PROPOSED Medicaid Youth Mental Health Fee Schedule

~~July 1, 2021~~October 1, 2021

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. The conversion factor for psychologists, social workers, and professional counselors in calculating reimbursement rates can be found at 37.85.

The current RBRVS fee schedule is available at http://medicaidprovider.mt.gov/

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.

It is the responsibility of all providers to be familiar with the Children's Mental Health Bureau (CMHB) Medicaid Services Provider Manual, referenced in ARM 37.87.903, which includes medical necessity criteria, clinical guidelines and prior authorization information.

Distance providers should submit claims for telehealth services using the appropriate procedure code for the service along with the GT modifier (interactive communication). Telehealth guidelines are available at https://medicaidprovider.mt.gov/manuals/generalinformationforprovidersmanual

Children's Mental Health Medicaid services do not require co-pay.

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.

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

The following table summarizes services available through licensed mental health centers.
Note: Leave modifier blank on the claim where "No Modifier" is indicated.

Service	Procedure	Modifier 1	Modifier 2	Unit	Reimburse-ment	Unit Limits
Non Medicaid Respite Care – Youth	S5150	HA	No Modifier	15 min.	$2.76	Up to 24 units/24 hrs and 48 units/mo
Youth Day Treatment	H2012	HA	No Modifier	Hour	$11.71	6 hours/day
Community-based psychiatric rehabilitation & support – individual	H2019	HA	No Modifier	15 min.	$7.25	None
Community-based psychiatric rehabilitation & support – group	H2019	No Modifier	No Modifier	15 min.	$2.17	2 hours per day
Comprehensive School and Community Treatment (CSCT)	H0036	No Modifier	No Modifier	~~15 min.~~ Day	~~$17.85~~ $96.00	~~720 units/mo per Team. CSCT and CSCT IAR combined are limited to 720 Units/Month per Team.~~ For limits, please refer to the Children's Mental Health Medicaid Services Provider Manual

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Service	Procedure	Modifier 1	Modifier 2	Unit	Reimburse-ment	Unit Limits
Comprehensive School and Community Treatment (CSCT) Frontier Differential*	H0036	~~No Modifier~~ TN	No Modifier	~~15 min.~~ Day	~~$17.85~~ $110.40	~~720 units/mo per Team. CSCT and CSCT IAR combined are limited to 720 Units/Month per Team.~~ For limits, please refer to the Children's Mental Health Medicaid Services Provider Manual
CSCT Intervention, Assessment and Referral (IAR)	H2027	No Modifier	No Modifier	~~15 min.~~ Day	~~$17.85~~ $96.00	~~20 Units/youth per SFY. CSCT and CSCT IAR combined are limited to 720 Units/Month per Team.~~ For limits, please refer to the Children's Mental Health Medicaid Services Provider Manual
CSCT Intervention, Assessment and Referral (IAR)	H2027	~~No Modifier~~ TN	No Modifier	~~15 min.~~ Day	~~$17.85~~ $110.40	~~20 Units/youth per SFY.~~

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Service	Procedure	Modifier 1	Modifier 2	Unit	Reimburse-ment	Unit Limits
Frontier Differential*						~~CSCT and CSCT IAR combined are limited to 720 Units/Month per Team.~~ For limits, please refer to the Children's Mental Health Medicaid Services Provider Manual

IV. Therapeutic Youth Group Home Services

This table summarizes Therapeutic Group Home services available to Medicaid beneficiaries.
Note: Leave modifier blank on the claim where "No Modifier" is indicated.

Service	Procedure	Modifier 1	Modifier 2	Unit	Reimburse-ment	Limits
Therapeutic Youth Group Home	S5145	No Modifier	No Modifier	Day	$201.82	Prior Authorized
Therapeutic Youth Group Home Therapeutic home leave	S5145	U5	No Modifier	Day	$201.82	14 days/year
Extraordinary Needs Aide Services	H2019	TG	No Modifier	15 min.	$4.07	Prior Authorized

V. 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.
Note: Leave modifier blank on the claim where "No Modifier" is indicated.

Service	Procedure	Modifier 1	Modifier 2	Unit	Reimburse-ment	Limits
Home Support Services	H2020	No Modifier	No Modifier	15 min.	$18.69	None
Home Support Services Frontier Differential*	H2020	TN	No Modifier	15 min	$21.49	None
Therapeutic Foster Care	S5145	HR	No Modifier	Day	$50.91	None
Permanency Therapeutic Foster Care	S5145	HE	No Modifier	Day	$140.90	None

*For a listing of frontier and non-frontier counties please see the Children's Mental Health Medicaid Services Provider Manual

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VI. Partial Hospitalization

This table summarizes partial hospitalization services available to Medicaid beneficiaries.
Note: Leave modifier blank on the claim where "No Modifier" is indicated.

Service	Procedure	Modifier 1	Modifier 2	Unit	Reimburse-ment	Limits
Acute Partial Hospitalization Full day	H0035	U8	No Modifier	Full Day	$175.86	Prior Authorized
Acute Partial Hospitalization Half day	H0035	U7	No Modifier	Half Day	$131.89	Prior Authorized
Sub-acute Partial Hospitalization Full day	H0035	U6	No Modifier	Full Day	$111.70	Prior Authorized
Sub-acute Partial Hospitalization Half day	H0035	No Modifier	No Modifier	Half Day	$83.77	Prior Authorized

VII. In-State and Out of State Psychiatric Residential Treatment Facility (PRTF) Services

This table summarizes PRTF services available to Medicaid beneficiaries.
Note: Leave modifier blank on the claim where "No Modifier" is indicated.

Service	Procedure	Modifier 1	Modifier 2	Unit	Reimburse-ment	Limits
In-State PRTF	Revenue Code 124	No Modifier	No Modifier	Day	$339.88	Prior Authorized
In-State PRTF Therapeutic Home Visit	Revenue Code 183	No Modifier	No Modifier	Day	$339.88	14 days/year
In-State PRTF Assessment Services	Revenue Code 220	No Modifier	No Modifier	Day	$390.86	Prior Authorized
Out of State PRTF Services	Revenue Code 124	No Modifier	No Modifier	Day	50% of usual and customary charges	Prior Authorized Payment not to exceed 133% of in-state PRTF rate
Out of State Therapeutic Home Visit	Revenue Code 183	No Modifier	No Modifier	Day	50% of usual and customary charges	Prior Authorized Payment not to exceed 133% of in-state PRTF rate