Applied Behavior Analysis: Health Home for Beneficiaries with Fetal Alcohol Spectrum Disorder

Overview

Nevada's Health Home for beneficiaries with Fetal Alcohol Spectrum Disorder (HH FASD) provides comprehensive care management and coordination services to Medicaid beneficiaries with an established FASD diagnosis. Comprehensive care management involves the initial and ongoing assessment of an enrollee's needs and aims to integrate primary, behavioral, and specialty health care alongside community support services. A person-centered care plan addresses both clinical and non-clinical needs, promotes wellness, and manages chronic conditions to achieve optimal health outcomes.

Comprehensive care management includes, but is not limited to:

- Outreach and engagement activities to gather information from the enrollee, the enrollee's support member(s), and other primary and specialty care providers
- Assessment of each enrollee, including behavioral and physical health care needs
- Development of a comprehensive person-centered care plan
- Documentation of the assessment and care plan in the Electronic Health Record (EHR)
- Periodic reassessment of each beneficiary's treatment, outcomes, goals, self-management, health status, and service utilization in relation to the health home
- Chronic care management (e.g., management of multiple chronic conditions)
- Management of unmet health-related resource needs and high-risk social environments

The Health Home for beneficiaries with FASD serves as the central point of contact for coordinating patient-centered care across the broader health care system. Beneficiaries collaborate with an interdisciplinary team of providers to develop a person-centered health action plan tailored to their needs. This team addresses the full spectrum of a beneficiary's physical, behavioral, and health-related social concerns.

Designated providers must meet the qualifications outlined in the State Plan and Medicaid Service Manuals (MSM) while delivering the six federally required core health home services.

Policy

Nevada Medicaid's policies can be found on the Nevada Health Authorities website, https://nvha.nv.gov/, under Medicaid Services Manual (MSM).

- MSM Chapter 4200 covers policy for Health Home for beneficiaries with Fetal Alcohol Spectrum Disorder
- MSM Chapter 3700 covers policy for Applied Behavior Analysis (ABA) providers
- MSM Chapter 400 covers policy for Behavioral Health providers
- MSM Chapter 100 contains important information applicable to all provider types, including information regarding medical necessity

Covered Services

The Health Home Provider (HHP) aims to enhance access to and coordination of care for beneficiaries. Within the Medicaid State Plan option, states have the flexibility to tailor core health home services to meet their specific needs. However, they must provide the delivery of all six core services, integrating them effectively through health information technology wherever feasible. These essential services include:

- Comprehensive care management

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- Care coordination
- Health promotion
- Comprehensive transitional care/follow-up
- Patient and family support
- Referral to community and social supports

Nevada's HHPs must coordinate with other community-based providers to manage the full breadth of beneficiary needs. For coverage and limitations, refer to MSM Chapter 4200.

Non-covered Services

- Services outside of the six core health home services cited in MSM 4200.
- Case management, care coordination, or other services covered by other Nevada Medicaid programs/benefits that may result in duplication with health home services.

Prior Authorization (PA)

HH services do not require prior authorization. Once an eligible beneficiary is enrolled, HH provider must submit claims to Nevada Medicaid's fiscal agent.

Rates

Health Home for beneficiaries with Fetal Alcohol Spectrum Disorder (HH FASD) Provider Type (PT) 85 Specialty 320 rates are listed on the Nevada Medicaid website on the Rates webpage. Rates are also available on the Provider Web Portal at https://www.medicaid.nv.gov through the Search Fee Schedule function, which can be accessed on the Provider Login (PWP) webpage under Resources (you do not need to log in).

Billing Requirements or Instructions

Health Home Providers (HHP) must follow the billing requirements cited in the MSMs and this billing guide. Nevada Medicaid will provide a monthly Fee-For-Service (FFS) case rate to the HHP with at least one of the six core Health Home services in a calendar month that are not duplicative of other Nevada Medicaid-covered services. To prevent duplication of services, the HHP will contact ManagedCare@nvha.nv.gov to verify that the MCO is not already providing these services to the recipient. Health Home for beneficiaries with FASD is carved out of MCO so the HHP will bill health home services directly through Fee-For-Service regardless of whether the Medicaid enrollee is enrolled with an MCO or in Fee-For-Service Medicaid. For Medicaid-covered services outside the six core HH services, providers will bill and be reimbursed in accordance with current Nevada Medicaid FFS or MCO policies.

In every HH billing claim, S0280 is the primary code and T1016 with appropriate modifier is the companion service code. At each billing occurrence throughout the month, S0280 must be billed in conjunction with at least one of the six T1016 and applicable modifier service codes listed on the table below. The monthly rate will be paid at the first billing occurrence of each calendar month provided that the dates of service, along with the combination of S0280 and at least one of the six T1016 and applicable modifier codes for an enrolled and eligible HH member are included. Additionally, the service must not duplicate other Nevada Medicaid covered services. All other HH billing occurrences within the same calendar month after the initial monthly submission must be billed to capture the services rendered. The six T1016 service codes are "shadow billed" capturing the number of units with the actual date of service and will be paid at $0.00. Shadow

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billing helps to ensure compliance with regulations and contributes to data collection for future policies and reimbursement rates. All service codes must be billed with the correct number of units, actual date of service, and billed charge amount.

NOTE: Providers should avoid listing multiple months on a single claim. Doing so may result in claim denials due to overlapping service dates.

Code	Modifier	Description	Unit
S0280		HHPs must bill S0280 at the Primary code in addition to at least one of the six core Health Home service codes shown below, at the detail-level of the claim.	
T1016	U1	Comprehensive Care Management	15 minutes
T1016	U2	Care Coordination	15 minutes
T1016	U3	Comprehensive Transitional Care	15 minutes
T1016	U4	Individual and Family Support	15 minutes
T1016	U5	Referral to Community and Social Support Services	15 minutes
T1016	U6	Prevention and Health Promotion	15 minutes

Use Direct Data Entry (DDE) or the 837P electronic transaction to submit claims to Nevada Medicaid. Claim submission instructions can be found in the Provider Web Portal (PWP) Chapter 3 Claims or in the Professional Health Care Claim: Fee-for-Service (837P) Companion Guides on the Electronic Claims/EDI page of the Nevada Medicaid provider website.

Home Health Providers under PT 85 must submit the PT 85 Specialty 320 Eligibility Checklist with the initial claim for a beneficiary. Note: Subsequent dates of service do not require the Eligibility Checklist. This is effective on claims with dates of service on or after October 1, 2025.

The Eligibility Checklist is located next to this Billing Guide on the Providers/Claims Billing Information webpage. See the PWP User Manual Chapter 3 Claims and the Electronic Data Interchange (EDI) Companion Guides for instructions on submitting claims, and the PWP User Manual Chapter 8 File Exchange for instructions on attaching documentation to claims