DIVISION OF HEALTH CARE FINANCING AND POLICY
CLINICAL POLICY TEAM, BEHAVIORAL HEALTH PROGRAM
BEHAVIORAL HEALTH TECHNICAL ASSISTANCE (BHTA)
Minutes – Wednesday, June 8, 2022
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. May 2022 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.

- BH Updates
- Medicare Recipients (WA#2638 and WA#2287)
- Neurotherapy Prior Authorization Requests

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
- **06/01/2022** -- 1915(i) Home and Community Based State Plan Option and Alternative Benefit Plan
- **06/02/2022** – MSM 400 Provider Qualification for Mental Health and Rehabilitative Mental Health Services

Public Hearings
- **06/28/2022** – State Plan Amendment for COVID ARPA; Nevada Checkup COVID ARPA; FQHC; Payment Date Extension and HCBS
- **06/28/2022** – Medicaid Services Manuals (MSM 600 – Physician Services); (MSM Chapter 2900- FQHC); (MSM Chapter 2200 - HCBS) (MSM Chapter 2300 - HCBS Waiver for Persons with Physical Disabilities)

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#2796** -- COVID-19 Billing Guides Updated
- **WA#2789 –** It's Not Me or Is It?: Implicit Bias in Medicine ECHO Session Scheduled for May 31, 2022
- **WA#2788 –** Attention All Providers: Clinical Records Procurement for Encounter Data Validation
- **WA#2786 –** Attention All Providers, Delegates and Staff: Upcoming Training Sessions for June 2022
- **WA#2785 –** Reminders to Out-of-State and Catchment Area Providers Enrolling with Nevada Medicaid
- **WA#2782 –** Notice of Public Workshop for Nevada Administrative Code (NAC) Chapter 439A - Planning for the Provision of Health Care
- **WA#2781 –** Public Notice: COVID-19 American Rescue Plan Act (ARPA) State Plan Amendments

Carin Hennessey, SSPS II

- BH Updates –
  - **Crisis Stabilization Centers** – We are adding information through a State Plan Amendment to update the Rates pages. We are looking toward scheduling a presentation during the BHTA for the CSCs in September.
  - During February Interim Finance Committee (IFC), Nevada Medicaid was approved to use Home and Community Based (HCBS) American Rescue Plan Act (ARPA) quarterly spending, to provide **funding for a consultant to assist with recommendations for strengthening behavioral health services available to children through Medicaid**. The state is awaiting Centers for Medicare and Medicaid Services (CMS) approval of the HCBS ARPA request which was submitted on February 2, 2022. This consultant work will include things like facilitating stakeholder engagement; conducting a gap analysis, providing recommendations and assistance with identifying authority needed for CMS approval for identified services; providing recommendations related to service delivery model; and assistance with fiscal impact and projections for identified services. We are currently finalizing a statement of work with one of the state vendors to be this consultant.
  - Under MSM 3400, currently **Nevada Medicaid is working to align state plan and MSM 3400 policy with Senate Bill 5 during the 81st Nevada Legislative Session by removing restrictions around audio-only as well as aligning payment parity across audio-only,**

audio-visual, and in person services. A Public Hearing was held on may 31, 2022.
    - The **ABA quarterly dashboard** has been posted to the DHCFP website located at https://dhcfp.nv.gov/uploadedFiles/dhcfpnvgov/content/Pgms/CPT/ABA/ABAQuarterlyDashboardSFY2021(providers%20excluded).pdf
    - The **1115 Waiver** will "expand statewide access to comprehensive behavioral health services for the most vulnerable Nevadans, including those with opioid use disorders (OUDs) and other substance use disorders (SUDs). Specifically, DHHS seeks authority to provide a limited waiver of the federal Medicaid Institutions for Mental Diseases (IMD) exclusion." DHCFP was approved to resubmit the 1115 Demonstration application to CMS during the May 31, 2022, Public Hearing.
- Care Coordination – With the launch of the 988 Crisis Line in July 2022, there will be changes coming in the form of Crisis Stabilization Centers and Mobile Crisis Services, related to the crisis continuum. There is a coordination that comes with working with recipients (in crisis). Whenever possible, it's important to be working with recipients and their caregivers to plan for treatment. Sometimes this may involve referring patients to services outside of your agency, especially for Substance Use Disorder (SUD) treatment (in the case of a PT 14 agency), and for treatment in our CCBHC models.
  This could involve ending active PAs, if the recipient has moved or has gone to a different agency, or if the patient has completed treatment with you and they still have an open PA. Those open PAs can prevent recipients from receiving treatment from another provider, because the open PA is holding those services.
  We can talk more about coordination. Services are recipient-based and recipients may need assistance with managing their care; it's important that we have these discussions about how to facilitate that and make that care accessible to our recipients. Once the recipients are invested in their care, they may be more successful in their treatment. For example, engaging the recipient to access their information through the Medicaid app, Login (nv.gov), where they can see their treatment history. Access to care issues arising from recipients not having the information about their treatment history and not being able to access the current care they need. **CORRECTION: The link to the Nevada Medicaid app is https://mdp.medicaid.nv.gov/; the link provided during the BHTA was incorrect and is the link to apply for Nevada Medicaid, https://accessnevada.dwss.nv.gov/public/landing-page.**
- Next month we have Social Entrepreneurs Inc. (SEI) scheduled to present on 988. Here is a link to the SAMHSA website for 988; https://www.samhsa.gov/find-help/988. We want to address any questions providers on this call may have about 988, so the presentation can address these specific questions. Please let us know at this time if you have any questions.

- There is a grant opportunity through SAMHSA related to community crisis response partnerships, https://www.samhsa.gov/grants/grant-announcements/sm-22-016.

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/

   - Servicing Provider Listed on Claims: We have seen instances where providers have not been following policy related to this. Under Chapter 400, **Progress Note** requirements (MSM 403.2B.6.b.) states that you must list the **name**, **credentials**, and **signature of the provider who actually delivers the service**; this will be the same as the person on the claim listed as the **qualified servicing provider**; especially for psychotherapy, the servicing provider must be the qualified therapist that delivers the services and is listed on the claim.
     It applies to most services within behavioral health, **with these exceptions: Day Treatment; Intensive Outpatient Program; Partial Hospitalization Program; Crisis Intervention with HT (team) modifier**. All of these services can involve multiple servicing providers, rendering services to the recipient; they must have a team lead who is actually involved in the service and taking leadership of the service; and this is the individual under whom the claim for these services must be billed. It is not the Clinical Supervisor of the agency/entity/group or the supervisor of the individuals providing the service. The servicing provider must be the team lead on the service. For example, the team lead may determine that the recipient of the service (Day Treatment, IOP, PHP, CI with HT modifier) may need Basic Skills Training (BST) component, provided by a Qualified Behavioral Aide (QBA) or another qualified and enrolled provider of the component of the service.
     The documentation of each component of these services must be completed by the provider of the individual component and signed by that provider delivering the component. For example, if you have a QBA delivering BST as a component of Crisis Intervention, there should be a page for that component of the service and who delivered it. That is part of the documentation necessary to support the Crisis Intervention billing.
     The other service area to talk about is Neurotherapy. Neurotherapy is defined by the Current Procedural Terminology (CPT) manual as individual "psychophysiological therapy incorporating biofeedback training". This service is a psychotherapy service provided by a QMHP, LCSW, LMFT, LCPC, or otherwise qualified individual (i.e., psychiatrist); they may be assisted in this service by a biofeedback technician, who must be a Medicaid-enrolled individual. But the service must be billed under the servicing

provider of the psychotherapy component. The psychotherapy must be provided; this is not a biofeedback session, that is billed under a different code and paid less. Neurotherapy is a combined service; the therapist must provider psychotherapy and the service must be billed under the therapist.

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
NVMMIS.EDIsupport@gainwelltechnologies.com
nv.providerapps@gainwelltechnologies.com
Prior Authorization Information: (800) 525-2395
nvpeer_to_peer@gainwelltechnologies.com
Field Service Representatives: nevadaprovidertraining@gainwelltechnologies.com

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

- PAs for Psychotherapy Services and Calendar Year Service Limitations: This is a quick reminder, for psychotherapy service limitations. Under Web Announcement #2437, providers are reminded of the service limitations for our psychotherapy codes. Some questions have come up.
  When we are talking about getting prior authorizations for those services, under the service limitations, there is a sentence at the bottom of the WA, "Regardless of a provider's active prior authorization, all sessions billed on behalf of the recipient will count toward the session limits from January 1 of each calendar year." Even if you have a prior authorization approved and billed on a claim, if the service limitations for the service have not been met yet, we are going to use those billed units toward the service limitations; the units will not be deducted from the prior authorization.
  We are currently researching and have identified a few claims situations where the units are being deducted from the PA and also being counted toward the service limitation without PA. We are looking into those. What we recommend and what we offer as a workaround for this, if that PA is not yet required and the recipient hasn't met that service limitation for that calendar year yet, you really don't need to include that prior authorization number on that claim. The PA number should only be added once that limitation has been met. Nothing has changed; this is just a general reminder.

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: Under the qualifications for QMHA, I see the TB screening and testing. School Health Services (SHS) employees are not required to have TB testing during the hiring process. Are there any waivers for this qualification?
A: The Chapter 400 Provider Qualifications update intersects with SHS, which are different than our Provider Type (PT 14) delivery model. There may be some different regulations around this requirement in a school setting. Please email BehavioralHealth@dhcfp.nv.gov and we can involve the Program Specialists for SHS in this conversation.

Q: If we have a PAR (that says we have 12 units), then there is a lapse or gaps in between, are you saying that if there are still some units remaining we can use those because the 12 did not count against possibly? You're not going to take them from the PA first? Sometimes you will have a PA request (PAR) and it will go past the first of the year, so you start the year on a PAR. A lot of providers are worried, so they get a PAR to be better safe than sorry. If there is a delay in getting a PAR turned in, it lapses past the date, they always wonder, "do I have some available?"
A: Starting on January 1st, we see the 18 or 26 units available under the service limitations (for psychotherapy services). All of the service units billed on claims will be applied to the service limitations until the service limitations are met; then we will move to prior authorizations and start deducting from those approved PAs. If a PA is not required yet, then we will not deduct units from the PA.
All of those service limits will be used up before we start pulling from the PAs. If providers are not sure where they are as far as utilized units, we do have a process within the Call Center; you can submit a Secure Correspondence Request, through the EVS portal and request a treatment history. You will usually get a response in 24-48 hours, so that you will have that count, so you will know whether or not to request a PA.
NOTE: This applies to psychotherapy PAs and service limits that renew each calendar year beginning January 1.

Q: Providers are getting PA's early because we don't know what other providers the patient has seen. We don't have a true session count. Can you put the link for the secure correspondence in the chat?
Can that be repeated and written in chat, the procedure for treatment history?
A: Providers can request treatment history using the Secure Correspondence feature in the EVS provider portal. You will need to be logged into the portal to access this feature. Once logged in, click on Secure Correspondence on the right

side of the Home page. Once on the Secure Correspondence page, click on Create New Message hyperlink. Instructions can be found in the EVS User Manual Chapter 1, page 61, Section 1.15 Secure Correspondence.
https://www.medicaid.nv.gov/Downloads/provider/NV_EVS_User_Manual_Ch1.pdf

Q: If you are in fact counting the units on the prior auths against the limitations, how are providers supposed to request prior authorizations in advance to capture some of those unexpected length of time psychotherapy sessions. For example, we might routinely request 90834s, but a client shows up late and we need to bill a shorter session. Or they need a longer session. When we had tried to request those authorizations on the PAR to circumvent that, we would get denied for excessive units. So if you are deducting authorized from the service limits, it puts providers in a bind. How would you guide providers to help that process?
A: When you do those prior authorization requests (PARs), unfortunately, those codes do not umbrella. As we know, each code needs to be submitted on the PA and approved on the PA exactly as it is submitted on the claim. So a code that goes 60 minutes does not also therefore include the 45 minute, or the 40 minute or 30 minutes code. On the PA, to address if the recipient comes in late of has to leave early, providers have to submit a FA-29 Data Correction form in order to get that specific code. That would be what needs to happen instead of the "excessive". You can't submit a PA for the "what ifs". The way you get [the PA] approved, it's approved. If something changes, you submit the FA-29 Data Correction form; once that's approved, once you have the correct code, that's when you can bill. The way that I help providers understand, **the service limitations are of the service codes listed on the Billing Guideline,** NV_BillingGuidelines_PT14.pdf, **under the "Psychotherapy" headline (pg. 8-11, not including Neurotherapy, which currently has its own service limitations in Chapter 400 policy)**. For example, if a provider has 26 units of 90837 [for a child or adolescent], they may think they have 26 units of that code, but it's 26 units of all the codes under the Psychotherapy headline. I like to visualize it as a pot of gold; the recipient has the pot of gold and all the hands in the pot of gold are the providers. The service limitations will follow the recipient only from January 1 to December 31, not a recipient and a provider together.
***NOTE: Please pay attention to the service limitations based on Intensity of Needs grids in Chapter 400.**

Q: Does the 90785 Interactive Complexity add a count onto the session?
A: That does not count separately because it is an add-on code.

Q: Is Chapter 400 going to be updated to reflect that is not 26 sessions of authorized services, but is 26 sessions of combined authorized and unauthorized services?
A: We can take a look at that there are always updates happening within our chapter, different sections, under the different service delivery models. We do

recognize that our chapter does need to be updated, some areas really need updates. We are always looking at that. I appreciate you bring that up. I think it's a great question to go back at policy and see how it reads and make sure that it is clear. You can email the BehavioralHealth@dhcfp.nv.gov inbox and state your concern, that will be great. NOTE: It's always best to access the MSM policies through the links on the Medicaid website, as these are the most updated policies.

Q: What is the turn around time on the secure correspondence? Is that like a chat and instant or same day?
A: 24-48 hours is the current turnaround time. I do not know the maximum time frame that exists, but they are currently getting to them in 2 days. It is not an instant response; it's related to an email correspondence that goes back and forth between the provider and the agent.

Q: Can we use a data correction form to move [PA approved] group therapy sessions to individual sessions?
A: To reiterate what Gainwell has indicated, what is requested on the PA is what is used and billed for. What you are submitting on the PA is for what you are intending to submit claims. If that doesn't happen, then you may need to submit a new PA or form other than the FA-29. Related to the data correction, if it doesn't impact the clinical piece of the approved PA, you can submit the FA-29 (i.e., to change a modifier). Otherwise, you would submit an unscheduled revision because the treatment is changing because of a condition change [using the Form FA-11].

Q: So, like a long therapy session to shorter therapy session is data correction, but Group to individual would be a change in the actual treatment and need Unscheduled Revision.
A: There is an explanation of this in the Billing Manual (pgs. 25-26). Any change to the condition or any change to the clinical information, adjust CPT codes, or units, you will use the FA-11 for unscheduled revision. To correct non-clinical information, you will use the FA-29.

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