DIVISION OF HEALTH CARE FINANCING AND POLICY
CLINICAL POLICY TEAM, BEHAVIORAL HEALTH PROGRAM
BEHAVIORAL HEALTH TECHNICAL ASSISTANCE (BHTA)
Minutes – Wednesday, October 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 call offers providers guidance and updates on DHCFP Behavioral Health policy. The TEAMS meeting format offers providers an opportunity to ask questions using the chat feature and receive answers in real time. The webinar is recorded. If you have questions prior to or after the monthly call, submit requests directly to the behavioralhealth@dhcfp.nv.gov.

   - Introductions – BHU, Provider Enrollment, SUR, Gainwell Technologies

2. September 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 information from previous and current meetings. Please review if you have questions and if you were not able to attend the BHTA last month; this is a great place to check up on what we discussed.

- Crisis Intervention (CI) Services related to WA#2558 and WA#2564
- QA Program –– Clinical and Supervisory Trainings – MSM 403.2(B)(6)(c)

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 Hearings
- **10/26/2021** – State Plan Amendment for 1115 Substance Use Disorder (SUD) Demonstration Waiver
- **10/26/2021** -- Chapter 1200 Prescribed Drugs AND MSM Chapter 4000 – 1915(i) HCBS State Plan Option for Intensive In-Home Services and Crisis Stabilization

Public Workshops
- **9/29/2021** – Transportation and Services Provided to the Categorically Needy
- **10/20/2021** – Quadrennial Rate Review Process Overview and Provider Survey Instructions

Public Meetings
- **10/13/2021**-- Tribal Consultation

- **10/19/2021** – Medical Care Advisory Committee

4. **DHCFP Behavioral Health Updates:**

Behavioral Health Web Announcements (WA):
https://www.medicaid.nv.gov/providers/newsannounce/default.aspx
(Please refer to this link for a complete list of web announcements)

- **WA#2601 --** Update: Reprocessing of Claims for Procedure Code H2011 (Crisis Intervention Services) Completed
- **Volume 18 Issue 3 –** Nevada Medicaid and Nevada Check Up News (Third Quarter 2021 Provider Newsletter)
- **WA#2599 –** Medicare Crossover Claims that Denied Incorrectly for Timely Filing Have Been Reprocessed
- **WA#2597 –** Attention Provider Type 63 (Residential Treatment Center/Psychiatric Residential Treatment Center): Residential Treatment Center Concurrent Review Form Updated
- **WA#2596 –** All Applied Behavior Analysis Linkage – Provider Type 85
- **WA#2594 –** Current DHCFP Rate Review Survey Deadline Extended to October 29, 2021
- **WA#2593 --** New Provider Orientation Scheduled for November 2021
- **WA#2590 –** Medication-Assisted Treatment (MAT) Services with an Opioid Use Disorder (OUD) Diagnosis Must Be Billed with Modifier U5
- **WA#2589** – Additional Provider Relief Fund Payments to Be Available Due to COVID-19 Pandemic
- **WA#2588 --** Search Fee Schedule Tool Enhanced to Improve Provider Experience
- **WA#2582** – 2022 Annual ICD-10-CM Diagnosis Code and ICD-10-PCS Inpatient Procedure Code Updates
- **WA#2580 –** Reminder: Do Not Bill Procedure Codes H0004, H2011 and H2014 with Duplicate Details
- **WA#2579 –** Update on the Urgent Announcement Regarding Claims Suspending for Budget Relief (Suspension Removed)
- **WA#2575 –** Nevada Medicaid Expands Dates for 2021-2022 Respiratory Syncytial Virus (RSV) Season
- **WA#2573 –** New Provider Orientation Scheduled for October 2021

Carin Hennessey, SSPS II

- **Provider Type (PT 14) Billing Guideline Update** – There has been an update to our PT 14 Billing Guideline. Under the "Providers" drop down menu, under "Billing Information", you will find the billing guidelines for behavioral health services. It has been a long time coming and hopefully this helps to answer a lot of questions. A lot of the updates to this Billing Guideline that were not reflected previously have hopefully been addressed. We have tried to remove information that doesn't apply and clean-up anything that has changed. It is always recommended that you access the most updated billing information through Nevada Medicaid (nv.gov).

You'll see (on page 2) the information on the Emergency request for Crisis Intervention, which we are working on a web announcement for updates related to the forms to submit. There is an update to the claims submission instructions that may not have been reflected previously. We've updated the intensity of needs grid section.
The most exciting part is the format of this guide. We tried to make it user friendly and more responsive to a lot of the questions that we do receive. Hopefully, when you look at this, you'll be able to find the answers more clearly than on past versions. We really tried to listen to providers and receive as much input as we could from the different units at Nevada Medicaid.
In addition to breaking down the codes into appropriate categories, we've tried to include the information on service limitations and who is providing this service; you can review the fee schedule for further information on the billing of the services. There is information on the prior authorization requirements and applicable intensity of needs level of these services. Since the intensity of needs grid has been removed from the Billing Guide, you are directed into the Chapter 400 policy for further information.

It is suggested that you look at the codes you most commonly bill as a way to review this updated Billing Guide. You are also encouraged to read the section descriptions, which we also tried to make more helpful. We tried to arrange the codes in a manner by which you may bill the codes when you are working with a beneficiary/ recipient.

Please take a look at it. We are also updating the PT 26 Billing Guide.That does not include the codes, but does reflect some of the information on the PT 14 Billing Guide that is specific to the delivery of services by a Psychologist.

- **Part 5: QA Program** – Always navigate to the policy through the Nevada Medicaid website or the DHCFP website, for access to the most current version. This will be the last section of the QA Program that we review. MSM 403.2(B)(6)(d) states, "Demonstration of effectiveness of care, access/availability of care and satisfaction of care. The BHCN must adhere to the QIO-like vendor's billing manual for further instructions concerning the required quality measures below." When you enroll or revalidate, you must submit the initial QA Program or updated QA Program as required and guided by Medicaid policy. I will present the quality measures in a different order than as listed in policy. The following quality measures are required:

Access and availability to care: *Measure timeliness of appointment scheduling between initial contact and rendered face to face services*.
Here we can also refer to the Nevada Medicaid website, under Providers drop down menu, "Billing Information", Billing Manual (pp. 5-6).
Effectiveness of care: *a. Identify the percentage of recipients demonstrating stable or improved functioning. b. Develop assessment tool to review treatment and/or rehabilitation plans and report results of assessment*.

- Narrative explanation of how you will perform this measure of care effectiveness and illustrate with the forms. Be sure the forms adhere to your delivery of services.
- Percentage is relative to the number of patients seen and how rigorous your process of corrective action is within your agency (like with 100% stable/improved functioning.
- Not just CASII/LOCUS – use other aspects of treatment to inform successful treatment, over a stated period of time.

Satisfaction of care: *a. Conduct a recipient and/or family satisfaction survey(s) and provide results. b. Submit a detail grievance policy and procedure.*

- The grievance policy is how patients/family/caregivers can be invested in treatment, by having a voice. DHCFP will not enforce this policy; that's for you to utilize within your agency, but you tell us how you give beneficiaries voice in treatment.
- Satisfaction surveys – what you use to measure the recipient satisfaction with services; consider what you use to measure your agency, how you build quality improvement for your agency and its providers

One final detail to mention that refers back to the Billing Manual (pp. 6-7) is the information required on your QA document. You must include medical provider ID (NPI), BHCN name, mailing address, Phone number, mailing address, phone number, fax number, email, and contact person specific to the BHCN QA Program. If this information is not included, your QA Program may be returned to you without an initial review.

Great, so far, we have reviewed the (f) individualization of the QA Program; the (b) organizational chart; (a) the list of services with descriptions; and (c) clinical and supervisory trainings. Please let us know if there is a specific area of the QA Program that you would like to review. And you can review the previous sections we've covered in our meeting minutes.

- Providerwellbeing.org website – Mental Health Technology Transfer Center (MHTTC)

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 Enrollment https://www.medicaid.nv.gov/providers/enroll.aspx
Provider Training https://www.medicaid.nv.gov/providers/training/training.aspx
Contact Information

Nevada Medicaid Customer Service: (877) 638-3472
Prior Authorization Information: (800) 525-2395
Field Service Representatives: nevadaprovidertraining@dxc.com

Alyssa Kee Chong, Provider Relations Field Service Representative - North
Susan McLaughlin, Provider Relations Field Service Representative – South

- Nevada Provider Training Self-Paced Training Courses can be accessed by clicking on this link **Self-Paced Training Courses**
- Field Service Representatives are not able to tell providers how to bill (i.e., what codes to use) nor override timely filing limitations.

Joann Katt, Prior Authorization Nurse- Behavioral Health Team Lead

- Appropriate Use of FA-29, FA-29A, and FA-29B Forms –
  Form FA29 is to be used by providers. If you need to make a correction on your prior authorization (i.e., dates of service), to end services, or to terminate services if you discharge a recipient from your care. This is the really the only use of this form, for the providers.
  There has been some confusion with the FA-29A form. This form is for the recipient. If they wish to move from one agency to another agency for their care. **Form FA-29A** was created so there is not a break in their service waiting for their previous provider agency to submit the FA-29. This form does need to be filled out by the recipient. It does need every section to be filled out. It does need to have the terminating agency that [the recipient] was going to previously (the agency that they are leaving); they may need to take the form to that agency for assistance filling that out. We do need the services that were being provided by that terminating agency. We will reject a form that lists every service that is available. We only want the recipient having the services that the terminating agency is currently providing, so that we can appropriately discharge the recipient and send them a letter. This is for the recipient, so that they can go from one agency to another.
  Form FA-29B is for a reconsideration. That is for a service that has been denied for medical necessity. When you upload this form it must contain that information that may have been omitted from your original submission, clarification on your original submission, a change in status since the original was submitted. It does need to have additional information. It can only be for the dates of service that were denied and for the services that were denied or modified (from what you submitted).
  The confusing part between the three forms is that you do not need to upload service lines, especially for reconsiderations (FA-29B); I see that a lot – you upload the FA-29B form and then you'll also upload the service lines that were modified or denied. You do not have to do that. We have reviewed the denied line/modified line. You do not need to do that; we actually review the denied

line or the modified line, so we have to cancel those service lines that you upload through the portal.
So simply on any FA form, you do not have to upload service lines for us to review it. You just have to upload that form. There is an edit field you can use on your end to get that form uploaded.
Basically, FA-29 form is for the provider. What I have seen lately is providers using FA-29A to end their own services on their PA; that is not appropriate. We need form FA-29. F-29A is for the recipient to move from one agency to another. And FA-29B is a reconsideration for denied or modified services.

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 TEAMS meeting 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 TEAMS meeting. The previous month's questions with answered on the posted minutes for the meeting.

Q: When people get the [enrollment] denial letter, I know some are having a hard time pin-pointing the issue. There is a lot of back and forth. Do they contact you if they need more assistance in identifying what exactly is missing for incorrect?
A: It is best to review MSM 403(B)(6) where the QA program information is noted. If there are additional questions, you can contact behavioralhealth@dhcfp.nv.gov.

Q: Also, a couple of providers have mentioned getting denial reason quoting MSM 100.2 (I believe) that says DHCFP has the discretion to enroll providers and is not mandated to do so. That seems kind of like the end all? What do they do or how do they address something like that? Do they get told a reason for closure at least? Is there a moratorium? You mentioned high volume of these coming in as well... What are typical turn around times as well? I tell people to submit 6 months early, if possible. Do they get closure? Or final info on that? Should they appeal? Or is there a process? Or is it just that they are not allowing new providers right now?
A: We deny applications based on MSM 102.1, at the discretion of DHCFP. Sometimes we determine to apply that regulation under MSM Chapter 100. Usually, when we deny we deny the applicant, it is an initial application. If you are already enrolled as a provider and you no longer fulfill the conditions of enrollment, we

proceed with termination. Unfortunately, applicants do not have appeal rights, only providers. There is not a moratorium on enrollments.

Q: What is the current timeline for processing completed enrollment applications?
A: Once we receive a completed application, timeline is 5 days once the application is completed. If it has been more than 5 business days, you may email providerenrollment@dhcfp.nv.gov.

Q: On the 5 days for provider enrollment processing once an application is complete, is that for PT 14 only or does the timeline apply to physicians (PT 20) too?
A: That timeline applied to all provider types.

Q: Also, is "under review" different from the usual processing?
A: Under review is still part of the review process, but it does change the timeframe. "Under review" means that the Fiscal Agent may have new information and they want to do quality assurance on the application. Or the application is under review because it came to DHCFP for further review and approval. It does change the time that will be needed to process.

Q: Recipients don't always know codes though, but just know "services or therapies". Can you explain that if it's the case?
A: The recipient can hand-deliver that FA-29B to the agency they are going to and have assistance from that agency to fill out those codes.

Q: If you submit for a 90837 or H0004, but then need to change to 90834 or vice versa because the wrong code was requested initially, is that just error correction or considered clinical? I'm hearing FA-29, correct? Not the A or B?
A: Yes, you would utilize for FA-29 to request the code in error to be cancelled. You would upload the correct service line through the portal and form FA-11. Not necessarily for clinical but the service. It's not necessary to do this as an unscheduled revision or additional clinical documentation, but you do need to submit the FA-11 form and you may identify in the "Notes" field why you are changing the service code.

Q: Is Medicaid considering a "lesser than logic"? If a patient has 90834 sessions approved, [what if they] show up late and 90832 is billed.
A: No, a lesser than logic is not used. All codes must be billed to match the way they are approved on the PA.

Q: Another issue is billing H0004 with a POS code 02 for Telehealth. I have cautioned people and instructed them that this is probably not a good practice. If someone was doing In-home therapy and had a PAR Approved for

in-home, that would be the only code they had available immediately to bill with Telehealth with.
A: Regarding H0004, there isn't a restriction on billing with the 02 POS code. H0004 indicates counseling and therapy is not happening in an office. POS 02 identifies that the service is being delivered via telehealth.

Q: If the [beneficiary] had Medi/Medi and it was a CPC/MFT [providing H0004], they wouldn't even have the option to get a 90837 billed with the 02 POS?
A: If a provider has an approved PA for H0004 with remaining units and has determined there's a more appropriate POS and procedure code, they would need to submit an FA-29 Data Correction form and indicate the changes needed, along with the effective date for the change. If claims have been billed and paid with POS 02, the provider would need to add a new service line with the appropriate procedure code to the approved PA and attach the FA-29 Data Correction form. I recommend including a brief explanation of what is being requested in the Notes section at the top of the FA-29 form. There's also a section to include additional information in the "Information to Modify" section of the FA-29.

Q: What form do we submit PA for crisis intervention?
A: For emergency requests of crisis intervention services (beyond the service limits in a 90 day period), use the FA-11 form. Submit within 5 business days, from the first day of the first additional occurrence. We are in the process of updating the form and it currently doesn't specifically address the emergency request. In the meantime, list the request in the "Notes" section of the form.

Q: When you have a recipient that was adopted during the PAR approval and therefore their ID number and name changed. Do you submit a new FA 11 for services A.S.A.P or do you submit the new PAR request as of the date the other period ended?
A: When a Recipient is adopted you would submit form FA29 to the current PA to end date it effective the date of adoption and then submit a PA under their new Medicaid ID with form FA11.

Q: I wanted to share what you said about QA with some struggling providers. Did we figure out if the videos could be viewed, or do I just need to wait until next months written minutes?
A: The information provided today on the QA Program is listed in the meeting minutes for October.

Q: Can we backdate a PAR? If so how long can we backdate?
A: A retrospective authorization is only allowed when a recipient is made retro-eligible. The Billing Guidelines is the best source of information for submission guidelines.

Q: Initial PARS can be back dated up to 15 Calendar days still, right?

A: Submit no more than 15 business days before and no more than 15 calendar days after the start date of service, unless otherwise specified for a service in the Billing Guide or in the Billing Manual. The Billing Guidelines is the best source of information for submission guidelines.

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