Provider Bulletin
December 2022

Behavioral health therapy session limitations

Anthem Blue Cross and Blue Shield Healthcare Solutions (Anthem) follows the limitations for behavioral therapy sessions from the Medicaid services manual. This update is in alignment with web announcement 1663 issued by the Nevada Department of Health and Human Services on August 13, 2018, and has been effective with Anthem since August 1, 2019.

Prior authorization (PA) is required once the session's limitations have been met. Therapy limits apply to the following to codes: 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90845, 90846, 90847, 90849, 90853, and H0004.

Therapy codes have the following limitations:

Billing provider type (PT)	Number of therapy sessions allowed per recipient per calendar year from all providers without prior authorization
PT 14 (Behavioral health outpatient treatment)	26 (recipient under 18)
PT 14 (Behavioral health outpatient treatment)	18 (recipient 18 and older)
PT 26 (Psychologist)	26
PT 20 (Physician, M.D., osteopath, D.O.)	No limits
PT 82 (Behavioral health rehabilitative treatment)	Not covered

A PA is required to exceed the limitations. PT 20 and PT 26 billing therapy codes under a PT 14 are subject to the PT 14 limits. **Claims for the above codes that exceed the limitations with no PA present will be denied.**

Important: Psychotherapy service limitations restart January 1 each calendar year

Anthem follows outpatient psychotherapy service limitations set forth in the Medicaid services manual chapter 400 *(Mental Health and Alcohol and Substance Abuse Services)*, which restart on January 1 each calendar year. See web announcement 2437 issued by the Nevada Department of Health and Human Services on February 25, 2021.

Service limitations for individual, group, and family therapy sessions (combined) without a PA are:

- 10 to 26 sessions under the child and adolescent service intensity instrument (CASII).
- 6 to 18 sessions under the level of care utilization system for adults (LOCUS).

When the service limitations are met in a calendar year and the recipient continues to meet medical necessity for these services, a PA request for the service may be submitted by the provider. If approved, the provider may administer the services as described in the approved PA and should include the PA number on their claims in order to be paid.

For service limitations based on the calendar year, providers may end-date PA requests for December 31, as appropriate. If a PA is approved for a psychotherapy service with dates of service which span from one calendar

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year into the following calendar year, those services may be delivered according to the approved PA. Regardless of a provider's active PA, all sessions billed on behalf of the recipient will count toward the session limits from January 1 of each calendar year.

For information on PA requirements Anthem, please see our website **https://providers.anthem.com/nevada-provider/home** > *Resources* > *Precertification Requirements*.

For even more information, including your rights as a provider, refer to Anthem provider bulletin: *Prior authorization/notification requirements and other important information*.

- For behavioral health requests, submit using our preferred electronic method at **www.Availity.com**.
- If you prefer to fax, correct fax forms can be located on the provider website at **https://providers.anthem.com/nevada-provider/home**

Providers, who do not find the information needed on Anthem resources, should utilize the Medicaid services manual chapter 400 *(Mental Health and Alcohol and Substance Abuse Services)* for documentation requirements, PA requirements, and limitations.

Important: Provider responsibilities

As an Anthem provider, obligations include but are not limited to the following:

- Verifying member eligibility and prior authorization requirements at each visit.
- Complying with all applicable statutory and regulatory requirements of the Medicaid program.
- Submitting to us all required claims information in a clean claim within timely filing limits: 180 days from date of service.
- If you believe a claim has been improperly adjudicated for a covered service for which you have timely submitted a clean claim, you must submit a dispute appeal within timely filing limits: 90 days from date of original EOP/EOB/RA.
- If you do not follow these guidelines, claim denials will be upheld.
- See the **provider manual** for more information.

If you have questions about this communication or need immediate assistance with any other item, use the *Chat* feature in Availity* or call Provider Services at **844-396-2330**. Otherwise, use the *Contact Us* feature on our **website** to submit an inquiry and you will receive a response within 48 hours.

Email is the quickest and most direct way to receive important information from Anthem Blue Cross and Blue Shield Healthcare Solutions.

To start receiving email from us (including some sent in lieu of fax or mail), submit your information using the QR code to the right or via our online form (**https://bit.ly/3lGTrCq**).