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

BEHAVIORAL HEALTH TECHNICAL ASSISTANCE
Minutes – Wednesday, September 11, 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, Sheila Heflin-Conour, SURS Representative and DXC Technology, Joann Katt, LPN, Medical Management

2. **DHCFP Review Recent Notifications DHCFP Public Notices:**
   Please follow the following link provided to the DHCFP Public Notices, http://dhcfp.nv.gov/Public/AdminSupport/PublicNotices/
   - Reviewed Proposed Solutions for Psychotherapy and Neurotherapy, September 11, 2018 per the Division of Health Care Financing and Policy Website. Navigated provider to the website to Public Notification to provide the information and review all posted (agenda and power point presentation). Reviewed and highlighted the Behavioral Health Focus Group discussions. Providers suggested further comments those will be referred to the Behavioral Health Supervisor and DHCFP administration.

   Other items reviewed:
   - Where to find past BHTA Agendas and Minutes per DHCFP Behavioral Health Services Program site. Reminded providers all Q/A 's discussed during the BHTA will be included in the minutes. This is to assist with further education and training to clarify policy questions.
   - Reviewed the Nevada Medicaid Provider enrollment checklist requirements below addressing Policy Declaration:

     Policy Declaration below:
     - ✓ I hereby declare that I have read the current MSM Chapters 100, 400 and 3300 as of the date above and understand the policies and how they apply to my scope of practice.
     - ✓ I acknowledge that, as a Nevada Medicaid-contracted provider, I am responsible for complying with the MSM, and with any updates that may occur to these policies as applicable by state and federal laws.
     - ✓ Based on this understanding, I agree to abide by the scope of service, provider qualifications, service limitations and admission criteria detailed in sections: "Outpatient Mental Health (OMH) Services" and "Rehabilitative Mental Health (RMH) Services."

   Below is the link to all Medicaid Services Manuals (MSM) Chapter's 100, 400,and 3300.
   http://dhcfp.nv.gov/Resources/AdminSupport/Manuals/MSM/MSMHome/

3. **Behavioral Health Community Networks (BHCN) Updates:**
   DHCFP Social Services Program Specialist, Sheila Heflin-Conour.
   Where to find BHCN Frequently Asked Questions (FAQs)
   http://dhcfp.nv.gov/uploadedFiles/dhcfpnvgov/content/Pgms/CPT/BHCNFAQ-Ver111-07-16.pdf
   - Shelia reviewed the FAQ's with the providers. Providers were asked to submit any questions they felt would assist them or other providers that have not been included or addressed in the current BHCN FAQ's. Please provide those suggestion questions related to the BHCN FAQ's attention. The new FAQ will be update by October 31, 2018 to assist the BHCN providers.
   - Email address provided: MCandQuality@dhcfp.nv.gov

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

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

6. **NEW Behavioral Health Provider Questions/Answers:**

Q: We can submit the FA29 on the online portal?
A: Yes, to your current authorization
FA-29 FORMS:
The difference between a FA-29 and a FA-29A. Links to forms located on the Nevada Medicaid Provider Website. https://www.medicaid.nv.gov/providers/forms/forms.aspx
The FA-29 – Data Correction Form: should be utilized to update the recipient's services, such as if a recipient has decided to change providers. The primary provider should utilize the FA-29 to end the open prior authorization of the outstanding prior authorization request.
The FA-29 (A) – Request to Termination of Service: Use this form to terminate services from an existing provider. This should only be utilized if the new provider has tried to contact the prior provider with no success to ask for the existing provider to close the open PAR with a FA-29. At this point the new provider would have the Nevada Medicaid Recipient fill out and sign the FA-29A to terminate the existing providers PA. Again, the recipient must sign this form not just the new provider. You need to fill out the terminating providers contact information which should have been obtained per reaching out to close existing services for the recipient with the existing provider. This is when as the new provider you would request past treatment history and obtain the service information for the list of services that need to be closed.
Per question below DXC Technology will review the following forms the BH providers to understand the different FA-29 forms in October BHTA.

Q: What form is used if you were approved for a specific therapy auth but halfway through the auth period, you would like to change the therapy code? is it still reconsideration form since it was approved and not denied?
Next Month Discuss the FA-29 (B) - Prior Authorization Reconsideration Request
Purpose: Request a reconsideration on any denied services on an authorization request

CURRENT POLICY CHANGES:

Q: In regard to yesterday's public meeting to ensure no interruption of service is it permissible to begin submit PA's on 9/21/18

Q: I understand that many parking lot items will be addressed at the next focus meeting with the date of October 1st. still be implemented?

Q: We don't have to guess if clients have been to another agency, sessions re-start to 0

A: Please review posted Medicaid Update per the recent Nevada Medicaid Conference. https://www.medicaid.nv.gov/Downloads/provider/Behavioral_Health_Conference_Presentation.pdf

DHCFP BH Specialist will also review per the October agenda upcoming public notifications.

CRISIS INTERVENTION SERVICES:

Q: For crisis intervention, is it 3 occurrences per rolling 90 days or PA period

Q: Back to CI, if there an active PA for RMH services and therapy do we get 3 occurrences of CI during the PAR period or any 3 month?

A: Per Crisis intervention services, if a recipient is in at this higher level of care it would be directed by clinical oversight to determine a need for further services per the required follow-up CI services which stabilize the recipient to prevent a hospitalization, conduct situational risk-of-harm assessment and follow-up with de-briefing sessions to ensure stability of the recipient and identify further ongoing services needed per the clinical oversight from the QMHP or the identified lead QMHP. .

403.6H CRISIS INTERVENTION (CI) SERVICES

1. Scope of Services: CI services are RMH interventions that target urgent situations where recipients are experiencing acute psychiatric and/or personal distress. The goal of CI services is to assess and stabilize situations (through brief and intense interventions) and provide appropriate mental and behavioral health service referrals. The objective of CI services is to reduce psychiatric and personal distress, restore recipients to their highest level of functioning and help prevent acute hospital admissions. CI interventions may be provided in a variety of settings, including but not limited to psychiatric emergency departments, emergency rooms, homes, foster homes, schools, homeless shelters, while in transit and telephonically. CI services do not include care coordination, case management, or targeted case management services (see MSM Chapter 2500, Targeted Case Management).

CI services must include the following:

a. Immediate and intensive interventions designed to help stabilize the recipient and prevent hospitalization;

b. Conduct situational risk-of-harm assessment;

c. Follow-up and de-briefing sessions to ensure stabilization, continuity of care and identification of referral resources for ongoing community mental and/or behavioral health services.

2. Provider Qualifications: QMHPs may provide CI services. If a multidisciplinary team is used, the team must be led by a QMHP. The team leader assumes professional liability over the CI services rendered.

3. Service Limitations: Recipients may receive a maximum of four hours per day over a three-day period (one occurrence) without prior authorization. Recipients may receive a maximum of three occurrences over a 90-day period without prior authorization.

Service Limitations	Children: CASII	Adults: LOCUS
Levels I to VI	• Maximum of four hours per day over a three-day period (one occurrence) • Maximum of three occurrences over a 90-day period	• Maximum of four hours per day over a three-day period (one occurrence) • Maximum of three occurrences over a 90-day period

4. Admission Criteria: Clinical documentation must demonstrate that the recipient meets any combination of the following:

a. Recipient's behavior requires immediate and intensive interventions to help stabilize the current situation and prevent hospitalization;
b. Recipient presents a moderate risk of danger to themselves and others (or to deteriorate to this dysfunctional level);
c. Recipient's immediate behavior is unmanageable by family and/or community members; and/or
d. Recipient will benefit from the stabilization, continuity of care and the referrals for ongoing community mental and/or behavioral health services.

Q: This may have been answered in previous meetings, if so, I apologize. Do you still plan on requiring one treatment plan for rehab and clinic services, rather than separate plans?
A: Until new policy per the Individualized Treatment plan is proposed for review and public input, please utilize the current MSM Chapter 400 Behavioral health guidelines as they are indicated per treatment planning. Please refer to the October agenda under Public notifications.

Q: Is it permissible to submit a FA-11 with the service provider NPI the same as the requesting provider NPI. For example, the requesting provider is the Behavioral Health Center and the servicing provider is the Behavioral Health Center NPI, instead of a specific providers NPI? That way if a case is transferred or something the existing PAR is still good?
A: A PAR can not be "transferred to another provider" The NPI for the rendering provider is to make sure the rendering provider is qualified to provide the requested services. IF a change occurs the PAR can be updated to reflect the change in the NPI of the new rendering provider. services requested. **Please review the attached billing guide and note the request timelines for an unscheduled revision.**
https://www.medicaid.nv.gov/Downloads/provider/NV_BillingGuidelines_PT14.pdf

Q: This was excellent. Huge improvement.
A: Thank you! The purpose for the Nevada Medicaid Behavioral Health Technical assistance (BHTA) calls is to assist Nevada Medicaid enrolled Behavioral Health providers**.** Glad you like the new format appreciate your feedback.

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.