration (previously dba First Health Services)
1-800-770-3084 Phone
1-800-639.8982 or 1-800-247-3844 Fax

The adult program manuals and forms for prior authorized services are available at the Magellan Medicaid Administration website, <https://montana.fhsc.com>. Click on the Providers tab and choose Adult Program and either the Manuals or Forms link.

Claims for services that require prior authorization must have the prior authorization number indicated in the appropriate field on the claim form. Providers must bill Medicaid according to the information supplied on the prior authorization. Each line on the claim must match the line information on the authorization with respect to dates of service, procedure code, and units of service.

A Certificate of Need (CON) that complies with the requirements of 42 CFR, Part 441, Subpart D must be completed for all Medicaid beneficiaries under age 21 who request the following services:

- Psychiatric Residential Treatment Facility (PRTF)
- Acute Care General Hospital, Psychiatric Hospital, and Distinct Part Psychiatric Unit of an Acute Care General Hospital (Acute)
- Partial Hospital Program
- Therapeutic Group Home (TGH)
- Therapeutic Foster Care-Permanency (TFC-P)

The CON is obtained by a team that includes a physician, who has competency in the diagnosis and treatment of mental illness, and has knowledge of the individual's condition. A licensed mental health professional must complete the CON. A case manager's signature is not required on the CON. However, the person who completes the CON must sign the form and provide contact information. The team must certify the services requested will be provided in the least restrictive environment that will meet the youth's needs and that the services can be reasonably expected to improve the youth's condition or prevent further regression.

For providers who bill using the CMS-1500 claim form, if the prior authorization issued has 3 lines of service, the provider must bill with 3 individual **lines** on the claim form that match the 3 lines on the prior authorization. A prior authorization number may have up to 21 claim lines.

For providers who bill using the UB-04 claim form, if the prior authorization issued has three lines of service, the provider must bill three individual UB-04 **claim forms** for each line of service indicated on the prior authorization.

If you bill for services on the CMS-1500 and need assistance, call Provider Relations or refer to <http://medicaidprovider.hhs.mt.gov/pdf/npionlyclaiminstructions1500.pdf>.

If you bill for services on the UB-04 claim form and need assistance, call Provider Relations or refer to <http://medicaidprovider.hhs.mt.gov/pdf/npionlyclaiminstructions1500.pdf>.

Those mental health services not requiring prior authorization will be subject to retrospective review by the Department for medical necessity and appropriateness.

Cost Sharing and Member Responsibility

Mental health services provided to individuals eligible for Medicaid will be subject to the cost sharing requirements published for individuals eligible for services under Montana Medicaid. Members are responsible for the designated cost sharing amounts. Members are informed of the cost sharing requirements at the time they are determined eligible for Medicaid. Providers are responsible for collecting cost sharing payments.

Children (under age 18), pregnant women, and nursing home residents are exempt from Medicaid cost sharing. Cost share amounts may not be charged to a Medicaid member for services provided during an emergency. Cost share amounts may not be charged when Medicare or another third party is the primary payer for the service.

Providers are required to accept, as payment in full, the amount paid by the Montana Medicaid program for a service provided to an eligible member. A provider may bill a member for noncovered services if the provider has informed the member in advance of providing the services that Medicaid will not cover the services and that the member will be required to pay privately for the services, and if the member has agreed to pay privately for the services. The member must be informed of the specific service and date of service for which he/she will be responsible for payment. Noncovered services are those that may not be reimbursed for the particular member by the Montana Medicaid program under any circumstances. Covered services are those that may be reimbursed by the Montana Medicaid program for the particular member if all applicable requirements, including medical necessity, are met.

A provider may not bill a member after Medicaid has denied payment for covered services because the services are not medically necessary unless the provider specifically informed the member in advance of providing the services that the services are not considered medically necessary under Medicaid criteria, that Medicaid will not pay for the services, and that the member will be required to pay privately for the services, and the member has agreed to pay privately for the services. The agreement to pay privately must be based upon definite and specific information given by the provider to the member indicating that the service will not be paid by Medicaid. The provider may not bill the member when the provider has informed the member only that Medicaid may not pay or where the agreement is contained in a form that the provider routinely requires members to sign.

A provider may not bill a member for services when Medicaid does not pay as a result of the provider's failure to comply with applicable enrollment, prior authorization, billing, or other requirements necessary to obtain payment (ARM 37.85.406(11)).

Eligibility Information

Whenever possible, the provider should view the member's ID card and verify eligibility information using one of the methods described below.

Providers can access Medicaid information by using the Montana Access to Health (MATH) web portal. MATH provides the tools and resources to help health care providers conduct business electronically. Providers must complete a Trading Partner Agreement and register to use the MATH web portal. Providers may register by clicking the [Web Registration](#) link on the left side of that page to register. Providers, who have not already completed a Trading Partner Agreement may click on the [Provider Enrollment](#) link for step-by-step instructions.

Another option is to call the Integrated Voice Response (IVR) at 1-800-714-0060 or FaxBack at 1-800-714-0075. IVR indicates whether a Medicaid or MHSP member has eligibility for a particular date of service. Providers must have their NPI/API, member identification number, and date of service available. FaxBack faxes a report of the member's eligibility including managed care details, insurance coverage, Medicare coverage, etc. To sign up for FaxBack, call Xerox at 1-800-624-3958 (in/out of state) or 406-442-1837 (Helena). Providers must have their NPI/API and fax number ready when they call.

Providers are given an audit number when contacting Xerox and IVR for eligibility. Providers are responsible for keeping the audit number on file in case there are discrepancies regarding eligibility during claims processing.

Medicaid Members on Passport

Medicaid members who are covered through Passport do **not** need a referral from their primary care provider to access mental health services. These mental health services will be paid through the Medicaid fee-for-service mental health program. All requirements of the mental health program, including prior authorization, apply to Passport enrollees obtaining mental health care.

Maintenance of Records

All providers of mental health services must maintain records which fully demonstrate the extent, nature, and medical necessity of services provided to Medicaid members that support the fee charged or payment sought and that demonstrate compliance with applicable requirements. These records must be retained for a period of at least 6 years and 3 months from the date on which the service was rendered or until any dispute or litigation concerning the services is resolved, whichever is later (ARM 37.85.414).

The Department, the Designated Review Organization, the Legislative Auditor, the Department of Public Health and Human Services, the Department of Revenue, the Medicaid Fraud Control Unit, and their legal representatives shall have the right to inspect or evaluate the quality, appropriateness, and timeliness of services performed by providers, and to inspect and audit all records required by ARM 37.85.414.

Services

Inpatient Hospital

Requirements

Inpatient hospital services are those items and services ordinarily furnished by a hospital for the care and treatment of inpatients. Services must be provided under the direction of a licensed physician in an institution maintained primarily for treatment and care of patients with disorders other than tuberculosis or mental illness. The institution must be currently licensed by the designated state licensing authority in the state where the institution is located and must meet the requirements for participation in Medicare as a hospital.

Prior Authorization

All inpatient hospital services for psychiatric diagnosis require prior authorization through Magellan Medicaid Administration. If the admitting diagnosis is not psychiatric, but the discharge diagnosis is psychiatric, contact Magellan Medicaid Administration within 3 days of the discharge for retroactive authorization.

The forms to request prior authorized services are available at the Magellan Medicaid Administration website <https://montana.fhsc.com>. Click on the Providers tab, choose Adult Program, and then choose the Forms link.

Billing/Reimbursement

All claims for inpatient hospital services provided to Medicaid beneficiaries must be submitted on a UB-04 form.

For further information on service coverage and billing requirements for inpatient services to Medicaid beneficiaries, refer to the Montana Medicaid *Hospital Inpatient Services* manual on the Hospital Inpatient page of the Montana Medicaid Provider Information website at <http://medicaidprovider.hhs.mt.gov/>.

For assistance completing the UB-04 claim form, call Provider Relations or refer to <http://medicaidprovider.hhs.mt.gov/pdf/npionlyclaiminstructions.pdf>.

Outpatient Hospital

Requirements

Outpatient hospital services are those preventive, diagnostic, therapeutic, rehabilitative, and palliative items or services provided to an outpatient under the direction of a physician, dentist, or other practitioner. Outpatient hospital services must be provided by an institution licensed as a hospital by the designated state licensing authority in the state where the institution is located and that meets the requirements for participation in Medicare as a hospital.

Outpatient means a person who has not been admitted by a hospital as an inpatient, who is expected by the hospital to receive services for less than 24 hours, who is registered on the hospital records as an outpatient, and who receives outpatient hospital services other than supplies alone.

Prior Authorization

Prior authorization is not required for outpatient hospital services.

Billing/Reimbursement

Outpatient hospital services for mental health diagnosis will be reimbursed using the Outpatient Prospective Payment System (OPPS), which is based on the Ambulatory Payment Classification (APC), if applicable, or based on a fee established by the Department for out-of-state hospitals or in-state PPS hospitals. For in-state critical access hospitals (CAHs), outpatient hospital services will be reimbursed based on a hospital specific percent of charges. Claims must be submitted on a UB-04 form.

For further information, refer to the Montana Medicaid *Hospital Outpatient Services* manual on the Hospital Outpatient page of the Montana Medicaid Provider Information website, <https://medicaidprovider.hhs.mt.gov>.

For assistance completing the UB-04 claim form, contact Provider Relations or refer to <http://medicaidprovider.hhs.mt.gov/pdf/npionlyclaiminstructions.pdf>.

Partial Hospitalization

Partial hospitalization means an active treatment program that offers therapeutically-intensive, coordinated, structured clinical services provided only to individuals who are determined to have a severe disabling mental illness (ARM 37.86.3001(7)).

Requirements

Full-day programs require provision of services for a minimum of 6 hours per day, 5 days per week. Half-day programs require provision of services for a minimum of 4–6 hours per day, 4 days per week.

Partial hospitalization is provided by programs that are operated by a hospital with a distinct psychiatric unit and are co-located with that hospital such that in an emergency a patient of the partial hospitalization program can be transported to the hospital’s inpatient psychiatric unit within 15 minutes. Partial hospitalization programs serve primarily individuals being discharged from inpatient psychiatric treatment and are designed to stabilize patients sufficiently to allow discharge to a less intensive level of care, on average after 15 or fewer treatment days.

All partial hospitalization services require prior authorization through Magellan Medicaid Administration Services. When full-day partial hospitalization is requested and authorized, Magellan Medicaid Administration Services will also enter an authorization for an equal number and span of half-day partial hospitalization. This will allow the partial hospitalization provider to bill only for half-day service when the individual can only be present for a half-day session.

Billing/Reimbursement

Claims must be submitted on a UB-04 form.

If you need assistance, call Provider Relations or refer to: <http://medicaidprovider.hhs.mt.gov/pdf/npionlyclaiminstructions.pdf>.

Partial hospitalization services must be billed under Revenue Code 912 and must include a Montana-specific procedure code in the HCPCS field (Form Locator 44) on the UB-04 form. For partial hospitalization services, use Code H0035 with the appropriate modifier.

Service	Procedure Code	Modifier
Partial Hospitalization – Full Day	H0035	U8
Partial Hospitalization – Half Day	H0035	U7

Reimbursement for partial hospitalization is based on a bundled rate that includes all of the services associated with the psychiatric diagnosis. These services include psychologists, social workers and licensed professional counselors, and medications received during treatment. Physicians and psychiatrists are the only providers allowed to bill separately for their services.

Institution for Mental Disease

Requirements

Institution for mental disease means a hospital, nursing facility, or other institution with more than 16 beds which the Department has determined is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services. An institution for the mentally retarded, including an intermediate care facility for the mentally retarded, is not an institution for mental diseases.

Mental disease means a disease listed as a mental disorder in the current edition of the *Diagnostic and Statistical Manual of Mental Diseases* but does not include mental retardation, senility, and organic brain syndrome.

An institution for mental disease, as a condition of participation in the Montana Medicaid program, must be a nursing facility that meets the following requirements (ARM 37.88.1405):

- a. Complies with the requirements of ARM 37.40.306 for Medicaid nursing facility service providers;
- b. Has been determined by the Department to be an institution for mental diseases;
- c. Complies with ARM 37.40.352 regarding utilization review and quality of care for nursing facilities; and
- d. Enters into and maintains a written agreement with the Department that specifies the respective responsibilities of the Department and the provider.

Individual Treatment Plan

Institutions for mental diseases providing services must provide for and maintain recorded individual plans for treatment and care to ensure that institutional care maintains the member at, or restores the member to, the greatest possible degree of health and independent functioning. The plans must include:

- a. Designation for needed care at a level higher than personal care;
- b. An initial review of the member's medical, psychiatric and social needs within 30 days after the date of admission;
- c. Periodic review of the member's medical, psychiatric and social needs;
- d. A determination at least every 90 days of the member's need for continued institutional care and for alternative care arrangements;
- e. Appropriate medical treatment in the institution; and
- f. Appropriate social services.

Billing/Reimbursement

The Montana Medicaid program reimburses for services provided for members age 65 or over or members under 21 receiving nursing facility services in a nursing facility that the Department has determined to be an institution for mental diseases. Reimbursement calculation will be in accordance with the rules adopted by the Department for institutions for mental diseases (ARM 37.88.1410).

Providers must bill for all services and supplies in accordance with the provisions of ARM 37.85.406. The Department pays a provider on a monthly basis the amount determined under rules established by the Department upon receipt of an appropriate billing which reports the number of patient days provided to authorized members during the billing period. Institution for mental disease providers will bill on the Department MA-3 for these per diem amounts.

Mental Health Centers

Definitions and Requirements

A licensed mental health center (MHC) is a facility providing services for the prevention or diagnosis of mental health issues, the care and treatment of mental health issues, the rehabilitation of individuals with mental health issues, or any combination of these services.

For an MHC to be licensed, it must provide the following services: crisis telephone services; medication management; outpatient therapy; community-based psychiatric rehabilitation and support; and chemical dependency services. Beyond the required chemical dependency services defined in ARM 37.106.1902, chemical dependency treatment is not reimbursed by the Mental Health Services Bureau.

An MHC with an appropriate license endorsement may provide one or more of the following services; adult intensive case management; adult day treatment; adult foster care; mental health group home; an inpatient crisis stabilization response facility; or an outpatient crisis response facility.

Benefits and Limitations

Mental health center services include the following:

- a. Practitioner services include inpatient and outpatient therapy provided by licensed mental health professionals, including physicians, mid-level practitioners, psychologists, social workers, and licensed professional counselors. Practitioner services are subject to the respective requirements of each provider type.
- b. In-training practitioner services provided under the supervision of a licensed practitioner by an individual who has completed all academic requirements for licensure. Services are subject to the same requirements that apply to licensed practitioners.
- c. Day treatment
- d. Community-based psychiatric and rehabilitation support
- e. Crisis intervention facility
- f. Group and foster home services
- g. Mental health group home therapeutic home visits and mental health foster care therapeutic home visits. No more than 14 days per individual in each rate year will be allowed for therapeutic home visits. For purposes of the 14-day limit, all therapeutic home visits must be included.
- h. Intensive community-based rehabilitation facility
- i. Program of Assertive Community Treatment (PACT)
- j. Intensive outpatient services
- k. Illness management and recovery

Each MHC shall employ or contract with an administrator and medical director. This requirement does not mean the medical director must be an employee of the MHC or be used on a full-time basis or be present in the facility during all hours of service provided. However, each patient's care must be under the supervision of a physician directly affiliated with the MHC.

To meet this requirement, a physician must see the member at least once and prescribe the type of care to be provided. If the services prescribed are not limited by the prescription, the physician must periodically review the need for continued care. Although the physician does not have to be on the premises when the member is receiving covered services, the physician must assume professional responsibility for the services provided and assure the services are medically necessary and appropriate.

Billing/Reimbursement

MHCs are required to bill current CPT codes for services provided by physicians, mid-level practitioners, psychologists, social workers, professional counselors, and in-training practitioners (under clinical supervision). Reimbursement will be according to the Department’s Resource-Based Relative Value Scale (RBRVS) fee schedule, adjusted for the provider type.

Refer to the appropriate provider type descriptions in the Services section of this manual for additional information.

For assistance completing the CMS-1500, call Provider Relations or refer to: <http://medicaidprovider.hhs.mt.gov/pdf/npionlyclaiminstructions1500.pdf>.

The following HCPCS codes are accepted by Montana Medicaid and must be billed on the CMS-1500:

Procedure	Modifier	Service
S5102		MH Group Home, per day
S5102	U5	MH Group Home Therapeutic Home Visit
S5140		MH Foster Care, per day
S5140	U5	MH Foster Care Therapeutic Home Visit
H2012	HB	Day Treatment, per hour
H2019		Community-Based Psychiatric Rehabilitation & Support, Individual, per 15-minute increment
H2019	HQ	Community-Based Psychiatric Rehabilitation & Support, Group, per 15-minute increment
S9485		Crisis Intervention, per day
S5120	HE	Intensive Community-Based Rehabilitation, per day
H0040		Program of Assertive Community Treatment, per day
H0046	HB	Intensive Outpatient Psychotherapy
H2014		Dialectical Behavior Therapy, Skill Development, Individual
H2014	HQ	Dialectical Behavior Therapy, Skill Development, Group
H2015	HB	Illness Management & Recovery, Individual
H2015	HQ	Illness Management & Recovery, Group

Psychiatrists and other physicians billing with an MHC provider number are eligible for reimbursement for evaluation and management (E/M) services provided to Medicaid beneficiaries. Use the current CPT codes for complete descriptions and coding guidelines for E/M services.

An updated fee schedule that includes these new services for mental health center psychiatrist/physician services is available on the Mental Health Center page of the Montana Medicaid Provider Information website, <http://medicaidprovider.hhs.mt.gov/>.

Use of the Modifier 22 is prohibited for Mental Health Services. In January 1, 2013, the CPT manual added two codes specifically for crisis with instructions and guidance for providers.

Providers should submit their **usual and customary** charge for the crisis response service or initial intake examination they are providing. Federal guidelines require that a provider's usual and customary charge for this particular service must not be more than the provider would charge a private-pay patient or another payer.

Valid ICD-9-CM diagnosis codes must be used for dates of service on or before September 30, 2014. For dates of service October 1, 2014 and after, ICD-10-CM diagnosis codes must be used. Failure to use valid diagnosis and procedure codes will result in claims being denied. **Note: DSM codes are not valid in the Medicaid claims processing system.**

Physician Services

Reimbursement for mental health services will be in accordance with the RBRVS schedule established by the Department. Claims must be submitted on a CMS-1500 form.

For assistance completing the CMS-1500, call Provider Relations or refer to:
<http://medicaidprovider.hhs.mt.gov/pdf/npionlyclaiminstructions1500.pdf>

Psychiatrists

Physicians who practice psychiatry must be board certified or board eligible and licensed by the State of Montana or in the state where they maintain their practice and enrolled as a psychiatrist with Montana Medicaid.

Reimbursement for mental health services will be in accordance with the RBRVS schedule established by the Department. Claims must be submitted on a CMS-1500 form.

For assistance completing a CMS-1500, call Provider Relations or refer to
<http://medicaidprovider.hhs.mt.gov/pdf/npionlyclaiminstructions1500.pdf>.

Mid-Level Practitioners

Reimbursement for mental health services will be in accordance with the RBRVS schedule established by the Department. Claims must be submitted on a CMS-1500 form. Refer to the *Physician-Related Services* manual for additional billing instructions.

For assistance completing a CMS-1500, call Provider Relations or refer to
<http://medicaidprovider.hhs.mt.gov/pdf/npionlyclaiminstructions1500.pdf>.

Psychologist Services

Psychologist services are those services provided by a licensed psychologist that are within the scope of the practices of the profession as provided for in Title 37, Chapter 17, of Montana Code Annotated (MCA).

Psychologists are required to bill on a CMS-1500 form using current CPT codes for services.

Reimbursement for mental health services will be in accordance with the RBRVS schedule established by the Department. Claims must be submitted on a CMS-1500 form. Refer to the *Physician-Related Services* manual for additional billing instructions.

For assistance completing a CMS-1500, call Provider Relations or refer to <http://medicaidprovider.hhs.mt.gov/pdf/npionlyclaiminstructions1500.pdf>.

Individual and family outpatient therapy is limited to a total of 24 sessions per year for individuals 18 years of age and older. To request additional sessions, contact Magellan Medicaid Administration at <https://montana.fhsc.com>. Click on the Providers tab, choose Adult Program, and the Forms link. Group therapy sessions are not counted in the limited sessions. A group may not have more than 8 patients.

Valid ICD-9-CM diagnosis codes must be used for dates of service on or before September 30, 2014. For dates of service October 1, 2014 and after, ICD-10-CM diagnosis codes must be used. Failure to use valid diagnosis and procedure codes will result in claims being denied. **Note: DSM codes are not valid in the Medicaid claims processing system.**

A family therapy session must not be billed under more than one family member's Medicaid number. The family member must be Medicaid eligible on the date of service.

Medicaid covers inpatient psychologist services as part of the inpatient payment rate in the following circumstances:

- a. When services are provided by psychologists who are employed by the hospital or under contract with the hospital involving consideration; and
- b. When services are part of discharge planning as required in 42 CFR 482.21(b) or other services, such as group therapy, which are required as part of licensure or certification of the hospital.

All other inpatient services provided by a psychologist are a benefit, up to the limits specified in this manual.

Licensed Clinical Social Worker (LCSW)

Those services provided by a LCSW that are within the scope of the practice of the profession as provided for in Title 37, Chapter 2, of the Montana Code Annotated (MCA).

Social workers will be required to bill on a CMS-1500 form using current CPT codes for services. Individual and family outpatient therapy is limited to a total of 24 sessions per year for individuals 18 years of age and older. To request additional sessions, contact Magellan Medicaid Administration at <https://montana.fhsc.com>. Click on the Providers tab, choose Adult Program, and choose the Forms link. Group therapy sessions are not counted in the limited sessions. A group may not have more than 8 patients.

Valid ICD-9-CM diagnosis codes must be used for dates of service on or before September 30, 2014. For dates of service October 1, 2014 and after, ICD-10-CM diagnosis codes must be used. Failure to use valid diagnosis and procedure codes will result in claims being denied. **Note: DSM codes are not valid in the Medicaid claims processing system.**

Reimbursement for mental health services will be in accordance with the RBRVS schedule established by the Department. Claims must be submitted on a CMS-1500 form. Refer to the *Physician-Related Services* manual for additional billing instructions.

For assistance completing the CMS-1500, call Provider Relations or refer to <http://medicaidprovider.hhs.mt.gov/pdf/npionlyclaiminstructions1500.pdf>

A family therapy session must not be billed under more than one family member's Medicaid number. The family member must be Medicaid eligible on the date of service.

Medicaid covers inpatient social worker services as part of the inpatient payment rate in the following circumstances:

- a. When services are provided by a social workers who is employed by the hospital or under contract with the hospital involving consideration; and
- b. When services are part of discharge planning as required in 42 CFR 482.21(b) or other services, such as group therapy, which are required as part of licensure or certification of the hospital.

All other inpatient services provided by a social worker are a benefit, up to the limits specified in this manual.

Licensed Clinical Professional Counselor (LCPC)

Licensed clinical professional counselor (LCPC) services are those services provided by an LCPC which are within the scope of the practices of the profession as provided for in Title 37, Chapter 23, Montana Code Annotated (MCA).

Professional counselors will be required to bill on a CMS-1500 form using current CPT codes for services.

For assistance completing the CMS-1500, call Provider Relations or refer to <http://medicaidprovider.hhs.mt.gov/pdf/npionlyclaiminstructions1500.pdf>.

Individual and family outpatient therapy is limited to a total of 24 sessions per year for individuals 18 years of age and older. To request additional sessions, contact Magellan Medicaid Administration at <https://montana.fhsc.com>. Click on the Providers tab, choose Adult Program, and choose the Forms link. Group therapy sessions are not counted in the limited sessions. A group may not have more than 8 patients.

Valid ICD-9-CM diagnosis codes must be used for dates of service on or before September 30, 2014. For dates of service October 1, 2014 and after, ICD-10-CM diagnosis codes must be used. Failure to use valid diagnosis and procedure codes will result in claims denial. **Note: DSM codes are not valid in the Medicaid claims processing system.**

Reimbursement for mental health services will be in accordance with the RBRVS schedule established by the Department. Claims must be submitted on a CMS-1500 form. Refer to the *Physician-Related Services* manual for additional billing instructions.

For assistance completing the CMS-1500, call Provider Relations or refer to <http://medicaidprovider.hhs.mt.gov/pdf/npionlyclaiminstructions1500.pdf>.

A family therapy session must not be billed under more than one family member's Medicaid number. The family member must be Medicaid-eligible on the date of service.

Medicaid covers inpatient professional counselor services as part of the inpatient payment rate in the following circumstances:

- a. When services are provided by a professional counselor who is employed by the hospital or under contract with the hospital involving consideration; and
- b. When services are part of discharge planning as required in 42 CFR 482.21(b) or other services, such as group therapy, which are required as part of licensure or certification of the hospital.

All other inpatient services provided by a professional counselor are a benefit, up to the limits specified in this manual.

Inpatient Psychiatric Services (for persons age 18 to age 21)

Inpatient Psychiatric Hospitalization

Inpatient psychiatric services are services provided in an inpatient hospital facility.

Certificate of Need and Prior Authorization

Certificate of Need – Requirements

A certificate of need (CON) that complies with the requirements of 42 CFR, Part 441, Subpart D must be completed for all Medicaid beneficiaries under age 21 who request inpatient psychiatric services. A team specified in 42 CFR, Part 441.154 must certify that:

- a. Ambulatory care resources available in the community do not meet the treatment needs of the member;
- b. Proper treatment of the member's psychiatric condition requires services on an inpatient basis under the direction of a physician; and
- c. The services can reasonably be expected to improve the member's condition or prevent further regression so that services will no longer be needed.

Certificate of Need – Signature and Date

For individuals under age 21 determined to be Medicaid-eligible at the time of admission, the certificate of need must be completed, signed by team members, and dated prior to but no more than 30 days before admission. For emergency admissions, the certification must be made by the team responsible for the plan of care within 14 days after admission.

For members determined to be Medicaid-eligible by the Department after admission to or discharge from the facility, the certificate of need must be completed, signed, and dated within 14 days after the eligibility determination for members determined eligible during the stay in the facility, or 90 days after the eligibility determination for members determined eligible after discharge from the facility.

Prior authorization is required prior to the member's admission to inpatient psychiatric services. Authorization must be obtained from Magellan Medicaid Administration Services.

Billing/Reimbursement

Payment for inpatient psychiatric services provided outside the state of Montana will be made only under the conditions specified in ARM 37.86.2801. Reimbursement for inpatient psychiatric services provided to Montana Medicaid members in facilities located outside the state of Montana will be as provided in ARM 37.86.2947.

Claims must be submitted on a UB-04 form.

For assistance completing the UB-04 claim form, call Provider Relations or refer to <http://medicaidprovider.hhs.mt.gov/pdf/npionlyclaiminstructions.pdf>.

The day of discharge is not a patient day for purposes of reimbursement.

Targeted Case Management for Adults with Severe and Disabling Mental Illness (SDMI)

Targeted case management services for adults (age 18 and older) with SDMI are case management services provided by a licensed mental health center in accordance with these rules and the provisions of Title 50, Chapter 5, Part 2, MCA.

A member may temporarily receive case management services from more than one case management provider. Refer to ARM 37.86.3305 for the criteria.

Definition

Targeted case management is defined as services that assist individuals eligible in gaining access to needed, medical, educational and other services.

Covered Services and Requirements

Case management activities for adults with severe and disabling mental illness include the following assistance:

- a. Comprehensive assessment and reassessment at least once every 90 days of an eligible member to determine service needs, including activities that focus on needs identification determination of the need for any medical, educational, social, or other services. These assessment activities include the following:
 - (i) Taking member history;
 - (ii) Identifying the needs of the individual, and completing related documentation; and
 - (iii) Gathering necessary information from other sources, such as family members, medical providers, social workers, and educators, if necessary, to make a complete assessment of the eligible member.
- b. Development (and periodic revision) of a specific care plan based on the information collected through the assessment that:

- (i) Specific goals and actions to address the medical, social and educational, and other services needed by the eligible member;
 - (ii) Includes activities such as ensuring the active participation of the eligible member and working with the member (or the member’s authorized health care decision maker) and others to develop those goals; and
 - (iii) Identifies a course of action to respond to the assessed needs of the eligible member.
- c. Referral and related activities (such as making referrals and scheduling appointments for the member) to help the eligible member obtain needed services, including activities to help link the member with medical, social and educational providers, or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan; and
- d. Monitoring and follow-up activities, including activities and contacts to ensure that the care plan is effectively implemented and addresses the needs of the eligible member. Activity may be with the member, family members, service providers, or other entities or members and conducted as frequently as necessary, and at least once every 90 days, to help determine whether the following conditions are met:
- (i) Services are being furnished in accordance with the member’s care plan;
 - (ii) Services in the care plan are adequate to meet the needs of the member;
 - (iii) There are changes in the needs or status of the eligible member. Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.
- e. Case management may include contacts with non-eligible members that are directly related to the identification of the eligible member’s needs and care, for the purpose of helping the eligible member access services, identifying needs and supports to assist the eligible member in obtaining services, providing case managers with useful feedback, alerting case managers to changes in the eligible member's needs, and averting crisis.
- f. Case management does not include the:
- Non-Medicaid individuals can receive outreach, application, and referral activities; however, these activities are not allowable as case management services, rather they are an administrative function.
 - Direct medical services including counseling or the transportation or escort of consumers;
 - Duplicate payments that are made to public agencies or private entities under the State Plan and other program authorities;
 - The writing, recording, or entering case notes for the consumer’s file;
 - Coordination of the investigation of any suspected abuse, neglect, and/or exploitation cases;
 - Travel to and from member activities; and
 - Any service less than 8 minutes duration if it is the only service provided that day and any service that does not incorporate the allowable targeted case management components, even if written into the individualized care plan.

Provider Requirements

All providers of service must maintain records which fully demonstrate the extent, nature, and medical necessity of services and items provided to Montana Medicaid members. The records must support the fee charged or payment sought for the services and items and demonstrate compliance with all applicable requirements.

TCM for adults with SDMI must be provided by a licensed MHC with a license endorsement permitting the MHC to provide TCM. Licensed MHCs that have an endorsement to provide TCM services must

enroll with Xerox as a TCM provider of mental health services before any case management claims can be paid. MHCs providing TCM services to adults with SDMI must have a program supervisor and employ case managers who have a Bachelor’s degree in a human services field with at least one year of full-time experience serving individuals with SDMI. Individuals with other educational background, who have developed the necessary skills, may also be employed as case managers. The MHC’s case management position description must contain equivalency provisions. The availability of case management services may not be made contingent upon a member’s willingness to receive other services.

Billing/Reimbursement

TCM services for adults with SDMI will be reimbursed according to the Department’s fee schedule.

The Montana Medicaid program will not pay more than one provider for intensive case management services for the same period of time for the same member.

Case managers must inform eligible individuals they have the right to refuse case management at the time of eligibility determination and annually thereafter at the time of reassessment; and providers must document in the case record that the individual has been informed and if the individual has refused services.

All providers of service must maintain records which fully demonstrate the extent, nature, and medical necessity of services and items provided to members. The records must support the fee charged or payment sought for the services and items and demonstrate compliance with all applicable requirements. The amount, duration, and scope of the case management activities must be documented in an member’s plan of care which includes case management activities prior to and post-discharge, to facilitate a successful transition to the community.

The Department will pay the lower of the provider’s actual submitted charge or the Department’s fee schedule for case management services for adults with SDMI.

Case management services for adults will be reimbursed under the following procedure code by Montana Medicaid. They must be billed on the CMS-1500:

Procedure	Modifier	Service
T1016	HB	Targeted case management—Adult, 15 minute unit

For assistance completing the CMS-1500, call Provider Relations or refer to <http://medicaidprovider.hhs.mt.gov/pdf/npionlyclaiminstructions1500.pdf>:

Valid ICD-9-CM diagnosis codes must be used for dates of service on or before September 30, 2014. For dates of service October 1, 2014 and after, ICD-10-CM diagnosis codes must be used. Failure to use valid diagnosis and procedure codes will result in claims denial. **Note: DSM codes are not valid in the Medicaid claims processing system.**

Pharmacy Services

Medicaid Pharmacy Program

There is no change in processing pharmacy claims for Medicaid-eligible members. Refer to the current Medicaid *Prescription Drug Program* manual for billing and reimbursement instructions.

To request prior authorization, providers must submit the information asked for on the Request for Medicaid Drug Prior Authorization form to the Drug Prior Authorization Unit.

The prescriber (e.g., physician) or pharmacy provider may submit requests by mail, telephone, or fax to:

Drug Prior Authorization Unit
Mountain-Pacific Quality Health
3404 Cooney Drive
Helena, MT 59602
406-443-6002 or 1-800-395-7961 (Phone)
406-513-1928 or 1-800-294-1350 (Fax)

Requests will be reviewed and approvals or denials will be made, in most cases, immediately. Decisions on requests requiring further peer review because of unusual or special circumstances will be made within 24 hours. Requests received after the PA Unit's regular working hours of 8 a.m. to 5 p.m., Monday through Friday or on weekends or holidays will be considered to be received at the start of the next working day.

If an after-hours, weekend, or holiday request is for an emergency situation, an emergency 72-hour supply may be dispensed by using 3 in the Days Supply field and Medical Certification Code 8 in the PA/MC code field. Payment will be authorized for these emergency supplies.

To receive payment for drugs requiring prior authorization, pharmacies must obtain approval from the Drug Prior Authorization Unit prior to dispensing the drug.

Coverage

Prescriptions are limited to a 34-day supply. Refills may be dispensed after 75% of a previous dispensing of the same prescription has been used, if taken according to the doctor's orders. Exceptions to this refill rule must be authorized by the Department.

Reimbursement

Reimbursement information is available in the *Prescription Drug Program* manual.

Billing

Billing information is available in the *Prescription Drug Program* manual. If you have questions or experience problems, call Xerox Provider Relations:

1-800-624-3958 (In/Out of state)
406-442-1837 (Helena)

Copayment

Preferred generic drugs
Preferred brand drugs only with generic available
Brand name drugs with no generic
Generic non-preferred
Non-preferred brand
No copayment for Clozaril and Clozapine

The Medicaid copayments are 5% of the allowable amount between \$1 and \$5 with a maximum cost share of \$5 per prescription, and \$25 per month.

Preferred products are drugs listed on the formulary for which the State of Montana has a rebate agreement with the drug manufacturer.

Indian Health Service (IHS)

Indian Health Service providers may be reimbursed for mental health services for Medicaid members. Indian Health Service providers should bill using the mental health encounter **Revenue Code 513** or the inpatient physician services **Revenue Code 987**.

Federally Qualified Health Centers (FQHCs)

FQHC mental health services are a core service. FQHC providers bill using core services **Revenue Code 900** for mental health services provided to Medicaid members.

Rural Health Clinics (RHCs)

RHC mental health services are a core service. RHC providers bill using core services **Revenue Code 900** for mental health services provided to Medicaid members.

Non-Covered Services

Experimental or investigational services are not covered by Montana Medicaid.

Other Services

Programs listed below will be billed and reimbursed according to their respective manuals for Medicaid eligible members:

- Ambulance
- Ambulatory Surgical Centers
- Audiology
- Case Management (Non-Mental Health)
- Dental
- Denturist
- Durable Medical Equipment
- Eyeglasses
- Hearing Aids
- Home and Community-Based Services
- Home Health
- Hospice
- Inpatient Hospital
- Laboratory and X-Ray
- Non-Emergency Transportation
- Nursing Facility
- Optometric
- Outpatient Hospital – Emergency Room
- Personal Care
- Physical Therapy
- Podiatry
- Private Nursing
- Public Health Clinics
- QMB Chiropractor
- Speech Pathology
- Swing Bed Hospital
- Transportation & Per Diem

Appendix A: Definitions and Acronyms

This section contains definitions, abbreviations, and acronyms used in this manual.

270/271 Transactions

The ASC X12N eligibility inquiry (270) and response (271) transactions.

276/277 Transactions

The ASC X12N claim status request (276) and response (277) transactions.

278 Transactions

The ASC X12N request for services review and response used for prior authorization.

835 Transactions

The ASC X12N payment and remittance advice (explanation of benefits) transaction.

837 Transactions

The ASC X12N professional, institutional, and dental claim.

Accredited Standards Committee X12, Insurance Subcommittee (ASC X12N)

The ANSI-accredited standards development organization, and 1 of the 6 designated standards maintenance organizations (DSMO), that created and is tasked with maintaining the administrative and financial transactions standards adopted under HIPAA for all health plans, clearinghouses, and providers who use electronic transactions.

Administrative Rules of Montana (ARM)

The rules published by the executive departments and agencies of the state government.

Adult

A person who is 18 years or older. (Note: Children's Mental Health continues to

cover a person 18–21 who is enrolled in secondary school.)

Adult Day Treatment

A program that, in accordance with mental health center license requirements, provides a variety of mental health services to adults with severe disabling mental illness.

Allowed Amount

The maximum amount reimbursed to a provider for a health care service as determined by Medicaid or another payer. Other cost factors (such as cost sharing, TPL, or incurment) are often deducted from the allowed amount before final payment. Medicaid's allowed amount for each covered service is listed on the Department fee schedule.

Ancillary Provider

Any provider who is subordinate to the member's primary provider or is providing services in the facility or institution that has accepted the member as a Medicaid member.

Assignment of Benefits

A voluntary decision by the member to have insurance benefits paid directly to the provider rather than to the member. The act requires the signing of a form for the purpose. The provider is not obligated to accept an assignment of benefits. However, the provider may require assignment in order to protect the provider's revenue.

Authorization

An official approval for action taken for, or on behalf of, a Medicaid member. This approval is only valid if the member is eligible on the date of service.

Basic Medicaid

Patients with Basic Medicaid have limited Medicaid services. See the *General Information for Providers* manual, Medicaid Covered Services chapter.

Cash Option

Cash option allows the member to pay a monthly premium to Medicaid and have Medicaid coverage for the entire month rather than a partial month.

Centers for Medicare and Medicaid Services (CMS)

Administers the Medicare program and oversees the state Medicaid programs.

Clean Claim

A claim that can be processed without additional information from or action by the provider of the service.

Code of Federal Regulations (CFR)

Rules published by executive departments and agencies of the federal government.

Coinsurance

The member's financial responsibility for a medical bill as assigned by Medicaid or Medicare (usually a percentage). Medicaid coinsurance is usually 5 percent of the Medicaid allowed amount, and Medicare coinsurance is usually 20 percent of the Medicare allowed amount.

Community-Based Psychiatric Rehabilitation and Support

Services provided in home, school, workplace, and community settings for adults with severe and disabling mental illness and youth with serious emotional disturbance.

Services are provided by trained mental health personnel under the direction of and according to individualized treatment plans prepared by licensed professionals. The services are provided outside of normal clinical or mental health program settings and

are designed to assist individuals in developing the skills, behaviors, and emotional stability necessary to live successfully in the community.

Community-based psychiatric rehabilitation and support services are provided on a face-to-face basis with the member, family members, teachers, employers or other key individuals in the member's life when such contacts are clearly necessary to meet goals established in the member's individual treatment plan.

Continuity of Care Payment

An annual payment made to qualifying hospital-based residential treatment facilities according to the eligibility criteria and payment calculation methodology in ARM 37.88.1137.

Conversion Factor

A state-specific dollar amount that converts relative values into an actual fee. This calculation allows each payer to adopt the RBRVS to its own economy.

Copayment

The member's financial responsibility for a medical bill as assigned by Medicaid (usually a flat fee).

Cost Sharing

The member's financial responsibility for a medical bill assessed by flat fee or percentage of charges.

Crisis Intervention Services

A program that, in accordance with mental health center license requirements, provides emergency short-term 24-hour care, treatment and supervision in a crisis intervention stabilization facility for persons age 18 or older with mental illness experiencing a mental health crisis.

Crossovers

Claims for members who have both Medicare and Medicaid. These claims may come electronically from Medicare or directly from the provider.

Dialectical Behavior Therapy (DBT)

A treatment designed specifically for individuals with self-harm behavior, such as self-cutting, suicide thoughts, urges to suicide, and suicide attempts. It is based on a bio-social theory that states that problems develop from the interaction of biological factors (physiological makeup) and environmental factors (learning history), which together create difficulty managing emotions. Core treatment techniques are problem solving, exposure techniques, skills training, contingency management, and cognitive modification. The four primary modes of treatment are individual therapy, group skills training, and phone coaching, along with therapist consultation.

Department

The Montana Department of Public Health and Human Services or its agents, including but not limited to parties under contract to perform audit services, claim processing, and utilization review.

DPHHS, State Agency

The Montana Department of Public Health and Human Services (DPHHS or Department) is the designated State Agency that administers the Medicaid program. The Department's legal authority is contained in Title 53, Chapter 6, MCA. At the Federal level, the legal basis for the program is contained in Title XIX of the Social Security Act and Title 42 of the Code of Federal Regulations (CFR). The program is administered in accordance with the Administrative Rules of Montana (ARM), Title 37, Chapter 86.

Dual Eligibles

Members who are covered by Medicare and Medicaid are often referred to as "dual eligibles."

Emergency Services

Those services which are required to evaluate and stabilize a medical condition manifesting itself by acute symptoms of sufficient severity (including pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or unborn child) in serious jeopardy, serious impairment to bodily function or serious dysfunction of any bodily organ or part.

Experimental

A noncovered item or service that researchers are studying to investigate its effect on health.

Fiscal Agent

Xerox State Healthcare, LLC, is the fiscal agent for the State of Montana and processes claims at the Department's direction and in accordance with ARM 37.86 et seq.

Foster Care for Adults with Severe Disabling Mental Illness

A supervised living environment in a licensed foster home with support services by mental health professionals.

Full Medicaid

Patients with Full Medicaid have a full scope of Medicaid benefits. See the *General Information for Providers* manual, Medicaid Covered Services.

Gross Adjustment

A lump sum debit or credit that is not claim specific made to a provider.

Hospital

A facility licensed, accredited or approved under the laws of Montana or a facility

operated as a hospital by the State that provides, by or under the supervision of licensed physicians, services for the diagnosis, treatment, rehabilitation, and care of persons with mental disease.

Illness Management and Recovery

An evidence-based practice that gives consumers information about mental illnesses and coping skills to help them manage their illness, develop goals, and make informed decisions about their treatment.

Indian Health Service (IHS)

IHS provides health services to American Indians and Alaska Natives.

Individual Adjustment

A request for a correction to a specific paid claim.

Inpatient Hospital Psychiatric Care

Hospital-based active psychiatric treatment provided under the direction of a physician.

Institution for Mental Diseases

A hospital, nursing facility, or other institution with more than 16 beds which the Department has determined is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services.

An institution for the mentally retarded, including an intermediate care facility for the mentally retarded, is not an institution for mental diseases.

An institution for mental diseases is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such.

In making a determination of whether an institution is an institution for mental

diseases, the Department shall consider the guidelines set forth in Subsection C of Section 4390 of the State Medicaid manual, but no single guideline or combination of guidelines shall necessarily be determinative.

Intensive Community-Based Rehabilitation Facility

An adult mental health group home that provides medically necessary rehabilitation services to adults with severe and disabling mental illness who have a history of institutional placements due to mental illness and a history of repeated unsuccessful placements in less intensive community-based programs.

In-Training Practitioner Services

Services provided under the supervision of a licensed practitioner by an individual who has completed all academic requirements for licensure as a psychologist, clinical social worker, or licensed professional counselor, and is in the process of completing the supervised experience requirement for licensure.

The in-training practitioner services must be supervised by a licensed practitioner in the same field, and, other than licensure, the services are subject to the same requirements that apply to licensed practitioners. In-training practitioner services are only available through licensed mental health centers.

Investigational

A noncovered item or service that researchers are studying to investigate how it affects health.

Mass Adjustment

Request for a correction to a group of claims meeting specific defined criteria.

Medicaid

A program that provides health care coverage to specific populations, especially low-income families with children, pregnant women,

disabled people, and the elderly. Medicaid is administered by state governments under broad Federal guidelines.

Medically Necessary

A term describing a requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the member.

These conditions must be classified as one of the following: endanger life, cause suffering or pain, result in an illness or infirmity, threaten to cause or aggravate a handicap, or cause physical deformity or malfunction.

There must be no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the member requesting the service. For the purpose of this definition, course of treatment may include mere observation or, when appropriate, no treatment at all.

Medicare

The federal health insurance program for certain aged or disabled members.

Member

An individual enrolled in a Department medical assistance program.

Mental Health Center Services

Adult day treatment services, community-based psychiatric rehabilitation and support respite care, in-training practitioner services and the therapeutic component of crisis intervention services, foster care for mentally ill adults, and mental health group home services and programs of assertive community treatment, as defined in ARM 37.88.901.

Mental Disease

A disease listed as a mental disorder in the current edition of the Diagnostic and Statistical Manual of Mental Diseases but

does not include mental retardation, senility and organic brain syndrome.

Mental Health Group Home Services

A supported living environment provided under a group home endorsed mental health center license and providing independent living and social skills development services.

Mental Health Services Plan (MHSP)

This plan is for individuals who have a severe and disabling mental illness (SDMI), are ineligible for Medicaid, and have a family income that does not exceed an amount established by the Department.

Montana Access to Health (MATH) Web Portal

A secure website on which providers may view members' medical history, verify member eligibility, submit claims to Medicaid, check the status of a claim, verify the status of a warrant, and download remittance advice reports.

Nursing Facility Services

Services defined in ARM 37.40.302, but not including intermediate care facility services for the mentally retarded.

Passport to Health

A Medicaid primary care case management program where the member selects a primary care provider who manages the member's health care needs.

Patient Contribution

The total of all of a resident's income from any source available to pay the cost of care, less the resident's personal needs allowance. The patient contribution includes a resident's incurment determined in accordance with applicable eligibility rules.

Patient Day

A whole 24-hour period in which a person is present and receiving inpatient psychiatric services or nursing facility services,

regardless of payment source. Even though a person may not be present for a whole 24-hour period on the day of admission or the day of death, such day will be considered a patient day. Subject to the limitations and requirements of ARM 37.88.1106, therapeutic home leave days are patient days. The day of discharge is not a patient day for purposes of reimbursement.

Practitioner

A physician, mid-level practitioner, licensed psychologist, licensed clinical social worker or licensed professional counselor.

Practitioner Services

Services provided by a practitioner which could be covered and reimbursed by the Montana Medicaid program if the individual practitioner were enrolled in the program and provided the services according to applicable Medicaid requirements.

Prior Authorization (PA)

The approval process required before certain services or supplies are paid by Medicaid. Prior authorization must be obtained before providing the service or supply.

Private-Pay

When a member chooses to pay for medical services out of his or her own pocket.

Program of Assertive Community Treatment (PACT)

A self-contained clinical team which:

- Provides needed treatment, rehabilitation and support services to identified members with severe disabling mental illness;
- Minimally refers members to outside service providers;
- Provides services on a long-term basis;
- Delivers 75% or more of team service time outside program offices;

- Serves individuals with severe disabling mental illness (SDMI) who are at least 18 years old, have severe symptoms and impairments not effectively treated by other available, less-intensive services, or who have a history of avoiding mental health services;
- Provides psychiatric services at the rate of at least 20 hours per week for each 70 persons served; and
- Maintains a ratio of at least 1 staff person, not including the psychiatrist, for each 9 persons served.

Assertive community treatment teams must be approved by the Addictive and Mental Disorders Division.

Provider or Provider of Service

An institution, agency, or person having a signed agreement with the Department to furnish medical care, goods, and/or services to members, and eligible to receive payment from the Department.

Qualified Medicare Beneficiary (QMB)

QMB members are members for whom Medicaid pays their Medicare premiums and some or all of their Medicare coinsurance and deductibles.

Reference Lab Billing

Reference lab billing occurs when a Medicaid provider draws a specimen and sends it to a reference lab for processing. The reference lab then sends the results back to the Medicaid provider. Medicaid does not cover lab services when they are billed by the referring provider.

Relative Value Scale (RVS)

A numerical scale designed to permit comparisons of appropriate prices for various services. The RVS is made up of the relative value units (RVUs) for all the objects in the class for which it is developed.

Relative Value Unit (RVU)

The numerical value given to each service in a relative value scale.

Remittance Advice

The results of claims processing (including paid, denied, and pending claims) are listed on the remittance advice.

Resident

A person admitted to the provider's facility who has been present in the facility for at least one 24-hour period.

Resource-Based Relative Value Scale (RBRVS)

A method of determining physicians' fees based on the time, training, skill, and other factors required to deliver various services.

Retroactive Eligibility

When a member is determined to be eligible for Medicaid effective prior to the current date.

Sanction

The penalty for noncompliance with laws, rules, and policies regarding Medicaid. A sanction may include withholding payment from a provider or terminating Medicaid enrollment.

Specified Low-Income Medicare Beneficiaries (SLMB)

For these members, Medicaid pays the Medicare premium only. They are not eligible for other Medicaid benefits, and must pay their own Medicare coinsurance and deductibles.

Spending Down

Members with high medical expenses relative to their income can become eligible for Medicaid by "spending down" their income to specified levels. The member is responsible for paying for services received before eligibility begins, and Medicaid pays for remaining covered services.

Targeted Case Management for Adults with Severe Disabling Mental Illness

Services that assist members eligible in gaining access to needed medical, social, educational, and other services.

Third Party Liability (TPL)

Any entity that is, or may be, liable to pay all or part of the medical cost of care for a Medicaid/HMK *Plus*, MHSP, or HMK/CHIP member.

Timely Filing

Providers must submit clean claims to Medicaid within:

- Twelve months from whichever is later:
 - ◆ the date of service
 - ◆ the date retroactive eligibility or disability is determined
- Six months from the date on the Medicare explanation of benefits approving the service
- Six months from the date on an adjustment notice from a third party payer who has previously processed the claim for the same service, and the adjustment notice is dated after the periods described above.

Treatment Day

A calendar day, including night, daytime or evening, during which a patient is present at the provider's facility and receiving services according to applicable requirements.

Usual and Customary

The fee that the provider most frequently charges the general public for a service or item.

WINASAP 5010

WINASAP 5010 is a Windows-based electronic claims entry application for Montana Medicaid. It was developed as an alternative to submitting claims on paper. For more information, contact the EDI Support Unit. (See Key Contacts.)

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