DIVISION OF HEALTH CARE FINANCING AND POLICY
CLINICAL POLICY TEAM, BEHAVIORAL HEALTH PROGRAM
BEHAVIORAL HEALTH TECHNICAL ASSISTANCE (BHTA)
Minutes – Wednesday, June 10, 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, DXC Technology

2. **May 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.

   - Psychosocial Rehab services via Telehealth (see WA#2183)
   - Removal of Medical Supervision and Medical Supervisor from BHCN, including updates to the supervision within the BHCN and the BH Rehabilitative Treatment – *Effective Date April 29, 2020*
   - Documentation for Telehealth Services
   - Documentation for Crisis Intervention Services
   - COVID-19 Web Announcements and the DHCFP Webpage

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
   - **6/23/2020 Medicaid Services Manuals (MSM 1200 – Pharmacy Services; MSM 3800 Medication Assisted Treatment)**

4. **DHCFP Behavioral Health Updates:**
   Behavioral Health Web Announcements (WA):

https://www.medicaid.nv.gov/providers/newsannounce/default.aspx

- **WA#2215** – Attention Provider Type 13 (Psychiatric Hospital, Inpatient) Providers: Training Sessions Scheduled
- **WA#2214 –** New Provider Orientation Schedule for July 2020
- **WA#2211 –** Attention All Providers: Providers Cannot Charge Nevada Medicaid Recipients for Personal Protective Equipment
- **WA#2210 –** Attention All Providers: Additional Provider Training Sessions Scheduled Regarding Telehealth during the Novel Coronavirus
- **WA#2208 –** Update to Telehealth Services Regarding Applied Behavioral Analysis (ABA) Services
- **WA#2196** – Attention All Behavioral Health Community Network (BHCN) Groups (Provider Type 14 Specialty 814): Removal of Medical Supervision Requirement
- **WA#2192 –** Attention All Providers: Tope 10 Enrollment Return Reasons and Resolutions for April 2020

Carin Hennessey, SSPS II

- **Updates to Supervision in BH Entities/Groups/Agencies**
  - Clinical Supervision
    - Now we will discuss some of the changes to Chapter 400 policy related to Clinical Supervision. Looking at policy isn't always the easiest reading material and I take for granted sometimes that I'm reading this policy every day and I'm a lot more familiar with it. There are specific changes that you're aware of as you look at the policy and read it; interpreting it sometimes may not be as easily done when you're not as familiar with the policy in general. So I wanted to take some time to look at Clinical Supervision today and what the policy looks like with the removal of medical supervision. And so, as you'll see when you go into look at the policy, always pay attention to which version you're looking at. If you have, for example, a printed version of a policy within your office, or something on a link on your desktop, be sure to update it as the policy is updated. In in a revision, there's always going be a section that will tell you what has been updated. So, if you are more familiar with the policy, and you really want to look at the specific points that were updated, you can see what was changed within this version. Because the actual citation is listed, as well, you can go to the citation and read it for some further information. When we look at our service delivery models, and this is really going into the Provider Types 14 and 82. There are other service delivery models within our chapter, like PT 63 (Residential Treatment Centers) and PT 17 Specialty 215 (Substance Abuse Agency Model). There's other information in here. **The Behavior Health Community Network (BHCN) and the providers who are enrolled under the BHCN to provide OMH and RMH services.** There are the **Independent Professionals, which are typically**

your private practice professionals, although you can be an Independent Professional and be working within a BHCN. And then you have your **Individual Rehabilitative Mental Health providers.** This is the Behavioral Health Rehabilitative Treatment agency, PT 82, and the enrolling Individual Rehabilitative Mental Health providers.

A BHCN covers outpatient mental health (OMH) and rehabilitative mental health (RMH) services; all of these services are intended to restore a recipient to their highest level of functioning and are rehabilitative in nature. These OMH services include testing, assessment, and medication; other licensed mental health professionals -- the doctors, the psychologists, professionals not enrolled under PT 14 -- who are delivering these services and sometimes under a BHCN. Mental Health Therapies and Therapeutic Interventions (PHP and IOP) and the Day Treatment model are provided under the BHCN. Rehabilitative Mental Health (RMH) services may be provided underneath the BHCN.

With **Individual Rehabilitative Mental Health (RMH) service providers, we are looking at specifically at those rehabilitative services being provided to the recipient; these are provided under the PT 82 Behavioral Health Rehabilitative Treatment agency.**

It helps to hear the actual language from policy [Medicaid Service Manual 403.2A language has been omitted for space]. There have been questions from Clinical Supervisors about responsibility for services that they don't render themselves; **a Clinical Supervisor will oversee the delivery of these services within the agency and will be aware of the services being delivered to the recipient under the treatment plan.** When the Clinical Supervisor completes case reviews, they look at the person and review the services being delivered. This is where the oversight happens, and it really does come down to a level of communication with the providers of these services. If as a Clinical Supervisor, you see something in a chart, but you're not clear or have questions or concerns, then you would address these things with the professional rendering that service. Clinical supervision of these services isn't any different than it has been in our policy. Under the medical supervision, there may have been a deferment to the medical supervisor and that medical supervisor was often not available or onsite at the time the services were being delivered. Clinical Supervision is intended to be delivered onsite. **It is the intention that the Clinical Supervisor is onsite at the agency.** Now, if your Clinical Supervisor is overseeing more than one agency or also has a private practice, Nevada Medicaid doesn’t want to make its policy restrictive. However, it is intended to be rendered on site because if an issue arises with the services being

delivered, it's important that the Clinical Supervisor is available to provide that clinical oversight.
If you're are a Clinical Supervisor and you're not onsite and someone can't walk down to your office, then **provider needs to able to pick up the phone and call their Clinical Supervisor and ask a question or express a concern.** This provider may need your clinical assistance with a recipient at the time the service is being delivered.
The policy outlines who can be a Clinical Supervisor [Medicaid Service Manual 403.2A language has been omitted for space]. A Clinical Supervisor can oversee all of the services provided through the agency and has experience with the delivery of these services. It's a big responsibility. It really always has been. With the removal of the medical supervision, it's emphasizes the role of the Clinical Supervisor. It is the oversight for the agency, the Clinical Supervisor assumes professional responsibility for the mental and behavioral health services provided by clinical staff.
There's a breadth to the term clinical staff; it means, whoever is providing clinical services underneath the agency. **Clinical Supervisors may also function as Direct Supervisors.** And if you are doing that, then there is more of an onus to be available to the providers at the agency. A supervisor looks at each service and determines if they need to be onsite for direct supervision of a service; some services do specify direct supervision be onsite. Related to RMH services, LCSWs, LMFTs, CPCs, and QMHPs excluding Interns may function as Clinical Supervisors; this can be within the PT 14 and PT 82 agencies. **If you are an Individual RMH provider and you are a QMHP including Interns, you may not function as a Clinical Supervisor over OMH services; this includes the assessments, therapies, testing, and medication management.** This is how the PT 14 agency and PT 82 agencies are defined. We have attempted to clarify the policy language. We didn't change it too much, but we just tried to specify some of the services underneath the service models.
Here, the Clinical Supervisor must assure certain things [Medicaid Service Manual 403.2A language has been omitted for space]. This is information included in a Quality Assurance Program, ensuring that services are delivered according to Medicaid policy. This information is also included in the grievance policy of the QA Program.

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**

- **Intensive Outpatient Program (IOP)** -- We have seen providers who are not adhering to the policies, and I just want to review some of those policies. IOP is defined in Chapter 400 as a comprehensive interdisciplinary program. The purpose is to improve or maintain the individual's functioning level or prevention of relapse or hospitalization.
  - **Session Limits** -- These direct services are provided no more or less than three days a week, between three (3) and 6 hours in each of those days. If the recipient needs more then this time frame, then that indicates a higher level of care and the recipient needs to be re-evaluated. When the patient is first determined to be appropriate for IOP, there needs to be a new treatment plan and prior authorization request specifying these elements provided to the recipient as part of the IOP.
  - **Unbundling of Services** – It's really important to understand that the IOP includes OMH and RMH services, including mental health diagnostic testing, evaluations, labs, tests, medication management, medication training and support, crisis intervention, and supplies. The IOP requires the built-in availability of 24/7 psychiatric and psychological services. All of these are components are included in IOP and cannot be billed separately for a recipient engaged in IOP services. You bill IOP on the three (3) days, up to the 6 hours, the recipient received IOP services; IOP is the only thing you can bill for these recipients. If on the other days you are billing for other services the recipient has received, that is known as unbundling. Unbundling is improper billing and abuse of billing practice; those other services billed [outside the IOP program] are subject to recoupment.
  - **Prior Authorizations** – When the patient is first determined to be appropriate for IOP, there needs to be a new treatment plan and prior authorization request specifying these elements provided to the recipient as part of the IOP.
  - **Documentation** -- The documentation we want to see with the IOP is what was done on each day, with the duration the services were provided (3 to 6 hours total). We expect to see the components that were included in the treatment plan; you may have all sorts of different services that were determined to be necessary and important to keep this patient from relapsing. Include the individual actually rendering each service. Most providers complete the documentation just as if each service were standing alone and being built separately. For example, progress notes should have the same standard as for individual PSR documentation and by the actual individual who provided it; the IOP will be billed under the QMHP or licensed professional who is supervising the IOP, but that professional does not just put their signature on it or write a short note for the whole service. That's what we will be looking for if we request documentation. The documentation is necessary for you to be paid but the main purpose of the documentation is to create a complete and accurate medical record

for the recipient. There may be a point in time that the recipient may be hospitalized. Even in the near future, there may be a medical emergency, and there may be professionals who need to know what sort of services a recipient has been receiving and what sort of progress or regression that individual may have had. So, it's very important for the recipient's health and well-being that you maintain a complete and proper medical record for them.
We've gone over the elements that have to be in the documentation by Medicaid's rules, and those elements are required under the contract you signed with Nevada Medicaid if you want to be paid for the service. Providers are expected to follow the requirements. If you are following the minimum requirements it doesn't mean you are doing the best professional work that you can do. We cannot oversee every aspect of your work; we are overseeing what is required for you to be paid.

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 Relations Field Service Representative

- **Telehealth Trainings**
  - You can find the upcoming trainings on the Nevada Medicaid website, under the Calendar menu. There are telehealth trainings coming up and you can register for those. You can also look under the Provider Training, so this is also a link to the calendar. The training registration website includes the announcements on all of the trainings.

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

Q: So, provider 14 agencies do not need a medical supervisor?
A: A Medical Supervisor is no longer a requirement for a PT 14 agency to enroll. However, if your agency is offering services that require medical professionals, they must be practicing under the scope and experience of their licensure in the State of Nevada, and the Clinical Supervisor will provide oversight of those services rendered to the recipient under the PT 14 agency.

Q: We have received two denials for service 90791 for new patients who have received but did not report the service from another provider. How can we mitigate losses? The SMI don't always understand what svc they are receiving. This is for therapy service denials due to patients receiving the service with other providers. We are unable to identify when this is happening. We rely on patient report and the SMI many times do not report accurately.
A: Providers can support recipients in requesting their own medical records to determine what services have been provided. If the recipient knows their previous provider, the current provider can obtain a release of information from the recipient to inquire of services received.

Q: Where do we submit the inquiry [on services that have been provided to the recipient]?
A: You may assist the recipient, at their request, to submit the inquiry. You will find the information on the DHCFP website and click on Records Request. It will bring you to http://dhcfp.nv.gov/About/HIPAA/HIPAArecordreq/ and this will provide more information for a recipient requesting records.

Q: Can non-Medicaid providers attend trainings? I'm considering becoming a provider but have not yet submitted my provider application.
A: Trainings provided by Nevada Medicaid are currently designed for providers enrolled with Nevada Medicaid, providing services to Medicaid recipients.

Q: The new checklist states that you need all signatures we can just have each party sign it and scan it to a pdf version and attach it during enrollment as before or do we have to mail it in?
A: You can still scan the documents in. We do not accept mailed in documents.

Q: The new checklist for the agency has a new line on billing. It is requesting name, social, dob, phone, and address. What do we put if we have an in-house biller who could change when people quit of get hired or are out on vacation?
A: You would put your in-house biller's information. If that information changes, it should be reported as a change. If the biller is on vacation, it does not apply. The intent is to know who is billing for the group.

Q: What if you use an outside agency for billing and do not have the social security number but do have a tax ID? Can we use the tax ID there?
A: You would provide the information for the billing provider. The intent is to understand who is completing the billing for your group. If the biller is a business, a tax ID would be provided.

Q: Can recipients go to other providers to receive a service they are not receiving in their IOP program?
A: No, the treatment plan that identifies IOP as a service needs to fully encompass all services required by the recipient. If a Provider Type 14 BHCN is not able to meet this requirement, it should not be billing the IOP service. The IOP service under a Provider Type 14 BHCN is inclusive of Outpatient Mental Health (OMH) and Rehabilitative Mental Health (RMH) services.

Q: We are attempting to switch a provider from a QMHA to a QMHP. We have submitted the request and were told we have to create a new NPI # and re-enroll. We were also informed that we can attach a letter asking for the same NPI # to be used. Please assist.
A: Enrollments inquiries are addressed on a case by case basis. You may email behavioralhealth@dhcfp.nv.gov with the details to include: current NPI, name of provider, and application tracking number. You can also contact providerenrollment@dhcfp.nv.gov for assistance.

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