DIVISION OF HEALTH CARE FINANCING AND POLICY
CLINICAL POLICY TEAM, BEHAVIORAL HEALTH PROGRAM
BEHAVIORAL HEALTH TECHNICAL ASSISTANCE (BHTA)
Minutes – Wednesday, February 10, 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. **January 2021 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.

   - Quality Assurance (QA) Program (MSM 403.2.B.6.)
   - Crisis Intervention (H2011, H2011 HT) – QMHP and Team
   - Prior Authorizations and Service Utilization for 2021
   - IOP and PHP – General Questions?

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
   - **2/4/2021 --** The Future of Substance Abuse Treatment in Nevada: Feedback Forum on Policy, Payment, and Other Considerations
   - **1/25/2021** – for Increasing Access to Behavioral Health Services Provided by Substance Abuse Agency Model Clinics Through the Development of New Service Limitations

   Public Hearings
   - **2/23/2021 –** State Plan Amendments (Medication-Assisted Treatment (MAT) for Opioid Use Disorder (OUD))

- **1/26/2021 --** Medicaid Services Manual (MSM Chapter 1900– Transportation Services; MSM Chapter 2100–HCBS ID Waiver; MSM Chapter 2200–HCBS Waiver for FE; MSM Chapter 3900–HCBS Waiver for Assisted Living; MSM Chapter 4000–1915(i) HCBS Intensive In-Home Services and Crisis Stabilization)
- **1/26/2021 --** State Plan Amendments (Non-Emergency Behavioral Health Transports; 1915(i) HCBS))

4. **DHCFP Behavioral Health Updates:**

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

- **WA#2424** -- COVID-19 Flyers for Medicaid Recipients
- **WA#2423** – New Provider Orientation Scheduled for March 2021
- **WA#2422** – Implementation of CAPTCHA Program in Provider Web Portal
- **WA#2421** -- Medicaid Management Information System Updated with NCCI Quarter 1 2021 Files
- **WA#2419** -- Provider Relief Fund Reporting Update and Registration
- **WA#2416** -- Attention All Providers, Delegates and Staff: Upcoming Training Sessions for February 2021
- **WA#2415** -- Attention All Behavioral Health Community Network (BHCN) Groups and Substance Abuse Agency Model (SAAM) Groups: Updated Medicaid Policy for Partial Hospitalization Program (PHP) and Intensive Outpatient Program (IOP)
- **WA#2413** -- Provider Type 86 Created for Specialized Foster Care Services
- **WA#2411** – Attention All Providers: Top 10 Enrollment Return Reasons and Resolutions for Third Quarter 2020 Submissions
- **WA#2410** – Claims that Cutback in Error Have Been Reprocessed
- **WA#2409** – Attention All Providers: Non-Emergency Transportation is Available for Recipients to Receive the COVID Vaccine
- **WA#2407** – Medicaid Services Manual Chapter 400 Updated
- **WA#2406** – New Provider Orientation Scheduled for February 2021
- **WA#2405** – Attention All Providers: Top 10 Claim Denial Reasons and Resolutions/Workarounds for December 2020 Claims
- **WA#2404** – Paper Remittance Advices Will No Longer Be Mailed to Providers
- **Volume 17, Issue 4** -- Nevada Medicaid and Nevada Check Up News (Fourth Quarter 2020 Provider Newsletter)

Carin Hennessey, SSPS II

- **Clarifications and General Questions:** QA Programs -- In addition to last month's discussion on QA Programs for initial enrollment, revalidation, and updates to the QA Program, please be aware:
  If you are advised that your enrollment is not approved because your QA Program does not comply with BH policy for QA Programs, the intention is that you receive approval of your QA Program through the BHU. That means, you reach out to the BH inbox, you request assistance, you include the latest version

of your QA Program for review. The goal is working with BHU to clarify your policies and confirm that they are in compliance with current Medicaid policy. It is a back and forth process of editing. It can take time, which you must account for on your end. Once the approval is complete, BHU lets you know and also advises Provider Enrollment that your QA Program has been approved. That is the goal of the process.

Some examples of what we see in the BHU are:

- Provider doesn't supply document for review and sends email asking what's wrong with the QA – usually these go unresolved.
- Providers reach out to BHU, submit document, go through a revision and maybe a phone call; then the provider submits the QA through the portal and states BHU has approved. This is not an approval. For your record, you will receive an email with the attached approved document. You may have to upload this approved document to the portal, to your application; or the document may be uploaded to your application by Provider Enrollment, who will also receive a copy of the approved document. You will be advised of what you need to do when you receive the approval.
- While the provider has every opportunity to clarify information through a phone conversation or email exchange (the intent of your policy), the language of your policy has to reflect the clarifications also. We may need to refer back to your QA and you want it to be accurate. It's in your best interest.

For updates to your QA Program, if you need to submit an update because you are adding a service like IOP or PHP, or you are making other significant updates to your policies, please contact the BH inbox. The BHU will reach out to you and work with you to have the QA updated in our system, related to your enrollment. On language used in your policy, Medicaid policy is our policy and providers must write your policies in original language. This will be the best way for you to communicate how your policies comply with Medicaid policies.

Additionally, the minutes for January BHTA related to service limitations per calendar year and the use of PARs are explained very well under the SUR Unit and Gainwell Technologies sections. Take a look at this information. It could be extremely helpful in training staff within your agency regarding end-of-calendar-year PAs and service limitations at the start of the new calendar year.

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/

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 Harrison (McLaughlin), Provider Relations Field Service Representative - South

   - **Clarifications and General Questions:** Service Limitations and Prior Authorizations Requirements – Some questions have come up since it is the beginning of a new [calendar] year regarding therapy service limitations and how the PAs work, when it is time to request prior authorization. Our call center is able to pull up the service limitation history for the recipient, as long as there are paid claims on file for that recipient. We can look up information by service code/procedure code, number of units, etc., for any paid claims within the last calendar year. Providers can be aware of when the recipient is coming up on those service limitations being exhausted. If you have a relationship with you Field Service Representative, you can reach out and also receive that information that way as well.
     As far as the Fee For Service (FFS) program and the service limitations, Joann/Gainwell Technologies is also available to answer this question.
     The units do not start counting on a service limitation until those service limitations have been exhausted. It is better to not put in your PA request until the service limits have been (or are coming close) to being exhausted. It is good to keep track of where your patients are or to contact Gainwell to get the information so you know when to submit your PA request.

   - In addition to what has been said on this topic, for an upcoming webinar the topic of communication with the recipient, in effect to get more information about the services that the recipient is utilizing. If the provider knows the service, they can look up the code and be able to research through the Provider Call Center, using those specific codes. For example, you wouldn't want to inquire on the usage of one therapy code for individual therapy because the service limitations (based on the Intensity of Needs grid) includes all of the mental health therapies – individual, group, family. That discussion will be about the communication aspect with the recipient: how do you get this information, what problems are involved in getting this information, how does it affect the ability of providers to coordinate services across providers (if the recipient is seeing more than one provider at a time).

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. ***Please note that the Chat is not visible to all of the participants on the call. Those questions submitted in the Chat will not be transcribed in this section of future Meeting Minutes. Please continue to ask questions through the Q&A during the webinar.***

Q: Our agency has been contacted by Hometown Health stating they will be a new MCO with NV Medicaid. This hasn't been updated on the MCO list; no web announcement. Is this accurate? How can we check if this is legitimate?
A: The Managed Care RFP has not yet been released. We are currently in the quiet period so if you have any questions related to the RFP, please contact Teri Becker (tbecker@admin.nv.gov). She is the State Purchasing contact for the RFP.

Q: How do we find the old meetings again?
A: The previous meeting agendas and minutes can be found on DHCFP website, the Behavioral Health Services webpage, under "Meetings" sidebar, and under "Behavioral Health Agendas and Minutes"
http://dhcfp.nv.gov/Pgms/CPT/BHSmeetings/BHTAWebinars/

Q: I missed the Public Workshop for the increasing access to behavioral health through the SAAM model. Is there anything you can highlight or summarize from that meeting?
A: This workshop was specifically for PT 17 specialty 215 providers. It covered proposed changes to remove upfront PAs for Level 1 outpatient services and aligning psychotherapy and counseling services to MSM 400. The workshop notice has the proposed documents on it. The DHCFP Meeting Archives are located on the DHCFP website, under the Public Notices tab
http://dhcfp.nv.gov/Public/AdminSupport/MeetingArchive/MeetingArchiveHome/

Q: For clarification on therapy, at the beginning of every year we are able to not count the non-par required units as a part of the PAR request? So when

the PAR is submitted then it begins the units from zero. Also does that include group and family therapy?
A: The service limits for Mental Health Therapies (per the Intensity of Needs grids in Chapter 400) restart January 1st of each year; that includes services delivered to the recipient with and without an approved Prior Authorization. The first PA request submitted for a recipient that is new to a provider in a calendar year is considered an initial PA; however, if the provider has delivered any other services to the recipient in that calendar year or in the previous calendar year(s), then the PA would be submitted as concurrent to the continuous treatment being delivered to the recipient. Group and Family therapies are included in Mental Health Therapies under Chapter 400. Medicaid is looking at all applicable codes, including E/M codes that are hitting up against the service limitations for mental health therapies, to be sure they are being applied correctly.

Q: Regarding web announcement, is there a way to get notification, or must one just check periodically?
A: There is currently no automatic notification system for providers to be alerted on new web announcements. The web announcements are posted on the Nevada Medicaid homepage https://www.medicaid.nv.gov/home.aspx.

Q: [Is there] any info on potential cuts (6% retro that was proposed; specific service cuts that might be possible)?
A: You may refer to web announcement #2388 for current information on the proposed rate reductions. These reductions are still under review with the Centers for Medicare & Medicaid Services (CMS) and were submitted during special session under Assembly Bill (AB) 3.

Q: [When calling the Provider Call Center] what are the prompts we should select in the decision tree to get the service utilization results? Also, the phone number has a typo in the minutes, "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~~."
A: If you have questions on the recipient's utilization under the service limitations in the current calendar year, please contact the Provider Call Center **(877) 638-3472**. Providers can also use the automated self-service line at **(800) 942-6511**. Follow these prompts to speak to a customer service representative:

- Option #2 – Provider
- Option #0 – All other callers
- Option #2 – Claims

The instruction guide is available under the Nevada Medicaid Contact List webpage (under "Contact Us" at top right corner of Nevada Medicaid website)

Q: Would we need to list every possible service code on the call-in order to get an accurate count?

A: In order to determine an accurate number of units utilized by a recipient toward the service limitations listed in Chapter 400, a provider may ask for the utilization of all services that are counted toward those service limitations.

Q: WA 2415 on 1/22/21 Announced that PARS would be required for IOP services. However, this became effective 12/30/20. How else were we supposed to know about these changes with almost a month delay in announcement?

A: The upcoming changes to IOP were initially announced to providers on the BHTA webinars in September and October 2020. A Public Workshop to present the proposed language for the policy updates was held on 9/28/2020; the language for the requirement of PAs was made public at that time. Public comment was solicited. The DHCFP took into consideration provider comments made during that Public Workshop and some changes in the language resulted (i.e., the authorization period). The changes to policy regarding IOP went into effect 12/23/21; the original Public Hearing was scheduled for 12/30/20 but was rescheduled to 12/22/21. The final proposed policy, including the requirement of prior authorizations, were presented to the public for comment. The procedure changes, including the submissions of prior authorizations for the service, began 1/1/2021.

Q: So, if the CASII/LOCUS score changes then the limits change. I pointed out that you can't accurately set limits with something that changes by provider and every 90 days.

A: The Intensity of Needs grid (MSM 403.5.C.) lists the appropriate number of sessions used to treat a recipient based on intensity of needs determination, which involves a CASII or LOCUS score and clinical judgment. The treatment design reflects this information.

Q: Is the PA request initial if it is the first one of the calendar year?

A: On the initial request for the services, a provider is able to utilize the service limitations. Once those are utilized and used up, and the provider has not submitted a PAR previously for the recipient, that submitted PAR is considered an initial PA request (because it is the first time the provider has submitted that PAR, for that recipient, for that service). However, if a provider is submitting a PAR for therapy, but has already submitted a PAR in the past for any other services (i.e., RMH services), then the therapy submittal is not considered initial.

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