

MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

January 27, 2016

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: LYNNE FOSTER, CHIEF OF DIVISION COMPLIANCE

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 400 – MENTAL HEALTH AND ALCOHOL/SUBSTANCE
ABUSE SERVICES

BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Chapter 400 are being proposed to strengthen policy throughout the chapter, to ensure System of Care philosophy. Proposed revisions include adding verbiage to direct providers to appropriate chapter for Applied Behavior Analysis (ABA) services and;

Additional proposed revisions include further clarification language to promote the importance of the System of Care core philosophy and approach of family driven, community based and culturally and linguistically competent services, ensuring that recipients will receive individualized comprehensive health services that promote collaboration between providers, utilize evidence-based practices, and continue to be family driven community-based services.

Clarification that Rehabilitative Mental Health (RMH) services cannot be billed the same day as Applied Behavior Analysis (ABA) services and direct providers to the appropriate MSM Chapter.

These changes are effective January 28, 2016.

MATERIAL TRANSMITTED

CL 29498
CHAPTER 400 - MENTAL HEALTH
AND ALCOHOL/SUBSTANCE ABUSE
SERVICES

MATERIAL SUPERSEDED

MTL 21/15
CHAPTER 400 – MENTAL HEALTH
AND ALCOHOL/SUBSTANCE ABUSE
SERVICES

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
400	Introduction	Added clarification to include definition of instruction concerning System of Care.
403.6B	Rehabilitative Mental Health (RMH) Services	Added clarification to include definition of instruction concerning ABA Services.

DRAFT	MTL-21/15 CL 29498
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 400
MEDICAID SERVICES MANUAL	Subject: INTRODUCTION

MENTAL HEALTH AND ALCOHOL/SUBSTANCE ABUSE SERVICES

400 INTRODUCTION

Nevada Medicaid reimburses for community-based and inpatient mental health services to both children and adults under a combination of mental health rehabilitation, medical/clinical and institutional authority. The services must be recommended by a physician or other licensed practitioner of the healing arts, within their scope of practice under State law for the maximum reduction of a physical or mental disability and to restore the individual to the best possible functioning level. The services are to be provided in the least restrictive, most normative setting possible and may be delivered in a medical professional clinic/office, within a community environment, while in transit and/or in the recipient's home. All services must be documented as medically necessary and appropriate and must be prescribed on an individualized Treatment Plan.

Mental health rehabilitation assists individuals to develop, enhance and/or retain psychiatric stability, social integration skills, personal adjustment and/or independent living competencies in order to experience success and satisfaction in environments of their choice and to function as independently as possible. Interventions occur concurrently with clinical treatment and begin as soon as clinically possible.

Alcohol and substance abuse treatment and services are aimed to achieve the mental and physical restoration of alcohol and drug abusers. To be Medicaid reimbursable, while services may be delivered in inpatient or outpatient settings (inpatient substance abuse hospital, general hospital with a substance abuse unit, mental health clinic, or by an individual psychiatrist or psychologist), they must constitute a medical-model service delivery system.

All Medicaid policies and requirements (such as prior authorization, etc.) except for those listed in the Nevada Check Up (NCU) Chapter 1000, are the same for NCU. Chapter 400 specifically covers behavioral health services and for other Medicaid services coverage, limitations and provider responsibilities, the specific Medicaid Services Manual (MSM) needs to be referenced.

Nevada Medicaid's philosophy assumes that behavioral health services shall be person-centered and/or family driven. All services shall be culturally competent, community supportive, and strength based. The services shall address multiple domains, be in the least restrictive environment, and involve family members, caregivers and informal supports when considered appropriate per the recipient or legal guardian. Service providers shall collaborate and facilitate full participation from team members including the individual and their family to address the quality and progress of the individualized care plan and tailor services to meet the recipient's needs. In the case of child recipients, providers shall deliver youth guided effective/comprehensive, evidence-based treatments and interventions, monitor child/family outcomes through utilization of Child & Family Team meetings, and continuously work to improve services in order to ensure overall fidelity of recipient care. (Reference Addendum – Medicaid Services Manual (MSM) Definitions).

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DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 403
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initially and annually thereafter. Testing and surveillance shall be followed as outlined in NAC 441A.375.3.

f. The purpose of the annual training is to facilitate the development of specialized skills or knowledge not included in the basic training and /or to review or expand skills or knowledge included in the basic training. Consideration must be given to topics suggested by recipients. Documentation of the completed training and achieved competencies meeting this requirement must be maintained by the BHCN or Independent RMH provider. Training requirements may be waived if the QBA can provide written verification of comparable education and training. The BHCN or Independent RMH provider must document the comparability of the written verification to the QBA training requirements.

2. QMHA, refer to Section 403.3A.

3. QMHP, refer to Section 403.3B.

403.6B

REHABILITATIVE MENTAL HEALTH (RMH) SERVICES

1. Scope of Service: RMH services must be recommended by a QMHP within the scope of their practice under state law. RMH services are goal oriented outpatient interventions that target the maximum reduction of mental and/or behavioral health impairments and strive to restore the recipient's to their best possible mental and/or behavioral health functioning. RMH services must be coordinated in a manner that is in the best interest of the recipient. RMH services may be provided in a variety of community and/or professional settings. The objective is to reduce the duration and scope of care to the least intrusive level of mental and/or behavioral health care possible while sustaining the recipient's overall health. All RMH services must be directly and medically necessary. **RMH services cannot be reimbursed on the same day as Applied Behavior Analysis (ABA) services, refer to Medicaid Services Manual (MSM) Chapter 1500.**

Prior to providing RMH services, a QMHP must conduct a comprehensive assessment of an individual's rehabilitation needs including the presence of a functional impairment in daily living and a mental and/or behavioral health diagnosis. This assessment must be based on accepted standards of practice and include a covered, current ICD diagnosis. The assessing QMHP must approve a written Rehabilitation Plan. The rehabilitation strategy, as documented in the Rehabilitation Plan, must be sufficient in the amount, duration and scope to achieve established rehabilitation goals and objectives. Simultaneously, RMH services cannot be duplicative (redundant) of each other. Providers must assure that the RMH services they provide are coordinated with other servicing providers. Case records must be maintained on recipients receiving RMH services. These case records must include and/or indicate:

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SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 3600 – MANAGED CARE ORGANIZATION

BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Chapter 3600 are being proposed to incorporate the recent Centers for Medicare and Medicaid Services (CMS) approval that Managed Care Organizations (MCO) could provide services within an alternative inpatient setting, when the facility is licensed by the State of Nevada, and services within the facility are provided at a lower cost than that of services provided within a traditional inpatient hospital setting.

These changes are retroactively applied to align with revised covered services outlined within the managed care contract amendment number five.

These changes are effective November 3, 2014.

MATERIAL TRANSMITTED

CL 29160
CHAPTER 3600 - MANAGED CARE
ORGANIZATION

MATERIAL SUPERSEDED

MTL 29/12, 10/13, 06/14
CHAPTER 3600 - MANAGED CARE
ORGANIZATION

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
3603.4.f	Excluded Services and/or Coverage Limitations-IMDs	Removed language "Mentally Retarded", "MR" and added "Individuals with Intellectual Disabilities", "IID".
3603.4.i	Inpatient Hospital Services	Removed language "Institutions for Mental Disease (IMD)" and added "Inpatient Hospital Services". Revised language to reflect updated inpatient hospital services rules including alternative inpatient settings by Nevada licensed facilities when costs of services are lower than traditional inpatient settings.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
3603.15.A	Enrollment and Disenrollment Requirements and Limitations	Removed language "Situations" and added "A situation".
3603.15.A.6		Removed #6: "Enrollee enters an Institution for Mental Disease; or".

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DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 3603
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3603.2 GEOGRAPHIC AREA

The State assures individuals will have a choice of at least two MCOs for the Medicaid Managed Care recipients in each geographic area. When fewer than two MCOs are available for choice in the geographic areas listed, the Managed Care Program will be voluntary.

3603.3 COVERED SERVICES

No enrolled recipient shall receive fewer services in the Managed Care Program than they would receive in the current Nevada State Plans, except as contracted or for excluded services noted in Section 3603.4 below.

Any new services added or deleted from the Medicaid benefit package will be analyzed for inclusion or exclusion in the MCO benefit package.

3603.4 EXCLUDED SERVICES AND/OR COVERAGE LIMITATIONS

The following services are either excluded as an MCO covered benefit or have coverage limitations. Exclusions and limitations are identified as follows:

a. All services provided at IHS Facilities and Tribal Clinics

AI/AN may access and receive covered medically necessary services at IHS facilities and Tribal Clinics. If an AI/AN voluntarily enrolls with an MCO and seeks covered services from IHS, the MCO should request and receive medical records regarding those covered services/treatments provided by IHS. If treatment is recommended by IHS and the enrollee seeks the recommended treatment through the MCO, the MCO must either provide the service or must document why the service is not medically necessary. The documentation may be reviewed by the Division of Health Care Financing and Policy (DHC FP) or other reviewers. The MCO is required to coordinate all services with IHS. If an AI/AN recipient elects to disenroll from the MCO, the disenrollment will commence no later than the first day of the next administratively possible month and the services will then be reimbursed by Fee-For-Service (FFS).

b. Non-emergency transportation

A contracted vendor will authorize and arrange for all medically necessary non-emergency transportation. The MCO must verify medical appointments upon request by the DHC FP or their designee.

c. All Nursing Facility stays over 45 days

The MCO is required to cover the first 45 days of a Nursing Facility admission, pursuant

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to the Medicaid Services Manual (MSM). The MCO is also required to collect any patient liability (pursuant to 42 Code of Federal Regulations (CFR) 435.725) for each month a capitated payment is received, pursuant to the MSM. The MCO shall notify the DHCFP by the 40th day of any nursing facility stay expected to exceed 45 days. The enrollee will be disenrolled from the MCO and the stay will be covered by FFS commencing on the 46th day of the facility stay.

d. Swing bed stays in acute hospitals over 45 days

The MCO is required to cover the first 45 days of a swing bed admission pursuant to the MSM. The MCO is also required to collect any patient liability (pursuant to 42 CFR 435.725) for each month a capitated payment is received, pursuant to the MSM. The MCO shall notify the DHCFP by the 40th day of any swing bed stay expected to exceed 45 days. The enrollee will be disenrolled from the MCO and the stay will be covered by FFS commencing on the 46th day of the facility stay.

e. School Based Child Health Services (SBCHS)

The DHCFP has an agreement with several school districts to provide selected medically necessary covered services through SBCHS to eligible Title XIX Medicaid and Title XXI Nevada Check Up (NCU) recipients.

Eligible Medicaid enrollees, who are three years of age and older, can be referred to an SBCHS for an evaluation by their private physician, school physician, special education teacher, school nurse, school counselor, parent or guardian, or social worker. If the child is found eligible for these services, then an Individual Education Plan (IEP) is developed for the child. The IEP specifies services needed for the child to meet educational goals. A copy of the IEP will be sent to the child's Primary Care Physician (PCP) within the managed health care plan, and maintained in the enrollee's medical record.

The school districts provide, through school district employees or contract personnel, the majority of specified medically necessary covered services. Medicaid reimburses the school districts for these services in accordance with the school district contract. The MCO will provide covered medically necessary services beyond those available through school districts, or document why the services are not medically necessary. The documentation may be reviewed by the DHCFP or its designees. Title XIX Medicaid and Title XXI NCU eligible children are not limited to receiving health services through the school districts. Services may be obtained through the MCO rather than the school district, if requested by the parent/legal guardian. The MCO case manager shall coordinate with the school district in obtaining any services which are not covered by the plan or the school district.

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- f. Intermediate Care Facility for ~~the Mentally Retarded~~ Individuals with Intellectual Disabilities (ICF/~~MR~~IID)

Residents of ICF/~~MR~~IID facilities are not eligible for enrollment with the MCO. If a recipient is admitted to an ICF/~~MR~~IID after MCO enrollment, the recipient will be disenrolled from the MCO and the admission, bed day rate, and ancillary services will be reimbursed through FFS.

- g. Residential Treatment Center (RTC) Limitations

It is the MCO's responsibility to provide reimbursement for all ancillary services (i.e., physician services, optometry, laboratory, dental and x-ray services, and similar services) for enrollees under the Title XXI, NCU, throughout their RTC admission. These enrollees will remain enrolled with the MCO throughout their RTC stay. The RTC bed day rate will be covered by FFS for NCU enrollees commencing the first day of admission.

Enrollees who are covered under Title XIX Medicaid will be disenrolled from the MCO the first day of the next administratively possible month following the RTC admission. It is the MCO's responsibility to provide reimbursement for all RTC charges including admission, bed day rate, and ancillary services until properly disenrolled from managed care. The RTC admission, bed day rate, and ancillary services will be reimbursed through FFS thereafter for Title XIX Medicaid recipients.

- h. Hospice

Recipients who are receiving Hospice Services are not eligible for enrollment with the MCO. Hospice Services are an optional program under the Social Security Act XVIII Section 1905(o)(1)(A) and are governed by 42 CFR 418 and 489.102(I). Once admitted into hospice care, Medicaid members will be disenrolled immediately. NCU recipients will not be disenrolled. However, payment for NCU hospice services will be billed as FFS. It is the responsibility of the MCOs to provide reimbursement for all ancillary services until properly disenrolled from managed care.

- i. Institutions for Mental Diseases (IMDs)

~~Federal regulations stipulate that Medicaid can only reimburse for services to IMD/psychiatric hospital patients who are 65 years of age or older or under the age of 21 years.~~ Institutions for Mental Diseases are an excluded inpatient service provider in the Fee for Service Medicaid program. Managed Care Organizations may provide inpatient hospital services; to mandatorily enrolled recipients within an alternative inpatient setting, including an IMD, which is licensed by the State of Nevada, in lieu of services in an inpatient hospital. The alternative inpatient setting must be a lower cost than the

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~~64 years of age are not eligible for enrollment with the MCO. If a recipient is admitted to an IMD after MCO enrollment, the recipient will be disenrolled.~~

j. Adult Day Health Care

Recipients who are receiving Adult Day Health Care (ADHC) (Provider Type 39) services are not eligible for enrollment with the MCO. ADHC Services are optional Medicaid State Plan services and authorized under State Plan authority titled “Nevada 1915(i) State Plan Home and Community-Based Services (HCBS)”. If a recipient is made eligible for ADHC after MCO enrollment, the recipient will be disenrolled and the ADHC will be reimbursed through FFS. It is the responsibility of the MCOs to provide reimbursement for all ancillary services until properly disenrolled from managed care.

k. Home and Community Based Waiver (HCBW) Services

Recipients who are receiving HCBW Services are not eligible for enrollment with the MCO. If a recipient is made eligible for HCBW Services after MCO enrollment, the recipient will be disenrolled and the HCBW Services will be reimbursed through FFS.

l. All Pre-Admission Screening and Resident Review (PASRR) and Level of Care (LOC) Assessments are performed by the State’s Fiscal Agent.

Conducting a PASRR and LOC will not prompt MCO disenrollment, however, if the recipient is admitted to a nursing facility as the result of a PASRR and LOC, the MCO is responsible for the first 45 days of admission (see #c above).

m. SED/SMI

The MCO must ensure enrollees who are referred for evaluation for SED/SMI or who have been determined SED/SMI by the health plan are obtaining the medically necessary evaluations by an in-network provider and that enrollees are transitioned, as necessary, to another provider in order to obtain their mental health services if such services are not available within the network. The MCO is required to notify the DHCFP if a Title XIX Medicaid recipient elects to disenroll from the MCO following the determination of SED/SMI and forward the enrollee’s medical records to the provider from whom the enrollee will receive the covered mental health services. However, in the event the Medicaid enrollee who has received such a determination chooses to remain enrolled with the MCO, the MCO will be responsible for providing all patient care.

The MCO is required to adhere to MSM Chapter 400 and 2500 for all SED and SMI referrals and determinations and must reimburse providers of these services pursuant to the referenced MSM Chapters. Such services include, but are not limited to: case management; lab work; prescription drugs; acute in-patient; and, other ancillary medical

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- i. Such other necessary health care, diagnostic services, treatment, and other measures described in Section 1905(a) of the Social Security Act to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State Medicaid Plan.

The MCO is not required to provide any items or services which are determined to be unsafe or ineffective, or which are considered experimental. Appropriate limits may be placed on EPSDT services based on medical necessity.

The MCO is required to provide information and perform outreach activities to eligible enrolled children for EPSDT services. These efforts may be reviewed and audited by the DHCFP or its designee.

3603.15 ENROLLMENT AND DISENROLLMENT REQUIREMENTS AND LIMITATIONS

A. Eligibility and Disenrollment

The eligibility and enrollment functions are the responsibility of the DHCFP and the Division of Welfare and Supportive Services (DWSS). The MCO shall accept each recipient who is enrolled in or assigned to the MCO by the DHCFP and/or its enrollment sections and/or for whom a capitation payment has been made or will be made by the DHCFP to the MCO. The first date a Medicaid or NCU eligible recipient will be enrolled is not earlier than the applicable date in the MCO's specified contract.

The MCO must accept recipients eligible for enrollment in the order in which they apply without restriction, up to the limits set under the contract. The MCO acknowledges that enrollment is mandatory except in the case of voluntary enrollment programs that meet the conditions set forth in 42 CFR 438.50(a). The MCO will not, on the basis of health status or need for health services, discriminate against recipients eligible to enroll. The MCO will not deny the enrollment nor discriminate against any Medicaid or NCU recipients eligible to enroll on the basis of race, color or national origin and will not use any policy or practice that has the effect of discrimination on the basis of race, color or national origin. If the recipient was previously disenrolled from the MCO as the result of a grievance filed by the MCO, the recipient will not be re-enrolled with the MCO unless the recipient wins an appeal of the disenrollment. The recipient may be enrolled with another MCO.

The State reserves the right to recover pro-rated capitation whenever the MCO's responsibility to pay medical claims ends in mid-month. ~~Situations~~A situation where a mid-month capitation recovery may occur includes, but is not limited to:

- 1. Enrollee is in a nursing facility over 45 days;

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2. Enrollee is in an acute hospital swing bed over 45 days;
3. Enrollee is placed in an out of home placement;
4. Medicaid enrollee is placed in a hospice;
5. Enrollees enters an ICF/MR; **or**
- ~~6. Enrollee enters an Institution for Mental Disease; or~~
- ~~7.6.~~ Enrollee enters an HCBW Program.

The MCO is not financially responsible for any services rendered during a period of retroactive eligibility except in the specific situation(s) described in this Chapter. The MCO is responsible for services rendered during a period of retroactive enrollment in situations where errors committed by the DHCFP or the DWSS, though corrected upon discovery, have caused an individual to not be properly and timely enrolled with the MCO. In such cases, the MCO shall only be obligated to pay for such services that would have been authorized by the MCO had the individual been enrolled at the time of such services. For in-state providers in these circumstances, the MCO shall pay the providers for such services only in the amounts that would have been paid to a contracted provider in the applicable specialty. Out-of-state providers in these circumstances will be paid according to a negotiated rate between the MCO and the out-of-state provider. The timeframe to make such corrections will be limited to 180 days from the incorrect enrollment date. The DHCFP is responsible for payment of applicable capitation for the retroactive coverage. As described in Section 3603.15 (B) (1) of the MSM, the Vendor is responsible for Medicaid newborns as of the date of birth, provided the mother was actively enrolled or retro-actively enrolled at the date of birth.

The MCO must notify a recipient that any change in status, including family size and residence, must be immediately reported by the recipient to the DWSS eligibility worker.

The MCO must provide the DHCFP with weekly electronic notification of all births and deaths.

B. Enrollment of Pregnant Women

The eligibility of Medicaid applicants is determined by the DWSS. DWSS notifies the state's fiscal agent who enrolls the applicant. Letters are sent to the new recipients requiring them to select an MCO or an MCO will be automatically assigned. The MCO will be notified of the pregnant woman's choice by the State's fiscal agent. The MCO shall be responsible for all covered medically necessary obstetrical services and pregnancy related care commencing on the date of enrollment.