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Annual Medicaid Conference 2018 Behavioral Health



Objectives

- Program Integrity
 - Program
 - Provider
 - Recipient
- Implemented Policy Changes
- Resources
- Next Steps



Program Integrity

- The Division of Health Care Financing and Policy (DHCFP) is responsible for the fiscal integrity of the Medicaid and Nevada Check Up programs and is committed to a program that identifies and reduces fraud, abuse and improper payments. The DHCFP must ensure Medicaid and Nevada Check Up recipients have access to quality care and claims are paid appropriately and in accordance with state statutes and federal laws and regulations, program policies and billing manuals.
- Provider and recipient fraud, abuse and improper payments are regulated by federal law and state statute, specifically, the Social Security Act (SSA), United States Code (Title 42), Code of Federal Regulation (42 CFR) and the Nevada Revised Statutes (NRS).



Program Integrity

- Protects the program of services
 - This ensures that services are being provided to fidelity and demonstrating the appropriateness of services to recipients.
- Protects the providers
 - Issues with duplication of services/multiple providers billing
 - Helps with coordination of care
 - Wholistic care to recipients
- Protects the recipients
 - Being taken advantage of
 - Ensures appropriate and medically necessary services are being provided
 - Best health outcomes



Policy Changes

- Policy changes all take into consideration components of program integrity as well as the impact to recipients and stakeholders.
- Reviews include appropriate utilization of services, spikes in services, approval and denial rates and trends (prior authorizations and claims).
- DHCFP conducts public workshops to solicit feedback from stakeholders.



Policy Change – Medication Training and Support

- Medication Training and Support
 - This service must be provided by a professional other than a physician and is covered for monitoring of compliance, side effects, recipient education and coordination of requests to a physician for changes in medication(s). To be reimbursed for this service, the provider must be enrolled as: A Qualified Mental Health Professional (QMHP), a Licensed Clinical Social Worker (LCSW), a Licensed Marriage and Family Therapist (LMFT) or a Clinical Professional Counselor (CPC). A Registered Nurse (RN) enrolled as a Qualified Mental Health Associate (QMHA) may also provide this service if billed with the appropriate modifier. Medication Training and Support may only be billed if provided within 30 days after the recipient has a prescription filled. The nature and duration of the service should conform to best practices.



Policy Change - IOP

- Intensive Outpatient Program (IOP)
 - Service Limitations: IOP services are direct services provided no more or less than three days a week, with a minimum of three hours a day, and not to exceed six hours a day. IOP services may not exceed the day and hour limitations. Services that exceed this time frame indicate a higher level of care and the recipient should be reevaluated.
 - Direct services are face-to-face interactive services spent with licensed staff. Interns and assistants enrolled as a QMHP can provide IOP services while under the direct and clinical supervision of a licensed clinician. Direct supervision requires the licensed clinical supervisor to be onsite where services are rendered.
 - IOP includes: outpatient mental health services, rehabilitative mental health services, diagnostic testing and evaluations including neuro-psychological testing, lab tests including drug and alcohol tests, medication management, medication training and support, crisis intervention and supplies. IOP requires the availability of 24/7 psychiatric and psychological services. These services may not be billed separately as IOP is an all-inclusive rate.



Policy Change - IOP

- Non-Covered services in an IOP include, but are not limited to:
 1. Non-evidence based models;
 2. Transportation or services delivered in transit;
 3. Club house, recreational, vocational, after-school or mentorship program;
 4. Routine supervision, monitoring or respite;
 5. Participating in community based, social based support groups (i.e. Alcoholics Anonymous, Narcotics Anonymous);
 6. Watching films or videos;
 7. Doing assigned readings; and
 8. Completing inventories or questionnaires.



Policy Change - BST

- Basic Skills Training is a rehabilitative mental health service is only provided in conjunction with outpatient mental health services (psychotherapy, medication management).
 - All BST services must be prior authorized.
 - Up to two hours of BST services per day for the first 90 consecutive days.
 - One hour per day for the next 90 consecutive days.
 - Anything exceeding current service limitations, either daily hourly amount or above 180 consecutive days would require a prior authorization meeting medical necessity.
 - Services are based on a calendar year. BST services must be prior authorized. Prior authorizations may not exceed 90-day intervals.



Policy Change - Psychotherapy

- Psychotherapy
 - All psychotherapy sessions (individual, group, and family) are allowed up to five sessions, of any combination, without a PA. After five sessions, a PA will be required and may be requested from the QIO-like vendor for additional services above the service limitations for all levels demonstrating medical necessity.
- This allows clinicians the ability to begin sessions and submit Prior Authorization in a timely manner.
- Effective October 1, 2018



Policy Change – Neurotherapy

- Neurotherapy
 - Up to five neurotherapy sessions are allowed without a prior authorization for the below identified diagnoses. Prior authorization requirements and QIO-like vendor responsibilities are the same for all out-patient therapies, required for all subsequent neurotherapy services except for the following allowable service limitations for neurotherapy used for treatment.
- This allows clinicians the ability to begin sessions and submit Prior Authorization in a timely manner.
- **Effective October 1, 2018**



Resources

- Behavioral Health works towards providing helpful and meaningful information to providers.
 - Treatment Plan and Documentation Fact Sheet
 - Monthly Behavioral Health Technical Assistance Webinars



Nevada Department of Health and Human Services

Division of Health Care Financing and Policy

IN V

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BEHAVIORAL HEALTH SERVICES

Welcome to the State of Nevada Division of Health Care Financing and Policy (DHCFP) Behavioral Health Services (BHS) webpage. Nevada Medicaid Behavioral Health is a part of the Policy Development & Program Management unit that oversees policies for rehabilitative mental health, substance abuse prevention and treatment, targeted case management, inpatient psychiatric services as well as residential treatment centers. Policies are located within the Medicaid Service Manual (MSM), Chapter 400 for Mental Health and Alcohol/Substance Abuse Services and MSM, Chapter 2500 for Targeted Case Management. A link to Nevada Medicaid's MSM is found on DHCFP's main page under "Resources", "Publications" and under "Manuals". Under the section called Medicaid, click on Medicaid Services Manuals.

Enrollment for new behavioral health and substance abuse and treatment providers is provided through Nevada Medicaid's QIO-like vendor, Nevada Medicaid's fiscal agent. In addition, Nevada Medicaid's fiscal agent processes all Medicaid fee-for-service (FFS) provider claims and prior authorization requests. All MSM Chapter 400 changes and/or updates are provided on the [Nevada Medicaid Website](#) under the Provider Tab; then click Announcements.

Resources

[Informational Bulletin on Medications and Services for Substance Use Disorders](#)

[BHCN QA Policy - FAQ](#)

[Behavioral Health Treatment Plan Fact Sheet](#)

Reports

[Behavioral Health Report Cards](#)

[Out-of-State Residential Treatment Center Reports](#)

[Substance Abuse Agency Model Dashboards](#)

Contact

BehavioralHealth@DHCFP.nv.gov

Links

[Division of Public and Behavioral Health \(DPBH\)](#)

[Nevada Medicaid Website](#)

Meetings

[Public Notices](#)

[Behavioral Health WebEx Link](#)

[Behavioral Health WebEx Login Instructions](#)

[Behavioral Health Agendas and Minutes](#)

Regulatory

[MSM Chapter 400 - Mental Health](#)

[MSM Chapter 2500 - Targeted Case Management](#)

Forms

[RTC Medicaid Policy Compliance Form](#)



Nevada Medicaid
Outpatient Mental Health Treatment Plan
Components & Documentation
FACT SHEET

Elements of the Treatment Plan:

- ☒ Treatment planning is based upon the individual recipient's psychological assessment, diagnosis, reason for referral and Level of Intensity (LOI).
- ☒ Recipient and/or legal guardians are directly involved in the development of the treatment plan (identifying goals, service providers, etc.) and are required to sign.
- ☒ When family or others participate in services, the focus remains on supporting recipient progress and positive outcomes (e.g., parent training to manage recipient's behaviors).
- ☒ Services identified in the Treatment Plan are focused exclusively on the benefit of the recipient and aligned with the Intensity of Need Assessment tool.
- ☒ A Treatment Plan is a fluid document and needs to be reviewed/updated at regular intervals and revised based upon the recipient's progress and/or clinically indicated needs based upon Intensity of Needs Assessment tool.

Required Components of the Treatment Plan:

- ☒ Strengths of the recipients (and their families in the case of legal minors and when appropriate for an adult).
- ☒ Intensity of Needs Determination.
- ☒ Needs of the recipient based upon the Intensity of Needs Assessment tool.
- ☒ Goals:
 - o Goals are the larger, broader outcomes that the provider and client are working toward.
 - o Goals must be specific, measurable (action oriented), achievable, realistic and time limited.
 - o Examples of goals:



Jill will be less depressed.



Eric will be nicer to his family.



Symptoms of depression will be significantly reduced and will no longer interfere with Jill's functioning. This will be measured by a score of 60 or below on the YSR Withdrawn/Depressed scale at the time of discharge. Anticipated completion date is 6 months.



Reduce family conflict and increase positive family interactions. This will be measured by reducing evasive/withdrawn interactions with his father to 1 time a week for 3 consecutive weeks; reducing arguing/rudeness towards his step-mother to 7 times a week for 3 consecutive weeks; and family will report at least one positive interaction/family activity per day for 3 consecutive weeks. Anticipated completion date is 6 months.



- ✓ Objectives
 - Objectives are short-term steps that the client will take that are necessary to meet the overarching treatment goals.
 - Objectives must be specific, measurable (action oriented), achievable, realistic and time limited.
 - Objectives are what the recipient is going to do to accomplish their goals.
 - Examples of objectives and format:

Objective	Date established	Projected completion date	Date achieved
Jill and her father will develop a safety plan/no self-harm contract.	4/1/18	4/1/18	4/1/18
Jill will learn coping skills, including problem solving and emotional regulation. This will be measured by her demonstrating these skills during therapy sessions and bringing in homework assignments for two consecutive weeks that show she practiced them between sessions.	4/1/18	5/1/18	
Jill will report no suicidal ideation for 3 consecutive weeks.	4/1/18	6/1/18	

- ✓ Evidence-based treatment strategies or interventions that will be used:
 - Identified treatment strategies/interventions must specify **amount, scope, duration** and **anticipated provider(s)** of the services.
 - Examples - Strategies / Interventions:
 - Staff will assist client in scheduling an intake with the Domestic Abuse Women's Network (DAWN) by specified date.
 - Staff will allow client to call her primary care provider in session.
 - Staff will teach clients skills to cope with cravings for alcohol.
 - Staff will assist client in finding a sober support group for women.
- ✓ Discharge plan, which includes:
 - Expected timeframe and criteria for discharge based upon treatment goals and level of care determined by the Intensity of Needs tool
 - Identified aftercare service/providers
 - Current treatment provider's plan to assist recipient in accessing necessary aftercare services/providers upon discharge
- ✓ Evidence of care coordination by those involved with the recipient's care (for high-risk recipients accessing services from multiple government-affiliated and/or private agencies)
- ✓ Legible date and signatures of clinician, recipient (or guardian), other treatment team members. To include a statement that recipient participated and agreed with treatment plan; evidenced by recipient signature.

Progress Notes – Reflect the recipient's specific progress/regress toward meeting the goals and objectives within the Treatment Plan and/or identify any emerging needs that may require revisions to the Treatment Plan. The Progress Notes must be current and up-to-date with the information reflecting the justification or medical necessity of services.



Monthly TA Webinar

- A monthly Behavioral Health Technical Assistance webinar is done the 2nd Wednesday of every month at 10 AM.
- This includes information and updates from both the DHCFP and DXC.
- Agenda's and minutes are posted for reference.



Next Steps

- Monitoring of utilization of services and evaluate for changes
- Monitoring claims information and evaluate for changes
- Continued education and trainings



Questions?

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