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

BEHAVIORAL HEALTH TECHNICAL ASSISTANCE
Agenda – Wednesday, January 11, 2017
10:00 - 11:00 a.m.

Facilitator: Alexis Tucey, DHCFP Behavioral Health Supervisor

Webinar Address: WEBEX Registration Link

1. **Purpose of BH Monthly Calls**
   a. Questions and comments may be submitted to BehavioralHealth@dhcfp.nv.gov prior to the webinar or after for additional questions. The webinar meeting format offers providers an opportunity to ask questions via the Q & A or the "chat room" and receive answers in real time.
   b. Introductions – DHCFP, SURS, HPES

3. **DHCFP Updates**
   a. Policy updates and workshops – Alexis Tucey
   Public Notice Link
   b. Behavioral Health Community Networks (BHCN) Updates- Crystal Johnson
   BHCN FAQ's

4. **DHCFP Surveillance Utilization Review Section (SURS)**
   Updates or reminders for Providers: Kurt Karst, Surveillance and Utilization Review (SUR) Unit. No Updates

5. **HPES Updates**
   Ismael Lopez-Ferratt, MBA NV Medicaid Provider Field Services Behavioral Health
   a. HPE Reminder for Providers: Nevada Medicaid Behavioral Health Announcements & Newsletters
   Joann Katt, LPN, Medical Management Center/Behavioral Health Team Lead
   a. Request timelines: Provider Type 14 Billing Guidelines
      - Initial request for Outpatient Mental Health (OMH) and Rehabilitative Mental Health (RMH) services (Basic Skills Training, Day Treatment, Peer-To-Peer Support and Psychosocial Rehabilitation): Submit no more than 15 business days before and no more than 15 calendar days after the start date of service.
      - Continued service requests: If the recipient requires additional services or dates of service (DOS) beyond the last authorized date, you may request review for continued service(s) prior to the last authorized date. The request must be received by HPE by the last authorized date and it is recommended these be submitted 5 to 15 days prior to the last authorized date.
      - Unscheduled revisions: Submit whenever a significant change in the recipient's condition warrants a change to previously authorized services. Must be submitted during an existing authorization period and prior to revised units/services being rendered. The number of

requested units should be appropriate for the remaining time in the existing authorization period.

- Retrospective request: Submit no later than 90 days from the recipient's Date of Decision (i.e., the date the recipient was determined eligible for Medicaid benefits). All authorization requirements apply to requests that are submitted retrospectively.