DIVISION OF HEALTH CARE FINANCING AND POLICY
CLINICAL POLICY TEAM, BEHAVIORAL HEALTH PROGRAM

BEHAVIORAL HEALTH TECHNICAL ASSISTANCE (BHTA)
Minutes – Wednesday, January 8, 2020
10:00 - 11:00 a.m.

Facilitator: Carin Hennessey, DHCFP, Behavioral Health Unit (BHU), Social Services Program Specialist

1. **Purpose of BH Monthly Calls**:
   The BHTA webinar offers providers guidance and updates on DHCFP BHU policy. The WebEx meeting format also offers providers an opportunity to ask questions via the Q & A (the "chat room") and receive answers in real time. If you have questions prior to the monthly webinar or after, for additional assistance submit directly to the BehavioralHealth@dhcfp.nv.gov

   - Introductions – DHCFP, SUR, DXC Technology

2. **December 2019 BHTA Minutes:**
   The minutes from last month's BHTA are available on the DHCFP Behavioral Health webpage (under "Meetings"). You'll want to navigate to this page and click on "Behavioral Health Agendas and Minutes." You can find the past agendas and minutes for the meetings, as well as the current information. Please look at these if you have questions and if you were not able to attend last month; this is a great place to check up on what we discussed.

   - Requirements for daily OMH and RMH progress notes substantiating billed claims
   - Requirement for PT 14 and PT 82 claims billed with actual rendering provider

3. **Related DHCFP Public Notices:**
   Link for upcoming Public Hearings, Meetings, and Workshops related to Behavioral Health
   http://dhcfp.nv.gov/Public/AdminSupport/PublicNotices/

   Public Workshops
   - **01/07/2020 –** Medical Services Manual (Chapter 2800 – School-Based Child Health Services Updates)

   Public Hearings
   - **01/28/2020 –** State Plan Amendments (Anesthesia; PAs for Emergency Psych Admissions; Specialized Foster Care)
   - **01/28/2020 --** Medicaid Services Manual (MSM 400 – Mental Health Alcohol/Substance Abuse; MSM 600 – Physician Services; MSM 2700 – Certified Behavioral Health Center; MSM 200 – Hospital Services)

4. **DHCFP Behavioral Health Updates:**
   Behavioral Health Web Announcements (WA):
   https://www.medicaid.nv.gov/providers/newsannounce/default.aspx

   - **WA#2065 –** Attention All Providers: Revalidation and Changes Training Scheduled in 2020
   - **WA#2058 –** 2020 New Code Updates
   - **WA#2055** – Attention All Nevada Medicaid Providers: Update Regarding Claims Denied with Error Code 2502 (Client Covered by Medicare B)

- **WA#2054** – Attention All Providers: Top 10 Claim Denial Reasons and Resolutions/Workarounds for November 2019 Claims.
- **WA#2052 –** Update for Provider Types 14 (Behavioral Health Outpatient Treatment) and 17 (Special Clinics) Specialty 215 (Substance Abuse Agency Model [SAAM]) Regarding Claims for Procedure Code H0035.
- **WA#2044 –** Attention All Providers: Prior Authorization Requests Denied for Overlapping Services

Carin Hennessey, SSPS II

- Response to Public Workshop on Supervision Changes within the PT 14 and PT 82

6. **DHCFP Surveillance Utilization Review (SUR) Updates:**
   Report Provider Fraud/Abuse http://dhcfp.nv.gov/Resources/PI/SURMain/
   Provider Exclusions, Sanctions and Press Releases
   http://dhcfp.nv.gov/Providers/PI/PSExclusions/

   - Educational Updates

   Last month we talked about the requirements for progress notes and the requirement that the claims are billed with the actual rendering provider. From what we presented last month, we are interested in hearing questions and try to clarify.

   For the progress notes, we quoted the policy, showed the requirements for the progress notes, in MSM **403.2B.6.** That talks about all of the things that need to be in the progress note. One thing to clarify is **if you don't have an adequate progress note,** 1) documenting what you have in fact done that meets the criteria for the code that you have billed and 2) providing a detailed record of the care provided to the recipient (in case another professional needs to know what kind of treatment a recipient has received), **then you have not completed the service.** We have had providers tell us that "we can't find the note but we did provide the service"; if you have not completed the documentation for Medicaid then you have not completed the service. The service for which you are billing Nevada Medicaid is more than just the interaction with the recipient; it also includes proper documentation.

   If you are an individual billing for the service, the individual must have these records.

   If the agency/group is billing for the service, the agency/group must have these records.

   The documentation needs to show clearly who is the rendering provider. It is not sufficient to have a signature at the bottom [of the progress note] that indicates the Clinical or Direct Supervisor; [the progress note] needs to have the signature, name, credentials of the person who performed the service. **If you choose to have the signature of a supervisor on [the note], it must be indicated that the person is the supervisor and not the rendering individual.** However, [Nevada Medicaid] does not require the signature of the supervisor on that documentation. Services must be pursuant to the treatment plan, and that has the signature of the supervisor.

   Another issue related to the rendering provider is services such as Intensive Outpatient program (IOP), Neurotherapy, Day Treatment, or Crisis Intervention team services. In these cases, **there may be individuals who are providing portions of the service who are not the person under whom the service is billed. Nonetheless, the notes for the components those individuals completed must indicate who did those services, and there must be notes for each component.**

   For instance, with Crisis Intervention, you can say this QMHP was supervising the team, and then there should be a note from the QMHP saying that this is what I found when we discussed or examined the patient [recipient], this is what I recommended as the treatment,

and then notes from the people who actually fulfilled it. Each component needs the start and end time, not how long it was or how many units it was, not AM or PM; exact start and end times are needed.

As a quick run-through, **the progress note is required for each day the service was delivered; must be legible; must include the name of the recipient and whether or not it was in a group setting; the place of service; the date the service was delivered; the actual beginning and ending times the service was delivered; the name of the provider who delivered the service; the credentials of the provider who delivered the service; the signature of the provider who delivered the service; the goals and objectives that were discussed and provided during the time of the service; assessing the recipient's progress toward attaining the identified treatment plan goals and objectives requested by the QMHP.** Temporary but necessary clinical services do not require an alteration of the treatment plan; however, these types or services and their requirement must be identified in a progress note. The note must fulfill all requirements of a progress note (as stated in this session). This does not eliminate the need for prior authorization where prior authorization is required for the service; the service does not need to be delayed while you create a new treatment plan. It must be documented in the progress note that, yes, this is outside of the treatment plan, but for this reason we are adding this service in to treat the patient.

For doctor's visits...there is a parallel, if you have your receptionist give a recipient a questionnaire to fill out, the receptionist doesn't need to initial that [in a progress note]. If it is independent service or a key component of an independent service, that note must be completed by the individual providing it. This may not be a direct parallel to what is going on in an MD's office, but it is the policy within MSM Chapter 400 in order that we are able to determine quality services. If it is therapy that is being provided, we absolutely need to know who is providing it in order to determine that they are qualified to do so. If it is PSR or BST, we still need to know that the person who provided the component is qualified to provide it. A signature by the supervising QMHP of a summary of what happened is insufficient.

The definition of **Neurotherapy** [90875, 90876] **is individual psychophysiological therapy incorporating biofeedback training by any modality (face-to-face with the patient) with psychotherapy (e.g., insight oriented, behavior modifying or supportive psychotherapy). Within the body of this code are two parts: biofeedback and psychotherapy. [Psychotherapy, as part of this service] is not something that can be done as a follow-up.** There is no specific direction as to how much time is spent on each. The psychotherapy may be incorporated into the process when they are actually hooked up to the machine; or it may be at the end of the session to work with the patient to determine how they are feeling and how this is working for them. It is a component by definition of this service.

7. **DXC Technology Updates:**

Billing Information https://www.medicaid.nv.gov/providers/BillingInfo.aspx
Provider Training https://www.medicaid.nv.gov/providers/training/training.aspx
Provider Enrollment http://dhcfp.nv.gov/Providers/PI/PSMain/

NevadaProviderTraining@dxc.com

Alyssa Kee Chong, Provider Services Field Representative

Nevada MMIS Modernization Project

Please review the information per this Nevada Medicaid featured link area. There is information on Important System Dates, Known System Issues and Identified Workarounds, Training

Opportunities, and Helpful Resources: https://www.medicaid.nv.gov/providers/Modernization.aspx. Also listed on this page, are ***Modernization (New) Medicaid System Web Announcements***; please refer to these announcements for specific information related to Modernization.

8. **Behavioral Health Provider Questions:**
The Behavioral Health Policy WebEx would like to address provider questions each month. This will allow us to address topics, concerns, questions from the Behavioral Health providers and make sure the specialists are focusing training and educational components to your needs and gathering your direct input from the BHTA WebEx. We will review last month's questions in detail.

Q: Is it true that Medical Supervision is no longer needed for Behavioral Health companies? If so, when does that take effect?
Q: So, if an agency ends their contract for Medical Supervision today, would they be out of compliance, or is that technically ok since its January 2020??
Q: Is there a formal notice regarding the elimination of the Medical Director position. If so where can I find the notice?
A: Medical Supervision is required for the enrollment of Behavioral Health Community Network (BHCN), PT 14 Specialty 814. Please continue to monitor the Web Announcements on the Nevada Medicaid website for updated information.

Q: Can you go over what content are you looking for in the progress notes again?
A: Please refer to MSM 403.2B.6. further guidance on the content of the progress notes. You may also refer to previous meeting minutes from the BHTA for information.

Q: In discussions with Medicaid staff, several of our clinical staff understood that if one has a clinical license, clinical supervision is not required. Is this correct?
A: If you are a PT 14 or PT 82, clinical supervision is a requirement to be enrolled in Nevada Medicaid. If you are an Independent Professional (as defined under MSM Chapter 400) rendering services under a BHCN or a Behavioral Health Rehabilitative Treatment agency, you are providing services under the required Clinical Supervision of the agency.

Q: Is there a time limit for psychotherapy component of biofeedback. I have had different people tell me that it is just a follow up.
A: Neurotherapy is individual psychological therapy incorporating biofeedback training combined with psychotherapy as a treatment for mental health disorders. Biofeedback without psychotherapy is not Neurotherapy. Both components of the service must be included and documented appropriately. There are two billable codes for Neurotherapy: 30 minutes (90875) and 45 minutes (90876).
A: The requirement for Medical supervision has not been removed at this time.

Q: Related to the discontinuation of the Medical Supervisor requirement, I would imagine each PT 14 still requires a quality assurance plan? so the clinical sup is over the plan?
A: The Quality Assurance Plan is still a requirement per the MSM 403.2.B.6. No changes are being made to that requirement.

Q: With regards to maintaining an ethical conduct of operations, aside from the Manual - Chapter 400, do we have a summary guidelines or checklists where we can always refer on a periodic basis & evaluate the organization to ensure compliance.
A: The MSM Chapter 400 applies to services [rendered to the recipient] for which a provider will bill Nevada Medicaid. For the agency and each professional providing the services [under

Nevada Medicaid], it is recommended that you reach out to the Board of Examiners (BOE) for information. The Quality Assurance program is intended to describe your agency and how it operates. When reviewing QA Programs, we say, tell us how your agency works, tell us how your agency is put together, tell us what your policies are. There are internal policies that an agency operates under; these are separate from Medicaid in that the services provided through your agency are not always Medicaid billable. You have an ethical code of conduct under which your agency operates and that is where the QA program comes in: the services provided; how you identify individuals for the correct services; how you train your professionals to be able to provide those services; what happens when a recipient has a grievance; what happens when an employee has a grievance. There isn't a template or format that is required. Medicaid would not provide you with guidance on how to run your agency; so, in that sense you may reach out to your BOE for specific information. There are other sources of training and resources available for agencies. For this reason, Clinical Supervision is important to ensure that the agency is operating under an ethical code as established in the QA Program. The Clinical Supervisor oversees, for example, case reviews, making sure evaluations have been done appropriately; it is on the licensure of the Clinical Supervisor. You may also refer to MSM Chapters 100, Medicaid Program, and 3300, Program Integrity, for guidance.

Q: For web announcement 2058 regarding new code updates, will these updates affect provided types PT 14 or PT 17? The web announcement isn't clear on what changes are in place.
A: The codes are updated annually in January. These code updates can affect every provider type.

Q: So a Biofeedback Tech can provide the service but the QMHP needs to also sign off on the progress note.
A: Neurotherapy is billed under the QMHP. The QMHP provides the therapy component of the service. If a certified Biofeedback Technician renders the technical component of the service, it is included in the Neurotherapy rate. The progress note needs to include both components of the service, completed by the provider who rendered the component, with the necessary credentials and signatures.

Q: What are the differences between Psychophysiological services that can be rendered by a certified Biofeedback Tech? HeartMath?
A: The intention of Nevada Medicaid's Neurotherapy service is to utilize Neurofeedback / EEG biofeedback. The policy for Neurotherapy is currently under review for updates and clarifications.

Q: Prior Authorization - is there a specific order on what services can be used and when? I ask because clients need support in the home and community that requires interventions by a trained QMHA. However, PSR hours are not being approved when requested.
A: MSM 403.6B.4, Therapeutic Design, "[Rehabilitative Mental Health] services are adjunct (enhancing) interventions designed to complement more intensive mental health therapies and interventions. While some rehabilitative models predominately utilize RMH services, these programs must demonstrate the comprehensiveness and clinical appropriateness of their programs prior to receiving prior authorization to provide RMH services." The interpretation of this is that RMH services are enhancing services in addition to mental health therapies (individual, group, family, neurotherapy), which may happen in an office setting. RMH services tend to be delivered in the home or community setting, outside of an office setting. It is outside the scope of Medicaid to direct a provider to offer certain services. In the case of PSR, this service may not be approved for a recipient who has not been engaged with individual therapy first, to determine that

perhaps some of the RMH services may be beneficial to the recipient. The therapy also adds context to the needs of the recipient to be addressed through RMH services.

Q: Would IOP be a better request on a PAR instead of Group therapy?
A: Nevada Medicaid services are recipient-based. IOP services are a program of more intensive services, including both OMH and RMH services; IOP is delivered as a step-down from higher levels of service (IP, PHP, etc.) or step-up from lower levels of service to prevent hospitalization and inpatient treatment. Clinical oversight within an agency may determine what services are most appropriate for a recipient.

Please email questions, comments or suggested topics for guidance to BehavioralHealth@dhcfp.nv.gov