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

BEHAVIORAL HEALTH TECHNICAL ASSISTANCE
Minutes – Wednesday, November 14, 2018
10:00 - 11:00 a.m.

Facilitator: Kim Riggs, DHCFP, Behavioral Health Social Services Specialist

1. **Purpose of BH Monthly Calls**
   a. Questions and comments may be submitted to BehavioralHealth@dhcfp.nv.gov
   b. 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.
   c. Introductions – DHCFP, Kim Riggs, Carin Hennessey, SURS Representative and DXC Technology, Joann Katt, LPN, Medical Management

2. **DHCFP Public Notices Reviewed:**

Please follow the following link provided to the DHCFP Public Notices, http://dhcfp.nv.gov/Public/AdminSupport/PublicNotices/

- **Medication Training and Support, Date: 10/12/2018 Time: 2:30 PM**
- **Psychotherapy and Neurology Services Date: 10/25/2018 Time: 1:00 PM**
  Provider Question: Does the current policy need to be applied per the current policy prior to the October 25th schedule Public Hearing?
  Answer:
  http://dhcfp.nv.gov/uploadedFiles/dhcfpnvgov/content/Public/AdminSupport/MeetingArchive/PublicHearings/2018/MSM_PH_10_25_18_Ch_400.pdf
  The Division Administrator may choose to not implement a policy that would be more restrictive to providers if deemed appropriate. The previously approved policy for prior authorization after five sessions for psychotherapy and neurotherapy for the period of October 1, 2018 to October 25, 2018 will not be implemented to reduce impact to providers and recipients.

3. **Behavioral Health Community Networks (BHCN) Updates:**

DHCFP Social Services Program Specialist, Sheila Heflin-Conour. No updates. If you have further questions concerning BHCN. Please refer to email address provided on the DHCFP website.

4. **DHCFP Surveillance Utilization Review Section (SUR)**

Updates or reminders for Providers: Kurt Karst, Surveillance and Utilization Review (SUR) Unit.
Medical Services Manuals (MSM) Link:
Please remember that all MSM Chapters per your enrollment as a Nevada Medicaid Provider, under any specific provider, has more than one policy that needs to be reviewed. Per each enrollment it indicates per specific enrollments under the Provider Type 14 which can be found on www.medicaid.nv.gov for the following providers and what is required. Each provider specialty under PT 14 should be well acquainted with the requirements.
Reviewed example: Specialty 300, Qualified Mental Health Professional (QMHP), https://www.medicaid.nv.gov/Downloads/provider/NV_EnrollmentChecklist_PT14_Spec300.pdf

Policy Declaration:
"I hereby declare that I have read the current Medicaid Services Manual (MSM) Chapters 100, 400 and 3300 as of the date below and understand this policy and how it relates to my scope of practice. I acknowledge that, as a Nevada Medicaid-contracted provider, I am responsible for complying with the MSM Chapters, with any updates to this policy as may occur from time to time and with applicable state and federal laws."

QMHP Signature: _____ Date:

***This means that per your enrollment you have reviewed and signed that you understood all the following required MSM above and the State and Federal laws that are applicable.**

Reviewed the following policy citation:
Medicaid Services Manual 3300 – Program Integrity. AS stated this Chapter has not been updated since February 19, 2008. Please review the following policy per MSM Chapter 3300. Always review remittance clearly to avoid any issue concerning billing issues. Reviewed definitions under 3302 Definitions:

- **3302.1 ABUSE,**

Abuse means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid or Nevada Check Up programs, or in reimbursement for services that are not medically necessary or fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid or Nevada Check Up programs. (42 CFR 455.2)
Provided example: Recipient receiving Basic Skills training services in a daily assisted living center. No documentation to identify that the in-home services had been provided in a daily assisted living center.

- 3302.2 ADMINISTRATIVE ACTION,
- 3302.3 FRAUD,
- 3302.4 IMPROPER PAYMENT
- 3302.5 KICKBACKS
- 3302.6 OVERPAYMENT/UNDERPAYMENT
- 3302.7 PERM REVIEW ERRORS
- 3302.8 RECOUPMENT/RECOVERY
- **3302.9 UNBUNDLING**

Unbundling is the billing of separate procedure codes rather than one all-inclusive code, when an all-inclusive code is required to be billed. Provided examples: Intensive Outpatient Program, Partial Hospitalization Program (PHP) and Residential Treatment Center (RTC) are all inclusive codes.

- **3302.10 UP-CODING**

Up-coding is billing using procedure codes that overstate the level or amount of health care or other service provided.
Provided example: A child with Autism that cannot sit still for a one-hour therapy based on level of recipient's ability's. Therapy code requested one-hour of therapy while documentation states child cannot maintain attention for more than 30 minutes. Review documentation adjust to a 30-minute psychotherapy per recipient's needs.

Also reviewed: MSM Chapter 3300,3300.1A, Coverage and Limitations; Section 2. Fraudulent acts, false claims or abusive billing practices include, but not limited to; a- X highlighted 3300.1A, Coverage and Limitations;

t. Submitting a claim which misrepresents the description of the services, supplies or equipment dispensed or provided, the date of service, the identity of the recipient or of the attending, prescribing, referring or actual provider.
u. Submitting a claim for medically unnecessary services;
v. Coercion of recipients to sign Verification of Service forms for services not provided;
w. Reporting or billing for hours or services, when services were not provided to the extent reported or billed;

3303.1B Provider Responsibilities

1. Providers have an obligation to report to the DHCFP any suspicion of fraud or abuse in DHCFP programs, including fraud or abuse associated with recipients or other providers.
2. Providers must adhere to:
    a. DHCFP policy;
    b. Provider services and operations manuals;
    c. Fiscal agent billing manuals;
    d. All applicable federal law and state statutes; and
    e. Any other guidance furnished by the DHCFP or their fiscal agent regarding provider requirements and responsibilities.

Follow up per policy reviewed on BHTA: What is required for proper documentation per every RMH service.

403.6B REHABILITATIVE MENTAL HEALTH (RMH) SERVICES: Please review. RMH services must have a Rehabilitative Plan that ensures the recipients are receiving the correct services by the qualified mental health professional. Please make sure all staff reviews the following

a. the recipient's name;
b. progress notes must reflect the date and time of day that RMS services were provided; the recipient's progress toward functional improvement and the attainment of established rehabilitation goals and objectives; the nature, content and number of RMH service units provided; the name, credential(s) and signature of the person who provided the RMH service(s). Progress notes must be completed after each session and/or daily; progress notes are not required on days when RMH services are not provided; a single progress note may include any/all the RMH services provided during that day;
c. the recipients and their families/legal guardians (in the case of legal minors) acknowledgement of their freedom to select a qualified Medicaid provider of their choosing;
d. indications that the recipients and their families/legal guardians (in the case of legal minors) were involved in all aspects care planning;
e. indications that the recipients and their families/legal guardians (in the case of legal minors) are aware of the scope, goals and objectives of the RMH services made available; and
f. the recipients and their families/legal guardians (in the case of legal minors) acknowledgement that RMH services are designed to reduce the duration and intensity of care to the least intrusive level of care possible while sustaining the recipient's overall health.

5. **DXC Technology Updates:**

Peer to Peer or Reconsiderations: can be requested for prior authorizations that are denied or modified. The QIO Vendor, DXC Technology Hearing process, where can I find this information?

This information can be found on the Nevada Medicaid website, follow the link below which can be found per the www.medicaid.nv.gov. Go to Billing Information look for "Billing Manual" right above all provider types billing guides on the Billing Information page. Please review pages 32 and 33 for complete information for the requirements of the Peer to Peer or the Reconsideration process.
Again, remember only new additional medical information can be submitted. If a provider submits the same information the decision will stand denied or modified.
"Voluminous documentation will not be reviewed to determine medical necessity of requested services. It is the provider's responsibility to identify the pertinent information in the synopsis".

6. **NEW 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 providers and make sure the specialists are focusing training and educational components tailored to your needs and your direct input from the BHTA WebEx. Review last month's questions in detail.

Q: **Clarification needed: Neuro -Feedback and Psychotherapy are not counted together. If a patient was seen for Neuro for 1 session for the week and 1 time for individual psychotherapy, it will count towards service limitations of 1 session neuro and 1 ptherapy (psychotherapy)?**
A: Please review the Behavioral Health Announcements on the www.medicaid.nv.gov. Web Announcement 1681 for updated information to policy clarification. Please also visit MSM Chapter 400, 403.4 Outpatient Mental Health Services for Neurotherapy; C. Mental Health Therapies. MS Chapter 400 Link:
http://dhcfp.nv.gov/uploadedFiles/dhcfpnvgov/content/Resources/AdminSupport/Manuals/MSM/C400/MSM_400_18_10_26.pdf

Q. Neurotherapy
A. **Neurotherapy is individual psychological therapy incorporating biofeedback training combined with psychotherapy** as a treatment for mental health disorders. Medicaid will reimburse for medically necessary neurotherapy when administered by a licensed **QMHP within the scope of their practice and expertise**. A certified Biofeedback Technician may assist in the provision of biofeedback treatment; however, **a QMHP must provide the associated psychotherapy**. Reimbursement for biofeedback treatment provided by a Biofeedback Technician is imbedded in the QMHP rate.
As stated per the BHTA the Neurotherapy should include the psychotherapy.

Q: **Can I get a call regarding Neuro-feedback CPT codes. I emailed twice.**
A: Please review all billing information, including billing guides for specific Provider Types on the Nevada Medicaid Provider Website, www.medicaid.nv.gov. or review the American Medical Association current CPT 2018 Professional publication. If this is a clarification per policy, please reach out to Carin Hennessey at the following email address below.
DHCFP BH Specialist, Carin Hennessey, carin.hennessey@dhcfp.nv.gov

Please email questions, comments or topics that providers would like addressed any time or please ask per the BHTA WebEx to be discussed per the following months BHTA. Email Address: kriggs@dhcfp.nv.gov