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 Cessation Counseling for Pregnant Women

As of October 13, 2011, CPT codes 99406 and 99407 are used to bill smoking cessation counseling for pregnant women only. For all other recipients, these services are billed using the appropriate Evaluation and Management (E&M) office visit code.

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: Neurological testing
- Form FA-10C: Developmental testing (code 96111)
- Form FA-10D: Neurobehavioral Status Exam (code 96116)
- 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.

Request timelines

- **Initial request for Outpatient Mental Health (OMH) and Rehabilitative Mental Health (RMH) services** (Basic Skills Training, Day Treatment, Peer-To-Peer Support and Psychosocial Rehabilitation): 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 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**: 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.

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 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.

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.

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Covered services

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

Outpatient Mental Health (OMH) Services	
Assessment	
H0031	Mental health assessment by non-physician **Billing Instructions:** Use this code for services provided in a home or community setting, not in an office setting.
Screening	
H0002	Behavioral health screening to determine eligibility for admission to treatment program. **Billing Instructions:** This screening must be conducted face-to-face before the recipient can be determined eligible for Medicaid behavioral health services. After the initial screening, recipients must be re-screened every 90 days to reevaluate their Intensity of Needs (Level of Care). Use this code to bill for the initial screening and any re-screenings as necessary. Bill 1 unit for initial screening or re-screening. This code may be used to bill for an Intensity of Needs Determination, which includes a CASII or LOCUS. **Do not request prior authorization for this code.**
Program Therapy	
H0035	Mental health partial hospitalization, treatment, less than 24 hours **Limitation:** 1 unit per day, per recipient. **Billing Instructions:** One unit equals 1 day.
S9480	Intensive outpatient psychiatric services, per diem **Billing Instructions:** One unit equals 1 day.
Medication Management	
H0034 TD	Medication training and support, per 15 minutes **Limitation**: 2 units per calendar month per recipient. Prior authorization required when limitation has been met. **Billing Instructions:** Modifier TD must be used to indicate the service was provided by a Registered Nurse QMHA, provider type 14, specialty 301.
Diagnostic	
96101	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, (e.g., MMPI, Rorschach, WAIS), per hour of the psychologist's or physician's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report
96102	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, (e.g., MMPI and WAIS), with qualified health care professional interpretation and report, administered by technician, per hour or technician time, face-to-face
96103	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, (e.g., MMPI), administered by a computer, with qualified health care professional interpretation and report
96110	Developmental screening; limited (e.g., Developmental Screening Test II, Early Language Milestone Screen), with interpretation and report

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96111	Developmental testing; extended (includes assessment of motor, language, social, adaptive and/or cognitive function by standardized developmental instruments) with interpretation and report
96116	Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, e.g., acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities), per hour of the psychologist's or physician's time, both face-to-face time with the patient and time interpreting test results and preparing the report
96118	Neurological testing (e.g., Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), per hour of the psychologist's or physician's time, both face-to-face time with the patient and time interpreting test results and preparing the report
96119	Neurological testing (e.g., Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), with qualified health care professional interpretation and report, administered by technician, per hour of technician time, face-to-face
96120	Neurological testing (e.g., Wisconsin Card Sorting Test), administered by a computer, with qualified health care professional interpretation and report
96156	Health behavior assessment, or re-assessment (i.e., health-focused clinical interview, behavioral observations, clinical decision making)
96158	Health behavior intervention, individual, face-to-face, initial 30 minutes
96159	Health behavior intervention, individual, face-to-face, each additional 15 minutes
96164	Health behavior intervention, group (2 or more patients), face-to-face, initial 30 minutes
96165	Health behavior intervention, group (2 or more patients), face-to-face, each additional 15 minutes
96167	Health behavior intervention, family (with the patient present), face-to-face, initial 30 minutes
96168	Health behavior intervention, family (with the patient present), face-to-face, each additional 15 minutes
96170	Health behavior intervention, family (without the patient present), face-to-face, initial 30 minutes
96171	Health behavior intervention, family (without the patient present), face-to-face, each additional 15 minutes
Therapy	
90785	Interactive complexity; use only as an add-on with an appropriate CPT code
90791	Psychiatric diagnostic evaluation
90832	Psychotherapy, 30 minutes with patient and/or family member. **Billing Instructions:** Each unit equals 1 session.
90834	Psychotherapy, 45 minutes with patient and/or family member **Billing Instructions:** Each unit equals 1 session.
90837	Psychotherapy, 60 minutes with patient and/or family member **Billing Instructions:** Each unit equals 1 session.
90839	Psychotherapy for crisis; first 60 minutes **Billing Instructions:** Each unit equals 1 session.
90840	Psychotherapy for crisis; each additional 30 minutes
90845	Psychoanalysis **Billing Instructions:** Each unit equals 1 session.

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90846	Family psychotherapy (without the patient present) **Billing Instructions:** Each unit equals 1 session.
90847	Family psychotherapy (conjoint therapy) (with patient present) **Billing Instructions:** Each unit equals 1 session.
90849	Multiple-family group psychotherapy **Billing Instructions:** Each unit equals 1 session.
90853	Group psychotherapy (other than of a multiple-family group) **Billing Instructions:** Each unit equals 1 session.
90875	Individual psychophysiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy (e.g., insight oriented, behavioral modifying or supportive psychotherapy); **30 minutes** **Note:** Service limitations and coverage of this service is limited to those diagnosis codes that are outlined in MSM Chapter 400 Section 403.4(C)(4) for Neurotherapy services. **Billing Instructions:** Medicare does not cover this service. When a recipient is eligible for Medicare and Medicaid, submit the claim to *Medicaid* indicating Medicare coverage.
90876	Individual psychophysiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy (e.g., insight oriented, behavioral modifying or supportive psychotherapy); **45 minutes** **Note:** Service limitations and coverage of this service is limited to those diagnosis codes that are outlined in MSM Chapter 400 Section 403.4(C)(4) for Neurotherapy services. **Billing Instructions:** Medicare does not cover this service. When a recipient is eligible for Medicare and Medicaid, submit the claim to *Medicaid* indicating Medicare coverage.
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular **Billing Instructions:** Bill one unit per injection.
H0004	Behavioral health counseling and therapy, per 15 minutes **Billing Instructions**: Use this code for services provided in home or community setting, not in an office setting. 1 to 4 units on a claim line equal 1 session. 5 to 8 units on a claim line equal 2 sessions. 9 to 12 units on a claim line equal 3 sessions.
H0004 HQ	Behavioral health counseling and therapy, per 15 minutes **Billing Instructions**: Modifier HQ indicates group services. Use this code for services provided in home or community setting, not in an office setting.
Evaluation and Management, and Observation	
Observation	
99233	Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: a detailed interval history; a detailed examination; 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 patient is unstable or has developed a significant complication or a significant new problem. Typically, **35 minutes** are spent at the bedside and on the patient's hospital floor or unit. **Billing Instructions:** Bill 1 unit per visit.

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99234	Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date which requires these three key components: a detailed or comprehensive history; a detailed or comprehensive examination; and medical decision making that is straightforward or 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) requiring admission are of **low severity**. Typically, **40 minutes** are spent at the bedside and on the patient's hospital floor or unit. **Billing Instructions:** Bill 1 unit per visit.
99235	Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date which requires these three key components: a comprehensive history; a comprehensive 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) requiring admission are of **moderate severity**. Typically, **50 minutes** are spent at the bedside and on the patient's hospital floor or unit. **Billing Instructions:** Bill 1 unit per visit.
99236	Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date, which requires these 3 key components: a comprehensive history; a comprehensive 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 problems(s) and the patient's and/or family's needs. Usually the presenting problem(s) requiring admission are of **high severity**. Typically, **55 minutes** are spent at the bedside and on the patient's hospital floor or unit. **Billing Instructions:** Bill 1 unit per visit.
Evaluation and Management	
Evaluation and Management (E&M) codes are to be performed by physicians, nurse practitioners and physician assistants. Physician codes should be billed using the rendering provider's individual NPI.	
90833	Psychotherapy, 30 minutes with patient and/or family member when performed with an evaluation and management service (Use only as an add-on to the appropriate CPT code.) **Billing Instructions:** Each unit equals 1 session.
90836	Psychotherapy, 45 minutes with patient and/or family member when performed with an evaluation and management service (Use only as an add-on to the appropriate CPT code.) **Billing Instructions:** Each unit equals 1 session.
90838	Psychotherapy, 60 minutes with patient and/or family member when performed with an evaluation and management service (Use only as an add-on to the appropriate CPT code.) **Billing Instructions:** Each unit equals 1 session.
99201	Office or other outpatient visit for the evaluation and management of a **new patient**, which requires these three 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 problem(s) and the patient's and/or family's needs. Usually, the presenting **problem(s) are self-limited or minor**. Typically, **10 minutes** are spent face-to-face with the patient and/or family. **Billing Instructions:** Bill 1 unit per visit.

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99202	Office or other outpatient visit for the evaluation and management of a **new patient**, which 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**. Typically, **20 minutes** are spent face-to-face with the patient and/or family. **Billing Instructions:** Bill 1 unit per visit.
99203	Office or other outpatient visit for the evaluation and management of a **new patient**, which 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 severity**. Typically, **30 minutes** are spent face-to-face with the patient and/or family. **Billing Instructions:** Bill 1 unit per visit.
99204	Office or other outpatient visit for the evaluation and management of a **new patient**, which requires these three key components: a comprehensive history; a comprehensive 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 to high severity**. Typically, **45 minutes** are spent face-to-face with the patient and/or family. **Billing Instructions:** Bill 1 unit per visit.
99205	Office or other outpatient visit for the evaluation and management of a **new patient**, which requires these three key components: a comprehensive history; a comprehensive 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**. Typically, **60 minutes** are spent face-to-face with the patient and/or family. **Billing Instructions:** Bill 1 unit per visit.
99211	Office or other outpatient visit for the evaluation and management of an **established patient**, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services. **Billing Instructions:** Bill 1 unit per visit.
99212	Office or other outpatient visit for the evaluation and management of an **established patient**, which requires at least two of these three key components: a problem focused history; a problem focused examination; 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 self limited or minor**. Typically, **10 minutes** are spent face-to-face with the patient and/or family. **Billing Instructions:** Bill 1 unit per visit.
99213	Office or other outpatient visit for the evaluation and management of an **established patient**, which requires at least two of these three key components: an expanded problem focused history; an expanded problem focused examination; **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 to moderate severity**. Typically, **15 minutes** are spent face-to-face with the patient and/or family. **Billing Instructions:** Bill 1 unit per visit.

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99214	Office or other outpatient visit for the evaluation and management of an **established patient**, which requires at least two of these three key components: a detailed history; a detailed examination; **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**. Typically, **25 minutes** are spent face-to-face with the patient and/or family. **Billing Instructions:** Bill 1 unit per visit.
99215	Office or other outpatient visit for the evaluation and management of an **established patient**, which requires at least two of these three key components: a comprehensive history; a comprehensive examination; **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**. Typically, **40 minutes** are spent face-to-face with the patient and/or family. **Billing Instructions:** Bill 1 unit per visit.
99217	Observation care discharge day management. **Billing Instructions:** This code is to be utilized to report all services provided to a patient on discharge from "observation status" if the discharge is on other than the initial date of "observation status." To report services to a patient designated as "observation status" or "inpatient status" and discharged on the same date, us the codes for Observation or Inpatient Care Services [including Admission and Discharge Services, 99234-99236 as appropriate.]
99218	Initial observation care, **per day**, for the evaluation and management of a patient which requires these three key components: a detailed or comprehensive history; a detailed or comprehensive examination; and **medical decision making that is straightforward or 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 problems(s) requiring admission to "observation status" are of **low severity**. Typically, **30 minutes** are spent at the bedside and on the patient's hospital floor or unit.
99219	Initial observation care, **per day**, for the evaluation and management of a patient which requires these three key components: a comprehensive history; a comprehensive 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 problems(s) requiring admission to "observation status" are of **moderate severity**. Typically, **50 minutes** are spent at the bedside and on the patient's hospital floor or unit.
99220	Initial observation care, **per day**, for the evaluation and management of a patient, which requires these three components: a comprehensive history; a comprehensive 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 problems(s) and the patient's and/or family's needs. Usually the problem(s) requiring admission to "observation status" are of **high severity**. Typically, **70 minutes** are spent at the bedside and on the patient's hospital floor or unit.

Crisis Intervention and Case Management (non-targeted Levels I and II)	
Case Management	
T1016	One (1) unit equals 15 minutes. Prior authorization demonstrating medical necessity is required for provider type 14 (specialties 300, 301, 305, 306 and 307) 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 calendar year. The limit is based on per recipient, per calendar month. **Billing Instructions:** This service is covered for children and adults that meet Levels I and II in the Intensity of Needs Grid only. Providers must bill using the U1 modifier to determine the first starting month, U2 for the second month, U3 for the third month and U4 for the fourth month. If the claim is outside the four consecutive months, do not bill with modifiers U1 to U4. For Levels III-VI, Targeted Case Management (code T1017) is billed under provider type 54. See MSM Chapter 2500 for service limitations and criteria.
Crisis Intervention	
H2011	Crisis intervention service, per 15 minutes
H2011 GT	Crisis intervention service, per 15 minutes Modifier GT indicates telephonic services.
H2011 HT	Crisis intervention service, per 15 minutes Modifier HT indicates team services.
Rehabilitative Mental Health Services	
H0038	Self-help/peer services, per 15 minutes *(Peer-to-Peer Services)*
H0038 HQ	Self-help/peer services, per 15 minutes *(Peer-to-Peer Services)* Modifier HQ indicates group services.
H2012	Behavioral health day treatment, per hour **Prior Authorization and Billing Instructions:** Only Provider Type 14 Behavioral Health Community Network groups that have an approved Day Treatment Model and Specialty 308 Enrollment Checklist can request prior authorization for Day Treatment and bill code H2012. Prior authorization is required and authorization requests for Day Treatment services must be submitted via the Provider Web Portal effective April 1, 2015. Please be advised: No retroactive authorizations will be permitted for Day Treatment services. The provider must first enroll as a provider type 14 and will then be eligible to apply for the Day Treatment Specialty.
H2014	Skills training and development, per 15 minutes *(Basic Skills Training)* **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
H2014 HQ	Skills training and development, per 15 minutes *(Basic Skills Training)* Modifier HQ indicates group services. **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
H2017	Psychosocial rehabilitation services, per 15 minutes
H2017 HQ	Psychosocial rehabilitation services, per 15 minutes Modifier HQ indicates group services.