Behavioral Health Rehabilitative 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.

Authorization requirements

Authorization requirements are discussed in MSM Chapter 400. Use the Authorization Criteria search function in the Provider Web Portal at 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.

- Use Form FA-11 to request prior authorization for rehabilitation services.

All required information must be completed on the authorization request. The submitter will be notified if Nevada Medicaid 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 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.

Authorization request timelines

Initial Request for 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.

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. 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. All authorization requirements apply to requests that are submitted retrospectively.

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.

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 .

See Electronic Verification System (EVS) Chapter 3 Claims and the EDI companion guides for billing instructions.

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

For Rehabilitative Mental Health (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.

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).

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 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.

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.

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.

Limitation: Up to two hours (8 units) per day (H2014 and H2014 HQ combined) unless provider has an approved authorization to exceed the service limitation.

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.