DIVISION OF HEALTH CARE FINANCING AND POLICY
CLINICAL POLICY TEAM, BEHAVIORAL HEALTH PROGRAM
BEHAVIORAL HEALTH TECHNICAL ASSISTANCE (BHTA)
Minutes – Wednesday, August 12, 2020
10:00 - 11:00 a.m.

Facilitator: Carin Hennessey, DHCFP, Behavioral Health Unit (BHU), SSPS II

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. The webinar is recorded. 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, Provider Enrollment, DXC Technology

2. **July 2020 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.

   - Review of Provider Types 14 and 82 Checklists
   - Introduction of New Field Team Member

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
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   Public Hearings
   - **08/13/2020** State Plan Amendments (Fee Schedule Adjustments)
   - **08/25/2020** State Plan Amendments (Community Paramedicine Services and Nurse Anesthetist; Supplemental Payment for Inpatient Hospitals; Managed Care State Plan)

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

   - **WA#2273** – New Provider Orientation Scheduled for September 2020

- **WA#2272** – Attention All Nevada Providers: Deadline for Provider Relief Fund Applications Extended to August 28, 2020
- **WA#2267** – Revalidation Due Date and License Number/Effective Dates will Populate in Provider Web Portal
- **WA#2264** – Online Provider Enrollment Applications Begin Collecting Drug Enforcement Administration (DEA) Information
- **WA#2263** – Professional Claims Denied with Error Code 6100 Have Been Reprocessed
- **WA#2262** -- Update Regarding Professional Crossover and Outpatient Crossover Claims Payment Issue: Claims Have Been Reprocessed
- **WA#2261** – Use Form FA-11F to Request Applied Behavior Analysis (ABA) Services for Recipients with a Fetal Alcohol Syndrome (FAS) Diagnosis.
- **WA#2257** – Webcast Regarding Provider Relief Fund Application Process
- **WA#2256** – Attention All Providers: Provider Revalidation Deadlines Extended Another 60 Days
- **WA#2255** – Attention All Providers: Top 10 Enrollment Return Reasons and Resolutions for June 2020 Submissions
- **WA#2254** -- Attention All Providers: Top Prior Authorization Denial Reasons for the Second Quarter of 2020
- **WA#2253** -- Medication-Assisted Treatment (MAT) Services for Opioid Dependence
- **WA#2249** – Attention All Providers: Top 10 Claim Denial Reasons and Resolutions/Workarounds for June 2020 Claims
- **WA#2246** -- Attention Provider Type (PT) 26 (Psychologist): Updates to Service Limits on Neuropsychological and Psychological Testing Limits
- **Volume 17, Issue 2** – Nevada Medicaid and Nevada Check Up News (Second Quarter 2020 Provider Newsletter

Carin Hennessey, SSPS II

- **Prior Authorization (PA) Request –** How to assist providers with the PA request. There is a process of submitting. If it is denied, there are technical denials, is it filled out correctly and completed. Beyond the technical denial, if a PA request is denied for medical necessity or any host of other reasons it would be denied beyond a technical denial. There is the process of submitting a Reconsideration request and/or requesting a peer review. Those actions have been discussed in prior webinars.
  This is just about the completion of the PA request; we also know them commonly as PARs. We are reviewing this so that recipients can receive the services that they need, as you've determined as a provider. Also, we want providers to be able to complete the PAR and be able to provide these services knowing that they can bill for these services; the services have been approved beforehand and a provider can bill for them.
  Service limits can be exceeded with a prior authorization that is approved. The PAR is the request. The PA that is approved is the key element; you have an approved PA and that is what you can use to submit with your billing. The services and the treatment has been approved for which you may deliver that service and for which you may bill. You will include the authorization

number with your billing. It is helpful because having an approved PA, the focus becomes more about the treatment in and of itself, and less about how many units a provider is able to bill for that treatment. The PA allows for more treatment focus.

This is really an open forum for providers to ask questions about the PA requests, submitting them, and I will address them and maybe the other panelists can assist in answering questions. We want to take the frustration out of completing these requests and submitting them. We receive questions on how many units have been used and how many units are available (for a recipient to use) under the service limitations; there is no way for providers to determine this information and the recipient can request the records. We have reviewed this in previous webinars. ***Please see Questions section below for additional information.***

Because we create policy on this side, speaking for the BHU, we are not directing the clinical work and we rely on the providers to provide the clinical information on a recipient. The BHU attempts to assist with policy guidance for providers to document their clinical work in alignment with out policies. In this way, providers can do what they do best, which is to provide the services to the recipients. Providers have the interaction with the recipients and know what they need, determined through assessment and developed through the course of treatment. We know this because we hear from recipients and they tell us how much they benefit from the services that they receive.

Putting the work into submitting a PA can be viewed as an investment in the treatment of the recipient. Recipients have the right to seek treatment where they choose from who they choose. This can be frustrating; we hear from providers that recipients are no-shows or a recipient came to treatment for a while and then stopped. We cannot control these things because the recipient has the right to seek treatment or not, change providers; it is recipient-based treatment. But providers can have more control over the treatment that they provide.

Writing the treatment plan is an investment and submitting the prior authorization is an extension of that investment in the recipient's treatment. Having the approved PA is an assurance for the provider because a provider can't control what a recipient does. The provider can focus on the course of treatment when the recipient does show up, when they are there. When they come in you have assurance that their visit is covered under their insurance.

I am going to refer to the FA-11 for Behavioral Health. As a side note, if you refer to policy, there are services that require an approved prior authorization; you must submit a PAR to deliver the service. Some of you are very familiar with the submitting of PARs and this information may or may not be useful to you. For those of you who work within the available service limitations, this may be useful to give you other options. You will find the FA-11 form on the Nevada Medicaid website, under the "Providers" tab, under "Forms". Please ask the BHU if you have questions related to which form should be used to request a particular service.

I will go through the sections of the FA-11 form. Under “Request Type”, you will list the type of request; generally services are approved in 90-day increments, but other services have different time periods for PA submittals. The “Notes” section can be used to add additional information. “Section I” is where you will list your recipient information. Speaking to the technical aspect of the form submittal, you want to make sure all information here is completed to the best of your ability. “Section II” is for the diagnosis information. I want to point out here is that the authorization provides an ongoing record of treatment; this includes all of the services the recipient is receiving through prior authorization. This record helps to provide information on all of the treatment of a recipient. The diagnosis may be reviewed in terms of other prior authorizations approved for similar services that have been received under which diagnosis. The diagnosis here would typically be the diagnosis under which the recipient would receive these types of services. “Section III” provides the assessment information; there is an assessment that happens prior to the submittal of the PA request. How the submittal happens is determined within your agency based upon your internal policy. The PA request is submitted prior to treatment. “Section IV”, medication disclosures are always important. The recipient may come in and not have the information to assist the provider in completing this form; this is frustrating for providers and indicates the need to work with recipients and supports of the recipient to determine this information. The more complete the PA request is, the better opportunity the provider has to treat the recipient based on their current status.

In “Section V”, it is important to communicate the *current* situation of the recipient. Significant life events are important to note but relating these events to the current symptoms of the recipient are crucial in requesting services for treatment. In “Section VI”, I can point out that the information from a completed treatment plan can be stated here. You don’t have to reinvent anything here for treatment and you can use what has already been created for the treatment of the recipient. This includes goals, specific services, and your progress can be based on the treatment plan goals, any service that has been delivered, and how the recipient is responding to these services (progressing or not progressing). “Section VII” addresses all of the services the recipient has already received or is currently receiving; similar to the medication section, if this section is blank, the current situation is not being communicated. Being able to access this information really is crucial to support services being requested. There is a narrative section to address anything that isn’t part of a check-off list for this section. “Section VIII” is where you will identify the estimated discharge date and what will be addressed in that time frame. If you approach the estimated discharge date and you need to reassess, it can be reflected in submitting authorizations, for example, concurrent prior authorizations or unscheduled revisions.

“Section IX” is where you request the specific services, with codes and modifiers, for the requested period of time; units per day, per week, and total units being requested are listed here. Finally, you have your attestations by

your QMHP and Clinical Supervisor as required if the QMHP is not able to sign off on the treatment plan themselves.
Hopefully providers will find this useful in investing in the recipient's treatment and having some assurance that the treatment designed for the recipient will be covered by their insurance. We cannot instruct you on how to write the PA request, but we can address policy questions on the services being requested.

6. **DHCFP Provider Enrollment Unit Updates:**
Nevada Medicaid Website: https://www.medicaid.nv.gov/providers/enroll.aspx
DHCFP Website: http://dhcfp.nv.gov/Providers/PI/PSMain/

- **Updating Provider Contact Information –** It is a requirement that providers keep their contact information updated. This includes telephone numbers, service address and mailing address/pay to address, email addresses. As we move closer to a totally virtual environment, phone numbers and email addresses will become critical. We need to ensure we are able to reach you; it is a requirement that when DHCFP or DXC Technology (our fiscal agent) need to reach you, we are able to reach you.
As an individual provider, when you initially enroll with Nevada Medicaid and you link to a group, quite often the group's mailing address will be associated with the individual's NPI. Let's say after a year, the individual becomes affiliated with another group and unlinks from the original group, the individual will need to update their address at that time if they haven't done so already; any correspondence for the individual will go to the original group if that address is not changed. This is one of the important reasons that you keep your address up to date.
Additionally, if any mail is mailed to you and it is returned by the post office with no forwarding address, then per Chapter 100 policy, the DHCFP will terminate your contract for loss of contact. There can be bigger ramifications of not being able to reach you; it could result in a termination of your provider contract.
Thank you!

7. **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/

As a general overview, you may refer to the SUR Unit webpage on the DHCFP website (under "Resources" tab) for further information. The SUR Unit ensures the integrity of the different programs within Nevada Medicaid. You may have interacted with SUR in relation to billing for services or for information on documentation of services. On the billing side of things, there is utilization and service limitations. *"The SUR Unit performs a variety of other functions, such as detecting areas where Medicaid regulations and/or policy may be modified, administers the provisions of the Federal and Nevada False Claims Acts, conducts provider training on fraud, waste, abuse, and improper payments,*

and prevents fraud and abuse from occurring." On this webpage, there are links to report fraud, waste, and abuse by providers and by recipients.
SUR is requesting specific topics that providers have interest in education for future webinars.

8. **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 Relations Field Service Representative - North
   Susan McLaughlin, Provider Relations Field Service Representative – South

   - You can email NevadaProviderTraining@dxc.com to request specific training on how to enter on the Provider Portal, where to find the resources on the FA forms, or to find the trainings that are already posted to the Medicaid website. Please include your NPI number, and your location in Northern Nevada or Southern Nevada.

   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.

   - To research information on claims issues, you can go to the Known System Issues and Identified Workarounds section of the Nevada Medicaid website (under the Modernization Project).

9. **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. The previous month's questions with answered on the posted minutes for the meeting.

   Q: We are running into reoccurring instances where individuals have received services from another provider. Individuals with Serious Mental Illness (SMI) don't always understand what service they have received. We have had many instances where services are denied due to recipient having received services from a community provider in the same calendar year. Providers have supported recipients in requesting their own medical records with no

response. Recipients are not reporting services received accurately. We never want to duplicate services. We also want to make sure clients are aware of and approve any services they had or are receiving, ensuring appropriate reimbursement for services provided.
A: Providers can call into the Provider Call Center at DXC for treatment history as long as they have the recipient ID # and CPT procedure codes, since this is not an option for Provider Type 14 through the EVS portal. The phone number to contact the **Provider Call Center is (877) 638-3472**.

Q: Can an agency request training for staff around the prior authorizations?
A: You can email the BHU for questions on the prior authorization of services and policy guidance can be provided, based on the services being requested. The request for more training will be considered for future webinars.

Q: Do managed care companies follow the Medicaid guidelines or do they add additional guidelines for policies.
A: MCOs cannot be less restrictive with Medicaid guidelines, but can be more restrictive as appropriate to the populations and their' health needs served.

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