Behavioral Health Outpatient Treatment

State policy

The Medicaid Services Manual (MSM) is on the Division of Health Care Financing and Policy (DHCFP) website at http://dhcfp.nv.gov (select "Manuals" from the "Resources" webpage).

- MSM Chapter 400 covers policy for behavioral health providers.
- MSM Chapter 100 contains important information applicable to all provider types.

Rates

Reimbursement rates are listed online at http://dhcfp.nv.gov on the Rates Unit webpage. Rates are also available on the Provider Web Portal at www.medicaid.nv.gov through the Search Fee Schedule function, which can be accessed on the Provider Login (EVS) webpage under Resources (you do not need to log in).

Smoking/Tobacco Cessation Counseling

Effective on claims with dates of service on or after December 1, 2021, Current Procedural Terminology (CPT) codes 99406 (Smoking and tobacco use cessation counseling visit, intermediate, 3-10 minutes) and 99407 (Smoking and tobacco use cessation counseling visit, intensive, greater than 10 minutes) may be used to bill smoking cessation counseling for all Nevada Medicaid recipients. Procedure codes 99406 and 99407 are no longer restricted to counseling for pregnant women only. The limitation for both codes is a maximum of 24 encounters per year. These limitations can be exceeded if determined medically necessary by Nevada Medicaid.

Authorization Requirements

Authorization is required for most behavioral health services, including those referred through the Early Periodic Screening, Diagnostic and Treatment (EPSDT) program. Use the Authorization Criteria search function in the Provider Web Portal at https://www.medicaid.nv.gov to verify which services require authorization. Authorization Criteria can be accessed on the Provider Login (EVS) webpage under Resources (you do not need to log in).

For questions regarding authorization, call Nevada Medicaid at (800) 525-2395 or refer to MSM Chapter 400. Prior authorization may be requested through the Provider Web Portal, https://www.medicaid.nv.gov, by using the appropriate FA form listed below:

- Form FA-10A: Psychological testing
- Form FA-10B: Neuropsychological testing
- Form FA-10D: Automated Testing
- Form FA-11: Behavioral Health Outpatient or Rehabilitative Authorization Request
- Form FA-11B: Mental Health Request for PHP/IOP Services (Partial Hospitalization Program and Intensive Outpatient Program)

Incomplete requests may receive either a technical denial or may be pended for additional information, determined by what elements are missing. If the request is pended for additional information, the submitter has five business days to resubmit with complete information or a technical denial will be issued.

Please note that form FA-11 requires the signature of the Qualified Mental Health Professional (QMHP). If the QMHP is an intern, the signature of the Clinical Supervisor is also required. Requests will be denied if the required signatures are not included.

Authorization does not guarantee payment of a claim. Payment is contingent upon eligibility, available benefits, contractual terms, limitations, exclusions, coordination of benefits and other terms and conditions set forth by the benefit program.

Behavioral Health Outpatient Treatment

Request timelines

- **Initial request for Outpatient Mental Health (OMH) and Rehabilitative Mental Health (RMH) services**: 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.
- **Continued service requests**: If the recipient requires additional services or dates of service (DOS) beyond the last authorized date, you may request review for continued service(s) prior to the last authorized date. The request must be received by Nevada Medicaid by the last authorized date of service and it is *recommended these be submitted 5 to 15 business days prior to the last authorized date*.
- **Unscheduled revisions**: Submit whenever a significant change in the recipient's condition warrants a change to previously authorized services. Must be submitted during an existing authorization period and prior to revised units/services being rendered. The number of requested units should be appropriate for the remaining time in the existing authorization period.
- **Retrospective request (for recipient retroactive eligibility)**: Submit no later than 90 calendar days from the recipient's Date of Decision (i.e., the date the recipient was determined eligible for Medicaid benefits). All authorization requirements apply to requests that are submitted retrospectively.
- **Emergency request for Crisis Intervention only**: Submit within five (5) business days of the delivery of additional services, including the first date of service of the first occurrence.

Claim instructions

Use Direct Data Entry (DDE) or the 837P electronic transaction to submit claims to Nevada Medicaid. See Electronic Verification System (EVS) Chapter 3 Claims and the EDI companion guides for billing instructions.

Billing Instructions for Span Dating of Outpatient Mental Health (OMH) and Rehabilitative Mental Health (RMH) Services

For OMH and RMH services, **non-consecutive dates and services that are not the same unit/time amount** must not be span dated on a single claim line. Providers risk claim denials due to duplicate logic, overlapping dates and/or mutually exclusive edits.

When span dating, services must have been provided on every day within that span of dates and be for the same quantity of units on each day. In the following examples, it would be incorrect to submit a single span-dated claim line for the following services:

- The entire week or month when services were only performed on Thursday and Saturday within the same week; or
- The entire month was billed and services were only rendered on January 1 and January 10 (two days within the same month; see the example below); or
- If one hour, four units, were performed on January 1 and two hours, eight units were performed on January 2.

The claim should only contain dates of service the service was rendered on. If services were rendered January 1, January 5 and January 10, the claim would be submitted as follows with one line charge for each date of service:

01/01/15
01/05/15
01/10/15

When billing weekly or monthly, a single claim line cannot include dates from two calendar months. For example:

- A claim line with dates of service April 15-May 15 is not allowed, but a claim line with May 1-May 31 is acceptable, if services were provided on every day in the date span and the above criteria are met regarding same quantity of units provided on each day.

- A claim line with dates of service March 28-April 3 is not allowed, but one claim line with March 28-March 31 and a second claim line with April 1-April 3 is acceptable, if services were provided on every day in the date span and the above criteria are met regarding same quantity of units provided on each day.

Services billed must match services authorized. For example, if code H0038 with modifier HQ was authorized, this same code/modifier combination must be entered on the claim.

National Correct Coding Initiative (NCCI) Edits and Service Limitations

The objective of the National Correct Coding Initiative (NCCI) is to promote correct coding methodologies. The Centers for Medicare & Medicaid Services (CMS) is responsible for the development and administration of the NCCI Edits: *"The CMS developed its coding policies based on coding conventions defined in the American Medical Association's CPT Manual, national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practices, and a review of current coding practices."*

Nevada's Medicaid Management Information System (MMIS) uses NCCI Edits in the processing of Nevada Medicaid claims. DHCFP receives quarterly and annual NCCI Edit updates that are added to the MMIS. Providers can find the most current Annual Code report and the quarterly Medically Unlikely Edits (MUE), Procedure to Procedure (PTP) and Add-On Code reports on the following website:

https://www.medicaid.gov/medicaid/program-integrity/national-correct-coding-initiative-medicaid/index.html

It is not possible to provide the most current quarterly or annual changes in this billing guide; for the most current information please reference the website link provided above.

Providers are reminded to bill procedures with the correct modifier combinations, units of service provided and correct code combinations.

Note: It is the responsibility of providers to ensure the use of current CPT codes, service limitations and MUEs are applied when billing claims.

Intensity of Needs Grid

The Intensity of Needs grid is an approved Level of Care (LOC) utilization system, which bases the intensity of services on the assessed needs of a recipient. The determination level on the grid guides the interdisciplinary team in planning treatment to improve or retain a recipient's level of functioning or prevent relapse. Each Medicaid recipient must have an Intensity of Needs determination completed prior to approval to transition to more intensive services (except in the case of a physician or psychologist practicing as an independent provider). The Intensity of Needs grid is found in Medicaid Services Manual Chapter 400, Section 403.5 Outpatient Mental Health (OMH) Services – Utilization Management. The service limitations for RMH services are found under the individual RMH service descriptions.

NOTE: Assessment, as listed in the Intensity of Needs grid, refers to H0031 (Mental Health Assessment by non-physician) and 90791 (Psychiatric Diagnostic Evaluation), also referred to as a full assessment. These limits do not apply to H0002 (Behavioral Health Screening to determine eligibility for admission to treatment program), also referred to as a Mental Health Screen. When H0031 or 90791 are performed, H0002 may not be billed separately.

Behavioral Health Outpatient Treatment

Covered services

The following table lists covered codes, code descriptions and billing information as needed. The requirements for coverage and limitations are governed by MSM Chapter 400. If you need further clarification, please contact the Medicaid QIO-like vendor.

Qualified Provider Types as noted in the following table:

LCPC: Licensed Clinical Professional Counselor
LCSW: Licensed Clinical Social Worker
LMFT: Licensed Marriage and Family Therapist
QBA: Qualified Behavioral Aide
QMHA: Qualified Mental Health Associate
QMHP: Qualified Mental Health Professional

Billing Code	Brief Description	Service Limitations	Qualified Provider Type(s)	Additional Instruction / Restriction	Prior Authorization Requirement	Intensity of Need
Screening and Assessment						
96127	Brief emotional/behavioral assessment (e.g., Depression Inventory, ADHD) with scoring and documentation per standardized instrument.	Assessment = 1 unit; limit 2 units per day	QMHP, LCSW, LMFT, LCPC, QMHA	**NOTE:** This is considered a screening tool. Bill one unit for each screening. NOTE: A screening may also be a component of a full assessment, but only the full assessment (including a CASII or LOCUS) will be reimbursable.	No	All Levels

Behavioral Health Outpatient Treatment

Billing Code	Brief Description	Service Limitations	Qualified Provider Type(s)	Additional Instruction / Restriction	Prior Authorization Requirement	Intensity of Need
H0002	Behavioral Health Screening to determine eligibility for admission to treatment program	1 time every 90 days. This screening must be conducted face-to-face before the recipient can be determined eligible for Medicaid behavioral health services	QMHP, LCSW, LMFT, LCPC, QMHA	Bill one unit for each screening. Recipients must be re-screened every 90 days to reevaluate their Intensity of Needs, which includes a CASII or LOCUS. NOTE: A screening may also be a component of a full assessment, but only the full assessment (including a CASII or LOCUS) will be reimbursable.	Prior Authorization is required to exceed the service limitations	All Levels
H0031	Mental Health Assessment by non-physician	Covered up to 4 times per calendar year (CASII) or 2 times per calendar year (LOCUS) based on Intensity of Needs grid	QMHP, LCSW, LMFT, LCPC	Use this code for services provided in a home or community setting, not in an office setting. Psychotherapy services, including for crisis, may not be reported on the same day. E/M codes may not be reported on the same day performed by the same individual for the same patient.	No	All Levels
90791	Psychiatric Diagnostic Evaluation	Covered up to 4 times per calendar year (CASII) or 2 times per calendar year (LOCUS) based on Intensity of Needs grid	QMHP, LCSW, LMFT, LCPC	Integrated biopsychosocial assessment, including history, mental status and recommendations. Psychotherapy services, including for crisis, may not be reported on the same day. E/M codes may not be reported on the same day performed by the same individual for the same patient.	Yes. If there is substantial change in condition, subsequent assessments may be requested through a PA.	All Levels

Behavioral Health Outpatient Treatment

Billing Code	Brief Description	Service Limitations	Qualified Provider Type(s)	Additional Instruction / Restriction	Prior Authorization Requirement	Intensity of Need
Diagnostic						
96138	Psychological or Neuropsychological Test administration and scoring by technician	First 30 minutes	QMHP, LCSW, LMFT, LCPC	Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method.	Yes	All Levels
96139	Psychological or Neuropsychological Test administration and scoring by technician	Each additional 30 minutes	QMHP, LCSW, LMFT, LCPC	Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method.	Yes	All Levels
96146	Psychological and Neuropsychological test, automated	N/A	QMHP, LCSW, LMFT, LCPC	Psychological or neuropsychological test administration, with single automated, standardized instrument via electronic platform, with automated result only.	Yes	All Levels
96156	Health and Behavior Assessment or reassessment	Initial assessment, face-to-face with patient	QMHP, LCSW, LMFT, LCPC	Health behavior assessment, or re-assessment (i.e., health-focused clinical interview, observations, clinical decision-making). Qualifying recipients present with primary physical illnesses, diagnoses or symptoms and may benefit from interventions that focus on biopsychosocial factors related to the recipient's health status.	4 units allowed per calendar year, PA to exceed	All Levels
96158	Health and Behavior Intervention	Individual, face-to-face, Initial 30 minutes	QMHP, LCSW, LMFT, LCPC	Includes promotion of functional improvement, minimizing psychological and/or psychosocial barriers to recovery, and management of and improved coping	No	All Levels

Behavioral Health Outpatient Treatment

Billing Code	Brief Description	Service Limitations	Qualified Provider Type(s)	Additional Instruction / Restriction	Prior Authorization Requirement	Intensity of Need
				with medical conditions. These services emphasize active patient/family engagement and involvement. Do not report for less than 16 minutes of service.		
96159	Health and Behavior Intervention	Each additional 15 minutes	QMHP, LCSW, LMFT, LCPC	Includes promotion of functional improvement, minimizing psychological and/or psychosocial barriers to recovery, and management of and improved coping with medical conditions. These services emphasize active patient/family engagement and involvement.	No	All Levels
96164	Health and Behavior Intervention, group (2 or more patients)	Initial 30 minutes, face-to-face	QMHP, LCSW, LMFT, LCPC	Qualifying recipients present with primary physical illnesses, diagnoses or symptoms and may benefit from interventions that focus on biopsychosocial factors related to the recipient's health status. Do not report for less than 16 minutes of service.	No	All Levels
96165	Health and Behavior Intervention, group (2 or more patients)	Each additional 15 minutes, face to face	QMHP, LCSW, LMFT, LCPC	Qualifying recipients present with primary physical illnesses, diagnoses or symptoms and may benefit from interventions that focus on biopsychosocial factors related to the recipient's health status.	No	All Levels
96167	Health and Behavior Intervention, family (with patient present)	Initial 30 minutes, face-to-face	QMHP, LCSW,	Qualifying recipients present with primary physical illnesses, diagnoses or symptoms and may benefit from interventions that	No	All Levels

Behavioral Health Outpatient Treatment

Billing Code	Brief Description	Service Limitations	Qualified Provider Type(s)	Additional Instruction / Restriction	Prior Authorization Requirement	Intensity of Need
			LMFT, LCPC	focus on biopsychosocial factors related to the recipient's health status. Do not report for less than 16 minutes of service.		
96168	Health and Behavior Intervention, family (with patient present)	Each additional 15 minutes, face-to-face	QMHP, LCSW, LMFT, LCPC	Qualifying recipients present with primary physical illnesses, diagnoses or symptoms and may benefit from interventions that focus on biopsychosocial factors related to the recipient's health status.	No	All Levels
96170	Health and Behavior Intervention, family (without the patient present)	Initial 30 minutes, face-to-face	QMHP, LCSW, LMFT, LCPC	Qualifying recipients present with primary physical illnesses, diagnoses or symptoms and may benefit from interventions that focus on biopsychosocial factors related to the recipient's health status. Do not report for less than 16 minutes of service.	No	All Levels
96171	Health and Behavior Intervention, family (without the patient present)	Each additional 15 minutes, face-to-face	QMHP, LCSW, LMFT, LCPC	Qualifying recipients present with primary physical illnesses, diagnoses or symptoms and may benefit from interventions that focus on biopsychosocial factors related to the recipient's health status.	No	All Levels
Psychotherapy: *For services beyond the Intensity of Needs grid to be considered for reimbursement, an approved PA must be listed on the claim. Service provision is based on the calendar year, beginning January 1. In accordance with the Current Procedural Terminology (CPT) manual, do not report psychotherapy of less than 16 minutes duration and follow the "Time Rule" when selecting the appropriate code.*						
90785	Interactive Complexity	Use only as an add-on with an	QMHP, LCSW,	Refers to specific communication factors that complicate the delivery of a psychiatric	No	All Levels

Behavioral Health Outpatient Treatment

Billing Code	Brief Description	Service Limitations	Qualified Provider Type(s)	Additional Instruction / Restriction	Prior Authorization Requirement	Intensity of Need
		appropriate CPT code	LMFT, LCPC	procedure.		
90832	Psychotherapy	30 minutes; bill one unit per day	QMHP, LCSW, LMFT, LCPC	The patient must be present for all or most of the session.	Yes, based on the Intensity of Needs grid.	All Levels
90834	Psychotherapy	45 minutes; bill one unit per day	QMHP, LCSW, LMFT, LCPC	The patient must be present for all or most of the session.	Yes, based on the Intensity of Needs grid.	All Levels
90837	Psychotherapy	60 minutes; bill one unit per day	QMHP, LCSW, LMFT, LCPC	The patient must be present for all or most of the session.	Yes, based on the Intensity of Needs grid.	All Levels
90839	Psychotherapy for Crisis, with patient and/or family	First 60 minutes, face-to-face; bill one unit per day	QMHP, LCSW, LMFT, LCPC	Treatment must include psychotherapy, mobilization of resources and implementation of psychotherapeutic interventions. The patient must be present for all or some of the service.	No	All Levels
90840	Psychotherapy for Crisis, with patient and/or family	Each additional 30 minutes	QMHP, LCSW, LMFT, LCPC	Treatment must include psychotherapy, mobilization of resources and implementation of psychotherapeutic interventions. The patient must be present for all or some of the service.	No	All Levels
90845	Psychoanalysis	Bill one unit per day	QMHP, LCSW, LMFT, LCPC	The patient must be present for all or most of the session.	Yes, based on the Intensity of Needs grid.	All Levels

Behavioral Health Outpatient Treatment

Billing Code	Brief Description	Service Limitations	Qualified Provider Type(s)	Additional Instruction / Restriction	Prior Authorization Requirement	Intensity of Need
90846	Family Psychotherapy (without patient present)	50 minutes; bill one unit per day	QMHP, LCSW, LMFT, LCPC	The services must deal with issues relating to the constructive integration/reintegration of the patient into the family.	Yes, based on the Intensity of Needs grid.	All Levels
90847	Family Psychotherapy (with patient present)	50 minutes; bill one unit per day	QMHP, LCSW, LMFT, LCPC	The services must deal with issues relating to the constructive integration/reintegration of the patient into the family.	Yes, based on the Intensity of Needs grid.	All Levels
90849	Multiple-Family Group Psychotherapy	Bill one unit per day; maximum of two (2) hours per session	QMHP, LCSW, LMFT, LCPC	N/A	Yes, based on the Intensity of Needs grid.	All Levels
90853	Group psychotherapy	Bill one unit per day; maximum of two (2) hours per session	QMHP, LCSW, LMFT, LCPC	Other than of a multiple-family group. Minimum group size is three (3) and maximum therapist to participant ratio is one (1) to 10.	Yes, based on the Intensity of Needs grid.	All Levels
H0004	Behavioral Health Counseling and Therapy	Per 15 minutes; 15 minutes = 1 unit	QMHP, LCSW, LMFT, LCPC	Use this code for services provided in home or community setting, not in an office setting. Modifier HQ indicates group services; only individual services can be billed without the HQ modifier. 1-4 units per claim line = 1 session 5-8 units per claim line = 2 sessions 9-12 units per claim line = 3 sessions	Yes, based on the Intensity of Needs grid.	All Levels

Behavioral Health Outpatient Treatment

Billing Code	Brief Description	Service Limitations	Qualified Provider Type(s)	Additional Instruction / Restriction	Prior Authorization Requirement	Intensity of Need
				NOTE: Documentation must reflect medical necessity for in-home and community services.		
90875	Individual Psycho-physiological Therapy Incorporating Biofeedback Training	30 minutes; bill one unit per day; face-to-face with patient The session limits in MSM 400 are recipient-specific, and multiple diagnoses do not allow a recipient to have additional sessions without prior authorization	QMHP, LCSW, LMFT, LCPC Biofeedback Technician qualifies under applicable Provider Type and Specialty	Psychotherapy incorporating biofeedback by a certified Biofeedback Technician. Billing is inclusive of both Psychotherapy and Biofeedback components. Both components must be delivered by a Nevada Medicaid enrolled provider; Biofeedback Technician may be separate from the provider of the psychotherapy component and must be enrolled. Documentation of the service must include both components, completed appropriately by the provider of the component.	Requires prior authorization to exceed service limits.	Service limitations based on recipient diagnosis. Refer to MSM 400 for covered ICD Codes.
90876	Individual Psycho-physiological Therapy Incorporating Biofeedback Training	45 minutes; bill one unit per day; biofeedback must be delivered face-to-face with patient. The session limits in MSM 400 are recipient-specific, and multiple diagnoses do not allow a recipient to	QMHP, LCSW, LMFT, LCPC Biofeedback Technician qualifies under applicable Provider Type and Specialty	Psychotherapy incorporating biofeedback by a certified Biofeedback Technician. Billing is inclusive of both Psychotherapy and Biofeedback components. Both components must be delivered by a Nevada Medicaid enrolled provider; Biofeedback Technician may be separate from the provider of the psychotherapy component and must be enrolled. Documentation of the service must include both components, completed appropriately	Requires prior authorization to exceed service limits.	Service limitations based on recipient diagnosis. Refer to MSM 400 for covered ICD Codes.

Behavioral Health Outpatient Treatment

Billing Code	Brief Description	Service Limitations	Qualified Provider Type(s)	Additional Instruction / Restriction	Prior Authorization Requirement	Intensity of Need
		have additional sessions without prior authorization		by the provider of the component.		
Evaluation and Management (E/M) Services: *E/M codes are to be performed by physicians, nurse practitioners and physician assistants. Physician codes shall be billed using the rendering provider's individual NPI. Providers shall refer to the documentation standards in the Current Procedural Terminology (CPT) code book. Other qualified health care professional is defined as an individual who is qualified by education, training, licensure/regulation, and facility privileging to perform a professional service within their scope of practice and independently (or as incident-to) report the professional service without requiring physician supervision.*						
99202	Office or other outpatient visit for the evaluation and management of a **new patient**	Typically, **20 minutes** are spent face-to-face with the patient and/or family; bill one unit per visit	Physician or other qualified health care professional, can be enrolled as QMHP	Requires these three key components: an expanded problem focused history; an expanded problem focused examination; and straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the **presenting problem(s) are of low to moderate severity**.	No	All Levels
99203	Office or other outpatient visit for the evaluation and management of a **new patient**	Typically, **30 minutes** are spent face-to-face with the patient and/or family; bill one unit per visit	Physician or other qualified health care professional, can be enrolled as	Requires these three key components: a detailed history; a detailed examination; and medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the	No	All Levels

Behavioral Health Outpatient Treatment

Billing Code	Brief Description	Service Limitations	Qualified Provider Type(s)	Additional Instruction / Restriction	Prior Authorization Requirement	Intensity of Need
			QMHP	nature of the problem(s) and the patient's and/or family's needs. Usually, the **presenting problem(s) are of moderate severity**.		
99204	Office or other outpatient visit for the evaluation and management of a **new patient**	Typically, **45 minutes** are spent face-to-face with the patient and/or family; bill one unit per visit	Physician or other qualified health care professional, can be enrolled as QMHP	Requires these three key components: a detailed history; a detailed examination; and medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the **presenting problem(s) are of moderate to high severity**.	No	All Levels
99205	Office or other outpatient visit for the evaluation and management of a **new patient**	Typically, **60 minutes** are spent face-to-face with the patient and/or family; bill one unit per visit	Physician or other qualified health care professional, can be enrolled as QMHP	Requires these three key components: a detailed history; a detailed examination; and medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the **presenting problem(s) are of moderate to high severity**.	No	All Levels
99212	Office or other outpatient visit for the evaluation and management of	Typically, **10-19 minutes** are spent	Physician or other	Requires a medically appropriate history and/or examination and **straightforward**	No	All Levels

Behavioral Health Outpatient Treatment

Billing Code	Brief Description	Service Limitations	Qualified Provider Type(s)	Additional Instruction / Restriction	Prior Authorization Requirement	Intensity of Need
	an **established patient**	face-to-face with the patient and/or family; bill one unit per visit	qualified health care professional, can be enrolled as QMHP	**medical decision making**. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the **presenting problem(s) are self-limited or minor**.		
99213	Office or other outpatient visit for the evaluation and management of an **established patient**	Typically, **20-29 minutes** are spent face-to-face with the patient and/or family; bill one unit per visit	Physician or other qualified health care professional, can be enrolled as QMHP	Requires a medically appropriate history and/or examination and **medical decision making of low complexity**. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) **are of low severity**.	No	All Levels
99214	Office or other outpatient visit for the evaluation and management of an **established patient**	Typically, **30-39 minutes** are spent face-to-face with the patient and/or family; bill one unit per visit	Physician or other qualified health care professional, can be enrolled as QMHP	Requires a medically appropriate history and/or examination **and medical decision making of moderate complexity**. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are **of moderate severity**.	No	All Levels

Behavioral Health Outpatient Treatment

Billing Code	Brief Description	Service Limitations	Qualified Provider Type(s)	Additional Instruction / Restriction	Prior Authorization Requirement	Intensity of Need
99215	Office or other outpatient visit for the evaluation and management of an **established patient**	Typically, **40-54 minutes** are spent face-to-face with the patient and/or family; bill one unit per visit	Physician or other qualified health care professional, can be enrolled as QMHP	Requires a medically appropriate history and/or examination and **medical decision making of high complexity**. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the **presenting problem(s) are of high severity.**	No	All Levels
Services Supportive of Medication Management: Services delivered under the Behavioral Health Community Network (BHCN) agency/entity/group that support Medication Management.						
H0034 TD	Medication Training and Support	Per 15 minutes	Registered Nurse (RN) enrolled as a QMHA	Modifier TD indicates that service is provided by a Registered Nurse (QMHA) under the supervision of a PT 14 BHCN agency. **Limitation:** 2 units per calendar month per recipient. **NOTE:** This service must be preceded by a filled medication prescription within 30 days.	Yes. Prior authorization required to exceed service limitations.	All Levels
96372	Therapeutic, prophylactic, or diagnostic injection beneath the skin (subcutaneous) or into muscle (intramuscular)	Bill one unit per injection	Physician or other qualified health care professional, can be	QMHPs delivering this service must be practicing under their licensure and scope of practice. Specify substance or drug.	No	All Levels

Behavioral Health Outpatient Treatment

Billing Code	Brief Description	Service Limitations	Qualified Provider Type(s)	Additional Instruction / Restriction	Prior Authorization Requirement	Intensity of Need
			enrolled as QMHP, Registered Nurse (RN) enrolled as QMHA			
Evaluation and Management (E/M) Psychotherapy Services: *Use only as an add-on to the appropriate CPT code for the primary procedure. The patient must be present for all or most of the session. Other qualified health care professional is defined as an individual who is qualified by education, training, licensure/regulation, and facility privileging to perform a professional service within their scope of practice and independently (or as incident-to) report the professional service without requiring physician supervision. In accordance with the Current Procedural Terminology (CPT) manual, do not report psychotherapy of less than 16 minutes duration and follow the "Time Rule" when selecting the appropriate code.*						
90833	Psychotherapy when performed with an evaluation and management service	30 minutes, with patient; bill one unit per day	Physician or other qualified health care professional, can be enrolled as QMHP	Include ongoing assessment and adjustment of psychotherapeutic interventions, and may include involvement of informants in the treatment process.	Yes, based on the Intensity of Needs grid.	All levels
90836	Psychotherapy when performed with an evaluation and management service	45 minutes, with patient; bill one unit per day	Physician or other qualified health care professional, can be enrolled as QMHP	Include ongoing assessment and adjustment of psychotherapeutic interventions, and may include involvement of informants in the treatment process.	Yes, based on the Intensity of Needs grid.	All levels

Behavioral Health Outpatient Treatment

Billing Code	Brief Description	Service Limitations	Qualified Provider Type(s)	Additional Instruction / Restriction	Prior Authorization Requirement	Intensity of Need
90838	Psychotherapy when performed with an evaluation and management service	60 minutes, with patient; bill one unit per day	Physician or other qualified health care professional, can be enrolled as QMHP	Include ongoing assessment and adjustment of psychotherapeutic interventions, and may include involvement of informants in the treatment process.	Yes, based on the Intensity of Needs grid.	All levels
Crisis Intervention						
H2011	Crisis Intervention service	Per 15 minutes	QMHP, LCSW, LMFT, LCPC	Maximum of four hours per day over a three-day period (one occurrence) without prior authorization; maximum of three occurrences over a 90-day period without prior authorization.	Yes. To exceed service limitations use emergency request. Refer to *Request Timelines* above.	All Levels
H2011 HT	Crisis Intervention service, team services	Per 15 minutes	QMHP, LCSW, LMFT, LCPC, QMHA, QBA	Delivered by a team of providers under the coordinating QMHP-level provider. QBA and QMHA providers render services only within the scope of their certification and practice. Maximum of four hours per day over a three-day period (one occurrence) without prior authorization; maximum of three occurrences over a 90-day period without prior authorization.	Yes. To exceed service limitations use emergency request. Refer to *Request Timelines* above.	All Levels

Behavioral Health Outpatient Treatment

Billing Code	Brief Description	Service Limitations	Qualified Provider Type(s)	Additional Instruction / Restriction	Prior Authorization Requirement	Intensity of Need
Outpatient Programs (Intensive)						
H0035	Partial Hospitalization Psychiatric program, less than 24 hours	At least 4 hours per day, up to 5 days per week	QMHP, LCSW, LMFT, LCPC, QMHA, QBA	Services are delivered under the coordinating QMHP. QBA and QMHA providers render services only within the scope of their certification and practice. This program is delivered under a provider type 14 BHCN agency and is only covered for recipients who are determined SED or SMI. All-inclusive rate to include OMH and RMH services. See MSM Chapter 400 for complete guidelines. Submit contractual documentation with hospital or FQHC to behavioralhealth@dhcfp.nv.gov, as required.	Yes, required every 3 weeks. Concurrent authorizations must be submitted 5-15 days prior to last date of service.	Level III and higher only

Behavioral Health Outpatient Treatment

Billing Code	Brief Description	Service Limitations	Qualified Provider Type(s)	Additional Instruction / Restriction	Prior Authorization Requirement	Intensity of Need
S9480	Intensive Outpatient Psychiatric program	3-6 hours per day, up to 3 days per week	QMHP, LCSW, LMFT, LCPC, QMHA, QBA	Services are delivered under the coordinating QMHP. QBA and QMHA providers render services only within the scope of their certification and practice. This program is only covered for recipients who are determined SED or SMI. All-inclusive rate to include OMH and RMH services. See MSM Chapter 400 for complete guidelines. Submit curriculum/schedule for review to behavioralhealth@dhcfp.nv.gov, as required.	Yes, required every 3 weeks. Accepted curriculum/ schedule must be submitted with each authorization request. Concurrent authorizations must be submitted 5-15 days prior to last date of service.	Level III and higher only
Rehabilitative Mental Health (RMH) Services						
H2012	Behavioral Health Day Treatment	Per hour; request authorization of hours according to age group **and** ION determination. See MSM Chapter 400, Attachment A, for complete guidelines.	QMHP, LCSW, LMFT, LCPC, QMHA, QBA	Services must be provided by a QMHP or by a QMHA under the Direct Supervision of an onsite QMHP. QBA and QMHA providers render services only within the scope of their certification and practice. Only enrolled provider type 14 BHCN groups with an approved Day Treatment Model **and** additional enrollment as Specialty 308 can request prior authorization for Day	Yes**.** Retroactive authorizations will not be accepted for Day Treatment services.	Level III and higher

Behavioral Health Outpatient Treatment

Billing Code	Brief Description	Service Limitations	Qualified Provider Type(s)	Additional Instruction / Restriction	Prior Authorization Requirement	Intensity of Need
				Treatment to bill code H2012. **Claims shall include a Place of Service code.**		
H2014	Skills Training and Development (Basic Skills Training)	Per 15 minutes; maximum of 2 hours per day; only individual services can be billed without the HQ modifier	QMHP, LCSW, LMFT, LCPC, QMHA, QBA	Recipients may receive up to two (2) hours per day for the first 90 days; one (1) hour per day for the next 90 days; based on a rolling calendar and consecutive months with no break in service. RMH services cannot be reimbursed on the same day as Applied Behavior Analysis (ABA) services; refer to MSM Chapter 3700.	Yes, every 90 days. Authorization requests above 180 consecutive days must demonstrate adequate medical necessity.	I, II, III, IV, V
H2014 HQ	Skills Training and Development group (Basic Skills Training)	Per 15 minutes; maximum of 2 hours per day (H2014 and H2014 HQ combined)	QMHP, LCSW, LMFT, LCPC, QMHA, QBA	Group size is 4 to 15 recipients; up to two (2) hours per day for the first 90 days; one (1) hour per day for the next 90 days; based on a rolling calendar and consecutive months with no break in service. RMH services cannot be reimbursed on the same day as Applied Behavior Analysis (ABA) services; refer to MSM Chapter 3700.	Yes, every 90 days. Authorization requests above 180 consecutive days must demonstrate adequate medical necessity.	I, II, III, IV, V
H2017	Psychosocial Rehabilitation Services	Per 15 minutes; only individual services can be billed without the HQ modifier	QMHP, LCSW, LMFT, LCPC, QMHA	Intensity of Needs Level III, maximum of 2 hours per day; Level IV & V, maximum of 3 hours per day; Level VI, maximum of 4 hours per day. RMH services cannot be reimbursed on the same day as Applied	Yes, every 90 days. Authorization requests above 180	Levels III and higher

Behavioral Health Outpatient Treatment

Billing Code	Brief Description	Service Limitations	Qualified Provider Type(s)	Additional Instruction / Restriction	Prior Authorization Requirement	Intensity of Need
				Behavior Analysis (ABA) services; refer to MSM Chapter 3700.	consecutive days must demonstrate adequate medical necessity.	
H2017 HQ	Psychosocial Rehabilitation Services group	Per 15 minutes; maximum of 2 hours per day (H2017 and H2017 HQ combined)	QMHP, LCSW, LMFT, LCPC, QMHA	Group size is 4 to 15 recipients. Intensity of Need Level III, maximum of 2 hours per day; Level IV & V, maximum of 3 hours per day; Level VI, maximum of 4 hours per day; based on a rolling calendar and consecutive months with no break in service. RMH services cannot be reimbursed on the same day as Applied Behavior Analysis (ABA) services; refer to MSM Chapter 3700.	Yes, every 90 days. Authorization requests above 180 consecutive days must demonstrate adequate medical necessity.	Levels III and higher
H0038	Self-help/Peer Services (Peer-to-Peer Support Services)	Per 15 minutes; only individual services can be billed without the HQ modifier	QMHP, LCSW, LMFT, LCPC, QMHA, QBA	Intensity of Needs Level I & II, maximum of 6 hours per 90-day period; Level III, maximum of 9 hours per 90-day period; Level IV, V & VI, maximum of 12 hours per 90-day period.	Yes	All Levels
H0038 HQ	Self-help/Peer Services group (Peer-to-Peer Support Services)	Per 15 minutes	QMHP, LCSW, LMFT, LCPC, QMHA, QBA	Group size is 4 to 15 recipients. Intensity of Needs Level I & II, maximum of 6 hours per 90-day period; Level III, maximum of 9 hour per 90-day period; Level IV, V & VI, maximum of 12 hours per 90-day period.	Yes	All Levels

Behavioral Health Outpatient Treatment

Billing Code	Brief Description	Service Limitations	Qualified Provider Type(s)	Additional Instruction / Restriction	Prior Authorization Requirement	Intensity of Need
Case Management (non-targeted Levels I and II)						
T1016	Case Management	One (1) unit equals 15 minutes	QMHP, LCSW, LMFT, LCPC, QMHA	This service is covered for children and adults determined non-SED or non-SMI only. See MSM Chapter 2500 for service limitations and criteria.	Prior authorization is required for PT 14 if service will exceed 10 hours for initial calendar month, 5 hours for the next three consecutive calendar months. Services are allowed on a rolling cal year.	Levels I and II