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

BEHAVIORAL HEALTH TECHNICAL ASSISTANCE
Minutes – Wednesday, May 9, 2018
10:00 - 11:30 a.m.

Facilitator: Kim Riggs, DHCFP, Social Services Program Specialist

Webinar Address: WEBEX Registration Link

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, SURS, DXC Technology

2. **Monthly Training,** Social Services Program Specialist, Kim Riggs
   Outpatient Mental Health Services, Medicaid Services Manual (MSM) Chapter 400, 403.4
   http://dhcfp.nv.gov/uploadedFiles/dhcfpnvgov/content/Resources/AdminSupport/Manuals/MSM/C400/MSM_400_17_11_17.pdf

403.4 OUTPATIENT MENTAL HEALTH SERVICES
These services include assessment and diagnosis, testing, basic medical and therapeutic services, crisis intervention, therapy, partial and intensive outpatient hospitalization, medication management and case management services. For case management services, refer to MSM Chapter 2500 for Non-SED and Non-SMI definitions, service requirements, service limitations, provider qualifications and documentation requirements.

A. Assessments are covered for problem identification (diagnosis) and to establish measurable treatment goals and objectives by a QMHP or designated QMHA in the case of a Mental Health Screen.

   a. **Mental Health Screen** – A behavioral health screen to determine eligibility for admission to treatment program.

   b. **Comprehensive Assessment** – A comprehensive, evaluation of a recipient's history and functioning which, combined with clinical judgment, is to include a covered, current ICD diagnosis and a summary of identified rehabilitative treatment needs. Health and Behavior Assessment – Used to identify the psychological, behavioral, emotional, cognitive and social factors important to the prevention, treatment or management of physical health needs. The focus of the assessment is not on the mental health needs, but on the biopsychosocial factors important to physical health needs and treatments. The focus of the intervention is to improve the recipient's health and well-being utilizing cognitive, behavioral, social and/or psychophysiological procedures designed to ameliorate specific disease related needs. This type of assessment is covered on an individual basis, family with the recipient present or family without the recipient present.

   c. **Psychiatric Diagnostic Interview** – Covered once per calendar year without prior authorization. If there is a substantial change in condition, subsequent assessments may be requested through a prior-authorization from the QIO-like vendor for Nevada Medicaid. A psychiatric diagnostic interview may consist of a clinical interview, a medical and mental history, a mental status examination, behavioral observations, medication evaluation and/or prescription by a licensed psychiatrist. The psychiatric diagnostic

interview is to conclude with a written report which contains a current ICD diagnosis and treatment recommendations.

d. **Psychological Assessment** – Covered once per calendar year without prior authorization. If there is a substantial change in condition, subsequent assessments may be requested through a prior-authorization from the QIO-like vendor for Nevada Medicaid. A psychological assessment may consist of a clinical interview, a biopsychosocial history, a mental status examination and behavioral observations. The psychological assessment is to conclude with a written report which contains a current ICD diagnosis and treatment recommendations.

e. **Functional Assessment** - Used to comprehensively evaluate the recipient's skills, strengths and needs in relation to the skill demands and supports required in the particular environment in which the recipient wants or needs to function; as such, environment is consistent with the goals listed in the recipient's individualized Treatment Plan. A functional assessment is used to assess the presence of functional strengths and needs in the following domains: vocational, education, self-maintenance, managing illness and wellness, relationships and social. A person-centered conference is covered as part of the functional assessment to collaboratively develop and communicate the goals and objectives of the individualized Treatment Plan. The conference must include the recipient, a QMHP, family or legal representative, significant others and case manager(s). The case manager(s) or lead case manager, if there are multiple case managers shall provide advocacy for the recipient's goals and independence, supporting the recipient's participation in the meeting and affirming the recipient's dignity and rights in the service planning process.

f. **Intensity of Needs Determination** - A standardized mechanism to determine the intensity of services needed based upon the severity of the recipient's condition. **The intensity of needs determination is to be utilized in conjunction with the clinical judgment of the QMHP and/or trained QMHA**. This assessment was previously known as a level of care assessment. Currently, the DHCFP recognizes the Level of Care Utilization System (LOCUS) for adults and the Child and Adolescent Screening Intensity Instrument (CASII) for children and adolescents. There is no level of care assessment tool recognized by the DHCFP for children below age six, however, providers must utilize a tool comparable to the CASII and recognized as a standard of practice in determining the intensity of needs for this age group.

   NOTE: After the Intensity of Needs determinations per the qualified provider noted above, please review as suggested within the WebEx the Intensity of Needs Grid (MSM CHAPTER 400, 403.5 – pages 20-23.

g. **Intensity of Needs Grid** - The intensity of needs grid is an approved Level of Care (LOC) utilization system, which bases the intensity of services on the assessed needs of a recipient. The determined level on the grid guides the interdisciplinary team in planning treatment to improve or retain a recipient's level of functioning or prevent relapse. Each Medicaid recipient must have an intensity of needs determination completed prior to approval to transition to more intensive services (except in the case of a physician or psychologist practicing as independent providers). The intensity of needs grid was previously referred to as level of services grid.

h. **Severe Emotional Disturbance (SED) Assessment** - Covered annually or if there is a significant change in functioning. The SED assessment is a tool utilized to determine a recipient's eligibility for higher levels of care and Medicaid service categories.

i. **Serious Mental Illness (SMI) Assessment** - Covered annually or if there is a significant change in functioning. The SMI assessment is a tool utilized to determine a recipient's eligibility for higher levels of care and Medicaid service categories.

B. Neuro-Cognitive, Psychological and Mental Status Testing

a. Neuropsychological Testing with interpretation and report involves assessment and evaluation of brain behavioral relationships by a neuropsychologist. The evaluation consists of qualitative and quantitative measurement that consider factors such as the interaction of psychosocial, personality/emotional, intellectual, environmental, neurocognitive, biogenetic, and neurochemical aspects of behaviors in an effort to understand more fully the relationship between physiological and psychological systems. This service requires prior authorization from the QIO-like vendor.

b. Neurobehavioral Testing with interpretation and report involves the clinical assessment of thinking, reasoning and judgment, acquired knowledge, attention, memory, visual spatial abilities, language functions and planning. This service requires prior authorization.

c. Psychological Testing with interpretation and report is the administration, evaluation and scoring of standardized tests which may include the evaluation of intellectual functioning, clinical strengths and needs, psychodynamics, insight, motivation and other factors influencing treatment outcomes. Prior authorization may be requested for additional services based upon medical necessity.

C. Mental Health Therapeutic Interventions

a. **Partial Hospitalization Program (PHP)** – Traditional – Services furnished under a medical model by a hospital, in an outpatient setting, which encompass a variety of psychiatric treatment modalities designed for recipients with mental or substance abuse disorders who require coordinated, intensive, comprehensive and multidisciplinary treatment not generally provided in an outpatient setting. These services are expected to reasonably improve or maintain the individual's condition and functional level to prevent relapse of hospitalization. The services are intended to be an alternative to inpatient psychiatric care and are generally provided to recipients experiencing an exacerbation of a severe and persistent mental illness. PHP services include active therapeutic treatment and must be targeted to meet the goals of alleviating impairments and maintaining or improving functioning to prevent relapse or hospitalization.

b. **Intensive Outpatient Program (IOP)** – A comprehensive interdisciplinary program of an array of direct mental health and rehabilitative services which are expected to improve or maintain an individual's condition and functioning level for prevention of relapse or hospitalization. The services are provided to individuals who are diagnosed as severely emotionally disturbed or seriously mentally ill.

NOTE: Per Billing Guide, which can be found on https://www.medicaid.nv.gov/providers/BillingInfo.aspx, Provider Type 14 Partial Hospitalization and Intensive outpatient psychiatric services an evidenced based treatment programs. Per policy highlighted and discussed these programs are an all-inclusive rate that needs to be prior Authorized (2 week at a time). Please make sure per policy that all other services per the, Intensity of Needs Grid have been exhausted and remember that when billing IOP services, no other services can be requested in conjunction with procedure Code S9480, Intensive outpatient program. PHP and IOP services, should divert a recipient from a higher level of care by providing intensive services and be directly provided by a multidisciplinary team at the all-inclusive rate to include all OMH and RMH services.

Program Therapy	
H0035	Mental health partial hospitalization, treatment, less than 24 hours **Billing Instructions: One unit equals 60 minutes**.
S9480	Intensive outpatient psychiatric services, **per diem** **Billing Instructions: One unit equals 1 day.**

c. **Medication Management** – A medical treatment service using psychotropic medications for the purpose of rapid symptom reduction, to maintain improvement in a chronic recurrent disorder, or to prevent or reduce the chances of relapse or reoccurrence. Medication management must be provided by a psychiatrist or physician licensed to practice in the State of Nevada and may include, through consultation, the use of a physician's assistant or a certified nurse practitioner licensed to practice in the State of Nevada within their scope of practice. Medication management may be used by a physician who is prescribing pharmacologic therapy for a recipient with an organic brain syndrome or whose diagnosis is in the current ICD section of Mental, Behavioral and
Neurodevelopmental Disorders and is being managed primarily by psychotropic drugs. It may also be used for the recipient whose psychotherapy is being managed by another mental health professional and the billing physician is managing the psychotropic medication. The service includes prescribing, monitoring the effect of the medication and adjusting the dosage. Any psychotherapy provided is minimal and is usually supportive only. If the recipient received psychotherapy and drug management at the same visit, the drug management is included as part of that service by definition and medication management should not be billed in addition.
NOTE: (Refer below to DHCFP Updates)

C. Mental Health Therapies

Mental health therapy is covered for individual, group and/or family therapy with the recipient present and for family therapy without the recipient present and described as follows:

a. **Family Therapy**
Mental health treatment service provided to a specific recipient by a QMHP using the natural or substitute family as the means to facilitate positive family interactions among individuals. The recipient does not need to be present for family therapy services; however, the services must deal with issues relating to the constructive integration/reintegration of the recipient into the family.

b. **Group Therapy**
Mental Health treatment service facilitated by a QMHP within their scope of licensure or practice, which utilizes the interactions of more than one individual and the focus of the group to address behavioral health needs and interpersonal relationships. The therapy must be prescribed on the Treatment Plan and must have measurable goals and objectives. Group therapy may focus on skill development for learning new coping skills, such as stress reduction, or changing maladaptive behavior, such as anger management. Participation in group therapy must be documented on the clinical record. Minimum group size is three and maximum therapist to participant ratio is one to ten. Group therapy can be less than three but more than one based on unforeseen circumstances such as a no-show or cancellation but cannot be billed as individual therapy. Group therapy may also include a family without the recipient present and/or multi-family groups.

c. **Individual Therapy Services**

Mental health treatment service provided to a specific recipient for a presenting need by an individual therapist for a specified period of time. The amount, scope and duration of individual therapy services may vary depending on the stage of the presenting mental health need, treatment program and recipient's response to the treatment approach. Individual is one recipient. Each direct one-on-one episode must be of a sufficient length of time to provide the appropriate skilled treatment in accordance with each patient's treatment/rehabilitative plan.

d. **Neurotherapy**

i. 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.

NOTE: All providers utilizing a certified Biofeedback technician must make sure they have a current certification on file. Please refer to the qualified Biofeedback Certification International Alliance (BCIA) providers. This site below can confirm all registered BCIA Board Certified Practitioners within any state for reference. http://certify.bcia.org/4DCGI/resctr/search.html

ii. Prior authorization requirements and QIO-like vendor responsibilities are the same for all out-patient therapies, except for the following allowable service limitations for neurotherapy used for treatment of the following covered ICD Codes:

1. Attention Deficit Disorders – 40 sessions
   Current ICD Codes: F90.0, F90.8 and F90.9
2. Anxiety Disorders – 30 sessions
   Current ICD Codes: F41.0 and F34.1
3. Depressive Disorders – 25 sessions
   Current ICD Codes: F32.9, F33.40, F33.9, F32.3 and F33.3
4. Bipolar Disorders - 50 sessions
   Current ICD Codes: F30.10, F30.9, F31.0, F31.10, F31.89, F31.30, F31.60, F31.70, F31.71, F31.72, F31.9 and F39
5. Obsessive Compulsive Disorders – 40 sessions
   Current ICD Codes: F42
6. Opposition Defiant Disorders and/or Reactive Attachment Disorders – 50 sessions
   Current ICD Codes: F93.8, F91.3, F94.1, F94.2, F94.9 and F98.8
7. Post-Traumatic Stress Disorders – 35 sessions
   Current ICD Codes: F43.21, F43.10, F43.11 and F43.12
8. Schizophrenia Disorders – 50 sessions
   Current ICD Codes: F20.89, F20.1, F20.2, F20.0, F20.81, F20.89, F20.5, F25.0, F25.1, F25.8, F25.9, F20.3 and F20.9

Prior authorization may be requested for additional services based upon medical necessity.

3. **DHCFP Updates**
   a. The DHCFP Behavioral Health Unit Staff Updates
   b. Public Workshops Update: http://dhcfp.nv.gov/Public/AdminSupport/PublicNotices/
   c. Announcements/Updates: https://www.medicaid.nv.gov/providers/newsannounce/default.aspx
      Web Announcement 1581, Important Information Regarding Authorization Criteria Search Function
      Web Announcement 1577, Payer path Claim Submission Training for May 2018
      Web Announcement 1575, New Provider Training Scheduled for May 2018
   d. Behavioral Health Community Networks (BHCN) Updates: Social Services Program Specialist, Sheila Heflin-Conour.
      Refer to MSM CHpater400, specific to Behavioral Health Community Networks (BHCN) Section 403.1 Outpatient Services Delivery Models, Section 403, pages 1 -5.
   e. Social Services Program Specialists: DHCFP Outpatient Services, Kim Riggs
      - Upcoming MSM, Chapter 400 Training. Intensive Outpatient Programs, Thursday, May 17th at 10:00 am. Currently, if you receive an e-mail reminder for the Behavioral Health Technical Assistance Webinars, you will also receive an invitation reminder for the May 17th training.
      - Medication Training and Support (H0034), this service must be preceded by a prescribed medication, can only be provided by a QMHP and/or a Registered Nurse and must be medically appropriate and within best practices.
        Q: Who can provide Medication Training and Support service? A: MSM 403.4(d)(4): Medication Training and Support – Provided by a professional other than a physician, is covered for monitoring of compliance, side effects, recipient education and coordination of requests to a physician for changes in medication(s). Please also refer to State Plan, Attachment 3.1-A, Page 6b.3.
        Q: Who qualifies as a “professional”? A: A QMHP other than a physician, Licensed Clinical Social Worker, Licensed Marriage and Family Therapist, Clinical Professional Counselor and a register nurse enrolled as a QMHA. Please refer to Provider Type 14 Billing guide for utilization of Modifier TD when utilizing a register nurse to provide Medication training and support. Please make sure all services provided per the indicated professional are within the scope of their practice under state law.

   f. Social Services Program Specialists: DHCFP Briza Virgen, as a reminder, it is the responsibility of the Behavioral Health providers to have read and understand the following Medicaid Service Manuals:
      - Chapter 100, Medicaid Program
      - Chapter 400, Mental Health and Alcohol and Substance Abuse Services
      - Chapter 3300, Program Integrity
   g. Governor’s Audit of BH Providers and resulting activities
      New training component within monthly BH TA Meetings
      - June 13th, Therapy treatment milieus
      - July 11th, Rehabilitative Mental Health Services

4. **DHCFP Surveillance Utilization Review Section (SURS)**
   Updates or reminders for Providers: Kurt Karst, Surveillance and Utilization Review (SUR) Unit. Qualified Behavioral Aides (QBA) and Qualified Mental Health Associates (QMHA) cannot bill independently.

5. **DXC Technology Updates**
   Updates or reminder for Providers:
   Joann Katt, LPN, Medical Management Center/Behavioral Health Team Lead.

Group therapy is requested in “sessions”. A session is no more than 2 hours. If requesting 2, 3, 4 sessions please clarify in documentation as to why. Individual therapy is coded according to a timeframe and not in units. If requesting above policy limits, documentation must support it.

RMH services are in MSM Chapter 400 with limitations as a “guide” for timeframe. We would expect to see a change after 6 months of providing RMH services. If no progress is made documentation should indicate if a different avenue is being looked at to alter a better outcome, i.e.: Psych. Testing to determine alternate dx. Or extent of current dx, is there a change in the approach to the treatment plan to facilitate different learning styles of all individuals. Prefer documentation of treatment plan to not be “cut and paste” of MSM Chapter 400 but rather individualized per recipient and “how” the provider will support the definition of the RMH service.
Utilize therapy prior to requesting RMH to determine by the therapist vs. parent, grandparent, aunt, uncle, foster parent which service would benefit recipient. RMH are short term to improve a lost skill or learned behavior with the anticipation to step back down to individual therapies.

Stephanie Ferrell, Provider Services Field Representative Updates.

Please email questions, comments or topics that providers would like addressed any time prior to the monthly webinar.
Email Address: BehavioralHealth@dhcfp.nv.gov