DIVISION OF HEALTH CARE FINANCING AND POLICY
CLINICAL POLICY TEAM, BEHAVIORAL HEALTH PROGRAM
BEHAVIORAL HEALTH TECHNICAL ASSISTANCE (BHTA)
Minutes – Wednesday, December 8, 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. November 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.

- Behavioral Health Counseling and Therapy (H0004) Service Limitations
- Crisis Intervention (H2011) and Emergency Request FA-11
- Submission of Secondary Claims and LMFT/LCPC/QMHP Delivering Services to Medicare Recipients
- Search Fee Schedule Tool

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

Public Workshops
- **12/13/2021** -- Crisis Stabilization Center

Public Meetings

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#2643 –** Attention Provider Types 60 (School Health Services) and 85 (Applied Behavioral Analysis): Training Scheduled for December 13, 2021
- **WA#2640 –** Seriously Mentally Ill (SMI) Adults or Recipients in Residential Treatment Centers (RTCs) to be Enrolled in Managed Care
- **WA#2638 –** Some Behavioral Health Claims Denied in Error if Recipient Was Covered by Medicare
- **WA#2637** – Attention All Providers: Please Distribute Flyer Regarding Managed Care Organizational Changes
- **WA#2635 –** Attention All Providers: 2022 Managed Care Caseload Distribution Notice
- **WA#2634** – Medicaid Services Manual Chapters Updated

Carin Hennessey, SSPS II

- IOP program and unbundled services – Me are hoping to encourage more providers to deliver Intensive Outpatient Psychiatric (IOP) programs. IOP is one of our highest level outpatient services and serve an SMI or SED population. There are a lot of different ways to deliver IOP to the different populations you serve. There are exciting things that providers are doing to serve the communities they work within. We encourage providers to look at the IOP policy (MSM 403.4.D.2.). If you are currently providing an IOP program and are interested in billing Medicaid for this service, the Behavioral Health Unit is available to assist providers with the process of submitting the curriculum and schedule, as well as helping providers to transition into submission of prior authorization requests and submitting claims. If you don't have a program and interested in learning more, please email our Behavioral Health inbox.

  The IOP program is all inclusive, so services that your agency may provide separately are included in this program that runs three (3) days per week, 3-6 hours per day. It is a higher level program for patients that assessed as SED/SMI and would benefit from that higher level of care, where they are receiving a variety of Outpatient and Rehabilitative services combined in a group with others.

  Those services would not be billed individually because there is one code (S9480) and one rate for the program. This can help if you are already providing this variety of services to the recipient. You can encapsulate all of the services and bill under the one code. This also reflects the higher level of need for that recipient.

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/
   Contact Information: providerenrollment@dhcfp.nv.gov

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@gainwelltechnologies.com

Alyssa Kee Chong, Provider Relations Field Service Representative – North

- End-Dating a Prior Authorization (additional information) – Once a provider submits and confirm the submission of a prior authorization form in the portal, the provider cannot go in and make changes to any submitted data. Any changes that need to be made are done on the FA-29 Data Correction form. This includes end-dating a PA if a recipient is discharged from your facility. We are seeing this issue often and recently had an escalated issue where a provider is urgently trying to have a prior authorization approved but there is another PA approved through another facility (that did not end-date their PA). When you do not end-date your PA, you cause issues for other providers to give care to the recipients. If you know the recipient is leaving, end-date your PA please.

Susan McLaughlin, Provider Relations Field Service Representative – South

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:**

Q: Is there a way to check group updates via the portal other than needing to call Medicaid? When you update group information like linking a new provider, changing authorized rep, etc.
A: To check the status of linking, providers can reach out to your Field Service Representative (Alyssa or Susan for PT 14). We can get group reports for you, but providers don't have the capability on the portal themselves to pull the report to check the linkages.

Q: For the upcoming MCO changes, will the providers be able to verify MCO coverage prior to January 1?

A: You can forward any questions to the Provider Enrolment Unit providerenrollment@dhcfp.nv.gov and we will distribute accordingly.

Q: Can you speak to the system and if there is a way to do multiple enrollments without waiting for the previous submission [to clear before submitting more]? With Group Enrollments, when they submit any update, linking, etc., on the group portal, they have to wait to submit a new one until the 1st clears. It would be OK if they process in order, but they can't even submit them to put them in the que. If they submit a new one, it clears the old one out and it doesn't get processed.
A: The applications are processed in the order that they are received. We are not able to expedite one or the other, not picking or choosing hand selections of who gets processed. All of the applications are in a queue and there's not way to put one ahead of the line. As for multiple enrollments, if these are new and initial enrollments, they are processed in the order that they are received. If it is a change where you are trying to update your enrollment and then you submit a new update, the first update will be processed first.
There is information for enrollment located on the Provider Enrollment webpage on the Nevada Medicaid website, under the "Provider Enrollment Information Booklet" and the "Online Provider Enrollment User Manual".

Q: Is it considered open enrollment or are patients only able to return to their prior MCO beginning January 1, 2022? There are multiple providers that are still in the credentialing process (Anthem and HPN are taking over six months for credentialing). If patients are flipped to those coverages, there will be a gap in services while we refer them out to a community provider that accepts their coverage.
Also, many will be switching coverages who are receiving services with active PA's on file. How do we ensure there is no gap in services if coverage is changed without having prior notification of the change.
A: Here is a helpful flyer regarding the MCO redistribution: https://dhcfp.nv.gov/uploadedFiles/dhcfpnvgov/content/Members/BLU/Recipient%20Redistribution_FINAL.pdf.

Q: If you have a PAR in place for 90837, and end up providing a 90834 instead, is the downcoding also covered?
A: 90837 is not an umbrella code; it does not encompass any lower time codes. All codes need to be approved on the PA and submitted on the claim exactly as they are. In a situation where a client needs to leave early (i.e., to pick a child up from school), it is the providers' responsibility to go into the provider portal, submit an FA-29 Data Correction form, get the correct code on the PA, and then submit the claim. There is no "downcoding" within Nevada Medicaid whatsoever. All PAs are approved and billed to match exactly, otherwise you need to go in and make those changes appropriately. Once you hit *submit* and *confirm* on your prior auth in the portal, you cannot go in and make changes to any submitted data on that PA – you must utilize the FA-29 form to change anything that has been approved. If the recipient leaves a

prior authorized service early, you need to go in an correct this code that was approved.
Additional information can be found on these forms in the October BHTA meeting minutes BHTAWebinars (nv.gov)

Q: Is there a reason that the enrollment applications seem to be taking about 2-3 months to even be looked at? They used to take 7-10 business days and it seems to have happened during the change of the checklist for QMHA and QBA? Is there an update coming to the Manual about the 16-hour course list requirements? Even if the course list has all the required courses and more with the time broken down, they are still being denied saying it's not acceptable. But they were accepted before we had to add the time spent over each course.
A: Related to the breakdown of the requirements for the 16-hour training indicates that you need to identify that what is in policy is being addressed in the training. This is the same for initial enrollments as well as revalidations. *Clarification: the in-service requirements are separate from the requirements listed in the policy for the 16-hour training MSM 403.6A(1)(b); quarterly in-service training is not required at this time to be provided for revalidation but is a requirement per MSM 403.6A(1)(b)(2).*

Q: Scenario: Child in therapy being seen weekly; the clinician would like flexibility to provide 90846 OR 90847 as needed. Can you request both on the FA-11 for the same period? Without creating "mathematical inaccuracies"?
A: No, providers cannot ask for codes as needed. But as long as they is medical necessity for them, you can have both codes on the FA form. You must always have the medical necessity to justify the request, the reason why the service is being requested. There is no penalty for requesting codes that are approved but not delivered and billed.
You must include the dates of service on the FA form. It is recommended to providers that you fill out the FA form first, then go into the portal and fill in the field lines; it minimizes room for error because if you try to fill out the FA form while you're in the portal, we see a lot of times mis-matching dates. Providers receive technical denials for these types of errors. So, having that FA form filled out prior to going into the portal is always helpful to minimize any risk of having a return for mathematical inaccuracies.

Q: If a provider is currently enrolled in Medicaid, do we need to complete a new application or just link the provider to our group?
A: This is a link to the Provider Enrollment training information: https://www.medicaid.nv.gov/providers/enroll.aspx. Be sure to select the "Update Provider" option in the portal if your intention is to link an individual provider to your group.

Q: Providers are asking about Vaccine Mandate!? What is the requirements for us contracted providers? Silver Summit recently sent out a letter

addressing it as we are sub-contractors with them, and must adhere. Will there be audits for this, fines, can services be recouped if done by an unvaccinated provider?? Lots of questions and uncertainty surrounding this.
A: We are working with our sister agency, Health Care Quality and Compliance, and will be working to put out guidance about the vaccine mandates from Medicaid FFS.
Here is a list of Facilities falling in the Vaccine Mandate - https://www.cms.gov/Outreach-and-Education/Find-Your-Provider-Type/Facilities/Facilities-page and the Q&A from CMS https://www.cms.gov/files/document/cms-omnibus-covid-19-health-care-staff-vaccination-requirements-2021.pdf.

Q: If a provider is approved for Silver summit for example and their patient is changed to Molina and a gap in services will be clinically disruptive to the patient, will the sessions be reimbursed, or will the provider have to provide free service to the patient until referred to another community provider?
A: Please find more information on the Managed Care webpage on the DHCFP website MCOMain (nv.gov). More information will be provided in upcoming meetings.

Q: Generally speaking, have you seen a reduction in Fraud, Waste, and Abuse in our BH providers?
A: SUR is not able to comment on that.

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.

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