Licensed Mental Health Outpatient Psychotherapy (OP)

Behavioral Health and Developmental Disabilities Division

of Montana Medicaid

February 17, 2022

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Behavioral Health and Developmental Disabilities Division

- Children's Mental Health Bureau
- Substance Use Disorder & Adult Mental Health Treatment Bureau

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Outpatient Psychotherapy (OP)

- Individual, group, and family therapy
- Diagnosis, assessment, psychotherapy and related services
- Provided by a licensed mental health professional or an in-training mental health professional at a licensed mental health center.

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How does Montana Medicaid define a Mental Health Professional?

- According to the Administrative Rules of Montana (ARM):

  37.87.102(3) "Mental health professional" means one of the following practitioners:

  (a) physician;

  (b) licensed professional counselor;

  (c) licensed psychologist;

  (d) licensed clinical social worker;

  (e) licensed marriage and family therapist; or

  (f) advanced practice registered nurse, with a clinical specialty in psychiatric mental health nursing.

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OP for Youth with Serious Emotional Disturbance (SED) ARM 37.87.903

- For the first 24 sessions per state fiscal year (July 1 – June 30) the youth must have a recognized mental health diagnosis.
- Services that don't count toward the 24 sessions:
  - Psychiatric diagnostic or evaluative interview services
  - Group psychotherapy
  - Outpatient psychotherapy with evaluation and management (E/M) services
  - Pharmacological or medication management services
  - Central nervous system assessments/tests or psychological testing performed by a physician or psychologist
  - Outpatient therapy provided as part of CSCT services
  - Psychotherapy crisis codes

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OP for Youth with SED Continued

- For sessions in excess of 24 per state fiscal year:
  - Youth must meet SED criteria
  - A family-driven individualized treatment plan must be developed with achievable goals and measurable objectives
  - The youth and family must be invested in treatment and agree with the goals and objectives of the treatment plan.
  - Progress toward treatment goals has occurred as evidenced by a reduction of symptoms or behaviors that indicate responsiveness to treatment
  - A discharge plan must be developed and regularly reviewed and revised with specific target dates for meeting goals. It must also define criteria for concluding treatment.

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SED Criteria for Youth

A full list of qualifying SED is provided in the Children's Mental Health Bureau Medicaid Services Provider Manual, pages 13-16

- Youth aged six and older must:
  - Have been determined by a licensed mental health professional as having a mental disorder listed in the CMHB Medicaid Services Provider Manual; and
  - Meet functional impairment criteria as described in the CMHB Medicaid Services Provider Manual
- Youth under age six must:
  - Have a diagnosis or condition that may be a focus of clinical attention as listed in the current Diagnostic and Statistical Manual of Mental Disorders (DSM); and
  - Meet functional impairment criteria as described in the CMHB Medicaid Services Provider Manual

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Severe & Disabling Mental Illness Criteria-Adults

Adult Mental Health Policy 105 for reference

- Clinical Guidelines for Adult Mental Health Services:
  - Licensed clinical mental health provider must certify that the member continues to meet the criteria for having an SDMI annually.
  - The clinical assessment must be updated annually & must document how the member continues to meet the criteria for having an SDMI to continue to bill.
- SDMI criteria: (includes Diagnosis & Level Of Impairment)
  - Member must be 18 years or older; and
  - Presently or any time in the past 12 months had a diagnosable mental illness (see list in policy 105); and
  - Has significant difficulty in community living without supportive treatment/service of a long-term or indefinite duration as a result of members diagnosis.
  - The SDMI is chronic & persistent resulting in impaired functioning.

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SDMI Criteria-Adults (continued)

Adult Mental Health Policy 105 for reference

- A member who meets certain criteria is SDMI eligible, the provider does not need to complete the Level of Impairment (LOI) worksheet if:
  - Member has been involuntarily hospitalized for at least 30 consecutive days because of a mental disorder, at MSH or the MT Mental Health Nursing Care Center within the past 12 months, OR
  - The member has a diagnosis within the Schizophrenia Disorder Spectrum (see policy for list).
- If member does not meet criteria of involuntary hospitalization or diagnosis of Schizophrenia Disorder Spectrum:
  - Provider must complete the SDMI Eligibility AND LOI worksheet to determine is member meets the diagnostic & LOI criteria for SDMI designation. Worksheet: Forms and Applications (mt.gov)

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SDMI Criteria-Adults (continued)

Adult Mental Health Policy 105 for reference

- Provider must complete the SDMI Eligibility and LOI Worksheet annually & they must be kept in the file/chart of the member.
- Department or department's designee reserves the right to review the SDMI eligibility and LOI Worksheet of all mental health providers using the SDMI designation.
- SDMI covered diagnoses:
  - Category 1 includes Bipolar & related disorders, Depressive Disorder, Post-traumatic Stress Disorder, Personality Disorders, Neurodevelopmental Disorders
  - Category 2 includes Depressive Disorders, Dissociative Disorders, Panic Disorders, Generalized Anxiety Disorder, Obsessive Compulsive & Related Disorders (OCD), Persistent Depressive Disorder (dysthymia), Feeding & Eating Disorders and Gender Dysphoria.

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SED Criteria for Youth - Assessments

- SED must be determined annually due to the rapid clinical changes and circumstances of youth and families. Any date after 12 calendar months could be in violation of this rule. Typically, providers bill a Psychiatric Diagnostic evaluation (90791) to assess and diagnose youth to determine if they meet SED criteria. There is no annual limit on psychiatric diagnostic evaluations.
- The evaluation or clinical intake assessment may include communicating with family or other sources, as well as reviewing and ordering non-medical diagnostic studies.
- ARM 37.106.1915 contains Mental Health Center (MHC) requirements for client assessments. These are only required for MHC but can be used as a guide for all mental health professionals.

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Assessments for Adult Mental Health services

Adult Mental Health Policy 115 for reference

- Each member receiving behavioral health treatment must have a current integrated biopsychosocial assessment that is update annually and must meet following requirements:
  - Conducted by appropriately licensed mental health professional of licensed addictions counselor (LAC) trained in performing biopsychosocial assessments & operate within their scope of practice.
  - If assessment is performed within past 12 months, & provider determines it is not medically necessary to conduct another assessment, the provider must obtain the assessment for preparation of the individualized treatment plan and be kept in the member's file.
  - Assessment must include collateral information needed to support information given by the member.

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Assessments for Adult Mental Health services (Continued)

Adult Mental Health Policy 115 for reference

- Assessment must be relevant & organized according the 6 dimensions of the American Society of Addiction Medicine (ASAM) criteria. (specifically for SUD)
- Assessment must include information in narrative form to substantiate the diagnosis and provide sufficient detail to individualize treatment plan goals & objectives.
- List of items/information:
  - Presenting problems & history of problem
  - Family history
  - Developmental history
  - Substance use & addictive behavior
  - Personal/social history (list)
  - Treatment recommendations
  - * Legal history relevant to history of mental illness
  - * Psychiatric history
  - * Medical history
  - * Mental Status Exam & Physical Exam
  - * Diagnosis
  - * Survey of Strengths

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Coordination of Services Provided Concurrently to Youth with SED

A full list of services that cannot provided concurrently with Outpatient Psychotherapy is provided in the Children's Mental Health Bureau Medicaid Services Provider Manual, pages 5-10

- Medicaid services must not be provided to a youth at the same time as another service that is the same in nature and scope regardless of source, including Federal, State, local, and private entities
- All providers must be mindful of all community-based services, regardless of funding source, that are potentially duplicative including those which are not in the Children's Mental Health Bureau's array of services. To avoid duplication, community-based services that are provided concurrently require coordination.
- Providers must demonstrate and document attempts made for coordination of community-based services

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Coordination of Services Provided Concurrently to Adults - Mental Health and Substance Use Disorder

Adult Mental Health Policy 230 for reference

- Co-occurring integrated treatment is a best practice and recommended by SAMSHA.
- Many of the services have bundled rates. Bundled rates include multiple service components for a single rate, typically provided on a daily or per diem schedule.
- Medicaid does not allow concurrent reimbursement of services that share any service components because of Federal Medicaid regulations that prohibit **duplicative billing**.
- The statement above does not prohibit members who have co-occurring diagnoses from receiving both mental health and SUD treatment. It rather encourages integrated service delivery through the provision of co-occurring mental health service & SUD treatment. At the same time, it prohibits the separate reimbursement for duplicative services outside the bundled rate.
    - Please reference each service section for services provided as part of a bundled service rate & may not be reimbursed separately to ensure duplicative billing does not occur.

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SUD Outpatient Therapy (ASAM 1.0) Adult and Adolescent

Adult Mental Health Policy 520 for reference

SUD OP therapy include recovery or motivational enhancement therapies/strategies. Include individual, family, and group therapy in which diagnosis, assessment, psychotherapy, and related services are provided.

- ASAM is defined as less that nine hours of service a week (adults and less than six hours per week (adolescent).
- Must be provided by a state Approved Program or a licensed mental health professional with substance use within their scope of practice.
- Member must meet the SUD criteria described in the manual & meet the ASAM criteria for diagnostic & dimensional admission criteria for ASAM 1.0 level of care.

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Outpatient Psychotherapy via Telemedicine

- Telemedicine is the use of interactive audio-video equipment to link practitioners and members located at different sites. Montana Medicaid reimburses providers for medically necessary telemedicine services furnished to eligible members.
- Originating Provider or Originating Site – where the member is located. There may not always be an originating provider in every case.
  - Bill using procedure code Q3014 for the use of a room and telecommunication equipment.
  - The telehealth place of service code 02 does not apply to the originating site.
  - May bill for clinical services provided on-site the same day that telemedicine originating site service is provided if appropriate.
  - Member's residences do not qualify for originating provider reimbursement.
- Distant Provider – Provider providing services via telehealth.
  - Must be licensed in the State of Montana and enrolled with Montana Medicaid
  - May only bill procedure codes which they are already eligible to bill. Bill using the appropriate procedure code along with GT modifier (interactive communication) and place of service 02.
    - For more information, please see the Telemedicine chapter in the Montana Medicaid General Information for Providers Manual here: General Information for Providers Manual (mt.gov) and Provider Notice: Provider Notice (mt.gov)

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Montana Medicaid-Covered CPT Psychotherapy Codes

- Disclaimer: Per ARM 37.85.413, employees of the Department, or any contractor or agent of the Department (this includes Conduent), may only give general information as to what codes are available for billing. **We may not instruct providers as to what to put on claims.**
- Montana Medicaid adopts Current Procedural Terminology (CPT) coding criteria. Please refer to CPT guidance for the full list of codes and requirements for billing each code.
- Montana Medicaid requires that mental health professionals follow the CPT descriptions for each reported code. However, the mode and type of therapies provided are not specified. As long as a mental health professional is practicing within their scope of practice and the families have consented, the following psychotherapy codes are covered. (Please note that the list in this presentation is not the full and complete list that can be found in the American Medical Association's CPT 2022 Professional Edition codebook.)

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Montana Medicaid-Covered CPT Psychotherapy Codes

- Montana Medicaid requires that mental health professionals follow the CPT descriptions for each reported code. However, the mode and type of therapies provided are not specified. As long as a therapist is practicing within their scope of practice and the families have consented, the following psychotherapy codes are covered.
- Codes 90791 and 90792 are used for diagnostic integrated biopsychosocial assessment and reassessment and do not include psychotherapeutic services. Psychotherapy services, including for crisis, may not be reported on the same day.
- Codes 90832-90838 describe psychotherapy for the individual patient and may involve informants. These codes include ongoing assessment and adjustment of psychotherapeutic interventions. The patient must be present for all or a majority of the service.
- Code 90839 is psychotherapy in crisis, first 60 minutes. 90840 is each additional 30 minutes.
- Codes 90846 and 90847 are for when family psychotherapy techniques are utilized, such as focusing on family dynamics.
- Codes 90849 and 90853 are group psychotherapy codes.
- Code 90785 is an add-on code for interactive complexity to be reported with codes for diagnostic evaluation, psychotherapy, and group psychotherapy. It refers to specific communication factors that complicate the delivery of psychiatric services.

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NCCI Editing – PTP and MUE

- The Centers for Medicare & Medicaid (CMS) developed the National Correct Coding Initiative (NCCI) to promote national correct coding methodologies and to control improper coding leading to inappropriate payment. Medicaid adopts the rules of NCCI.
- Procedure to Procedure (PTP) edits – tells us if procedures can be billed together on the same day
- Medically Unlikely Edits (MUE) – tells us the reasonable frequency of a member receiving a service in a day
- Links to PTP and MUE tables in Resources slide

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RBRVS ARM 37.85.212

- The Resource-Based Relative Value Scale (RBRVS) is a payment system used by CMS and most other payers.
- Assigns procedures a relative value which is adjusted by geographic region to determine the Relative Value Unit (RVU). The value is multiplied by a fixed conversion factor, determined annually, to calculate the amount of payment.
- RVU is determined by three factors:
  - Physician work
  - Practice expense
  - Malpractice expense
- The most current fee schedule is effective July 2021, link in Resources slide

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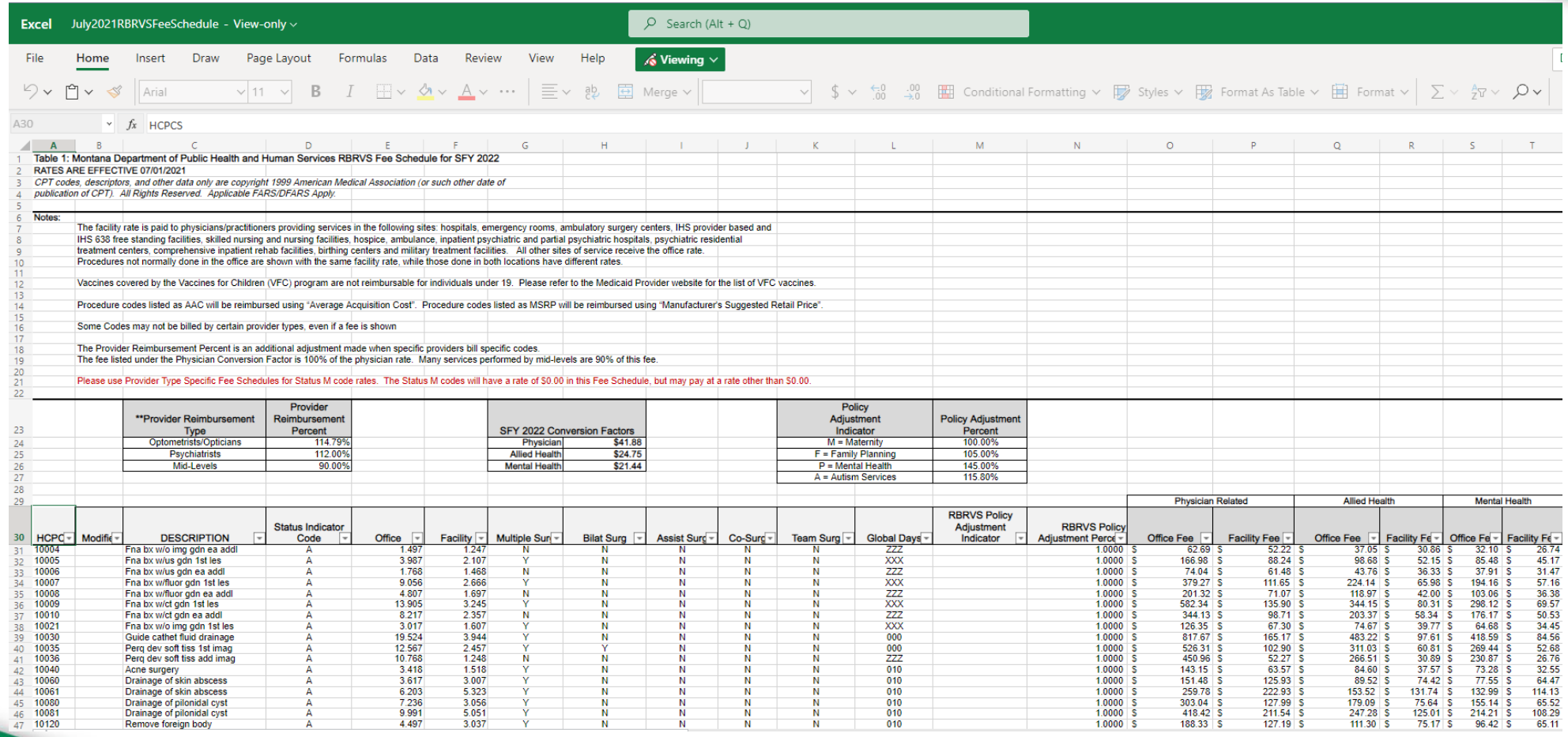
MT Medicaid RBRVS Fee Schedule



Excel July2021RBRVSFeeSchedule - View-only

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A30 HCPCS

Table 1: Montana Department of Public Health and Human Services RBRVS Fee Schedule for SFY 2022

RATES ARE EFFECTIVE 07/01/2021

CPT codes, descriptors, and other data only are copyright 1999 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS Apply.

Notes:

The facility rate is paid to physicians/practitioners providing services in the following sites: hospitals, emergency rooms, ambulatory surgery centers, IHS provider based and IHS 638 free standing facilities, skilled nursing and nursing facilities, hospice, ambulance, inpatient psychiatric and partial psychiatric hospitals, psychiatric residential treatment centers, comprehensive inpatient rehab facilities, birthing centers and military treatment facilities. All other sites of service receive the office rate. Procedures not normally done in the office are shown with the same facility rate, while those done in both locations have different rates.

Vaccines covered by the Vaccines for Children (VFC) program are not reimbursable for individuals under 19. Please refer to the Medicaid Provider website for the list of VFC vaccines.

Procedure codes listed as AAC will be reimbursed using "Average Acquisition Cost". Procedure codes listed as MSRP will be reimbursed using "Manufacturer's Suggested Retail Price".

Some Codes may not be billed by certain provider types, even if a fee is shown

The Provider Reimbursement Percent is an additional adjustment made when specific providers bill specific codes.
The fee listed under the Physician Conversion Factor is 100% of the physician rate. Many services performed by mid-levels are 90% of this fee.

Please use Provider Type Specific Fee Schedules for Status M code rates. The Status M codes will have a rate of $0.00 in this Fee Schedule, but may pay at a rate other than $0.00.

**Provider Reimbursement Type	Provider Reimbursement Percent
Optometrists/Opticians	114.79%
Psychiatrists	112.00%
Mid-Levels	90.00%

SFY 2022 Conversion Factors	
Physician	$41.88
Allied Health	$24.75
Mental Health	$21.44

Policy Adjustment Indicator	Policy Adjustment Percent
M = Maternity	100.00%
F = Family Planning	105.00%
P = Mental Health	145.00%
A = Autism Services	115.80%

														Physician Related		Allied Health		Mental Health	
HCPC	Modifie	DESCRIPTION	Status Indicator Code	Office	Facility	Multiple Sur	Bilat Surg	Assist Surg	Co-Surg	Team Surg	Global Days	RBRVS Policy Adjustment Indicator	RBRVS Policy Adjustment Perce	Office Fee	Facility Fee	Office Fee	Facility Fe	Office Fe	Facility Fe
10004		Fna bx w/o img gdn ea addl	A	1.497	1.247	N	N	N	N	N	ZZZ		1.0000	$ 62.69	$ 52.22	$ 37.05	$ 30.86	$ 32.10	$ 26.74
10005		Fna bx w/us gdn 1st les	A	3.987	2.107	Y	N	N	N	N	XXX		1.0000	$ 166.98	$ 88.24	$ 98.68	$ 52.15	$ 85.48	$ 45.17
10006		Fna bx w/us gdn ea addl	A	1.768	1.468	N	N	N	N	N	ZZZ		1.0000	$ 74.04	$ 61.48	$ 43.76	$ 36.33	$ 37.91	$ 31.47
10007		Fna bx w/fluor gdn 1st les	A	9.056	2.666	Y	N	N	N	N	XXX		1.0000	$ 379.27	$ 111.65	$ 224.14	$ 65.98	$ 194.16	$ 57.16
10008		Fna bx w/fluor gdn ea addl	A	4.807	1.697	N	N	N	N	N	ZZZ		1.0000	$ 201.32	$ 71.07	$ 118.97	$ 42.00	$ 103.06	$ 36.38
10009		Fna bx w/ct gdn 1st les	A	13.905	3.245	Y	N	N	N	N	XXX		1.0000	$ 582.34	$ 135.90	$ 344.15	$ 80.31	$ 298.12	$ 69.57
10010		Fna bx w/ct gdn ea addl	A	8.217	2.357	N	N	N	N	N	ZZZ		1.0000	$ 344.13	$ 98.71	$ 203.37	$ 58.34	$ 176.17	$ 50.53
10021		Fna bx w/o img gdn 1st les	A	3.017	1.607	Y	N	N	N	N	XXX		1.0000	$ 126.35	$ 67.30	$ 74.67	$ 39.77	$ 64.68	$ 34.45
10030		Guide cathet fluid drainage	A	19.524	3.944	Y	N	N	N	N	000		1.0000	$ 817.67	$ 165.17	$ 483.22	$ 97.61	$ 418.59	$ 84.56
10035		Perq dev soft tiss 1st imag	A	12.567	2.457	Y	Y	N	N	N	000		1.0000	$ 526.31	$ 102.90	$ 311.03	$ 60.81	$ 269.44	$ 52.68
10036		Perq dev soft tiss add imag	A	10.768	1.248	N	N	N	N	N	ZZZ		1.0000	$ 450.96	$ 52.27	$ 266.51	$ 30.89	$ 230.87	$ 26.76
10040		Acne surgery	A	3.418	1.518	Y	N	N	N	N	010		1.0000	$ 143.15	$ 63.57	$ 84.60	$ 37.57	$ 73.28	$ 32.55
10060		Drainage of skin abscess	A	3.617	3.007	Y	N	N	N	N	010		1.0000	$ 151.48	$ 125.93	$ 89.52	$ 74.42	$ 77.55	$ 64.47
10061		Drainage of skin abscess	A	6.203	5.323	Y	N	N	N	N	010		1.0000	$ 259.78	$ 222.93	$ 153.52	$ 131.74	$ 132.99	$ 114.13
10080		Drainage of pilonidal cyst	A	7.236	3.056	Y	N	N	N	N	010		1.0000	$ 303.04	$ 127.99	$ 179.09	$ 75.64	$ 155.14	$ 65.52
10081		Drainage of pilonidal cyst	A	9.991	5.051	Y	N	N	N	N	010		1.0000	$ 418.42	$ 211.54	$ 247.28	$ 125.01	$ 214.21	$ 108.29
10120		Remove foreign body	A	4.497	3.037	Y	N	N	N	N	010		1.0000	$ 188.33	$ 127.19	$ 111.30	$ 75.17	$ 96.42	$ 65.11

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Documentation for the Medical Record

ARM 37.85.414

- All providers must maintain records which fully demonstrate the extent, nature, and medical necessity of services provided to Montana Medicaid recipients. Records must support payment sought for the services and demonstrate compliance with all applicable requirements.
- Link to Adult Mental Health and Treatment Bureau documentation training video: Documentation for the Medical Record Training - YouTube

MAPP-Net Access Line

1-844-922-MAPP (6277) – 8:30am-4:30pm, M-F

- Toll-Free number mental health professionals caring for youth ages 0-21 years of age can call and consult with a Child and Adolescent Psychiatrist, Licensed Clinical Social Worker (LCSW), or Care Coordinator from Billings Clinic during daytime business hours.
- Call center at Billings Clinic will screen and triage calls to ensure they are appropriate for the line and ask the caller to provide demographics, contact information, and a brief summary of the consultation request.
- A Child and Adolescent Psychiatrist will then return the call within approximately 30 minutes.
- Calls for the LCSW and Care Coordinator will be returned within 24-48 hours.

What Can the Access Line Help With?

Child and Adolescent Psychiatrist

- Psychiatric Consultation
- Treatment Recommendations
- Medication Review and Management
- Diagnosis
- Recommended Screenings

Care Coordinator

- Recommendations to substance use and mental health treatment programming
  - Facility recommendations and contacts for admissions
  - Information regarding required records to be provided for treatment
- Connection to self-help services and/or peer support
- Connection to legal aid services
- Connection to Social Services programs

Behavioral Health Professional

- Therapy Recommendations
- Trauma-Informed Care
- Therapy Modalities
- Behavioral and Emotional Support Options and Guidance
- Road Map/Plan for Care

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Resources

- Montana Medicaid Provider website: Home (mt.gov)
- Children's Mental Health Bureau website: Children's Mental Health (mt.gov)
- Children's Mental Health Bureau Medicaid Services Provider Manual: Manuals and Guides (mt.gov)
- SED Checklist: Montana Scale for Children / Adolescents with SED (mt.gov)
- CMS MUE tables: Medically Unlikely Edits | CMS
- CMS PTP edits: PTP Coding Edits | CMS
- RBRVS Fee Schedule: RVRBS (mt.gov)
- Administrative Rules of Montana, Title 37: Public Health and Human Services: Dept. 37--PUBLIC HEALTH AND HUMAN SERVICES - Administrative Rules of the State of Montana (mt.gov)
    - Chapter 5: Fair Hearings and Contested Case Proceedings
    - Chapter 85: General Medicaid Services
    - Chapter 87: Children's Mental Health Services
    - Chapter 89: Mental Health Services
    - Chapter 106: Health Care Facilities

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Resources for Behavioral Health & Developmental Disabilities Division (Adult Mental Health)

- Adult Mental Health (formerly AMDD): BHDD (mt.gov)
- Adult Mental Health & SUD Provider Manuals (Medicaid & Non-Medicaid): BHDD (mt.gov)
- Level of Impairment (LOI) worksheet for SDMI : Forms and Applications (mt.gov)
- ARM Title 37: Public Health and Human Services: Dept. 37--PUBLIC HEALTH AND HUMAN SERVICES - Administrative Rules of the State of Montana (mt.gov)
  - Chapter 5: Fair Hearings and Contested Case Proceedings
  - Chapter 85: General Medicaid Services
  - Chapter 89: Mental Health Services
  - Chapter 106: Health Care Facilities

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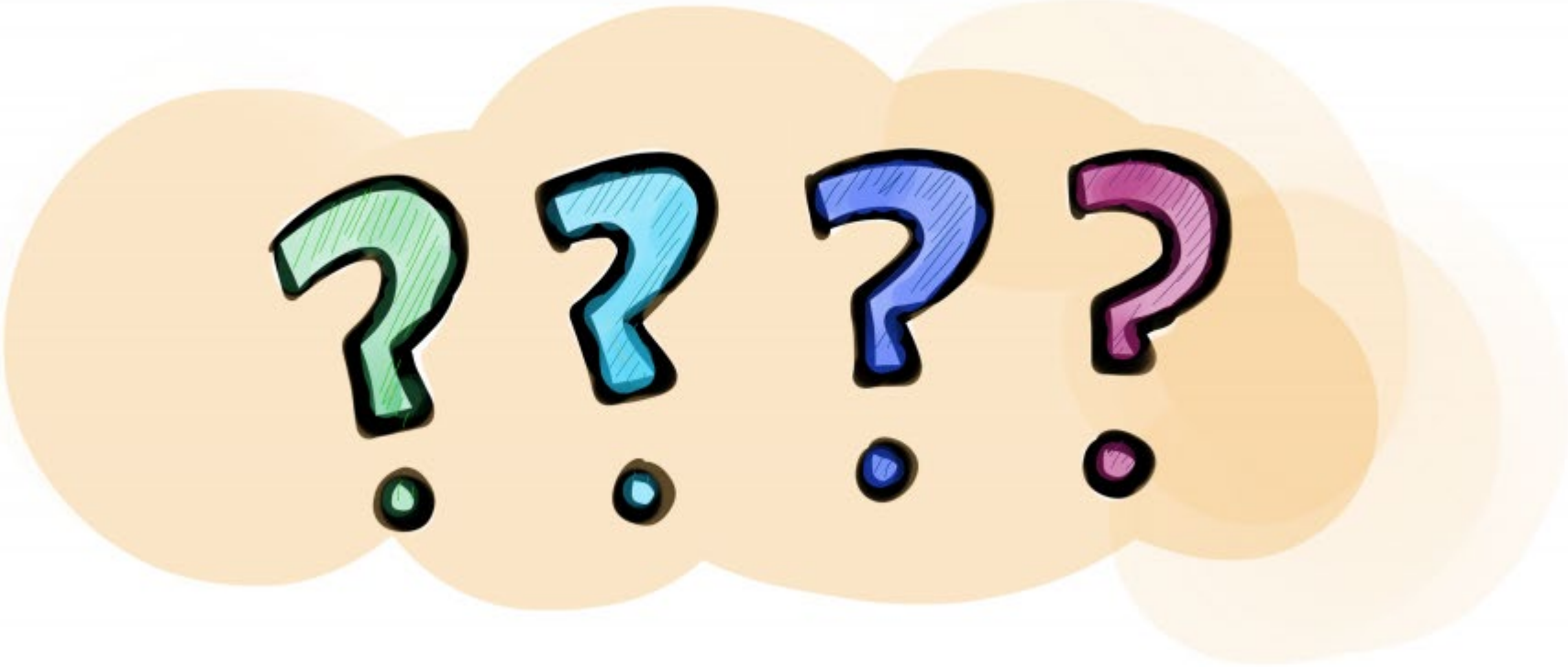

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