

Proposed Medicaid Youth Mental Health Fee Schedule

July 1, 2022January 1, 2023

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 | Reimbursement | 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 | \$11.83 | 6 hours/day |
| Community-based psychiatric rehabilitation & support – individual | H2019 | HA | No Modifier | 15 min. | \$7.32 | None |
| Community-based psychiatric rehabilitation & support – group | H2019 | No Modifier | No Modifier | 15 min. | \$2.19 | 2 hours per day |
| Comprehensive School and Community Treatment (CSCT) | H0036 | No Modifier | No Modifier | Day | \$96.96 | For limits, please refer to the Children’s Mental Health Medicaid Services Provider Manual |
| Comprehensive School and Community Treatment (CSCT) Frontier Differential* | H0036 | TN | No Modifier | Day | \$111.50 | 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 | Reimbursement | Unit Limits |
|---|--------------|--------------------|--------------------|------------|----------------|--|
| CSCT Intervention, Assessment and Referral (IAR) | H2027 | No Modifier | No Modifier | Day | \$96.96 | For limits, please refer to the Children's Mental Health Medicaid Services Provider Manual |
| CSCT Intervention, Assessment and Referral (IAR) Frontier Differential* | H2027 | TN | No Modifier | Day | \$111.50 | For limits, please refer to the Children's Mental Health Medicaid Services Provider Manual |
| <u>Intensive Outpatient Psychiatric Therapy</u> | <u>S9480</u> | <u>No Modifier</u> | <u>No Modifier</u> | <u>Day</u> | <u>\$98.55</u> | <u>Within 8-week span</u> |

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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 | Reimbursement | Limits |
|--|-----------|-------------|-------------|---------|---------------|------------------|
| Therapeutic Youth Group Home | S5145 | No Modifier | No Modifier | Day | \$203.84 | Prior Authorized |
| Therapeutic Youth Group Home Therapeutic home leave | S5145 | U5 | No Modifier | Day | \$203.84 | 14 days/year |
| Extraordinary Needs Aide Services | H2019 | TG | No Modifier | 15 min. | \$4.11 | 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 | Reimbursement | Limits |
|--|-----------|-------------|-------------|---------|---------------|--------|
| Home Support Services | H2020 | No Modifier | No Modifier | 15 min. | \$18.88 | None |
| Home Support Services Frontier Differential* | H2020 | TN | No Modifier | 15 min | \$21.70 | None |
| Therapeutic Foster Care | S5145 | HR | No Modifier | Day | \$51.42 | None |
| Permanency Therapeutic Foster Care | S5145 | HE | No Modifier | Day | \$142.31 | 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 | Reimbursement | Limits |
|---|-----------|-------------|-------------|----------|---------------|------------------|
| Acute Partial Hospitalization Full day | H0035 | U8 | No Modifier | Full Day | \$175.85 | 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 | Reimbursement | Limits |
|--------------------------------------|------------------|-------------|-------------|------|------------------------------------|--|
| In-State PRTF | Revenue Code 124 | No Modifier | No Modifier | Day | \$343.28 | Prior Authorized |
| In-State PRTF Therapeutic Home Visit | Revenue Code 183 | No Modifier | No Modifier | Day | \$343.28 | 14 days/year |
| In-State PRTF Assessment Services | Revenue Code 220 | No Modifier | No Modifier | Day | \$394.77 | 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 |

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VIII. Mobile Crisis Response Team Services

Mobile Crisis Response Services must be provided by a program that is approved by the department and enrolled in Montana Medicaid as a crisis provider.

| Service | Procedure | Modifier 1 | Modifier 2 | Unit | Reimburse- ment | Limits |
|--|--------------|---------------|------------------------|-------------------|--------------------|-------------|
| <u>American Rescue Plan Act (ARPA) Mobile Crisis Response Model (24/7)</u> | <u>H2011</u> | <u>U1</u> | <u>No Modifier</u> | <u>15 min</u> | <u>\$105.62</u> | <u>None</u> |
| <u>Mobile Crisis Team Services (12/7)</u> | <u>H2011</u> | <u>U2</u> | <u>No Modifier</u> | <u>15 min</u> | <u>\$51.42</u> | <u>None</u> |
| <u>Mobile Crisis Services (12/7)</u> | <u>H2011</u> | <u>U3</u> | <u>No Modifier</u> | <u>15 min</u> | <u>\$35.73</u> | <u>None</u> |