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

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

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. **February 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.

- Comment on Supervision of the BHCN and BH Rehabilitative Treatment group/agency
- SUR Unit Educational Updates: Signature Requirements

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

- **CANCELLED -- 03/12/2020 –** Public Meeting for Advisory Committee on Medicaid Innovation

Public Workshops
- **CANCELLED -- 03/27/2020 --** Medicaid Services Manual (MSM) Chapter 400 Updates to Supervision Within the Behavioral Health Community Network (BHCN) and the Behavioral Health Rehabilitative Treatment Agency

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

- **WA#2122 –** Instructions for 2020 Procedure Codes Requiring Prior Authorization
- **WA#2117 –** Attention All Providers: Frequently Asked Questions (FAQs) for the Electronic Verification System (EVS)

- **WA#2107 –** Attention Provider Types 34 (Therapy) and 85 (Applied Behavior Analysis): Update Regarding Claims for Procedure Codes 97153, 92507, 97155
- **WA#2104 –** Attention Provider Type 63 (Residential Treatment Centers): Claims That Cutback in Error Reprocessed
- **WA#2103 –** Attention All Providers: Top 10 Claim Denial Reasons and Resolutions/Workarounds for January 2020 Claims
- **WA#2101 –** New Provider Orientation Scheduled for March 2020

Carin Hennessey, SSPS II
Alyssa Kee Chong, Provider Services Field Representative, DXC Technology
Joann Katt, Prior Authorization Nurse-BH Team Lead, DXC Technology

- **Prior Authorizations: Adverse Determinations, Peer-to-Peer, Hearings:** You submit a PA request and it receives an adverse determination due to medical necessity (we are not talking about technical denials), denial or reduction to any or all services requested; the Coordinating QMHP, the clinician who submitted the PA request has the option to request a Peer-to-Peer review of the medical necessity. The request is discussed with a clinical reviewer from DXC Technology (Nevada Medicaid's Quality Improvement Organization (QIO)-like vendor). A provider can submit a Reconsideration request on an adverse determination of a PA request (also known as a PAR); however, if you do this first then a Peer-to-Peer review is not an option on this PA request. If you do the Peer-to-Peer review first and you feel that you want to submit a Reconsideration request based on your discussion during the Peer-to-Peer review, then you can submit the Reconsideration request.
- Our Behavioral Health training slide deck is posted to the Nevada Medicaid website ("Behavioral Health Provider Training" under Workshop Materials), if you are confused on which path to go on when you want to appeal. Beginning on Slide 80.
    - **Denied Prior Authorization**: If you go straight to a Reconsideration request, you will lose your Peer-to-Peer rights.
    - **Peer-to-Peer review**: Intent is to clarify the reason the PA request was denied or approved but modified; there is a chance to overturn the adverse determination through this clarification. No new medical information is presented. **Request within 10 business days of the denial, email nvpeer_to_peer@dxc.com** (*slide information is incorrect*). Provider is responsible for having a licensed clinician with knowledge of the request as part of the verbal conversation with the clinician who reviewed the request. If there is a reversal in the adverse determination, it will be put into the system at that point in time; no additional paperwork is required.
    - **Reconsideration request**: Peer-to-Peer is not required first. Only available for denials related to medical necessity. FA-29B form to request is uploaded to the "file Exchange" on the Provider WebPortal; you **do not need to add the service lines but attach the FA-29B form to the PA that was denied or modified**. Additional medical information can be presented and will be reviewed by a different clinician than who reviewed

the original documentation; only additional medical records (not voluminous) that support the issues identified in the synopsis will be review. You have a **30-day calendar window from the date of the denial (90-days for Residential Treatment Center providers) to submit for Reconsideration** and this is an independent timeline from a Peer-to-Peer review.

- Please review **MSM Chapter 3100 Hearings** for further information. Once you follow through with a Hearing, it is beneficial to recipients; if you feel that there is medical necessity for a service then it is beneficial to follow through with the hearings process. On the other hand, when recipients participate in the hearing preparation meetings (HPM) without the provider, the recipients sometimes experience difficulty in understanding the reasoning behind the denial. The recipients have every right to request the hearing (as they receive the Notice of Decision letters that the provider receives) and sometimes schedule hearings because they believe that their Medicaid eligibility is being denied. **Communication between the provider and the recipient is important in this hearings process, so that the recipient understands the denial of specific services and how to move forward.** During the hearing with the recipient, if there is a discrepancy as to what services the recipient is actually receiving -- different from services that have been requested by the provider and/or approved by Medicaid – then there may be a referral to Surveillance Utilization Review (SUR) Unit or any other appropriate entity. Communicating is very important between the recipient and provider during the hearings process is important so that the recipient understands what the denial means, that there is not a loss of all services, and that some services are being denied or modified. There can be a discussion between the recipient and provider of how to move forward, especially if the services benefit the recipient. In the worst cases, during the hearings, it appears that the provider is taking advantage of the recipient and a referral is necessary or the well-being of the recipient. We want to stress that this process of requesting services is important and that we hope that providers support recipients who benefit from your services.
- **It is important to go over the clinical documentation with the recipient to make sure that they understand what you have submitted to Medicaid.** Sometimes [during the hearings with the them], the recipients disagree with what is being said about them [in the documentation], don't feel that there was the correct information about them, and that there may be too much information written about them. A recipient's appeals right is explained to them in the hearing process, and that if the provider does not appeal the determinations made then Medicaid assumes that the provider agrees with the determination. Based on that, a lot times the recipient is upset with the determination, they feel that they benefit from the services, but because the provider did not

pursue the appeals process we feel that the provider agrees with Medicaid.

Future webinars are planned to address the information on the PA request and how to take the information from the treatment plan; it is not necessary to reinvent the justification for the services on the PA request. The hope if to clarify for providers what information is needed on the PA request.

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: Neurotherapy Policy and Billing** -- We have reviewed documentation requirements in the past and we want to review this in relation to Neurotherapy. We are finding so many consistent findings across providers that we want to narrow the conversation down to [billing codes] 90875 (30 minutes) and 90876 (45 minutes). These codes are combination codes: biofeedback training and psychotherapy. Both components are part of billing the Neurotherapy service. When billing Neurotherapy, there are two (2) important things to keep in mind:

#1) The individuals who are rendering this service need to be qualified. MSM 403.4(C)(4)(a) states that the Biofeedback portion needs to be rendered by a certified Biofeedback Technician and the Psychotherapy portion needs to be rendered by a licensed QMHP. Both of these professionals need to be credentialed at the appropriate level and they both need to be enrolled in Nevada Medicaid to be able to render the services.

- We are finding in a lot of cases that Biofeedback Technicians are not enrolled. This will be a finding, an overpayment, that we will be taking back. It is important to make sure the qualifications of the provider fit the policy. *NOTE: the current certification for Biofeedback Technician is obtained by a professional organization, such as the Biofeedback Certification International Alliance (BCIA).

#2) Additionally, in regards to documentation, there needs to be documentation and progress notes for both portions/components of the Neurotherapy service.

- We are finding in many cases that the documentation includes the Biofeedback portion and not the Psychotherapy portion. Again, this will be a finding and these claims will be identified for overpayment.

We want to make sure that in accordance with policy there are qualified and enrolled providers rendering and documenting both components of the Neurotherapy service.

As it relates to MSM 403.4(C)(4)(b), there is a list currently in policy for the ICD codes that are covered for the delivery of Neurotherapy and the session limits. Of course, you can offer Neurotherapy up to these session limits for recipients with these diagnoses before a PA is required. Once you request to exceed these service limits, you will want to have an approved PA.

- As far as the Surveillance Utilization and Review (SUR) Unit, we want you to know, we are going be looking to ensure that recipients receiving these services are identified with these diagnoses. We are looking at the treatment plans as well as what is indicated on the claims. Most important is to be sure that the treatment plans are identifying that diagnosis. If we don't see a matching diagnosis, it [the claim] will be identified as a finding.

The Behavioral Health Unit will field questions on this service. We are reviewing the policy to improve this service and to clarify the requirements that the SUR Unit is currently reviewing for compliance. If you are writing a PA for this service, it needs to contain the required information.

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

- There are trainings posted to the Medicaid website, including an upcoming training for Secondary Claims. There will be a Web Announcements (WA) posted for those trainings, so that providers can register. They are currently posted on the Provider Training webpage (under "Training Announcements").

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: Has progress been made in establishing providers/patients to obtain quicker access to service utilization for therapy services?
A: Service utilization is private recipient information that would not be available to providers. For a variety of reasons and based on confidentiality law, what a recipient

has accessed and how much they have accessed is for the recipient to know [and disclose as needed]. The provider's role is to assist the recipient in accessing this information. You may assist the recipient in requesting records through the DHCFP website (under Resources tab, under "Data and Records Request").

Q: How are Biofeedback technicians registered or certified by Medicaid. As a QBA? QMHA?
A: A Biofeedback Technician is not currently registered with or certified by Nevada Medicaid. However, in order to render the brainwave biofeedback portion of the Neurotherapy service (referred to as EEG biofeedback or neurofeedback), the individual performing brainwave biofeedback must be certified as a Technician; please refer to a professional organization, such as Biofeedback Certification International Alliance (BCIA), BCIA.org, for further information on this certification. The individual rendering brainwave biofeedback must also be enrolled with Nevada Medicaid and must document their portion of the Neurotherapy service delivery in the recipient progress notes. A Biofeedback Technician will be enrolled with Nevada Medicaid at the professional or paraprofessional level for which they qualify; examples include Independent Professional, QMHP, and QMHA. The Biofeedback Technician does not bill Medicaid directly for their role in the Neurotherapy service.

Q: I would like to be shown how to access minutes for these meetings again if possible.
A: To access the minutes and agendas for BHTA webinars, please refer to the Division of Health Care Financing and Policy (DHCFP) website, under Programs/Behavioral Health Services, on the righthand sidebar under "Meetings".

Q: Once a provider's re-enrollment has been approved can a retro authorization be requested for services the provider did performed while the re-enrollment was being processed?
A: These could possibly be looked at on a case-by-case basis. If you have a specific request or specific situation, please email the Behavioral Health inbox at BehavioralHealth@dhcfp.nv.gov with details.

Q: Crisis Interventions – When our youth require a PAR for their 4th Crisis in 90 days. A youth has a current PAR out; therefore, I believe an unscheduled revision PAR is required. It cannot be back dated and the crisis begin at night or on a weekend. How do we address this issue on a PAR and how do we submit it to meet requirements?
A: For the 4th Crisis in 90 days, a Prior Authorization (PA) request would be submitted with medical necessity provided. Service limitations do not mean the service will not be reimbursed. If a Prior Authorization Request (PAR) is denied, peer to peer review can be requested, which can be beneficial.
However, another consideration is what service is most appropriate for the recipient; if a youth is experiencing a 4th crisis within a 90-day period, it may be necessary to re-evaluate that youth's needs. Crisis Intervention is not intended to be a maintenance service for recipients. The service limitations for Crisis Intervention are

in place to indicate what is a reasonable service within a 90-day period. A re-evaluation of the youth's needs may indicate a different level of care or a different service to address the youth's needs.

Q: There is a big roar about BST and PSR being done in the same day. This is always been something that was allowed with respect to CASII/LOCUS scores, and the according time limits for services in a day. Now claims are being returned unexpectedly.
A: DHCFP is aware of this issue and is in the process of researching these denials. DHCFP will advise providers when more information has been received. At this time do not rebill any unpaid claims. Please contact the Behavioral Health inbox at BehavioralHealth@dhcfp.nv.gov if you have further inquiries.

Q: As the intergrated care models continue to united Medical and Behavior Health providers more I have doctors that have questions about the 99212,.. 213,.. 214, etc...codes and if they are indeed complexity codes or timed codes. The guide says, "typically 15 minutes spent face to face", or whatever, but they are unclear if that is a hard time limit of not?
A: The Current Procedural Terminology (CPT) 2020 Professional Edition codebook is specific in the definition of these codes. Please refer to the 2020 CPT codebook, as code definitions are located here. These codes have multiple levels within them, all apply.

Q: About those codes. The issue came up when the doctor and a clinical director were debating on if the Psychiatrist can do 90833 and 99213 in a total time of 30 minutes, or does the sesin need to be 45 minutes long. Complexity versus time?
A: 90833 and 99213 are separate codes that can be used in conjunction with each other. Each code has to apply to the services provided.

Q: I think the question is whether for those 992121, 213, 214 codes are judged by complexity over "typical time". The guide does NOT say is has to be a certain time, but suggest in typical situations the provider spends a certain amount of time. When you are combining with a timed code, we are trying to figure out if there is a minimum time for BOTH, or just the 90833 add-on because it is based solely from time.
A: When combining two codes, both codes are billed to reflect the services rendered to the recipient; the codes are recipient-based, not provider-based. Each code must stand on its own. If a code indicates a typical time frame, that time frame would be the approximate time spent on that service with the recipient.

Q: How long does it take a family to get a hearing? It seems hopeless for a family to do an appeal hearing if it takes 90 days. Then an entire PAR period or 3 months has gone by and they were without their services. How would they benefit from a hearing at that point?

A: There are other ways for a provider (on behalf of the recipient) to appeal the adverse determination of a Prior Authorization (PA) request, including peer-to-peer and reconsideration, which would take less time than the hearing process. Please refer to these minutes for recent discussion on adverse determinations of PA requests (also known as PARs). You may also consult the Billing Manual, located on the Nevada Medicaid website.

Q: Question on credentialing new providers. How long does it typically take to fully credential a new provider? It appears its been taking long that usual to receive approvals. I have a provider who has been "under review status" since 02/04/2020.
A: There is no specific timeframe for an enrollment to be processed. If you have question regarding any enrollment, please contact DXC Technology Provider Enrollment at (877) 638-3472.

Q: For psychiatric medication management follower up visits when you do psycho therapy during the visit Do you have the option to use codes 99214, 90833 together?
A: Per the 2020 CPT codebook, under 90833, code 90833 could be used in conjunction with 99214 if the rendering provider is doing all of the services listed under both codes.

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