DIVISION OF HEALTH CARE FINANCING AND POLICY
CLINICAL POLICY TEAM, BEHAVIORAL HEALTH PROGRAM
BEHAVIORAL HEALTH TECHNICAL ASSISTANCE (BHTA)
Minutes – Wednesday, January 13, 2021
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 – BHU, Provider Enrollment, SUR, Gainwell Technologies

2. **December 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.

   - Provider Types 82, 14, and 26 – Linking Providers
   - Psychological and Neuropsychological Testing
   - Resources – please contact for documents
   - Uploading Attachments with the Prior Authorizations

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

   Public Hearings

4. **DHCFP Behavioral Health Updates:**
   Behavioral Health Web Announcements (WA):
   https://www.medicaid.nv.gov/providers/newsannounce/default.aspx

   - **WA#2401** -- 1099-Misc. Forms for 2020 Tax Year to be Mailed to Providers by January 31, 2021
   - **WA#2398** -- Ownership/Controlling Interest Disclosure Information Required on Change/Update Request

- **WA#2397** -- Centers for Medicare & Medicaid Services (CMS) Temporarily Loosens National Correct Coding Initiatives (NCCI) Edits and the Medically Unlikely Edits (MUE)
- **WA#2396** – Attention All Providers: 2021 Dual Eligible Special Needs Plans (D-SNP) Information
- **WA#2394** – 2021 Annual New Code Update
- **WA#2392** -- Attention All Provider Types: Claims Appeals, Adjustments and Voids Training Sessions Scheduled in 2021
- **WA#2390** -- Attention Provider Types 13 (Psychiatric Hospital, Inpatient) and 63 (Residential Treatment Centers (RTC)): Inpatient Institutional Claims Reprocessed
- **WA#2388** -- Frequently Asked Questions Regarding Rate Reductions per Assembly Bill (AB) 3
- **WA#2387** -- Attention All Provider Types: Secondary Claims Training Sessions Scheduled in 2021
- **WA#2386** -- Attention All Providers: Top 10 Claim Denial Reasons and Resolutions/Workarounds for November 2020 Claims
- **WA#2384** – Attention All Providers: Revalidation and Changes Trainings Scheduled in 2021
- **WA#2375** – Nevada 211 Youth App – Please Share with Youth Patients
- **WA#2372** – Attention All Providers: Reading a Remittance Advice Training Sessions Scheduled in 2021
- **WA#2371** – Attention All Providers: COVID Monoclonal Antibody Treatments
- **WA#2368** – Attention All Providers: Please Participate in COVID-19 Vaccines Survey
- **WA#2367** – New Provider Orientation Scheduled for January 2021
- **WA#2366** – 2021 Annual New Code Update
- **WA#2358** -- Attention All Providers: Nevada Department of Health and Human Services Director's Office Urges Youth Screening

Carin Hennessey, SSPS II

- **Quality Assurance (QA) Program -- MSM 403.2(B)(6)**
  This is a large topic to review. We go through the QA Programs in the Behavioral Health Unit, and we are familiar with the language and the policy related to the language. It is an expansive topic and the most important aspects of the QA Program will be covered at this time. When a QA Program is reviewed, the provider receives initial comments and we can work with the provider to answer questions on the comments made. It usually becomes a process of going back and forth, to identify that Medicaid is seeing its requirements within your policy. Sometimes you may be referred specifically to the BHU for QA Program review and approval as part of your enrollment. Sometimes you will see a notice on your return letter that indicates your policy is not in compliance with policy; you are given the information to reach out to us at BehavioralHealth@dhcfp.nv.gov. You can reach out to us to have questions answered and to revise your document; it is up to you as a provider if you want to get additional assistance on your QA Program. The policy for the QA Program can be found at MSM MSM 403.2(B)(6). You always want to refer to the most

current policy for current issues (if you are looking for policy on older issues, you may search the earlier versions of policy that are made available through the DHCFP website or the Nevada Medicaid website.

When you enroll as a new provider type 14 specialty 814 BHCN agency/entity/group, you are required to submit a QA Program as part of your enrollment application. We'll focus on the submission of the QA Program at initial enrollment and then we will review the updates of the QA program and the submission at revalidation.

When you are submitting QA at initial enrollment, this is essentially the submission of your agency's policies, in these specific areas, in accordance with NV Medicaid guidelines to be a provider. Use the most current policy, as it is a living/breathing document.

Your goal as a provider is to explain these areas to NV Medicaid. Describing and explaining what you do is definitely a different task than doing what you do – which is providing the services -- but we encourage you to be as thorough as possible in your explanation.

It may be helpful to go back and look at MSM 403.2 Provider Standards. Going back to the basics. This policy outlines the overriding requirements for all providers and for the BHCN specifically. This information is part of your QA Program as you explain the services being provided and your functioning as an agency. This information leads up to the actual documentation of your QA Program. When you are submitting your QA Program with your enrollment and revalidations, you are agreeing to this policy listed for Provider Standards. For BHCN's, you are also agreeing to this policy listed under this section.

Now we get to the specific requirements of the QA Program document in MSM 403.2(B)(6). When you receive comments on your QA Program, they typically reference this information.

We will now review the specific requirements of the QA Program policy:

- List services and EBP, including goals and objectives, and method used to restore recipient to highest level of functioning. This is the specific listing and description of the services that the agency will be providing. An agency doesn't have to list every service listed under Chapter 400 Outpatient and/or Rehabilitative Mental Health services. Only list the services your agency is delivering. It is clear here when providers understand the service, how it is delivered and who is delivering it. An agency describes the service in their own language. If there is a service you'd like to deliver in the future, you are always able to update your QA to include this service, when you are able to deliver that service according to policy.
- Organizational Chart – this a visual representation of your supervisory structure within the agency. This is not a list of providers, with titles and National Provider Identifier numbers. Identify the roles of each supervisor and each provider. You may include the larger agency organization if you wish (including roles not necessarily specified in the policy, i.e. Owner, biller, Quality Assurance) – but if any of the supervisors or providers are filling these additional roles, and they are mentioned in your QA, it may be

best to list them. Required are the Clinical Supervisor(s), Direct Supervisor(s), affiliated mental health professional and paraprofessionals; include the names, positions, and NPI numbers for each.
For the process of bringing in enrolled providers, you must identify that you have a provider to deliver a service. It is acceptable to have some unfilled positions on your Organizational Chart (e.g., positions you plan to fill as your agency grows, etc.). It will not be accepted to not list any providers to deliver that service. The enrollment of these professionals may be happening simultaneous to the group enrollment, or these professionals may already be enrolled and just need to be linked to your group. The information does need to be included in the organizational chart.

- Clinical and Supervisory trainings, including Direct Supervision roles is the narrative of what we may see in the Organizational Chart. This follows our MSM 403.2A Supervision Standards policy. Include information on the case file reviews and review of treatment plans. You will consider the ongoing training needs of rendering providers, including QMHA and QBA providers. You can include areas of training if you know specifically what training will be made available in your agency. You don't have to provide the specific information on the training until you submit your QA Reporting each year and any corrective action associated with that reporting.
- Effectiveness of care, access/availability of care, and satisfaction of care. Some of this relates to the reporting, but in your QA Program you can specify how you determine this information. You can include the tool as well, it does help to give a visual to what your describe as your process.
    - Effectiveness of care will state the projected goal of recipient stability and improved functioning and how this information is determined;
    - Access and availability to care involves listing the urgency with which patients are seen based on initial level of need; and
    - Satisfaction of care includes patient surveys and any other means to assess the recipients' overall satisfaction with their services.
        - Grievance policy is detailed and must describe the process in detail of how you address a grievance from a recipient. How it's reported. How it's addressed. The resolution and the process if there is not resolution.
- Individualized language in QA Programs must be individualized to your agency. This includes not stating Medicaid policy word-for-word as policy your policy. The other piece includes duplication of language between agencies, which we do see. If your QA is a duplication in large part of another agency's QA, that could result in a rejection without a review.

These are your agency policies. Your agency is telling us what it does. You follow these policies and illustrate to Medicaid how your policies comply with Medicaid standards. It is not an easy task to put this documentation together. It requires clinical knowledge, as well as knowledge of the inner workings of the agency. It is up to you who will create this document for your agency. These

policies are as much for you as for Medicaid. These are the policies you will follow.

Regarding updates to your QA Program, if you want to make an update to the document on file (e.g., add a service, add a professional position, reflect a process that has been updated within your agency), please contact the Behavioral Health Unit. This will be important if you plan on delivering Partial Hospitalization Program (PHP) and/or Intensive Outpatient Program (IOP); there is documentation that will need to be filed with DHCFP in order to prior authorize and deliver these services.

Regarding the Revalidation process, policy is always changing and being updated. Time passes between your initial enrollment and revalidation; policies have likely changed. Your QA Program will need to reflect the changes. If you are submitting your reporting and your reviewing your quality assurance, you are seeing that these measures with which you are staying current and reflecting in your QA Reporting. An agency that submits the same QA Program that was submitted with enrollment may be denied because things have changed.

6. **DHCFP Provider Enrollment Unit Updates:**
   Nevada Medicaid Website: https://www.medicaid.nv.gov/providers/enroll.aspx
   DHCFP Website: http://dhcfp.nv.gov/Providers/PI/PSMain/

7. **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/

- **Crisis Intervention (H2011, H2011 HT) – QMHP and Team –** H2011 with the HT modifier, in the policy QMHPs may provide Crisis Intervention services. If a multidisciplinary team is used for this service, the team must be led by a QMHP; this is not the same as having the QMHP supervise. The policy indicates the service must include the following:
  - Immediate and intensive interventions designed to help stabilize the recipient and prevent hospitalization;
  - Conduct situational risk-of-harm assessment;
  - 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.

All of these components need to be documented and the QMHP needs to be a part of all of this, not signing off on this after the fact. When the person presents in crisis, there must be a QMHP to evaluate the situation and determine what is done.

- **IOP and PHP – General Questions**

- **Prior Authorizations and Service Utilization for 2021 –** The MCO's have their own policies so you would have to contact the MCO's to discuss. For

Fee For Service (FFS), there are no “free state units”. Each year we allow a certain number of sessions without a PA; this is to help the providers. When that limit has been reached, the provider needs to submit a new PA.
If you have questions on the utilization of codes by other providers, you may contact the Provider Call Center (877) 638-3972 and speak with a Field Service Representative. If you have an ongoing patient, you can discuss with that patient any other care that they are receiving.
The way our system works is that a provider submits a claim for a therapy session, the system checks how many sessions has it paid for the codes under this edit (service limitation), within this calendar year. It is looking at how many claims have been paid (it’s not asking for a PA number, only what has been paid). If the claims paid are under the service limitations, the claim continues to be processed. If the sessions paid on this claim are at or above the limits, the system then looks for a current PA number; if the PA number is attached and matches, the claim continue to be processed. If there is not a current corresponding PA number included, then the claim will deny.
Let’s say you have a PA that is authorized in December. This is for a minor and the available limit is 26 units under the service limitations per year (before a PAR is required). You use only three units in December. You have 23 more units that are authorized on the approved PA; you have a total of 26 that you can use in the calendar year – beginning January 1 – before you will need another PA based on medical necessity to deliver the service. You do not receive the remaining unit available on your PA and then bill 26 additional “free” units. The 26 is counting from the beginning of the calendar year, whether or not you have a carry-over PA from the previous year; the carryover PA doesn’t change the fact that after the service limitations are met, you need to provide a valid reason that this patient needs to continue receiving services. And the PA from the previous year does not make a difference in whether the recipient should continue to receive services.

8. **Gainwell Technologies 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 - North
Susan McLaughlin, Provider Relations Field Service Representative – South

- **Related to Prior Authorizations and Service Utilization for 2021 –** If the prior authorization is not on the claim but you have an approved PA number, the claim will deny if the service limitations are met. The system is not going to search for the PA if it is not included in the claim. If you have a PA and you do not include it on the claim, the claim will deny for no PA.

The SUR Unit also added that if you have a PA and it is under the service limits, the system will not go look for the PA number; and in this case if you don't include it on the claim, it certainly won't look for it.

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.

9. **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: How do I get to the archived meeting notes?
A: Behavioral Health Agendas and Minutes are found at http://dhcfp.nv.gov/Pgms/CPT/BHS/ under "Meetings" sidebar.

Q: For H2011 HT, Can all the team bill units for their portion as long as the time of services doesn't overlap?
A: The service H2011 HT is billed under the Qualified Mental Health Professional (QMHP); it is Crisis Intervention is delivered in 15-minute increments. And additional team members providing this service are included under the H2011.
If there is a QMHA or QBA providing a different Rehabilitative Mental Health (RMH) service when the crisis occurs, then it would depend on how much of that RMH service has been delivered before the focus shifts to Crisis Intervention. Psychosocial Rehab and Basic Skills training are delivered in 15-minute increments as well. Ultimately, it is a clinical decision how the services are rendered and billed. However, the H2011 cannot be billed simultaneously with the billing of another service by other providers.

Q: Is there a way to get an email when a new web announcement is posted?
A: Provider will need to refer to the Nevada Medicaid web site to check for the latest web announcements.

Q: If the provider is a QMHP (let's say an intern) and their supervisor is also a QMHP (licensed) and the supervisor is called during the crisis is that H2011 HT? or just H2011?
A: H2011 is rendered by the QMHP; the Clinical Supervisor does not bill for the service, even if the QMHP is an intern required to contact their supervisor. If the service is being rendered by more than 1 person, this would be a team service billed

as H2011 HT under the rendering QMHP; services provided are reflected in the documentation by the Medicaid-enrolled team member(s) who provided each portion of the service.

Q: Are [the webinars] recorded? When do the notes/summary post?
A: The minutes for the previous month's meeting posts by the following month's meeting. The minutes and the agendas for all the meeting are found on the DHCFP website, on the Behavioral Health Unit webpage, under "Meetings" sidebar, Behavioral Health Agendas and Minutes.

Q: Please address PARs today. Providers are getting different responses through GWT and each MCO regarding how the PAR limits and Free State units are handled at the beginning of the year. Medicaid is counting ones on PARS against the free ones, which makes them irrelevant in needed times. Anthem rejects PARS until the 18/26 are used, which who knows if a psychiatrist or anther provider has used any. You can track yours, but not everyone's.
A: With Fee for Service (FFS) Medicaid, units are counted toward the service limitations if they are included on an existing approved PA that is carried over from the previous calendar year. Providers who submit a PA request will include the approved PA number on their claims submissions and those units will be tracked against the approved PA. Those units will also be tracked against the service limitations. Providers are not required to submit a PA request for therapy services until the service limitations have been or are going to be exhausted.
Providers can call the provider call center (877) 638-3972 to inquire about a recipient's utilization on specific therapy codes or email the nevadaprovidertraining@dxc.com for a field representative to work with you directly.
If you have questions regarding Managed Care Organizations, you may refer to the Managed Care Organization webpage on the DHCFP website.

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