Residential Substance Use Treatment in an Institution for Mental Disease

State Policy

To locate the Medicaid Services Manual (MSM) chapters on the Division of Health Care Financing and Policy (DHCFP) website, click **Resources** from the toolbar across the top of the page, then select **Medicaid Services Manual** from the drop-down menu.

- MSM Chapter 400 (Attachment B) – Substance Use Services: covers policy for Substance Use Agency Model (SUAM) (pertains only to PT 93)
- MSM Chapter 400 (Attachment C) – Substance Use Services: covers limitations for SUAM (pertains only to PT93)
- MSM Chapter 400 (403.7) – Mental Health and Alcohol/Substance Use Services: covers outpatient alcohol and substance use service policy
- MSM Chapter 400 (403.10) – Mental Health and Alcohol/Substance Use Services: covers Inpatient alcohol/substance use withdrawal management and treatment services policy
- MSM Chapter 100 – Medicaid Program: contains important information applicable to all provider types
- MSM Chapter 3800 – Medication Assisted Treatment (MAT): covers policy for MAT services
- MSM Chapter 1200 – Prescription Drugs: covers medications for MAT
- MSM Chapter 800 – Laboratory Services: covers drug screening and testing requirements and prior authorization (PA)

Rates

Rates information is on the DHCFP website on the Rates Unit webpage. The Search Fee Schedule function can be found under **Featured Links** on the Provider Web Portal login page (you do not need to log in).

Authorization Requirements

For questions regarding authorization, call Nevada Medicaid (800) 525-2395 or refer to MSM Chapter 400 Attachment C, MSM Chapter 1200, and MSM Chapter 800.

The Authorization Criteria function can be found under **Featured Links** on the Provider Web Portal login page (you do not need to log in).

- FA-11D Substance Use Treatment/Outpatient Behavioral Health Authorization Request
- FA-6 for Outpatient Medical/Surgical Services for any laboratory services

Incomplete requests may be pended for additional information. The provider submitting the request has five business days from the date that the information is requested to resubmit complete or corrected information, or a technical denial will be issued.

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.

No prior authorization is required for the initiation and maintenance MAT services as listed in MSM Chapter 3800. An individual must meet the medical necessity criteria of MAT services as documented in the recipient's file.

No prior authorization is required for biopsychosocial assessment.

The individual providing these services must follow the guidelines listed in MSM chapters for policies, prior authorization requirements, and service limitations.

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Request Timelines

- **Initial request services**: It is recommended that the request be submitted 5-15 business days before the anticipated start date of service; however, submit no more than 15 business days *before* and no more than 15 calendar days *after* the start date of service.
- **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 and it is recommended these be submitted 5 to 15 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 and provide additional clinical information to document the need for the additional requested units/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. Note that the earliest start date may be date of submission of request and end date remains the same as previously authorized services.
- **Retrospective request**: Submit no later than 90 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 business days, including the first date of service of the first occurrence when prior authorizing additional services outside of the service limitations in MSM policy.

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 located on the EVS User Manual webpage and the 837P Companion Guide located on the Electronic Claims/EDI webpage for billing instructions.

Medication Assisted Treatment

MSM Chapter 3800, Medication Assisted Treatment, should be referred to for any policy questions. Providers eligible to prescribe MAT services must follow the guidelines listed in MSM Chapter 600, Physician Services, for their individual provider type.

Non-covered Services

When requested for MAT, buprenorphine prescription for any other reason than Opioid Use Disorder (OUD) is not covered.

Covered Services

Eligible providers with a Drug Enforcement Administration (DEA) license and who meet all of the provider requirements listed in MSM Chapter 3800 would be able to provide and bill for MAT services.

Billing for Medications Used for MAT:

- J0571 Buprenorphine, oral, 1 mg
- J0572 Buprenorphine/naloxone, oral, less than or equal to 3 mg
- J0573 Buprenorphine/naloxone, oral, greater than 3 mg, but less than or equal to 6 mg
- J0574 Buprenorphine/naloxone, oral, greater than 6 mg, but less than or equal to 10 mg
- J0575 Buprenorphine/naloxone, oral, greater than 10 mg

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Providers are required to list the National Drug Codes (NDCs) for the specific drug administered on the claim.

Use modifier U5 and the appropriate OUD diagnosis code with each claim to indicate MAT services.

One of the diagnosis codes for J0571 – J0575 must be: F11.20, F11.21, F11.222, F11.229, F11.23, F11.24, F11.250, F11.251, F11.259, F11.281, F11.282, F11.288 and F11.29.

Pre-Induction Visit:

- Visit type: Adult Wellness visit or acute visit for Opioid Use Disorder/Dependence.
- Comprehensive evaluation of new patient or established patient for suitableness for buprenorphine treatment.
    - New Patient: 99205
    - Established Patient: 99215

Induction Visit:

- Visit type: MAT medication induction.
- Any of the new patient Evaluation & Management (E/M) codes can be used for induction visits.
- Codes are listed in order of increasing length of time with patient and/or severity of the problems.
    - Patient Consult: 99242-99245
- Prolonged visits code (99417) may also be added onto E/M codes for services that extend beyond the typical service time. Time spent does not need to be continuous.

Maintenance Visits:

- Visit type: MAT medication. Acute visit for OUD/opioid dependence.
- Any of the established patient E/M codes can be used for maintenance visits.
- Counseling codes are commonly used to bill for maintenance visits, since counseling and coordination of service with addiction specialists comprise the majority of the follow-up visits.
    - Established Patient: 99212-99215

Use modifier U5 and the appropriate OUD diagnosis code with each claim to indicate MAT services.

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.

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

Covered Services

The following table lists covered codes, code descriptions and billing information as needed. For coverage and limitations, refer to MSM Chapter 400.

The "X" indicates the treatment levels for which each code may be billed.

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Code	Description	Level 3
	Behavior Change Intervention & Counseling Risk Factors	**Residential SUD Services**
99401	Preventive med counseling	X
99406	Smoking and tobacco cessation counseling	X
99407	Smoking and tobacco cessation counseling	X
99408	Alcohol and/or substance abuse screening with brief intervention (15-30 minutes)	X
99409	Alcohol and/or substance abuse screening with brief intervention (30+ minutes)	X
	HCPCS	**Residential**
H0001	Alcohol and/or drug assessment (1 unit per assessment at least 30 minutes)	X
H0002	Behavioral health screening to determine eligibility for admission to treatment program (1 unit per assessment at least 30 minutes)	X
H0005	Alcohol and/or drug services; group counseling by a clinician (1 unit per group at least 30 minutes)	X
H0007	Alcohol and/or drug services; crisis intervention (outpatient) (for substance use only)	X
H0034	Medication training and support; per 15 minutes	X
H0033	Oral mediation administration, direct observation	X
H0034	Medication training and support; per 15 minutes	X
H0038	Self-help/peer service; per 15 minutes Use modifier HQ when requesting/billing for a group setting	X
H0047	Alcohol and/or drug services; (State defined: individual counseling by a clinician). (1 unit per session at least 30 minutes)	X
H0049	Alcohol/drug screening (1 unit per screening)	X
H2011	Crisis intervention service; per 15 minutes (outpatient) (for co-occurring and mental health only) Use modifier GT when requesting/billing for telephonic services Use modifier HT when requesting/billing for team services 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	X

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Code	Description	Level 3
	Interactive Complexity & Psychiatric Diagnostic Procedures	**Residential**
90785	Interactive Complexity	X
90791	Psychiatric diagnostic evaluation	X
90792	Psychiatric diagnostic evaluation with medical services	X
	Psychotherapy	**Residential**
90832	Psychotherapy, **30 mins**, with pt and/or family member	X
90834	Psychotherapy, **45 mins**, with pt and/or family member	X
90837	Psychotherapy, **60 mins**, with pt and/or family member	X
90846	Family psychotherapy (without the patient present)	X
90847	Family psychotherapy (conjoint therapy) (with patient present)	X
90849	Multiple-family group psychotherapy	X
90853	Group psychotherapy (other than of a multiple-family group)	X
	Psychotherapy for Crisis	**Residential**
90839	Psychotherapy for Crisis first **60 mins**	X
90840	Psychotherapy for Crisis each additional **30 mins**	X
	Evaluation & Management *E&M codes are to be performed by physicians, nurse practitioners and physician assistants*	**Residential**
90833	Psychotherapy, **30 mins**, with pt and/or family member when performed with an E/M service.	X
90836	Psychotherapy, **45 mins**, with pt and/or family member when performed with an E/M service.	X
90838	Psychotherapy, **60 mins**, with pt and/or family member when performed with an E/M service.	X

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Code	Description	Level 3
99202	Office or other outpatient visit for the E/M of a **NEW PT,** which requires 3 components: a problem focused history, a problem focused exam, 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**. **20 mins** face-to-face.	X
99203	Office or other outpatient visit for the E/M of a NEW PT, which requires 3 components: a problem focused history, a problem focused exam, 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 severity**. **30 mins** face-to-face.	X
99204	Office or other outpatient visit for the E/M of a NEW PT, which requires 3 components: a problem focused history, a problem focused exam, 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 to high severity**. **45 mins** face-to-face.	X
99205	Office or other outpatient visit for the E/M of a NEW PT, which requires 3 components: a problem focused history, a problem focused 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 **moderate to high severity. 60 mins** face-to-face.	X
99211	Office or other outpatient visit for the E/M of an **ESTABLISHED** patient, that may not require the presence of a physician or other qualified healthcare professional. Usually, the presenting problems are minimal. Typically, **5 minutes** are spent performing or supervising these services.	X
99212	Office or other outpatient visit for the E/M of an **ESTABLISHED** patient, which requires at least 2 of these 3 key components: a problem focused history, a 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 patient's problem(s) and/or family's needs. Usually, problem(s) are **self-limited or minor.** Typically, **10 minutes** face-to-face.	X

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99213	Office or other outpatient visit for the E/M of an **ESTABLISHED** patient, which requires at least 2 of these 3 key components: a problem focused history, a problem focused 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 patient's problem(s) and/or family's needs. Usually, problem(s) are **low to moderate severity**. Typically, **15 minutes** face-to-face.	X
99214	Office or other outpatient visit for the E/M of an **ESTABLISHED** patient, which requires at least 2 of these 3 key components: a problem focused history, a problem focused 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 patient's problem(s) and/or family's needs. Usually, problem(s) are **of moderate to high severity**. Typically, **25 minutes** face-to-face.	X
99215	Office or other outpatient visit for the E/M of an **ESTABLISHED** patient, which requires at least 2 of these 3 key components: a problem focused history, a problem focused 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 patient's problem(s) and/or family's needs. Usually, problem(s) are **of moderate to high severity**. Typically, **40 minutes** face-to-face.	X
	Additional Medical Services	**Residential**
10060	Simple or single drainage of skin abscess	X
80305	Testing for presence of drug, read by direct observation	X
80306	Testing for presence of drug, read by instrument assisted observation	X
80307	Testing for presence of drug, by chemistry analyzers	X
86703	Analysis for antibody to hiv-1 and hiv-2 virus	X
86780	Analysis for antibody, treponema pallidum	X
96127	Assessment of emotional or behavioral problems	X
98966	Telephone medical discussion provided by nonphysician professional, 5-10 minutes	X
98967	Telephone medical discussion provided by nonphysician professional, 11-20 minutes	X
98968	Telephone medical discussion provided by nonphysician professional, 21-30 minutes	X

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Code	Description	Level 3
99242	Office or other outpatient consultation with straightforward medical decision making, if using total time, 20 minutes or more	X
99243	Office or other outpatient consultation with low level of medical decision making, if using time, 30 minutes or more	X
99244	Office or other outpatient consultation with moderate level of medical decision making, if using time, 40 minutes or more	X
99245	Office or other outpatient consultation with high level of medical decision making, if using time, 55 minutes or more	X
99417	Prolonged outpatient service, each 15 minutes of total time beyond required time of primary service	X
99441	Telephone medical discussion with physician, 5-10 minutes	X
99442	Telephone medical discussion with physician, 11-20 minutes	X
99443	Telephone medical discussion with physician, 21-30 minutes	X
G0445	High intensity behavioral counseling to prevent sexually transmitted infection; face-to-face, individual, includes: education, skills training and guidance on how to change sexual behavior; performed semi-annually, 30 minutes	X
G0513	Prolonged preventive service(s) (beyond the typical service time of the primary procedure), in the office or other outpatient setting requiring direct patient contact beyond the usual service; first 30 minutes (list separately in addition to code for preventive service)	X
G0514	Prolonged preventive service(s) (beyond the typical service time of the primary procedure), in the office or other outpatient setting requiring direct patient contact beyond the usual service; each additional 30 minutes (list separately in addition to code G0513 for additional 30 minutes of preventive service)	X
Q3014	Telehealth originating site facility fee	X