Provider Bulletin 26-21

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To:	All Providers Participating in the Nebraska Medicaid Program
From:	Jeremy Brunssen, Interim Director
Date:	November 20, 2026
Re:	Behavioral Health Providers: Mental Health, Substance Use, and Applied Behavior Analysis Provider Manual

This provider bulletin is being issued to notify providers that the final version of the Nebraska Medicaid Provider Manual for Mental Health, Substance Use, and Applied Behavior Analysis Services will be posted to the Medicaid and Long-Term Care website at https://dhhs.ne.gov/Pages/Medicaid-Behavioral-Health-Definitions.aspx.These service definitions are effective February 1, 2027, except as noted below.

DHHS received comments from mental health and substance use providers and members of the community across Nebraska. We want to sincerely thank all the providers who took the time to review the manual and provided their input on the draft version of this manual during the open provider review and feedback period. All comments were carefully reviewed and used to inform changes and clarifications in the final service definitions.

The provider manual was developed in consultation with mental health, substance use disorder, and applied behavior analysis experts including physicians, psychologists, psychiatrists, Doctoral Board Certified Behavior Analysts (BCBA-Ds), licensed mental health practitioners, licensed alcohol and drug counselors, certified peer support providers, and members of the community who considered industry best practices, Substance Use and Mental Health Administration (SAMHSA) guidelines, American Society of Addiction Medicine (ASAM) guidelines, Centers for Medicare & Medicaid Services (CMS) criteria, and national trends for mental health and substance use services.

Effective Dates

ASAM Criteria: For services requiring providers to move from ASAM Criteria, Third Edition, to ASAM Criteria Fourth Edition, providers have until **July 1, 2027,** to fully meet fourth edition criteria.

Where staffing requirements in the provider manual differ from currently posted service definitions, including Crisis Stabilization and Supervised Detoxification, providers have until **July 1, 2027** to fully meet staffing criteria.

Out-of-state provider enrollment: Beginning February 1, 2027, Medicaid provider enrollment will begin reviewing enrollments to ensure that out-of-state providers are enrolled with Medicaid in the state where they are physically located. Providers have until **07/01/2027** to fully meet this requirement.

All other changes in the Mental Health, Substance Use, and Applied Behavior Analysis Provider Manual are effective February 1, 2027.

Changes to Prior Authorization Requirements

The manual outlines new changes to prior authorization requirements for outpatient psychotherapy, initial diagnostic interviews, and substance use assessments.

The following coverage changes will apply to dates of service on and after February 1, 2027:

- 30 combined individual, family, and group psychotherapy sessions per beneficiary, per state fiscal year
    - CPT codes: 90832, 90833, 90834, 90836, 90837, 90838, 90846, 90847, 90853
    - The limit does **NOT** apply to Intensive Outpatient (IOP), Day Treatment, Day Rehabilitation, or specialty care (when the above codes are billed using modifiers: U3, U5, U7, U8, or U9)
    - Crisis psychotherapy is excluded from the limit: CPT 90839 and 90840
- 3 combined Initial Diagnostic Interviews or addendums per beneficiary, per state fiscal year
    - CPT codess: 90791, 90791 – 52, 90752
- 3 combined Substance Use Assessments or addendums per beneficiary, per state fiscal year
    - HCPCS codes: H0001, H0001 - 52

For all listed codes, additional hours may be requested with prior authorization and clinical documentation of medical necessity.

Changes to Intensive Outpatient (IOP) and Day Treatment Billing Procedures:

The manual outlines changes to billing procedures for IOP and Day Treatment services. The Mental Health and Substance Use fee schedule will be updated to reflect these changes on February 1, 2027. These billing changes will be effective February 1, 2027.

IOP:

IOP Psychotherapy services:

- Individual psychotherapy for IOP should be billed using the U5 modifier in combination with these codes: 90832, 90833, 90834, 90836, 90837, 90838
- Family psychotherapy for IOP should be billed using the U5 modifier in combination with these codes: 90846, 90847

IOP group treatment:

For groups led by licensed clinicians:

- H2014 Intensive Outpatient group led by licensed clinician

For IOP groups led by direct care staff:

- H2014 52 Intensive Outpatient Direct Care Staff (per 15 minutes)

No more than 3 hours of H2014 (any modifier) may be billed per day.
To indicate substance use disorder IOP services, use the HF modifier when billing the above codes

IOP discontinued codes and modifiers:

The U4 modifier, previously used to denote facility-based IOP, will be discontinued

The U5 modifier, previously used to denote home-based IOP, will be used to indicate all IOP psychotherapy services as indicated above.

IOP for substance use disorder should be indicated using the HF modifier.

Providers should use the appropriate place of service (POS) code to indicate the location where IOP services were provided.

HCPCS codes S9480 and H0015 for IOP services will be discontinued.

Day Treatment:

Day Treatment Psychotherapy services:

- Individual psychotherapy for Day Treatment should be billed using the U3 modifier in combination with these codes: 90832, 90833, 90834, 90836, 90837, 90838
- Family psychotherapy for Day Treatment should be billed using the U3 modifier in combination with these codes: 90846, 90847

Day Treatment groups and direct care staff time:

For groups led by licensed clinicians:

- H2027 Day Treatment group led by licensed clinician

For direct care staff time:

- H2012 Day Treatment, Full Day – Min 6 Units (per hour)
- H2012 52 Day Treatment, Partial Day - Max 3 Units (per hour)
- H2027 52 Day Treatment, Direct Care Staff (per 15 minutes)

To indicate substance use disorder Day Treatment services, use the HF modifier when billing the above codes

Limitations for IOP and Day Treatment Services

Providers cannot receive Medicaid reimbursement for treatment services provided to clients who live in an institution and are transported to the program. When a Medicaid beneficiary is receiving Therapeutic Group Home, Professional Resource Family Care, hospital or Psychiatric Residential Treatment Facility (PRTF) services, the client may not participate in Day Treatment or Intensive Outpatient Services.

For More Information

More information about behavioral health services, please refer to the following resources:

- Nebraska Administrative Code Title 471, Chapters 20, 32, and 35: https://rules.nebraska.gov/rules?agencyId=37&titleId=226
- Nebraska Medicaid State Plan:

https://dhhs.ne.gov/Documents/Medicaid%20State%20Plan%20Part%202.pdf

- Reimbursement rates: https://dhhs.ne.gov/Pages/Medicaid-Provider-Rates-and-Fee-Schedules.aspx

If you have questions regarding this bulletin, please contact DHHS.MedicaidMHSU@nebraska.gov.

Thank you in advance for your feedback to improve the quality of mental and behavioral health care for Nebraska Medicaid members.

Provider Bulletins, such as this one, are posted on the DHHS website at http://dhhs.ne.gov/pages/Medicaid- Provider-Bulletins.aspx. Please subscribe to the page to help you stay up to date about new Provider Bulletins.