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 4100 – Substance Use Treatment Services and Coverage
- 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).

Providers will need to reference the fee schedule that matches the provider type of the individual who is performing the service.

Authorization Requirements

For questions regarding authorization, call Nevada Medicaid (800) 525-2395 or refer to MSM Chapter 4100, 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

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.

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

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

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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.

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.

Level 3 claims should be submitted using the NPI for the group as the biller and the NPI for the clinician who oversees the clinical treatment for the recipient as the performer.

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.

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

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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 4100.

All providers including Licensed Clinical Alcohol and Drug Counselors (LCADC), LCADC Interns (LCADC-I) Licensed Alcohol and Drug Counselors (LADC), Certified Alcohol Drug Counselors (CADC), CADC Interns (CADC-I), and Peer Recovery Support Specialists (PRSS) may provide services that are appropriate within their scope of practice under Healthcare Common Procedure Coding System (HCPCS) codes.

Definitions of provider types:

14/305 LCSW—Licensed Clinical Social Worker

14/306 LMFT—Licensed Marriage and Family Therapist

14/307 LCPC—Licensed Clinical Professional Counselor

14/300 or 82/300 CSW-I—Clinical Social Work Intern

14/300 or 82/300 MFT-I–Marriage and Family Intern

14/300 or 82/300 CPC-I—Clinical Professional Counselor Intern

93/701 CADC—Certified Alcohol and Drug Counselor

93/702 LADC—Licensed Alcohol and Drug Counselor

93/709 LCADC—Licensed Clinical Alcohol and Drug Counselor

93/703 CADC-I—Certified Alcohol and Drug Counselor Intern

93/705 LCADC-I—Licensed Alcohol and Drug Counselor Intern

24 APRN— Advanced Practice Registered Nurse

77 PA—Physician Assistant

20—Physician

74—Nurse Midwife

26—Psychologist

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Code	Description	ASAM level	Qualified Provider Type
H0011	Behavioral health; short-term residential (nonhospital residential treatment program), without room and board, per diem	3.7WM	LCSW, LMFT, LCPC, LCADC, APRN, PA, Physician, Psychologist, Nurse Midwife
H0018	Behavioral health; long-term residential (nonmedical, nonacute care in a residential treatment program where the stay is typically longer than 30 days), without room and board, per diem.	3.1	CADC, CADC-I, LADC, LCSW, CSW-I, LMFT, MFT-I, LCPC, CPC-I, LCADC, LCADC-I, APRN, PA, Physician, Psychologist, Nurse Midwife
H0019	Alcohol &/or drug services; acute detoxification (residential addiction program inpatient)	3.5	CADC, CADC-I, LADC, LCSW, CSW-I, LMFT, MFT-I, LCPC, CPC-I, LCADC, LCADC-I, APRN, PA, Physician, Psychologist, Nurse Midwife