

# Medicaid Mental Health and Mental Health Services Plan Individuals under 18 years of age Fee Schedule July 1, 2009

These fee schedule rates include a one time only 2% provider rate increase for SFY 2010.

## I. Practitioner Services

Mental health practitioners include physicians, physician assistants, nurse practitioners, psychologists, social workers, and professional counselors. Practitioners bill using standard CPT-4 procedure codes and are reimbursed according to the Department's RBRVS system. Interactive psychotherapy codes are restricted to individuals 12 years of age and younger. (The conversion factor for psychologists, social workers, and professional counselors in calculating reimbursement rates is \$24.26.)

CPT Code	Procedure	Time	Psychologist	LCSW	LCPC
90801	Psychiatric diagnostic interview examination		\$97.26	\$97.26	\$97.26
90802	Interactive psychiatric diagnostic interview examination using play equipment, physical devices, language interpreter or other mechanisms of communication		\$103.76	\$103.76	\$103.76
90804*	Individual psychotherapy	20 - 30 min.	\$40.73	\$40.73	\$40.73
90806*	Individual psychotherapy	45 - 50 min.	\$57.50	\$57.50	\$57.50
90810*	Individual psychotherapy, interactive	20 - 30 min.	\$43.35	\$43.35	\$43.35
90812*	Individual psychotherapy, interactive	45 - 50 min.	\$62.42	\$62.42	\$62.42
90816*	Individual psychotherapy, inpatient, partial hospital, or residential	20 - 30 min.	\$38.21	\$38.21	\$38.21
90818*	Individual psychotherapy, inpatient, partial hospital, or residential	45 - 50 min.	\$56.99	\$56.99	\$56.99
90846*	Family psychotherapy without patient		\$56.36	\$56.36	\$56.36
90847*	Family psychotherapy with patient		\$69.84	\$69.84	\$69.84
90849	Multi family group psychotherapy		\$20.82	\$20.82	\$20.82
90853	Group psychotherapy (other than multi- family)		\$19.82	\$19.82	\$19.82
90857	Interactive group psychotherapy		\$22.22	\$22.22	\$22.22
96101	Psychological testing including psycho-diagnostic assessment of personality, psychopathology, emotionality, intellectual abilities	Per hour	\$54.78	N/A	\$54.78
96102	Psychological testing by technician	Per hour	\$31.00	N/A	N/A
96103	Psychological testing admin. by computer	Per test battery	\$28.12	N/A	N/A
96116	Neurobehavioral status exam	Per hour	\$60.60	N/A	N/A
96118	Neuropsychological testing battery by Psychiatrist or Psychologist	Per hour	\$67.78	N/A	N/A
96119	Neuropsychological testing battery by tech	Per hour	\$43.62	N/A	N/A
96120	Neuropsychological testing battery administered by computer	Per test battery	\$40.85	N/A	N/A

\* 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 prior authorized, and youth must be SED.

## II. Acute Inpatient Services

Acute care hospital services will be reimbursed for Medicaid beneficiaries under the Montana Medicaid program's All Patient Refined Diagnosis Related Groups (APR -DRG) reimbursement system. All admissions of Medicaid recipients require prior authorization.

Acute care inpatient treatment is not a benefit under the Mental Health Services Plan.

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

The following table summarizes services available through licensed mental health centers.

Service	Procedure	Modifier		Unit	Reimbursement	Co-pay	Limits	Management
		1	2					
Respite Care – Youth	S5150	HA		15 min	\$2.57	None	24 units/24 hours 48 units/mo	Retrospective
Youth Day Treatment	H2012	HA		Hour	\$10.67	None	6 hours/day	Retrospective
Community-based psychiatric rehabilitation & support – individual	H2019			15 min.	\$6.62	None	None	Retrospective
Community-based psychiatric rehabilitation & support – group	H2019	HQ		15 min.	\$1.98	None	None	Retrospective

## IV. Targeted Case Management Services

Targeted case management (TCM) services for youth are available through the Medicaid program when provided by a licensed mental health center with a case management area of endorsement.

Service	Procedure	Modifier		Unit	Reimbursement	Co-pay	Limits	Management
		1	2					
Targeted Case Management - Youth**	T1016	HA		15 min.	\$12.86	None	None	Prior Auth

\*\* TCM services for SED youth require prior authorization (PA). PA on intake is a pass through and youth must be SED. A medical necessity PA is required after 120 units in a state fiscal year.

V. Therapeutic Youth Group Home Services

The following table summarizes services available by therapeutic youth group homes for Medicaid beneficiaries.

Service	Procedure	Modifier		Unit	Reimbursement	Co-pay	Limits	Management
		1	2					
Therapeutic Youth Group Home – Moderate level	S5145			Day	\$99.26	None	None	Prior auth. CON
Therapeutic Youth Group Home –Intensive level	S5145	TG		Day	\$183.98	None	None	Prior auth. CON
Therapeutic Youth Group Home – Campus based	S5145	TF		Day	\$183.98	None	None	Prior auth. CON
Moderate Youth Group Home Therapeutic home leave	S5145		U5	Day	\$99.26	None	14 days/year	Retrospective
Campus-based Youth Group Home Therapeutic home leave	S5145	TF	U5	Day	\$183.98	None	14 days/year	Retrospective
Intensive Youth Group Home Therapeutic home leave	S5145	TG	U5	Day	\$183.98	None	14 days/year	Retrospective

VI. Therapeutic Youth Family Care Services

This table summarizes the services available to Medicaid beneficiaries through the therapeutic family (foster) care program.

Service	Procedure	Modifier		Unit	Reimbursement	Co-pay	Limits	Management
		1	2					
Therapeutic Family Care – Moderate level	S5145	HR		Day	\$46.41	None	None	Prior auth. CON
Moderate Therapeutic Family Care – Therapeutic home leave	S5145	HR	U5	Day	\$46.41	None	14 days/year	Retrospective
Permanency Therapeutic Family Care	S5145	HE	TG	Day	\$128.44	None	None	Prior auth. CON

## VII. Partial Hospitalization

Partial hospitalization services are available to Medicaid beneficiaries according to the following schedule:

Service	Procedure	Modifier		Unit	Reimbursement	Co-pay	Limits	Management
		1	2					
<b>Acute</b> Partial Hospitalization Full day	H0035	U8		Full Day	\$161.93	None	15 days*	Prior auth. CON
<b>Acute</b> Partial Hospitalization Half day	H0035	U7		Half Day	\$121.44	None	15 days*	Prior auth. CON
<b>Sub-acute</b> Partial Hospitalization Full day	H0035	U6		Full Day	\$102.84	None	60 days*	Prior auth. CON
<b>Sub-acute</b> Partial Hospitalization Half day	H0035			Half Day	\$77.14	None	60 days*	Prior auth. CON

\* Maximum recommended to utilization review agency; may be extended if medically necessary.

## VIII. In-State Psychiatric Residential Treatment Facility (PRTF) Services

This table summarizes PRTF services, which are reimbursed for Medicaid beneficiaries.

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

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