

MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

August 14, 2018

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: LYNNE FOSTER, CHIEF OF DIVISION COMPLIANCE

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

BACKGROUND AND EXPLANATION

Revisions to MSM Chapter 400, Sections 403.4(c) and 403.5C are being proposed to clarify service limitations and prior authorization (PA) requirements for all psychotherapy and neurotherapy services. Proposed changes clarify that all psychotherapy (individual, group and family) and neurotherapy sessions are allowed up to three sessions, of any combination, without a PA. After three sessions, a PA will be required, and may be requested from the QIO-like vendor for additional services above the service limitations for all levels demonstrating medical necessity.

Additionally, proposed changes clarify the Intensity of Services grid for both adolescents and adults to align with service limitations already in policy. This is not a change to policy.

Throughout the chapter, grammar, punctuation and capitalization changes were made, duplications removed, acronyms used and standardized and language reworded for clarity. Renumbering and re-arranging of sections was necessary.

Entities Financially Affected: Providers of psychotherapy and neurotherapy, including, but not limited to, Behavioral Health Outpatient Treatment (Provider Type (PT) 14), Psychologists (PT 26) and Behavioral Health Rehabilitative Treatment (PT 82).

Financial Impact on Local Government: Unknown at this time.

These changes are effective August 15, 2018.

MATERIAL TRANSMITTED

CL
MENTAL HEALTH AND ALCOHOL AND
SUBSTANCE ABUSE SERVICES

MATERIAL SUPERSEDED

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Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
403.4(c)(4)(b)	OUTPATIENT MENTAL HEALTH SERVICES	Language was added to specify that all neurotherapy sessions are allowed up to three sessions, of any combination, without a PA. After three sessions, a PA will be required and may be requested from the QIO-like vendor for additional services above the service limitations for all levels demonstrating medical necessity.
403.5(C)(2)(b)	OUTPATIENT MENTAL HEALTH SERVICES	Language was added to specify that all psychotherapy sessions (individual, group and family) are allowed up to three sessions, of any combination, without a PA. After three sessions, a PA will be required and may be requested from the QIO-like vendor for additional services above the service limitations for all levels demonstrating medical necessity.
403.5(C)(4)	OUTPATIENT MENTAL HEALTH (OMH) SERVICES – UTILIZATION MANAGEMENT	<p>Intensity of Services grid for adolescents was updated to reflect the service limitations already identified in policy.</p> <p>Additional language added after Intensity of Services Grid to specify that all psychotherapy sessions (individual, group and family) are allowed up to three sessions, of any combination, without a PA. After three sessions, a PA will be required and may be requested from the QIO-like vendor for additional services above the service limitations for all levels demonstrating medical necessity.</p> <p>Additional language added after Intensity of Services Grid to specify that PA are required for all neurotherapy sessions. Additional services above the service limitations may be requested with a PA demonstrating medical necessity.</p>
403.5(C)(5)	OUTPATIENT MENTAL HEALTH (OMH) SERVICES – UTILIZATION MANAGEMENT	<p>Intensity of Services grid for adults was updated to reflect the service limitations already identified in policy.</p> <p>Additional language added after Intensity of Services Grid to specify that all psychotherapy sessions (individual, group and family) are allowed up to three sessions, of any combination, without a PA. After three sessions, a PA will be required and may be requested from the QIO-like vendor for additional services above the service limitations for all levels demonstrating medical necessity.</p>

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
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Additional language added after Intensity of Services Grid to specify that PA are required for all neurotherapy sessions. Additional services above the service limitations may be requested with a PA demonstrating medical necessity.

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Interns/Psychological Assistants are excluded from functioning as a clinical supervisor.

The following are also considered QMHPs:

- a. Licensed Clinical Social Worker (LCSW) Interns meet the requirements under a program of internship and are licensed as an intern pursuant to the State of Nevada, Board of Examiners for Social Workers (Nevada Administrative Code (NAC) 641B).
- b. Licensed Marriage and Family Therapist (LMFT) and Licensed Clinical Professional Counselor Interns who meet the requirements under a program of internship and are licensed as an intern pursuant to the State of Nevada Board of Examiners for Marriage and Family Therapists and Clinical Professional Counselors.
- c. Psychological Assistants who hold a doctorate degree in psychology, is registered with the State of Nevada Board of Psychological Examiners (NAC 641.151) and is an applicant for licensure as a Licensed Clinical Psychologist who has not yet completed the required supervised postdoctoral experience approved by the Board.
- d. Psychological Interns registered through the Psychological Board of Examiners defined in NAC 641.165. Interns must be supervised in accordance with state regulations and may only provide services within the scope of their licensure.

403.4 OUTPATIENT MENTAL HEALTH SERVICES

These services include assessment and diagnosis, testing, basic medical and therapeutic services, crisis intervention, therapy, partial and intensive outpatient hospitalization, medication management and case management services. For case management services, refer to MSM Chapter 2500 for Non-SED and Non-SMI definitions, service requirements, service limitations, provider qualifications and documentation requirements.

- a. Assessments are covered for problem identification (diagnosis) and to establish measurable treatment goals and objectives by a QMHP or designated QMHA in the case of a Mental Health Screen.
 1. Mental Health Screen – A behavioral health screen to determine eligibility for admission to treatment program.

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2. Comprehensive Assessment – A comprehensive, evaluation of a recipient’s history and functioning which, combined with clinical judgment, is to include a covered, current ICD diagnosis and a summary of identified rehabilitative treatment needs. Health and Behavior Assessment – Used to identify the psychological, behavioral, emotional, cognitive and social factors important to the prevention, treatment or management of physical health needs. The focus of the assessment is not on the mental health needs, but on the biopsychosocial factors important to physical health needs and treatments. The focus of the intervention is to improve the recipient’s health and well-being utilizing cognitive, behavioral, social and/or psychophysiological procedures designed to ameliorate specific disease related needs. This type of assessment is covered on an individual basis, family with the recipient present or family without the recipient present.
3. Psychiatric Diagnostic Interview – Covered once per calendar year without prior authorization. If there is a substantial change in condition, subsequent assessments may be requested through a prior-authorization from the QIO-like vendor for Nevada Medicaid. A psychiatric diagnostic interview may consist of a clinical interview, a medical and mental history, a mental status examination, behavioral observations, medication evaluation and/or prescription by a licensed psychiatrist. The psychiatric diagnostic interview is to conclude with a written report which contains a current ICD diagnosis and treatment recommendations.
4. Psychological Assessment – Covered once per calendar year without prior authorization. If there is a substantial change in condition, subsequent assessments may be requested through a prior-authorization from the QIO-like vendor for Nevada Medicaid. A psychological assessment may consist of a clinical interview, a biopsychosocial history, a mental status examination and behavioral observations. The psychological assessment is to conclude with a written report which contains a current ICD diagnosis and treatment recommendations.
5. Functional Assessment – Used to comprehensively evaluate the recipient’s skills, strengths and needs in relation to the skill demands and supports required in the particular environment in which the recipient wants or needs to function; as such, environment is consistent with the goals listed in the recipient’s individualized Treatment Plan. A functional assessment is used to assess the presence of functional strengths and needs in the following domains: vocational, education, self-maintenance, managing illness and wellness, relationships and social.

A person-centered conference is covered as part of the functional assessment to collaboratively develop and communicate the goals and objectives of the individualized Treatment Plan. The conference must include the recipient, a QMHP, family or legal representative, significant others and case manager(s). The case manager(s) or lead case manager, if there are multiple case managers, shall

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provide advocacy for the recipient's goals and independence, supporting the recipient's participation in the meeting and affirming the recipient's dignity and rights in the service planning process.

6. Intensity of Needs Determination - A standardized mechanism to determine the intensity of services needed based upon the severity of the recipient's condition. The intensity of needs determination is to be utilized in conjunction with the clinical judgment of the QMHP and/or trained QMHA. This assessment was previously known as a level of care assessment. Currently, the DHCFP recognizes the Level of Care Utilization System (LOCUS) for adults and the Child and Adolescent Screening Intensity Instrument (CASII) for children and adolescents. There is no level of care assessment tool recognized by the DHCFP for children below age six, however, providers must utilize a tool comparable to the CASII and recognized as a standard of practice in determining the intensity of needs for this age group.
 7. Severe Emotional Disturbance (SED) Assessment - Covered annually or if there is a significant change in functioning. The SED assessment is a tool utilized to determine a recipient's eligibility for higher levels of care and Medicaid service categories.
 8. Serious Mental Illness (SMI) Assessment - Covered annually or if there is a significant change in functioning. The SMI assessment is a tool utilized to determine a recipient's eligibility for higher levels of care and Medicaid service categories.
- b. Neuro-Cognitive, Psychological and Mental Status Testing
1. Neuropsychological testing with interpretation and report involves assessment and evaluation of brain behavioral relationships by a neuropsychologist. The evaluation consists of qualitative and quantitative measurement that consider factors such as the interaction of psychosocial, personality/emotional, intellectual, environmental, neurocognitive, biogenetic and neurochemical aspects of behaviors in an effort to understand more fully the relationship between physiological and psychological systems. This service requires prior authorization from the QIO-like vendor.
 2. Neurobehavioral testing with interpretation and report involves the clinical assessment of thinking, reasoning and judgment, acquired knowledge, attention, memory, visual spatial abilities, language functions and planning. This service requires prior authorization.
 3. Psychological testing with interpretation and report is the administration, evaluation and scoring of standardized tests which may include the evaluation of

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intellectual functioning, clinical strengths and needs, psychodynamics, insight, motivation and other factors influencing treatment outcomes.

c. Mental Health Therapies

Mental health therapy is covered for individual, group and/or family therapy with the recipient present and for family therapy without the recipient present and described as follows:

1. Family Therapy

Mental health treatment service provided to a specific recipient by a QMHP using the natural or substitute family as the means to facilitate positive family interactions among individuals. The recipient does not need to be present for family therapy services; however, the services must deal with issues relating to the constructive integration/reintegration of the recipient into the family.

2. Group Therapy

Mental Health treatment service facilitated by a QMHP within their scope of licensure or practice, which utilizes the interactions of more than one individual and the focus of the group to address behavioral health needs and interpersonal relationships. The therapy must be prescribed on the Treatment Plan and must have measurable goals and objectives. Group therapy may focus on skill development for learning new coping skills, such as stress reduction, or changing maladaptive behavior, such as anger management. Participation in group therapy must be documented on the clinical record. Minimum group size is three and maximum therapist to participant ratio is one to ten. Group therapy can be less than three but more than one based on unforeseen circumstances such as a no-show or cancellation, but cannot be billed as individual therapy. Group therapy may also include a family without the recipient present and/or multi-family groups.

3. Individual Therapy Services

Mental health treatment service provided to a specific recipient for a presenting need by an individual therapist for a specified period of time. The amount, scope and duration of individual therapy services may vary depending on the stage of the presenting mental health need, treatment program and recipient's response to the treatment approach. Individual is one recipient. Each direct one-on-one episode must be of a sufficient length of time to provide the appropriate skilled treatment in accordance with each patient's treatment/rehabilitative plan.

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4. Neurotherapy

a. Neurotherapy is individual psychological therapy incorporating biofeedback training combined with psychotherapy as a treatment for mental health disorders. Medicaid will reimburse for medically necessary neurotherapy when administered by a licensed QMHP within the scope of their practice and expertise. A certified Biofeedback Technician may assist in the provision of biofeedback treatment; however, a QMHP must provide the associated psychotherapy. Reimbursement for biofeedback treatment provided by a Biofeedback Technician is imbedded in the QMHP rate.

b. ~~Up to three neurotherapy sessions are allowed without a prior authorization for the below identified diagnoses.~~ Prior authorization requirements and QIO-like vendor responsibilities are ~~the same for all out-patient therapies, required for all subsequent neurotherapy services except for the following allowable service limitations for neurotherapy~~ used for treatment of the following covered ICD Codes:

1. Attention Deficit Disorders – 40 sessions
Current ICD Codes: F90.0, F90.8 and F90.9
2. Anxiety Disorders – 30 sessions
Current ICD Codes: F41.0 and F34.1
3. Depressive Disorders – 25 sessions
Current ICD Codes: F32.9, F33.40, F33.9, F32.3 and F33.3
4. Bipolar Disorders – 50 sessions
Current ICD Codes: F30.10, F30.9, F31.0, F31.10, F31.89, F31.30, F31.60, F31.70, F31.71, F31.72, F31.9 and F39
5. Obsessive Compulsive Disorders – 40 sessions
Current ICD Codes: F42
6. Opposition Defiant Disorders and/or Reactive Attachment Disorders – 50 sessions
Current ICD Codes: F93.8, F91.3, F94.1, F94.2, F94.9 and F98.8
7. Post-Traumatic Stress Disorders – 35 sessions
Current ICD Codes: F43.21, F43.10, F43.11 and F43.12
8. Schizophrenia Disorders – 50 sessions

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Current ICD Codes: F20.89, F20.1, F20.2, F20.0, F20.81, F20.89, F20.5, F25.0, F25.1, F25.8, F25.9, F20.3 and F20.9

Prior authorization may be requested for additional services based upon medical necessity.

d. Mental Health Therapeutic Interventions

1. Partial Hospitalization Program (PHP) – Traditional – Services furnished under a medical model by a hospital, in an outpatient setting, which encompass a variety of psychiatric treatment modalities designed for recipients with mental or substance abuse disorders who require coordinated, intensive, comprehensive and multi-disciplinary treatment not generally provided in an outpatient setting. These services are expected to reasonably improve or maintain the individual’s condition and functional level to prevent relapse of hospitalization. The services are intended to be an alternative to inpatient psychiatric care and are generally provided to recipients experiencing an exacerbation of a severe and persistent mental illness. PHP services include active therapeutic treatment and must be targeted to meet the goals of alleviating impairments and maintaining or improving functioning to prevent relapse or hospitalization.

2. Intensive Outpatient Program (IOP) – A comprehensive interdisciplinary program of an array of direct mental health and rehabilitative services which are expected to improve or maintain an individual’s condition and functioning level for prevention of relapse or hospitalization. The services are provided to individuals who are diagnosed as severely emotionally disturbed or seriously mentally ill. IOP group sizes are required to be within four to 15 recipients.
 - a. Service Limitations: IOP services are direct services provided no more or less than three days a week, with a minimum of three hours a day and not to exceed six hours a day. IOP services may not exceed the day and hour limitations. Services that exceed this time frame indicate a higher level of care and the recipient should be reevaluated.

 - b. Direct services are face-to-face interactive services spent with licensed staff. Interns and assistants enrolled as a QMHP can provide IOP services while under the direct and clinical supervision of a licensed clinician. Direct supervision requires the licensed clinical supervisor to be onsite where services are rendered.

 - c. IOP includes: outpatient mental health services, rehabilitative mental health services, diagnostic testing and evaluations including neuro-psychological testing, lab tests including drug and alcohol tests, medication management,

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medication training and support, crisis intervention and supplies. IOP requires the availability of 24/7 psychiatric and psychological services. These services may not be billed separately as IOP is an all-inclusive rate.

d. Non-Covered services in an IOP include, but are not limited to:

1. Non-evidence-based models;
2. Transportation or services delivered in transit;
3. Club house, recreational, vocational, after-school or mentorship program;
4. Routine supervision, monitoring or respite;
5. Participating in community based, social based support groups (i.e. Alcoholics Anonymous, Narcotics Anonymous);
6. Watching films or videos;
7. Doing assigned readings; and
8. Completing inventories or questionnaires.

3. Medication Management – A medical treatment service using psychotropic medications for the purpose of rapid symptom reduction, to maintain improvement in a chronic recurrent disorder or to prevent or reduce the chances of relapse or reoccurrence. Medication management must be provided by a psychiatrist or physician licensed to practice in the State of Nevada and may include, through consultation, the use of a physician’s assistant or a certified nurse practitioner licensed to practice in the State of Nevada within their scope of practice. Medication management may be used by a physician who is prescribing pharmacologic therapy for a recipient with an organic brain syndrome or whose diagnosis is in the current ICD section of Mental, Behavioral and Neurodevelopmental Disorders and is being managed primarily by psychotropic drugs. It may also be used for the recipient whose psychotherapy is being managed by another mental health professional and the billing physician is managing the psychotropic medication. The service includes prescribing, monitoring the effect of the medication and adjusting the dosage. Any psychotherapy provided is minimal and is usually supportive only. If the recipient received psychotherapy and drug management at the same visit, the drug management is included as part of that service by definition and medication management should not be billed in addition.

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4. Medication Training and Support – This service must be provided by a professional other than a physician and is covered for monitoring of compliance, side effects, recipient education and coordination of requests to a physician for changes in medication(s). To be reimbursed for this service, the provider must be enrolled as: A Qualified Mental Health Professional (QMHP), a Licensed Clinical Social Worker (LCSW), a Licensed Marriage and Family Therapist (LMFT) or a Clinical Professional Counselor (CPC). A Registered Nurse (RN) enrolled as a Qualified Mental Health Associate (QMHA) may also provide this service if billed with the appropriate modifier. Medication Training and Support may only be billed if provided within 30 days after the recipient has a prescription filled. The nature and duration of the service should conform to best practices.

403.5 OUTPATIENT MENTAL HEALTH (OMH) SERVICES - UTILIZATION MANAGEMENT

A. INTENSITY OF NEEDS DETERMINATION

The assessed level of needs and the amount, scope and duration of RMH services required to improve or retain a recipient’s level of functioning or prevent relapse. The determination cannot be based upon the habilitative needs of the recipient. Intensity of needs determination is completed by a trained QMHP or QMHA. Intensity of needs determinations are based on several components consistent with person and family centered treatment/rehabilitation planning. Intensity of Needs redeterminations must be completed every 90 days or anytime there is a substantial change in the recipient’s clinical status.

These components include:

1. A comprehensive assessment of the recipient’s level of functioning;
2. The clinical judgment of the QMHP; and
3. A proposed treatment and/or rehabilitation plan.

B. INTENSITY OF NEEDS GRID

1. The intensity of needs grid is an approved Level of Care (LOC) utilization system, which bases the intensity of services on the assessed needs of a recipient. The determined level on the grid guides the interdisciplinary team in planning treatment to improve or retain a recipient’s level of functioning or prevent relapse. Each Medicaid recipient must have an intensity of needs determination completed prior to approval to transition to more intensive services (except in the case of a physician or psychologist practicing as independent providers). The intensity of needs grid was previously referred to as level of services grid.

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2. Intensity of Need for Children:

Child and Adolescent Service Intensity Instrument (CASII)	Service Criteria
Levels I Basic Services: Recovery Maintenance and Health Management	<ul style="list-style-type: none"> • Significant Life Stressors and/or current ICD Codes, Z55-Z65, R45.850 and R45.821 that does not meet SED criteria (excluding dementia, intellectual disabilities and related conditions or a primary diagnosis of a substance abuse disorder, unless these conditions co-occur with a mental illness).
Level II Outpatient Services	<ul style="list-style-type: none"> • Current ICD diagnosis in Mental, Behavioral and Neurodevelopmental Disorders that does not meet SED criteria (excluding Z55-Z65, R45.850 and R45.821 Codes, dementia, intellectual disabilities and related conditions, or a primary diagnosis of a substance abuse disorder, unless these conditions co-occur with a mental illness).
Level III Intensive Outpatient Services	<ul style="list-style-type: none"> • Current ICD diagnosis in Mental, Behavioral and Neurodevelopmental Disorders (excluding Z55-Z65, R45.850 and R45.821 Codes, dementia, intellectual disabilities and related conditions, or a primary diagnosis of a substance abuse disorder, unless these conditions co-occur with a mental illness); and • SED Determination.
Levels IV Intensive Integrated Services	<ul style="list-style-type: none"> • Current ICD diagnosis in Mental, Behavioral and Neurodevelopmental Disorders (excluding Z55-Z65, R45.850 and R45.821 Codes, dementia, intellectual disabilities and related conditions, or a primary diagnosis of a substance abuse disorder, unless these conditions co-occur with a mental illness); and SED Determination.
Level V Non-secure, 24 hour Services with Psychiatric Monitoring	<ul style="list-style-type: none"> • Current ICD diagnosis in Mental, Behavioral and Neurodevelopmental Disorders (excluding Z55-Z65, R45.850 and R45.821 Codes, dementia, intellectual disabilities and related conditions, or a primary diagnosis of a substance abuse disorder, unless these conditions co-occur with a mental illness); and • SED Determination; and • Requires specialized treatment (e.g., sex offender treatment, etc.).
Level VI Secure, 24 hour, Services with Psychiatric Management	<ul style="list-style-type: none"> • Current ICD diagnosis in Mental, Behavioral and Neurodevelopmental Disorders (excluding Z55-Z65, R45.850 and R45.821 Codes, dementia, intellectual disabilities and related conditions, or a primary diagnosis of a substance abuse disorder, unless these conditions co-occur with a mental illness); and • SED Determination; and • Requires inpatient/secured LOC.

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3. Intensity of Needs for Adults:

Level of Care Utilization System for Adults (LOCUS)	Service Criteria
Levels I Basic Services: Recovery Maintenance and Health Management	<ul style="list-style-type: none"> • Current ICD diagnosis in Mental, Behavioral and Neurodevelopmental Disorders, including Z55-Z65, R45.850 and R45.821 Codes, that do not meet SMI criteria (excluding dementia, intellectual disabilities and related conditions, or a primary diagnosis of a substance abuse disorder, unless these conditions co-occur with a mental illness).
Level II Low Intensity Community Based Services	<ul style="list-style-type: none"> • Current ICD diagnosis in Mental, Behavioral and Neurodevelopmental Disorders, including Z55-Z65, R45.850 and R45.821 Codes that do not meet SMI criteria (excluding dementia, intellectual disabilities and related conditions, or a primary diagnosis of a substance abuse disorder, unless these conditions co-occur with a mental illness).
Level III High Intensity Community Based Services (HCBS)	<ul style="list-style-type: none"> • Current ICD diagnosis in Mental, Behavioral and Neurodevelopmental Disorders (excluding Z55-Z65, R45.850 and R45.821 Codes, dementia, intellectual disabilities and related conditions, or a primary diagnosis of a substance abuse disorder, unless these conditions co-occur with a mental illness); and • SMI determination.
Levels IV Medically Monitored Non-Residential Services	<ul style="list-style-type: none"> • Current ICD diagnosis in Mental, Behavioral and Neurodevelopmental Disorders (excluding Z55-Z65, R45.850 and R45.821 Codes, dementia, intellectual disabilities and related conditions, or a primary diagnosis of a substance abuse disorder, unless these conditions co-occur with a mental illness); and • SMI determination.
Level V Medically Monitored Residential Services	<ul style="list-style-type: none"> • Current ICD diagnosis in Mental, Behavioral and Neurodevelopmental Disorders (excluding Z55-Z65, R45.850 and R45.821 Codes, dementia, intellectual disabilities and related conditions, or a primary diagnosis of a substance abuse disorder, unless these conditions co-occur with a mental illness); and • SMI determination; and • Requires specialized treatment (e.g. sex offender treatment, etc.).
Level VI Medically Managed Residential Services	<ul style="list-style-type: none"> • Current ICD diagnosis in Mental, Behavioral and Neurodevelopmental Disorders (excluding Z55-Z65, R45.850 and R45.821 Codes, dementia, intellectual disabilities and related conditions, or a primary diagnosis of a substance abuse disorder, unless these conditions co-occur with a mental illness); and • SMI determination; and • Requires inpatient/secured LOC.

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- C. Utilization Management for outpatient mental health services is provided by the DHCFP QIO-like vendor as follows:
1. For BHCN, all service limitations are based upon the Intensity of Needs Grid in the definitions. The recipient must have an Intensity of Needs determination to supplement clinical judgment and to determine the appropriate service utilization. The provider must document in the case notes the level that is determined from the Intensity of Needs grid;
 2. Independent psychologists are not subject to the service limitations in the Intensity of Needs Grid. The following service limitations are for psychologists:
 - a. Assessments – two per calendar year, additional services require prior authorization from the QIO-like vendor; and
 - b. Therapy (group, individual, family) – a combination of up to **three sessions per calendar year are allowed without a prior authorization. Up to ~~twenty-six~~26 visits per calendar year is allowed with~~out~~ prior authorization. Additional services require prior authorization from the QIO-like vendor meeting medical necessity.**
 3. Independent psychiatrists are not subject to the service limitations in the Intensity of Needs grid. No prior authorization is required for this particular provider.

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4. Medicaid Behavioral Health Intensity of Needs for Children and Adolescents.

Child and Adolescent Service Intensity Instrument (CASII)	Intensity of Services (Per Calendar Year ¹)
Levels I Basic Services: Recovery Maintenance and Health Management	<ul style="list-style-type: none"> • Assessment two total sessions (does not include Mental Health Screen) • Individual, Group or Family Therapy 10 total sessions; • Medication Management six total sessions
Level II Outpatient Services	<ul style="list-style-type: none"> • Assessments: four total sessions (does not include Mental Health Screen) • Individual, Group or Family Therapy: 26 total sessions • Medication Management: eight total sessions
Level III Intensive Outpatient Services	<p>All Level Two Services Plus:</p> <ul style="list-style-type: none"> • Assessments: four total sessions (does not include Mental Health Screen) • Individual, Group or Family Therapy: 26 total sessions • Medication Management: eight total sessions • Intensive Outpatient Program (IOP)
Levels IV Intensive Integrated Services	<p>All Level Three Services</p> <ul style="list-style-type: none"> • Assessments: four total sessions (does not include Mental Health Screen) • Individual, Group or Family Therapy: 26 total sessions • Medication Management: eight total sessions • Partial Hospitalization Program (PHP)
Level V Non-secure, 24-Hour Services with Psychiatric Monitoring	<p>All Level Four Services</p> <ul style="list-style-type: none"> • Assessments: four total sessions (does not include Mental Health Screen) • Individual, Group or Family Therapy: 26 total sessions • Medication Management: eight total sessions • PHP
Level VI Secure, 24-Hour, Services with Psychiatric Management	All level Five services

All psychotherapy sessions (individual, group, and family) are allowed up to three sessions, of any combination, without a PA. After three sessions, a PA will be required and may be requested from the QIO-like vendor for additional services above the service limitations for all levels demonstrating medical necessity.

Neurotherapy is allowed up to three sessions without a PA with identified covered diagnosis outlined in policy. After three sessions, a PA will be required and ~~Prior authorization~~ may be requested from the QIO-like vendor for additional ~~assessment~~

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~~and therapy~~ services for all levels above the service limitation demonstrating medical necessity.

- a. Service provision is based on the calendar year beginning on January 1.
- b. Sessions indicates billable codes for this service may include occurrence based codes, time-based or a combination of both. Session = each time this service occurs regardless of the duration of the service.

5. Medicaid Behavioral Health Intensity of Needs for Adults.

Medicaid Behavioral Health Intensity of Needs for Adults. Level of Care Utilization System for Adults (LOCUS)	Intensity of Service (Per Calendar Year ¹)
Levels I Basic Services - Recovery Maintenance and Health Management	<ul style="list-style-type: none"> • Assessment: two total sessions (does not include Mental Health Screen) • Individual, Group or Family Therapy: six total sessions • Medication Management: six total sessions
Level II Low Intensity Community Based Services	<ul style="list-style-type: none"> • Assessment: (two assessments; does not include Mental Health Screen) • Individual, Group or Family Therapy: 12 total sessions • Medication Management: eight total sessions
Level III High Intensity Community Based Services	<ul style="list-style-type: none"> • Assessment (two assessments; does not include Mental Health Screen) • Individual, Group and Family therapy: 12 total sessions • Medication Management: 12 total sessions • IOP
Level IV Medically Monitored Non-Residential Services	<ul style="list-style-type: none"> • Assessment (two assessments; does not include Mental Health Screen) • Individual, Group and Family Therapy: 16 total sessions • Medication Management (12 sessions) • Partial HospitalizationPHP
Level V Medically Monitored Residential Services	<ul style="list-style-type: none"> • Assessment (two assessments; does not include Mental Health Screen) • Individual, Group and Family therapy: 18 total sessions • Medication Management (12 sessions) • Partial Hospitalization-PHP
Level VI Medically Managed Residential Services	All Level Five Services

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All psychotherapy sessions (individual, group and family) are allowed up to three sessions, of any combination, without a PA. After three sessions, a PA will be required and may be requested from the QIO-like vendor for additional services above the service limitations for all levels demonstrating medical necessity.

Neurotherapy is allowed up to three sessions without a prior authorization with identified covered diagnosis outlined in policy. After three sessions, a PA will be required and ~~Prior authorization~~ may be requested from the QIO-like vendor for additional ~~assessment and therapy~~ services above the service limitations for all levels demonstrating medical necessity.

- a. Service provision is based on the calendar year beginning on January 1.
- b. Sessions indicates billable codes for this service may include occurrence based codes, time-based or a combination of both. Session = each time this service occurs regardless of the duration of the service.

D. Non-Covered OMH Services

The following services are not covered under the OMH program for Nevada Medicaid and Nevada Check Up (NCU):

1. Services under this chapter for a recipient who does not have a covered, current ICD diagnosis;
2. Therapy for marital problems without a covered, current ICD diagnosis;
3. Therapy for parenting skills without a covered, current ICD diagnosis;
4. Therapy for gambling disorders without a covered, current ICD diagnosis;
5. Custodial services, including room and board;
6. Support group services other than Peer Support Services;
7. More than one provider seeing the recipient in the same therapy session;
8. Services not authorized by the QIO-like vendor if an authorization is required according to policy; and
9. Respite.