Behavioral Health Rehabilitative Treatment

State policy

The Medicaid Services Manual (MSM) is on the DHCFP website at http://dhcfp.nv.gov (click "Medicaid Manuals" on the DHCFP Index at left, then select "NV Medicaid Services Manual").

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

Authorization requirements

Authorization requirements are discussed in MSM Chapter 400. For questions regarding authorization, call HP Enterprise Services at (800) 525-2395.

- Use Form FA-11A to request prior authorization for rehabilitation services.
- Use Form FA-11C to request retrospective authorization for crisis intervention services.

All required information must be completed on the authorization request. The submitter will be notified if HP Enterprise Services requires more information to complete the request. The submitter then has five business days to resubmit the requested information or a technical denial will be issued.

If you are requesting group services for code H0038, H2014 or H2017 include modifier HQ on your prior authorization request.

Authorization request timelines

Initial Request for Mental Health Rehabilitation Services: Submit no more than 15 business days *before* and no more than 15 calendar days *after* the start date of service.

Crisis Intervention Services: Submit within seven calendar days of initial intervention for each occurrence (limited to 3 occurrences per 90-day period).

Continued Service Requests: Submit the request before the expiration of the current authorized treatment period.

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 Retro-eligible Recipients: Submit no later than 90 calendar days from the date the recipient was determined eligible for Medicaid benefits.

Billing

Daily billing is not required; rehabilitation services may be billed daily, weekly or monthly at the provider's discretion.

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.
- 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.

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Services billed must match services authorized. For example, if code H0038 with modifier HQ was authorized, this same code/modifier combination must be entered in Field 24D on the claim form.

Rates

Reimbursement rates are listed online at http://dhcfp.nv.gov (select Rates from the DHCFP Index, then scroll down and click on Provider Type 82 Behavioral Health).

Covered services

The following services are billable by provider type 82. See MSM Chapter 400 for complete policy and limitations.

H0002 *(Assessment/Screening)*

Description: Behavioral health screening to determine eligibility for admission to treatment program.

Billing Instructions: One unit equals one screening. Use this code to bill for the initial screening and any rescreenings as necessary. This code may be used to bill for an Intensity of Needs Determination which includes a CASII or LOCUS. Modifiers do not apply to this code.

Policy Notes: This screening may be provided by a QMHA or QMHP. This screening determines the recipient's Intensity of Need and it must be conducted face-to-face before the recipient receives Medicaid behavioral health services. After the initial screening, recipients must be re-screened every 90 days to reevaluate their Intensity of Need. Prior authorization is not required.

H0031 *(Assessment/Screening)*

Description: Mental health assessment, by non-physician (home or community setting only).

Billing Instructions: One unit equals one assessment. Use this code for services provided in a home or community setting. Modifiers do not apply to this code.

Policy Notes: This assessment must be provided by a QMHP. Prior authorization is required to exceed two assessments per calendar year.

H2011 *(Crisis Intervention)*

Description: Crisis intervention service.

Billing Instructions: One unit equals 15 minutes. Bill modifier GT for telephonic services and modifier HT for team services. One-to-one, face-to-face service does not require a modifier.

Policy Notes: This service must be provided by a QMHP and is limited to 3 occurrences per 90-day period. Submit authorization request within seven calendar days of initial intervention for each occurrence.

H0038 *(Rehabilitation)*

Description: Self-help / Peer services (Peer-to-Peer Support).

Billing Instructions: One unit equals 15 minutes. Bill modifier HQ when group services were provided. One-to-one service does not require a modifier.

Policy Notes: This service may be provided by a QMHP, a QMHA or a QBA. Prior authorization is required. Both individual and group support sessions count toward policy limitations.

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H2012 *(Rehabilitation)*

Description: Behavioral health day treatment.

Billing Instructions: One unit equals 60 minutes. Modifiers do not apply to this code.

Policy Notes: This service must be provided by a QMHP or by a QMHA who is under the direct supervision of a QMHP. Prior authorization is required.

H2014 *(Rehabilitation)*

Description: Skills training and development (Basic Skills Training).

Billing Instructions: One unit equals 15 minutes. Bill modifier HQ when group services were provided. One-to-one service does not require a modifier.

Policy Notes: This service may be provided by a QMHP, a QMHA or a QBA. Prior authorization is required.

H2017 *(Rehabilitation)*

Description: Psychosocial rehabilitation service.

Billing Instructions: One unit equals 15 minutes. Bill modifier HQ when group services were provided. One-to-one service does not require a modifier.

Policy Notes: This service must be provided by a QMHP or a QMHA. Prior authorization is required.