

MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

May 11, 2010

MEMORANDUM

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL
FROM: MARTA STAGLIANO, CHIEF, COMPLIANCE *M. Stagliano*
SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 400 – MENTAL HEALTH AND ALCOHOL/SUBSTANCE ABUSE
SERVICES

BACKGROUND AND EXPLANATIONS

The proposed revisions to Medicaid Services Manual (MSM) Chapter 400, section 403.8 Residential Treatment Facilities, are being made to reflect a more appropriate clinical use of Therapeutic Home Passes and to further facilitate discharge planning for the recipient. The revisions are pursuant to regulations set forth by the Centers for Medicare and Medicaid Services (CMS) in 42 CFR, 441.155 (5). Changes are effective May 12, 2010.

MATERIAL TRANSMITTED

MTL 20/10

CHAPTER 400 – MENTAL HEALTH
AND ALCOHOL/SUBSTANCE ABUSE
SERVICES

Sec. 403.8A.6

Added “are allowed”

Added “three”

Added “T, H, P”

Added “es”

Added “and”

Added “H, P”

Added “calendar year”

Added “The QIO-like vendor must be notified by the RTC of all therapeutic home

MATERIAL SUPERSEDED

MTL 43/05

CHAPTER 400 – MENTAL HEALTH
AND ALCOHOL/SUBSTANCE ABUSE
SERVICES

Deleted “Nevada Medicaid allows”

Deleted “25”

Deleted “t, h, p”

Deleted “days”

Deleted “.”

Deleted “h, p”

Deleted “one-year”

Deleted “P”

passes at least 14 days prior to the pass being issued to the recipient. The notification form can be located on the QIO-like vendor website. All p”

Sec. 403.8A.6.a

Added “a.”

Deleted “Nevada Medicaid”

Added “T, H, P”

Deleted “t, h, p”

Sec. 403.8A.6.a.1

Added “1”

Deleted “a”

Added “T, H, P”

Deleted “t, h, p”

Sec. 403.8A.6.a.2

Added “2”

Deleted “b”

Added “A Therapeutic Home Pass will only occur within 90 days of the recipient’s planned discharge and in coordination with their discharge plan. The recipient must have demonstrated a series of successful incremental day passes before the Therapeutic Home Pass occurs. The recipient must also be in the final phase of treatment in the RTC program.”

Sec. 403.8A.6.a.3

Added “three”

Sec. 403.8A.6.a.c

Deleted “c. Therapeutic Home Pass days which are unused cannot be accumulated from one calendar year to the next.”

Sec. 403.8A.6.a.4

Added “4”

Deleted “d”

Added “es”

Deleted “days”

Added “the QIO-like vendor”

Deleted “Nevada Medicaid”

Added “three passes”

Deleted “25 days”

Sec. 403.8A.6.a.5

Added “5”

Deleted “e”

Added “the recipient will be considered discharged and the QIO-like vendor must be notified of the discharge and date the

Deleted “and returns/is returned to the RTC within three (3) days, the RTC may issue a current pass to cover this period.”

recipient left the facility.”

The reason for the leave and the treatment intervention must be documented in the clinical case file. If a recipient leaves without a Therapeutic Home Pass and is away from the RTC five (5) days or greater, a formal discharge and prior authorization for readmission must occur.”

Sec. 403.8A.6.a.6

Added “6”

Deleted “f”

Sec. 403.8A.6.a.7

Added “7”

Deleted “g”

Added “Certificate of Need (“

Added “) signed by a physician,”

Sec. 403.8A.6.a.8

Added “8”

Deleted “h”

Added “three passes”

Deleted “25-day”

Deleted “Nevada Medicaid”

Sec. 403.8A.6.a.9

Added “9”

Deleted “i”

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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 Chapter 1000, are the same for Nevada Check Up. Chapter 400 specifically covers behavioral health services and for other Medicaid services coverage, limitations, and provider responsibilities, the specific Medicaid Services manual needs to be referenced.

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401 AUTHORITY

In 1965, the 89th Congress added Title XIX of the Social Security Act authorizing varying percentages of federal financial participation (FFP) for states that elected to offer medical programs. States must offer the 11 basic required medical services. Two of these are inpatient hospital services (42 CFR 440.10) and outpatient hospital services (42 CFR 440.20). All other mental health and substance abuse services provided in a setting other than an inpatient or outpatient hospital are covered by Medicaid as optional services. Additionally, state Medicaid programs are required to correct or ameliorate defects and physical and mental illnesses and conditions discovered as the result of an EPSDT screening for children 21 years or younger, whether or not such services are covered under the state plan (section 1905 (a)).

Other authorities include:

Section 1902 (a) (20) of the Social Security Act (State Provisions for Mental Institution Patients 65 and Older)

Section 1905 (a)(13) of the Social Security Act (Other Diagnostic Screening, Preventative, and Rehabilitative Services)

Section 1905 (h) of the Social Security Act (Inpatient Psychiatric Services to Individuals Under Age 21)

Section 1905 (i) of the Social Security Act (Definition of an Institution for Mental Diseases)

Section 1905 (r) (5) of the Social Security Act (Mental Health Services for Children as it relates to EPSDT)

42 Code of Federal Regulations (CFR) 435.1009 (Institution for Mental Diseases)

42 CFR 440.160 (Inpatient Psychiatric Services to Individuals Under Age 21)

42 CFR 441.150 to 441.156 (Inpatient Psychiatric Services for Individuals under age 21 in Psychiatric Facilities or Programs)

42 CFR, Part 482 (Conditions of Participation for Hospitals)

42 CFR, Part 483 (Requirements for States and Long Term Care Facilities)

42 CFR, PART 435 (Eligibility In the States, District of Columbia, the Northern Mariana Islands, and American Samoa), 440.130 (Definitions relating to institutional status)

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42 CFR, PART 440 (Services: General Provisions), 440.130 (Diagnostic, screening, preventive, and rehabilitative services)

CMS 2261-P, Centers for Medicare and Medicaid Services (Medicaid Program; Coverage for Rehabilitative Services)

Nevada Revised Statute (NRS), Chapter 629 (Healing Arts Generally)

NRS 432.B (Protection of Children from Abuse and Neglect)

NRS, Chapter 630 (Physicians, Physician Assistants and Practitioners of Respiratory Care)

NRS Chapter 632 (Nursing)

NRS 433.B.010 to 433.B.350 (Mental Health of Children)

NRS 433.A.010 to 433.A.750 (Mental Health of Adults)

NRS 449 (Medical and other Related Facilities)

NRS 641 (Psychologists)

NRS 641.A (Marriage and Family Therapists and Clinical Professional Counselors)

NRS 641B (Social Workers)

Nevada State Plan, section 4-19.A, page 4.

Nevada Medicaid Inpatient Psychiatric and Substance Abuse Policy, Procedures and Requirements. The Joint Commission on the Accreditation of Health Care Organizations (JCAHO) Restraint and seclusion Standards for Behavioral Health.

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402 DEFINITIONS

402.1 ADMINISTRATIVE DAYS

The primary purpose and function of administrative days is to assist hospitals which, through no fault of their own, cannot discharge a recipient who no longer requires acute level services due to lack of, or a delay in, an alternative appropriate setting. There is specific utilization review requirements listed under the “Administrative Days” policy in Section 403.14 of this chapter.

402.2 ADMISSION - INPATIENT

An inpatient is a recipient whose acuity is such that they require admission to a hospital for immediate stabilization based on a physician’s determination of the patient’s need. The physician responsible for the recipient’s care at the hospital is also responsible for providing substantiating documentation to the QIO-like vendor for the admission.

402.3 AMOUNT

The number and frequency of treatment sessions provided.

402.4 BEHAVIORAL HEALTH COMMUNITY NETWORK (BHCN)

A public or private provider organization, under contractual affiliation through the provider enrollment process, with the State of Nevada, Department of Health and Human Services (DHHS), Division of Health Care Financing and Policy (DHCFP) which operates under medical and clinical supervision and utilizes practices consistent with professionally recognized standards of good practice and are considered to be effective by the relevant scientific community. The BHCN provides outpatient mental health services and may provide rehabilitative mental health services for persons with mental, emotional, or behavioral disorders. A BHCN must adhere to all provider requirements under this chapter and any other applicable MSM chapters.

402.5 CARE COORDINATION

A formal process that ensures ongoing coordination of efforts on behalf of Medicaid-eligible recipients who meet the care criteria for a higher intensity of needs. Care coordination includes: facilitating communication and enrollment between the recipient and providers and providing for continuity of care by creating linkages to and monitoring transitions between intensities of services. Care coordination is a required component of case management services and is not a separate reimbursable service.

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402.6 CHILD AND FAMILY TEAM

A family-driven, child-centered, collaborative service team, focusing on the strengths and needs of the child and family. The team consists of the child recipient (as appropriate), parents, service professionals and may also consist of family members, care providers, and other individuals identified as being integral to the child’s environment or mental health rehabilitation.

402.7 CLINICAL SUPERVISION

Qualified Mental Health Professionals (QMHP), operating within the scope of their practice under state law, may function as Clinical Supervisors. Clinical Supervisors must have the specific education, experience, training, credentials, and licensure to coordinate and oversee an array of mental and behavioral health services. Clinical Supervisors must assure that the mental and/or behavioral health services provided are medically necessary and clinically appropriate. Clinical Supervisors assume professional responsibility for the mental and/or behavioral health services provided. Clinical Supervisors can supervise QMHPs, Qualified Mental Health Associates (QMHA), and Qualified Behavioral Aides (QBA). Clinical Supervisors may also function as Direct Supervisors. Individual Rehabilitative Mental Health (RMH) providers, who are QMHPs, may function as Clinical Supervisors over RMH services. However, Independent Mental Health Rehabilitative providers, who are QMHPs, may not function as Clinical Supervisors over Outpatient Mental Health assessments or therapies. Clinical Supervisors must assure the following:

- a. An up to date (within 30 days) case record is maintained on the recipient;
- b. A comprehensive mental and/or behavioral health assessment and diagnosis is accomplished prior to providing mental and/or behavioral health services (with the exception of Crisis Intervention services);
- c. A comprehensive and progressive Treatment Plan and/or Rehabilitation Plan is developed and approved by the Clinical Supervisor and/or a Direct Supervisor, who is a QMHP;
- d. Goals and objectives are time specific, measurable (observable), achievable, realistic, time-limited, outcome driven, individualized, progressive, and age and developmentally appropriate;
- e. The recipient and their family/legal guardian (in the case of legal minors) participate in all aspects of care planning, that the recipient and their family/legal guardian (in the case of legal minors) sign the Treatment and/or Rehabilitation Plan(s), and that the recipient and their family/legal guardian (in the case of legal minors) receive a copy of the Treatment and/or Rehabilitation Plan(s) ;

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- f. The recipient and their family/legal guardian (in the case of legal minors) acknowledge in writing that they understand their right to select a qualified provider of their choosing;
- g. Only qualified providers provide prescribed services within scope of their practice under state law; and
- h. Recipients receive mental and/or behavioral health services in a safe and efficient manner.

402.8 COMMUNITY MENTAL HEALTH CENTER (CMHC)

Government-affiliated agency, which is defined by NRS 433.144 and operates under the guidelines of the State of Nevada, Department of Health and Human Services (DHHS). For purposes of Nevada Medicaid's provider qualifications, a CMHC is recognized as a Behavioral Health Community Network (BHCN).

402.9 CULTURAL COMPETENCE

An approach to the delivery of mental health services grounded in the assumption that services are more effective provided within the most relevant and meaningful cultural, gender-sensitive, and age-appropriate context for the people being served. The Surgeon General defines cultural competence in the most general terms as "the delivery of services responsive to the cultural concerns of racial and ethnic minority groups, including their languages, histories, traditions, beliefs, and values." In most cases, the term cultural competence refers to sets of guiding principles, developed to increase the ability of mental health providers, agencies, or systems to meet the needs of diverse communities, including racial and ethnic minorities.

402.10 DIAGNOSTIC CLASSIFICATION: 0-3 (DC:0-3)

The determination of a mental or emotional disorder for a child/birth through 48 months of age as described in the latest text version of the Manual for Diagnostic Classification: 0-3 published by the National Center for Clinical Infant Programs. The principal Axis I diagnosis or the Axis II PIR-GAS score of 40 or less provides the clinical basis for treatment and must be reassessed every 6 months for children under age 4. The DC:0-3 diagnosis may be used in place of the DSM Axis I Diagnosis to determine eligibility for and provide mental health services to recipients under 4 years of age.

402.11 DIRECT SUPERVISION

Qualified Mental Health Professionals (QMHP) or Qualified Mental Health Associates (QMHA) may function as Direct Supervisors. Direct Supervisors must have the practice specific education, experience, training, credentials, and/or licensure to coordinate an array of mental and/or behavioral health services. Direct Supervisors assure servicing providers provide services

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in compliance with the established treatment/rehabilitation plan(s). Direct Supervision is limited to the delivery of services and does not include Treatment and/or Rehabilitation Plan(s) modification and/or approval. If qualified, Direct Supervisors may also function as Clinical Supervisors. Direct Supervisors must document the following activities:

- a. Their face-to-face and/or telephonic meetings with Clinical Supervisors.
 1. These meetings must occur before treatment begins and periodically thereafter;
 2. The documentation regarding this supervision must reflect the content of the training and/or clinical guidance; and
 3. This supervision may occur in a group and/or individual settings.
- b. Their face-to-face and/or telephonic meetings with the servicing provider(s).
 1. These meetings must occur before treatment/rehabilitation begins and, at a minimum, every 30 days thereafter;
 2. The documentation regarding this supervision must reflect the content of the training and/or clinical guidance; and
 3. This supervision may occur in group and/or individual settings;
- c. Assist the Clinical Supervisor with Treatment and/or Rehabilitation Plan(s) reviews and evaluations.

402.12 DISCHARGE CRITERIA

The diagnostic, behavioral, and functional indicators that must be met to complete service provision as documented in the Treatment Plan and/or Rehabilitative Plan. Discharge criteria are developed as part of the discharge planning process, which begins on the date of admission to services.

402.13 DISCHARGE PLAN

A written component of the Treatment Plan and/or Rehabilitation Plan which ensures continuity of care and access to needed support services upon completion of the Treatment Plan and/or Rehabilitation Plan goals and objectives. A Discharge Plan must identify:

1. The anticipated duration of the overall services;
2. Discharge criteria;

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3. Required aftercare services;
4. The identified agency(ies) or Independent Provider(s) to provide the aftercare services; and
5. A plan for assisting the recipient in accessing these services.

402.14 DISCHARGE SUMMARY

Written documentation of the last service contact with the recipient, the diagnosis at admission and termination, and a summary statement that describes the effectiveness of the treatment modalities and progress, or lack of progress, toward treatment goals and objectives, as documented in the mental health Treatment and/or Rehabilitation Plan(s). The Discharge Summary also includes the reason for discharge, current level of functioning, and recommendations for further treatment. Discharge summaries are completed no later than 30 calendar days following a planned discharge and 45 calendar days following an unplanned discharge. In the case of a recipient's transfer to another program, a verbal summary must be given at the time of transition and followed with a written summary within seven (7) calendar days of the transfer. The Discharge Summary is a summation of the results of the Treatment Plan, Rehabilitation Plan, and the Discharge Plan.

402.15 DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (DSM)

The latest text revision of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.

402.16 DSM DIAGNOSIS

The determination of a recipient's mental or emotional disorder as described in the Diagnostic and Statistical Manual of Mental Disorders (DSM), published by the American Psychiatric Association. The principal Axis I diagnosis provides the clinical basis for treatment and must be reassessed annually for recipients under age 18. It is determined through the mental health assessment and any examinations, tests, procedures, or consultations suggested by the assessment, and is entered on a written individualized Treatment Plan. A DSM "V" code condition except 995.54 (Physical Abuse of Child-Victim), 995.53 (Sexual Abuse of Child – Victim) and 995.54 (Neglect of Child – Victim), substance use disorder or mental retardation may not be considered the principal diagnosis, although these conditions or disorders may co-occur with the diagnosable mental disorder.

402.17 DURATION

The length of time to provide a service and the anticipated or actual time of treatment.

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402.18 FAMILY

An individual who is a legally responsible adult for a child. Family for both children and adults may also include siblings and/or other individuals identified by the recipient or legal guardian as integral in their home/community environment or mental health stabilization.

402.19 FAMILY INVOLVEMENT

The family's active input, guidance and participation in treatment planning, implementation, monitoring, and follow up. Family involvement must be documented on the Treatment Plan anytime there is a legally responsible adult for a child and when a recipient identifies a family member as being integral to their mental health stabilization. Required family involvement in treatment planning must be documented on the Treatment Plan when the plan is reviewed every 90 days and at anytime the plan is revised. If is deemed clinically appropriate, family involvement may occur for adult recipients.

402.20 GOALS

Goals are components of Treatment and/or Rehabilitation Plans. Goals are outcome driven. Goals are created during the treatment/rehabilitation planning process and must include the involvement and agreement of the recipient and their family/legal guardian (in the case of legal minors). Treatment/rehabilitation goals are written statements that specify anticipated treatment/rehabilitation outcomes and provide indicators of treatment/rehabilitation success. Goals must be specific, measurable (observable), achievable, realistic, and time-limited. Goals must clearly address specific behaviors and/or problems and they must evolve in conjunction with the recipient's functional progress.

402.21 HOME ENVIRONMENT

The residence of the recipient whether it is the natural environment or a substitute setting.

402.22 INSTITUTION FOR MENTAL DISEASES (IMD)

A hospital, nursing facility or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services. Whether an institution is an IMD is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, regardless of its licensure status (42 CFR 432.1009). In Nevada, IMDs are commonly referred to as "psychiatric hospitals." Nevada Medicaid only reimburses for services to IMD/psychiatric hospital patients who are age 65 or older, or under age 21.

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402.23 INTENSITY OF NEEDS DETERMINATION

1. The assessed level of needs and the amount, scope and duration of rehabilitative mental health 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 Qualified Mental Health Professional (QMHP) or Qualified Mental Health Associate (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:
 - a. A comprehensive assessment of the recipient's level of functioning;
 - b. The clinical judgment of the Qualified Mental Health Professional; and
 - c. A proposed Treatment and/or Rehabilitation Plan.

402.24 INTENSITY OF NEEDS GRID

1. The intensity of needs grid is an approved level of care 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.
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 V-code Diagnosis that does not meet SED criteria (excluding "V" codes, dementia, mental retardation, 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"> • DSM Axis I Diagnosis that does not meet SED criteria (excluding "V" codes, dementia, mental retardation, or a primary diagnosis of a substance abuse disorder, unless these conditions co-occur with a mental illness); or • DC:0-3 Axis I Diagnosis or DC:0-3 Axis II PIR-GAS score

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	of 40 or less.
Level III Intensive Outpatient Services	<ul style="list-style-type: none"> • DSM Axis I diagnosis (excluding “V” codes, dementia, mental retardation, or a primary diagnosis of a substance abuse disorder, unless these conditions co-occur with a mental illness); or • DC:0-3 Axis I Diagnosis or DC:0-3 Axis II PIRGAS score of 40 or less; and • SED Determination
Levels IV Intensive Integrated Services	<ul style="list-style-type: none"> • DSM Axis I diagnosis (excluding “V” codes, dementia, mental retardation, or a primary diagnosis of a substance abuse disorder, unless these conditions co-occur with a mental illness); or • DC:0-3 Axis I Diagnosis or DC:0-3 Axis II PIRGAS score of 40 or less; and • SED Determination
Level V Non-secure, 24 hour Services with Psychiatric Monitoring	<ul style="list-style-type: none"> • DSM Axis I Diagnosis (excluding “V” codes, dementia, mental retardation, or a primary diagnosis of a substance abuse disorder, unless these conditions co-occur with a mental illness); or • DC:0-3 Axis I Diagnosis or DC:0-3 Axis II PIRGAS score of 40 or less; 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"> • DSM Axis I Diagnosis (excluding “V” codes, dementia, mental retardation, or a primary diagnosis of a substance abuse disorder, unless these conditions co-occur with a mental illness); or • DC:0-3 Axis I Diagnosis or DC:0-3 Axis II PIR - GAS score of 40 or less; and • SED determination; and • Requires inpatient/secured level of care.

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"> • DSM Axis I diagnoses, including “V” codes, that do not meet SMI criteria (excluding “V” codes, dementia, mental retardation, 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"> • DSM Axis I diagnoses, including “V” codes that do not meet SMI criteria (excluding “V” codes, dementia, mental retardation, or a primary diagnosis of a substance abuse disorder, unless these conditions co-occur with a mental

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	illness).
Level III High Intensity Community Based Services (HCBS)	<ul style="list-style-type: none"> • DSM Axis I diagnosis (excluding “V” codes, dementia, mental retardation, 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"> • DSM Axis I diagnosis (excluding “V” codes, dementia, mental retardation, 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"> • DSM Axis I diagnosis (excluding “V” codes, dementia, mental retardation, 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"> • DSM Axis I diagnosis (excluding “V” codes, dementia, mental retardation, 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 level of care.

402.25 LEAST RESTRICTIVE SETTING

The least confining, most normative environment possible, which is individualized to the recipient and does not subject the individual to unnecessary health or safety risks. Services are delivered with the least amount of intrusion, disruption, or departure from the individual’s typical patterns of living that most support the person’s level of independence, productivity, and inclusion in the community.

402.26 MEDICAL SUPERVISION

The documented oversight which determines the medical appropriateness of the mental health program and services covered in this chapter. Medical supervision must be documented at least annually and at all times when determined medically appropriate based on review of circumstance. Medical supervision includes the on-going evaluation and monitoring of the quality and effectiveness of the services provided and may be provided through on and offsite means of communication. Medical supervision may be secured through a current written agreement, job description, or similar type of binding document. Behavioral Health Community Networks and all inpatient mental health services are required to have medical supervision.

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402.27 MEDICAL SUPERVISOR

A licensed physician with at least two years experience in a mental health treatment setting who, as documented by the Behavioral Health Community Network (BHCN), has the competency to oversee and evaluate a comprehensive mental and/or behavioral health treatment program including rehabilitation services and medication management to individuals who are determined as Severely Emotionally Disturbed (SED) or Severely Mentally Ill (SMI).

402.28 OBJECTIVES

Objectives are benchmarks to measure progress towards treatment and/or rehabilitation goals. Objectives specify the steps that must be taken/achieved in order to reach treatment and/or rehabilitation goals. Objectives must be specific, measurable (observable), achievable, realistic, and time-limited. Objectives must clearly address specific behaviors and/or problems and they must evolve in conjunction with the recipient's functional progress.

402.29 PERSON-CENTERED TREATMENT PLANNING

Joint planning with a recipient and their family (when appropriate) of treatment services and interventions for the amelioration of symptoms of mental health needs which prohibit effective functioning. Recipient and family involvement in treatment planning must be documented on the Treatment Plan and/or Rehabilitation Plan, when the plan is reviewed every 90 days and at anytime the plan is revised.

402.30 PROGRESS

The movement toward treatment goals utilizing established criteria as written in the Treatment Plan.

402.31 PROGRESS NOTE

The written documentation of the treatment, services or services coordination provided which reflects the progress, or lack of progress towards the goals and objectives of the Treatment and/or Rehabilitation Plan(s). All progress notes reflecting a billable Medicaid mental health service must be sufficient to support the services provided and must document the amount, scope, duration and provider of the service. Progress notes must be completed at least monthly and at anytime there is a substantial change in the recipient's clinical status.

402.32 PSYCHOLOGICAL TESTING

The administration, evaluation and scoring of standardized tests which may include the evaluation of intellectual functioning, mental health strengths and needs, diagnosis(ses),

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psychodynamics, mental health risks, insight, motivation, and other factors influencing treatment and outcomes.

402.33 QUALITY ASSURANCE (QA)

A structured, internal monitoring and evaluation process designed to improve quality of care. Quality assurance involves the identification of quality of care criteria, which establishes the indicators for program measurements and needed improvements.

402.34 REHABILITATION PLAN

1. A comprehensive, progressive, and individualized written Rehabilitative Plan must include all the prescribed Rehabilitation Mental Health (RMH) services. RMH services include Basic Skills Training (BST), Program for Assertive Community Treatment (PACT), Day Treatment, Peer-to-Peer Support, Psychosocial Rehabilitation (PSR), and Crisis Intervention (CI). The plan must include the appropriate treatment coordination to achieve the maximum reduction of the mental and/or behavioral health disability and to restore the recipient to their best possible functional level. The plan must ensure the transparency of coverage and medical necessity determinations, so that the recipient, their family (in the case of legal minors), or other responsible individuals would have a clear understanding of the services that are made available to the recipient. In all situations, the ultimate goal is to reduce the duration and intensity of medical care to the least intrusive level possible - while sustaining overall health. All prescribed services must be medically necessary, clinically appropriate, and contribute to the rehabilitation goals and objectives.
2. The Rehabilitation Plan must include recovery goals. The plan must establish a basis for evaluating the effectiveness of the RMH care offered in meeting the stated goals and objectives. The plan must provide for a process to involve the beneficiary, and family (in the case of legal minors) or other responsible individuals, in the overall management of the RMH care. The plan must document that the services have been determined to be rehabilitative services consistent with the regulatory definition, and will have a timeline, based on the individual's assessed needs and anticipated progress.
3. The reevaluation of the plan must involve the recipient, the recipient's family (in the case of legal minors), or other responsible individuals. The reevaluation of the plan must include a review of whether the established goals and objectives are being met and whether each of the services prescribed in the plan has contributed to meeting the stated established goals and objectives. If it is determined that there has been no measurable reduction of disability and/or function level restoration, any new plan would need to pursue a different rehabilitation strategy including revision of the rehabilitative goals, objectives, services, and/or methods. The plan must identify the rehabilitation goals and

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objectives that would be achieved under the plan in terms of measurable reductions in a diagnosed physical or mental disability and in terms of restored functional abilities.

4. Rehabilitation goals and objectives are often contingent on the individual's maintenance of a current level of functioning. In these instances, services that provide assistance in maintaining functioning may be considered rehabilitative only when necessary to help an individual achieve a rehabilitation goal and objectives as defined in the rehabilitation plan. The plan must be reasonable and based on the individual's diagnosed condition(s) and on the standards of practice for provisions of rehabilitative mental and/or behavioral health services to an individual with the individual's condition(s). The written rehabilitation plan must ensure that services are provided within the scope (therapeutic intent) of the rehabilitative services and would increase the likelihood that an individual's disability would be reduced and functional level restored. Rehabilitation plans are living documents and therefore must evolve in concert (show progressive transformations in the amount, duration, and scope of services provided) with the recipient's functional progress. The rehabilitation plan must also demonstrate that the services requested are not duplicative (redundant) of each other. The written rehabilitation plan must:
 - a. Be based on a comprehensive assessment of an individual's rehabilitation needs including DSM or DC:0-3 diagnoses and presence of a functional impairment in daily living;
 - b. Ensure the active participation of the individual, individual's family (in the case of legal minors), the individual's authorized health care decision maker and/or persons of the individual's choosing in the development, review and modification of these goals and services;
 - c. Be approved by a Qualified Mental Health Professional (QMHP), working within the scope of their practice under state law;
 - d. Be signed by the individual responsible for developing the plan;
 - e. Specify the individual's rehabilitation goals and objectives to be achieved, including recovery goals for persons with mental health related disorders;
 - f. Identify the RMH services intended to reduce the identified physical impairment, mental and/or behavioral health related disorder;
 - g. Identify the methods that would be used to deliver services;
 - h. Indicate the frequency, amount and duration of the services;

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- i. Indicate the anticipated provider(s) of the service(s) and the extent to which the services may be available from alternate provider(s) of the same service;
 - j. Specify a timeline for reevaluation of the plan, based on the individual's assessed needs and anticipated progress, but not longer than every 90 days or more frequently if needs change;
 - k. Document that the individual, the individual's family (in the case of legal minors), or representative participated in the development of the plan, signed the plan, and received a copy of the rehabilitation plan; and
 - l. Document that the services have been determined to be rehabilitative services consistent with the regulatory definition.
5. Temporary, but clinically necessary, services do not require an alteration to Rehabilitation Plans; however, temporary services must be identified in progress notes. These progress notes must indicate the medical necessity, amount, scope, duration, and provider(s) of the service(s).
6. At a minimum, Rehabilitation Plans must include all of the following headings:
- a. Recipient's Full Name:
 - b. Recipient's 11-Digit Medicaid Billing Number:
 - c. Intensity of Needs Determination: See INTENSITY OF NEEDS DETERMINATION definition.
 - d. SED/SMI Determination: See SEVERE EMOTIONAL DISTURBANCE (SED) and SERIOUS MENTAL ILLNESS (SMI) definitions.
 - e. Measurable Goals and Objectives: See GOALS and OBJECTIVES definitions.
 - f. Prescribed Services:
 1. Identify the specific mental health service or services (i.e., family therapy, individual therapy, basic skills training, day treatment, etc.) to be provided;
 2. Identify the daily amount, service duration, and therapeutic scope for each service to be provided; and

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3. Identify the provider or providers that are anticipated to provide each service.
 - g. Rehabilitation Plan Evaluation and Recipient Progress: A QMHP must evaluate the Rehabilitation Plan at a minimum, every 90-days or more often when rehabilitation needs change. Rehabilitation Plan reviews must demonstrate the recipient's progress towards functional improvements towards established goals and objectives.
 - h. Discharge Criteria and Plan: Rehabilitation Plans must include discharge criteria and plans. See DISCHARGE CRITERIA and DISCHARGE PLAN definitions. And,
 - i. Required Signatures:
 1. Clinical Supervisor,
 2. Recipient and their family/legal guardian (in the case of legal minors),
 3. The individual responsible for developing the plan.

402.35 SCOPE

The extent or range of the mental health therapy, intervention, or services provided to a recipient and identified in the Treatment Plan.

402.36 SEVERE EMOTIONAL DISTURBANCE (SED)

1. Persons from birth through 48 months who currently or at anytime during the past year (continuous 12-month period) have a:
 - a. DC:0-3 Axis I diagnostic category in place of a DSM Axis I diagnostic category; or
 - b. DC:0-3 Axis II PIR-GAS score of 40 or less (the label for a PIR-GAS score of 40 is "Disturbed"); or
2. Persons from 4 to age 18 who currently or at anytime during the past year (continuous 12-month period) have a:
 - a. Diagnosable mental or behavioral disorder or diagnostic criteria that meets the coding and definition criteria specified in the DSM (excluding substance abuse or addictive disorders, irreversible dementias, mental retardation, developmental

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disorders, and V codes, unless they co-occur with a serious mental disorder that meets DSM criteria); and have a:

- b. Functional impairment which substantially interferes with or limits the child from achieving or maintaining one or more developmentally appropriate social, behavioral, cognitive, communicative or adaptive skill. Functional impairments of episodic, recurrent, and persistent features are included, however may vary in term of severity and disabling effects unless they are temporary and an expected response to stressful events in the environment. Children who would have met functional impairment criteria during the referenced year without the benefit of treatment or other support services are included in this definition.
3. SED determinations are made by a Qualified Mental Health Professional (QMHP) within the scope of their practice under state law and expertise.

402.37 SERIOUS MENTAL ILLNESS (SMI)

Persons who are 18 years of age and older who currently or at any time during the past year (continuous 12 month period):

1. Have had a diagnosable mental, behavioral or emotional disorder that meets the coding and definition criteria specified in the DSM (excluding substance abuse or addictive disorders, irreversible dementias as well as mental retardation, unless they co-occur with a serious mental illness that meets DSM criteria); and
2. Have a functional impairment which substantially interferes with or limits one or more major life activity such as psychological, social, occupational or educational and may include limiting an adult from achieving or maintaining housing, employment, education, relationships or safety.
3. SMI determinations are made by a Qualified Mental Health Professional (QMHP) within the scope of their practice under state law and expertise.

402.38 TREATMENT

A planned, medically appropriate, individualized program of interactive medical, psychological, rehabilitative procedures, therapeutic interventions and/or services designed to rehabilitate, relieve or minimize mental, emotional or behavioral disorders.

402.39 TREATMENT PLAN

A written individualized plan that is developed jointly with the recipient, their family (in the case of legal minors) and/or their legal representative and a Qualified Mental Health

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Professional within the scope of their practice under state law. When Rehabilitative Mental Health (RMH) services are prescribed, the provider must develop a Rehabilitation Plan (see definition). The Treatment Plan is based on a comprehensive assessment and includes:

1. The strengths and needs of the recipients and their families (in the case of legal minors and when appropriate for an adult);
2. Intensity of Needs Determination;
3. Specific, measurable (observable), achievable, realistic, and time-limited goals and objectives;
4. Specific treatment, services and/or interventions including amount, scope, duration and anticipated provider(s) of the services;
5. Discharge criteria specific to each goal; and for
6. High-risk recipients accessing services from multiple government-affiliated and/or private agencies, evidence of care coordination by those involved with the recipient's care.

The recipient, or their legal representative, must be fully involved in the treatment planning process, choice of providers, and indicate an understanding of the need for services and the elements of the Treatment Plan. Recipient's, family's (when appropriate) and/or legal representative's participation in treatment planning must be documented on the Treatment Plan.

Temporary, but clinically necessary, services do not require an alteration of the Treatment Plan, however, must be identified in a progress note. The note must indicate the necessity, amount, scope, duration and provider of the service.

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403 POLICY

403.1 SERVICE DELIVERY MODELS

Nevada Medicaid reimburses for outpatient mental health and/or mental health rehabilitative services under the following service delivery models:

1. Behavioral Health Community Networks (BHCN)

Public or private entities that provides or contracts with an entity that provides:

- a. Outpatient services, such as assessments, therapy, testing, and medication management, including specialized services for Nevada Medicaid recipients who are experiencing symptoms relating to a DSM Axis I diagnosis or who are individuals with a mental illness, and residents of its mental health service area who have been discharged from inpatient treatment;
- b. 24-hour per day emergency response for recipients; and
- c. Screening for recipients under consideration for admission to inpatient facilities.

BHCNs are a service delivery model and are not dependent on the physical structure of a clinic. BHCNs can be reimbursed for all services covered in this chapter and may make payment directly to the qualified provider of each service. BHCNs must coordinate care with mental health rehabilitation providers.

2. Independent Professionals - State of Nevada licensed psychologists and psychiatrists. These providers are directly reimbursed for the professional services they deliver to Medicaid-eligible recipients in accordance with their scope of practice, state licensure requirements and expertise.
3. Individual Rehabilitative Mental Health providers (RMH) must meet the provider qualifications for the specific service. If they cannot independently provide Clinical and Direct Supervision, they must arrange for Clinical and Direct Supervision through a contractual agreement with a BHCN or qualified independent professional. These providers may directly bill Nevada Medicaid or may contract with a BHCN.

403.2 PROVIDER STANDARDS

1. All providers must:
 - a. Provide medically necessary services;

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- b. Adhere to the regulations prescribed in this chapter and all applicable Division chapters;
 - c. Provide only those services within the scope of their practice and expertise;
 - d. Ensure care coordination to recipients with higher intensity of needs;
 - e. Comply with recipient confidentiality laws and HIPAA;
 - f. Maintain required records and documentation;
 - g. Comply with requests from the QIO-like vendor;
 - h. Ensure client's rights; and
 - i. Cooperate with DHCFP's review process.
2. Behavioral Health Community Network providers must also:
- a. Have written policies and procedures to ensure the medical appropriateness of the services provided;
 - b. Operate under medical supervision and ensure medical supervisors operate within the scope of their license and expertise and have written policies and procedures to document the prescribed process;
 - c. Ensure access to psychiatric services, when medically appropriate, through a current written agreement, job description, or similar type of binding document;
 - d. Utilize clinical supervision as prescribed in this chapter and have written policies and procedures to document the process to ensure clinical supervision is performed on a regular, routine basis at least monthly, and the effectiveness of the mental health treatment program is evaluated at least annually;
 - e. Work on behalf of recipient's in their care to ensure effective care coordination within the state system of care among other community mental health providers and other agencies servicing a joint recipient;
 - f. Have a developed, implemented and maintained quality assurance program, which includes:

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1. An organization chart showing lines of authority, including medical, clinical and direct supervision and responsibility for services;
2. Documentation of staff qualifications, licensures, and documented competencies;
3. Written position descriptions for all staff providing mental health services;
4. Documentation of staff training;
5. Philosophy and support for use of selected program clinical practices;
6. Accounting methods that reflect Medicaid billing standards;
7. A written quality assurance (QA) plan containing:
 - a. Identified aspects of quality of care which supports person and family-centered practice;
 - b. Indicators and clinical criteria to continually and systematically monitor these aspects of quality care;
 - c. Established markers, which indicate problems or opportunities to improve care;
 - d. Identified action to correct problems and improve substandard care;
 - e. Tools to assess the effectiveness of the actions taken; and
 - f. A process to submit an annual QA report to DHCFP/DHHS.

A BHCN that is JCAHO, CARF, or COA accredited may substitute a copy of the documented quality assurance processes and plan required for the certification in lieu of the requirements of 403.2(2)(f).

3. Recipient and Family Participation and Responsibilities
 - a. Recipients or their legal guardians and their families (when applicable) must:
 1. Participate in the development and implementation of their individualized Treatment Plan and/or Rehabilitation Plan;

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2. Keep all scheduled appointments; and
3. Inform their Medicaid providers of any changes to their Medicaid eligibility.

403.3 PROVIDER QUALIFICATIONS – OUTPATIENT MENTAL HEALTH SERVICES

1. Qualified Mental Health Associate (QMHA) - A person who meets the following documented minimum qualifications:
 - a. Licensure as a Registered Nurse (RN) in the State of Nevada or holds a Bachelor’s Degree from an accredited college or university in a human, social services, or behavioral field with additional understanding of rehabilitative mental health treatment services, and case file documentation requirements; or
 - b. Holds an Associates Degree from an accredited college or university in a human, social services or behavioral field with additional understanding of rehabilitative mental health treatment services, and case file documentation and has four years of relevant professional experience of providing direct services to individuals with mental health disorders; or
 - c. An equivalent combination of education and experience as listed in 403.1(a)(b) above; and
 - d. Whose education and experience demonstrate the competency under clinical supervision to:
 1. Direct and provide professional therapeutic interventions within the scope of their practice and limits of their expertise;
 2. Identify presenting problem(s);
 3. Participate in Treatment Plan development and implementation;
 4. Coordinate treatment;
 5. Provide parenting skills training;
 6. Facilitate Discharge Plans; and
 7. Effectively provide verbal and written communication on behalf of the recipient to all involved parties.

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- e. Has a FBI background check in accordance with the QBA provider qualifications listed under 403.6(3)(c).
2. Qualified Mental Health Professional (QMHP) - A Physician, Physician's Assistant or a person who meets the definition of a Qualified Mental Health Associate (QMHA) and also meets the following documented minimum qualifications:
- a. Holds any of the following educational degrees and licensure:
 - 1. Doctorate degree in psychology and license;
 - 2. Bachelor's degree in nursing and APN (psychiatry);
 - 3. Independent Nurse Practitioner; Graduate degree in social work and clinical license;
 - 4. Graduate degree in counseling and licensed as a marriage and family therapist or clinical professional counselor; OR
 - b. Who is employed and determined by a state mental health agency to meet established class specification qualifications of a Mental Health Counselor; and
 - c. Whose education and experience demonstrate the competency to: identify precipitating events, conduct a comprehensive mental health assessment, diagnosis a DSM and/or DC:0-3 Axis I mental or emotional disorder and document a multiaxial DSM diagnosis, determine intensity of services needs, establish measurable goals, objectives and discharge criteria, write and supervise a Treatment Plan, and provide direct therapeutic treatment within the scope and limits of their expertise.
 - d. Interns/Psychological Assistants

The following are also considered QMHPs:

- 1. 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 (NAC 641B).
- 2. 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

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of Nevada Board of Examiners for Marriage and Family Therapists and Clinical Professional Counselors.

3. 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.

Reimbursement for Interns/ Psychological Assistants is based upon the rate of a QMHP, which includes the clinical and direct supervision of services by a licensed supervisor.

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.

1. Assessments are covered for problem identification (diagnosis) and to establish measurable treatment goals and objectives by a Qualified Mental Health Professional or designated Qualified Mental Health Associate in the case of a Mental Health Screen.
 - a. Mental Health Screen – A behavioral health screen to determine eligibility for admission to treatment program.
 - b. Comprehensive Assessment – A comprehensive, evaluation of a recipient’s history and functioning which, combined with clinical judgment, is to conclude with a DSM 5-axial diagnosis or DC:0-3 and a summary of identified rehabilitative treatment needs.
 - c. 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.

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- d. 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 DSM 5-axial diagnosis and treatment recommendations.
- e. 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 DSM 5-axial diagnosis and treatment recommendations.
- f. 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 Qualified Mental Health Professional (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 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.

- g. 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 Qualified Mental Health Professional (QMHP) and/or trained Qualified Mental Health Associate (QMHA). This

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assessment was previously known as a level of care assessment. Currently, 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 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.

- h. 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.
 - i. 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.
 - j. Global Assessment of Functioning (GAF) Scale: GAF ratings are based on clinical judgment; GAF ratings measure overall psychological functioning and psychiatric disturbances; and are used to collaborate Intensity of Needs Determinations. The GAF scale is located in DSM-IV.
2. Neuro-Cognitive, Psychological and Mental Status Testing
- a. 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.
 - b. 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.
 - c. Psychological Testing with interpretation and report is the administration, evaluation and scoring of standardized tests which may include the evaluation of intellectual functioning, clinical strengths and needs, psychodynamics, insight, motivation and other factors influencing treatment outcomes.

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3. 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:

a. Family Therapy

Mental health treatment service provided to a specific recipient by a Qualified Mental Health Professional 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.

b. Group Therapy

Mental Health treatment service facilitated by a Qualified Mental Health Professional 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 (3) and maximum therapist to participant ratio is one to ten (10). Group therapy may also include a family without the recipient present and/or multi-family groups.

c. 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.

d. Neurotherapy

1. 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

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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.

2. Prior authorization requirements and QIO-like vendor responsibilities are the same for all out-patient therapies, except for the following allowable service limitations for neurotherapy used for treatment of the following covered ICD-9-CM Codes:
 - a. Attention Deficit Disorders – 40 sessions
ICD-9-Codes 314, 314.0, 314.00, 314.1, 314.2, 314.8, and 314.9
 - b. Anxiety Disorders – 30 sessions
ICD-9-Codes 300, 300.0, and 300.4
 - c. Depressive Disorders – 25 sessions
ICD-9-Codes 296.2, 296.3, and 298.0
 - d. Bipolar Disorders - 50 sessions
ICD-9-Codes 296, 296.0, 296.1, 296.4, 296.5, 296.6, 296.7, 296.8, and 296.9
 - e. Obsessive Compulsive Disorders – 40 sessions
ICD-9-Codes 300.3
 - f. Opposition Defiant Disorders – 40 sessions
ICD-9-Codes 313, 313.81, and 313.89
 - g. Post Traumatic Stress Disorders – 35 sessions
ICD-9-Codes 309, 309.81
 - h. Reactive Attachment Disorders – 50 sessions
ICD-9-Codes 313, 313.81, and 313.89
 - i. Schizophrenia Disorders – 50 sessions
ICD-9-Codes 295, 295.0, 295.1, 295.2, 295.3, 295.4, 295.5, 295.6, 295.7, 295.8, and 295.9

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

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4. Mental Health Therapeutic Interventions

- a. 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.
- b. 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.
- c. 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 ICD9 range of 290.0-319, 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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- d. Medication Training and Support – Provided by a professional other than a physician, is covered for monitoring of compliance, side effects, recipient education and coordination of requests to a physician for changes in medication(s).

403.5 OUTPATIENT MENTAL HEALTH (OMH) SERVICES - UTILIZATION MANAGEMENT

1. Utilization Management for outpatient mental health services is provided by the DHCFP QIO-like vendor as follows:
 - a. For Behavioral Health Community Networks (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;
 - b. Independent psychologists are not subject to the service limitations in the Intensity of Needs Grid. The following service limitations are for psychologists:
 1. Assessments – two per calendar year, additional services require prior authorization from the QIO-like vendor; and
 2. Therapy (group, individual, family) – a combination of up to twenty-six visits per calendar year is allowed without prior authorization. Additional services require prior authorization from the QIO-like vendor.
 - c. Independent psychiatrists are not subject to the service limitations in the Intensity of Needs grid. No prior authorization is required for this particular provider.
 - d. 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 2 total sessions (does not include Mental Health Screen) • Individual, Group, or Family Therapy 10 total sessions; • Medication Management 6 total sessions
Level II Outpatient Services	<ul style="list-style-type: none"> • Assessments: 4 total sessions (does not include Mental Health Screen) • Individual, Group, or Family Therapy: 26 total sessions
Level III Intensive Outpatient Services	All Level Two Services Plus: <ul style="list-style-type: none"> • Intensive Outpatient Services (IOP)
Levels IV Intensive Integrated Services	All Level Three Services <ul style="list-style-type: none"> • Partial Hospitalization (PHP)
Level V	All Level Four Services

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Non-secure, 24 Hour Services with Psychiatric Monitoring	
Level VI Secure, 24 Hour, Services with Psychiatric Management	All level Five services

Prior Authorization may be requested from the QIO-like vendor for additional assessment and therapy services for Levels III and above only.

1. Service provision is based on the calendar year beginning on January 1.
2. 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.

e. 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: 2 total sessions (does not include Mental Health Screen) • Individual, Group or Family Therapy: 6 total sessions • Medication Management: 6 total sessions
Level II Low Intensity Community Based Services	<ul style="list-style-type: none"> • Assessment: (2 assessments; does not include Mental Health Screen) • Individual, Group, or Family Therapy: 12 total sessions • Medication Management: 8 total sessions
Level III High Intensity Community Based Services	<ul style="list-style-type: none"> • Assessment (2 assessments; does not include Mental Health Screen) • Individual, Group and Family therapy: 12 total sessions • Medication Management: 12 total sessions
Level IV Medically Monitored Non- Residential Services	<ul style="list-style-type: none"> • Assessment (2 assessments; does not include Mental Health Screen) • Individual, Group and Family Therapy: 16 total sessions • Medication Management (12 sessions) • Partial Hospitalization
Level V Medically Monitored Residential Services	<ul style="list-style-type: none"> • Assessment (2 assessments; does not include Mental Health Screen) • Individual, Group and Family therapy: 18 total sessions • Medication Management (12 sessions) • Partial Hospitalization
Level VI Medically Managed Residential Services	All Level Five Services

Prior Authorization may be requested from the QIO-like vendor for additional assessment and therapy services for Level III and above only.

1. Service provision is based on the calendar year beginning on January 1.

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2. 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.

2. Non-Covered OMH Services

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

- a. Services under this chapter for a recipient who does not have a DSM or DC:0-3 diagnosis;
- b. Therapy for marital problems without a DSM diagnosis;
- c. Therapy for parenting skills without a DSM diagnosis;
- d. Therapy for gambling disorders without a DSM diagnosis;
- e. Custodial services, including room and board;
- f. Support group services other than Peer Support Services;
- g. More than one provider seeing the recipient in the same therapy session;
- h. Services not authorized by the QIO-like vendor if an authorization is required according to policy; and
- i. Respite.

403.6 PROVIDER QUALIFICATIONS

403.6A REHABILITATION MENTAL HEALTH (RMH) SERVICES

RMH services may be provided by specific providers who meet the following qualifications for an authorized service:

1. Qualified Behavioral Aide (QBA) - Is a person who has an educational background of a high-school diploma or General Education Development (GED) equivalent and has been determined competent by the overseeing Clinical Supervisor, to provide Rehabilitative Mental Health (RMH) services. These services must be provided under direct contract with a Behavioral Health Community Network (BHCN) or Independent Rehabilitative Mental Health (RMH) provider. A QBA must have the documented competencies to

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assist in the provision of individual and group rehabilitative services under the Clinical Supervision of a QMHP and the Direct Supervision of a QMHP or QMHA.

- a. QBAs must also have experience and/or training in service provision to people diagnosed with mental and/or behavioral health disorders and the ability to:
 1. Read, write, and follow written and oral instructions;
 2. Perform RMH services as prescribed on the Rehabilitation Plan;
 3. Identify emergency situations and respond accordingly;
 4. Communicate effectively;
 5. Document services provided; and
 6. Maintain recipient confidentiality.
- b. Competency and In-services Training
 1. Before QBAs can enroll as Medicaid providers, they are required to successfully complete an initial 16-hour training program. This training must be interactive, not solely based on self-study guides or videotapes, and should ensure that a QBA will be able to interact appropriately with individuals with mental health disorders. At a minimum, this training must include the following core competencies:
 - a. Case file documentation;
 - b. Recipient's rights;
 - c. Client confidentiality pursuant to state and federal regulations;
 - d. Communication skills;
 - e. Problem solving and conflict resolution skills;
 - f. Communication techniques for individuals with communication or sensory impairments;
 - g. Cardio Pulmonary Resuscitation (CPR) certification (certification may be obtained outside the agency); and

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- h. Understanding the components of a Rehabilitation Plan.
2. QBAs must also receive, at a minimum, 2 hours of quarterly in-service training. At a minimum, this training must include any combination (or single competency) of the following competencies:
 - a. Basic living and self-care skills: The ability to help recipients learn how to manage their daily lives, recipients learn safe and appropriate behaviors;
 - b. Social skills: The ability to help recipients learn how to identify and comprehend the physical, emotional, and interpersonal needs of others - recipients learn how to interact with others;
 - c. Communication skills: The ability to help recipients learn how to communicate their physical, emotional, and interpersonal needs to others – recipients learn how to listen and identify the needs of others;
 - d. Parental training: The ability to facilitate parents’ abilities to continue the recipient’s (child’s) Rehabilitative Mental health (RMH) care in home and community based settings.
 - e. Organization and time management skills: The ability to help recipients learn how to manage and prioritize their daily activities; and/or
 - f. Transitional living skills: The ability to help recipients learn necessary skills to begin partial-independent and/or fully independent lives.
 3. For QBAs whom will also function as Peer-to-Peer Supporters, their quarterly in-service training must also include, at a minimum, any combination (or single competency) of the following competencies:
 - a. The ability to help stabilize the recipient;
 - b. The ability to help the recipient access community based mental and/or behavioral health services;
 - c. The ability to assist during crisis situations and interventions;
 - d. The ability to provide preventative care assistance; and/or

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- e. The ability to provide personal encouragement, self-advocacy, self-direction training, and peer mentoring.
- c. Applicants must have a Federal Bureau of Investigations (FBI) criminal background check before they can enroll with Nevada Medicaid as QBAs. Applicants may not provide QBA services until they have enrolled with Nevada Medicaid as QBAs. Applicants must submit the results of their criminal background checks to the overseeing BHCN and/or the Individual Rehabilitative Mental Health (RMH) provider (who must also be a Clinical Supervisor). The BHCN and/or the Individual RMH provider must maintain both the requests and the results with the applicant's personnel records. Upon request, the BHCN and/or the Individual RMH provider must make the criminal background request and results available to the Nevada Medicaid (DHCFP) for review.
- d. Individuals who have been convicted of any of the following felonies or misdemeanors under federal or state law within the last 7 years for which DHCFP has determined to be inconsistent with the best interests of recipients are excluded from eligibility for qualification as a provider of services covered in this chapter.

The applicant or contractor has been convicted of:

1. Murder, voluntary manslaughter or mayhem;
2. Assault with intent to kill or to commit sexual assault or mayhem;
3. Sexual assault, statutory sexual seduction, incest, lewdness, indecent exposure or any other sexually related crime;
4. Abuse or neglect of a child or contributory delinquency;
5. A violation of any federal or state law regulating the possession, distribution or use of any controlled substance or any dangerous drug as defined in chapter 454 of NRS;
6. A violation of any provision of NRS 200.700 through 200.760;
7. Criminal neglect of a patient as defined in NRS 200.495;
8. Any offense involving fraud, theft, embezzlement, burglary, robbery, fraudulent conversion or misappropriation of property;
9. Any felony involving the use of a firearm or other deadly weapon;

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10. Abuse, neglect, exploitation or isolation of older persons;
11. Kidnapping, false imprisonment or involuntary servitude;
12. Any offense involving assault or battery, domestic or otherwise;
13. Conduct inimical to the public health, morals, welfare and safety of the people of the State of Nevada in the maintenance and operation of the premises for which a provider contract is issued;
14. Conduct or practice detrimental to the health or safety of the occupants or employees of the facility or agency; or,
15. Any other offense determined by DHCFP to be inconsistent with the best interests of all recipients.

The BHCN or Independent Rehabilitative Mental Health (RMH) provider upon receiving information resulting from the FBI criminal background check, or from any other source, may not continue to employ a person who has been convicted of an offense as listed above. If an applicant believes that the information provided as a result of the FBI criminal background check is incorrect, he or she must immediately inform the BHCN or Independent RMH provider, or DHCFP (respectively) in writing. The BHCN or Independent RMH provider or DHCFP, that is so informed within 5 days, may give the employee or independent contractor a reasonable amount of time, but not more than 60 days, to provide corrected information before denying an application, or terminating the employment or contract of the person pursuant to this section.

- e. Have had tuberculosis (TB) tests with negative results documented or medical clearance as outlined in NAC 441.A375 prior to the initiation of service delivery. Documentation of TB testing and results must be maintained in the BHCN or Independent RMH provider personnel record. TB testing must be completed 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.

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The BHCN or Independent RMH provider must document the comparability of the written verification to the QBA training requirements.

2. Qualified Mental Health Associate (QMHA), refer to 403.3.1
3. Qualified Mental Health Professional (QMHP), refer to 403.3.2

403.6B REHABILITATIVE MENTAL HEALTH SERVICES

1. **Scope of Service:** Rehabilitative Mental Health (RMH) services must be recommended by a Qualified Mental Health Provider (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.

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 DSM or DC:0-3 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:

- a. The recipient's name;
- b. Progress notes must reflect the date and time of day that RMS services were provided; the recipient's progress toward functional improvement and the attainment of established rehabilitation goals and objectives; the nature, content, and number of RMH service units provided; the name, credential(s), and signature of the person who provided the RMH service(s). Progress notes must be completed after each session and/or daily; progress notes are not required on days when RMH services are not provided; a single progress note may include any/all the RMH services provided during that day.

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- c. The recipients and their families/legal guardians (in the case of legal minors) acknowledgement of their freedom to select a qualified Medicaid provider of their choosing;
 - d. Indications that the recipients and their families/legal guardians (in the case of legal minors) were involved in all aspects care planning;
 - e. Indications that the recipients and their families/legal guardians (in the case of legal minors) are aware of the scope, goals, and objectives of the RMH services made available; and
 - f. The recipients and their families/legal guardians (in the case of legal minors) acknowledgement that RMH services are designed to reduce the duration and intensity of care to the least intrusive level of care possible while sustaining the recipient's overall health.
2. Inclusive Services: RMH services include Basic Skills Training (BST), Program for Assertive Community Treatment (PACT), Day Treatment, Peer-to-Peer Support, Psychosocial Rehabilitation (PSR), and Crisis Intervention (CI).
 3. Provider Qualifications:
 - a. Qualified Mental Health Professionals (QMHP): QMHPs may provide BST, PACT, Day Treatment, Peer-to-Peer Support, PSR and CI services.
 - b. Qualified Mental health Associates (QMHA): QMHAs may provide BST, PACT, Day Treatment, Peer-to-Peer Support, PSR services under the Clinical Supervision of a QMHP.
 - c. Qualified Behavioral Aides (QBA): QBAs may provide BST services under the Clinical Supervision of QMHP and the Direct Supervision of a QMHP/QMHA. QBAs may provide Peer-to-Peer Support services under the Clinical/Direct Supervision of a QMHP.
 4. Therapeutic Design: RMH services are adjunct (enhancing) interventions designed to compliment more intensive mental health therapies and interventions. While some rehabilitative models predominately utilize RMH services, these programs must demonstrate the comprehensiveness and clinical appropriateness of their programs prior to receiving prior authorization to provide RMH services. RMH services are time-limited services, designed to be provided over the briefest and most effective period possible. Service limitations are designed to help prevent rehabilitation diminishing return by remaining within reasonable age and developmentally appropriate daily limits. Also

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taken into consideration are other social, educational, and intensive mental health obligations and activities. RMH services are planned and coordinated services.

5. Non-Covered Services: RMH services do not include: (from CMS 2261-P)
- a. RMH services are not custodial care benefits for individuals with chronic conditions but should result in a change in status;
 - b. Custodial care and/or routine supervision: Age and developmentally appropriate custodial care and/or routine supervision including monitoring for safety, teaching or supervising hygiene skills, age appropriate social and self-care training, and/or other intrinsic parenting and/or care giver responsibilities;
 - c. Maintaining level of functioning: Services provided primarily to maintain a level of functioning in the absence of RMH goals and objectives, impromptu non-crisis interventions, and routine daily therapeutic milieus;
 - d. Case management: Conducting and/or providing assessments, care planning/coordination, referral and linkage, and monitoring and follow-up;
 - e. Habilitative services;
 - f. Services provided to individuals with a primary diagnosis of mental retardation or related conditions (Unless these conditions co-occur with a mental illness) and which are not focused on rehabilitative mental and/or behavioral health;
 - g. Cognitive/Intellectual functioning: Recipients with sub-average intellectual functioning who would distinctly not therapeutically benefit from RMH services;
 - h. Transportation: Transporting recipients to and from medical and other appointments/services;
 - i. Educational, vocational, or academic services: General and advanced private, public, and compulsory educational programs; personal education not related to the reduction of mental and/or behavioral health problem; and services intrinsically provided through the Individuals with Disabilities Education Improvement Act (IDEA);
 - j. Inmates of public institutions: To include detention facilities, forestry camps, training schools or any other facility operated primarily for the detention of children who are determined to be delinquent;

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- k. Room and board: Includes housing, food, non-medical transportation and other miscellaneous expenses, as defined below:
 - 1. Housing expenses include shelter (mortgage payments, rent, maintenance and repairs, and insurance), utilities (gas, electricity, fuel, telephone, and water), and housing furnishings and equipment (furniture, floor coverings, major appliances, and small appliances);
 - 2. Food expenses include food and nonalcoholic beverages purchased at grocery, convenience and specialty store;
 - 3. Transportation expenses include the net outlay on purchase of new and used vehicles, gasoline and motor oil, maintenance and repairs, and insurance;
 - 4. Miscellaneous expenses include clothing, personal care items, entertainment, and reading materials;
 - 5. Administrative costs associated with room and board;
- l. Non-medical programs: Intrinsic benefits and/or administrative elements of non-medical programs, such as foster care, therapeutic foster care, child welfare, education, child care, vocational and prevocational training, housing, parole and probation, and juvenile justice;
- m. Services under this chapter for a recipient who does not have a DSM or DC:0-3 diagnosis;
- n. Therapy for marital problems without a DSM diagnosis;
- o. Therapy for parenting skills without a DSM diagnosis;
- p. Therapy for gambling disorders without a DSM diagnosis;
- q. Support group services other than Peer Support services;
- r. More than one provider seeing the recipient in the same RMH intervention with the exception of Crisis Intervention (CI) services;
- s. Respite care;
- t. Recreational activities: Recreational activities not focused on rehabilitative outcomes;

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- u. Personal care: Personal care services intrinsic to other social services and not related to RMH goals and objectives; and/or
 - v. Services not authorized by the QIO-like vendor if an authorization is required according to policy.
6. Service Limitations: With the exception of Crisis Intervention (CI) services (CI service require post authorization), all RMH services require prior authorization by Medicaid's QIO-Like vendor. RMH services may be prior authorized up to 90-days.
- a. Intensity of Need Levels I & II: Recipients may receive Basic Skills Training (BST) and/or Peer-to-Peer services provided:
 - 1. DSM IV diagnosis (see DSM DIAGNOSIS definition), GAF score of 70 or less, and CASII/LOCUS Levels I or II; or
 - 2. DC:0-3 Axis I diagnosis or DC:0-3 Axis II Parent-Infant Relationship Global Assessment (PIR-GAS) score of 50 or less; and
 - 3. Clinical judgment; and
 - 4. The overall combination does not exceed a maximum of 2 hours per day; and
 - 5. The services provided in combination may not exceed the maximum individual daily limits established for each RMH service.
 - b. Intensity of Need Level III: Recipients may receive any combination of BST, PSR, Day Treatment, and/or Peer-to-Peer services provided:
 - 1. DSM IV diagnosis (see DSM DIAGNOSIS definition), GAF score of 60 or less, and CASII/LOCUS Level III; or
 - 2. DC:0-3 Axis I diagnosis or DC:0-3 Axis II PIR-GAS score of 40 or less; and
 - 3. Severe Emotional Disturbance (SED) or Serious Mental Illness (SMI) determination; and
 - 4. Clinical judgment; and
 - 5. The overall combination does not exceed a maximum of 4 hours per day; and

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6. The services provided in combination may not exceed the maximum individual daily limits established for each RMH service.
- c. Intensity of Need Level IV: Recipients may receive any combination of BST, PSR, Day Treatment, and/or Peer-to-Peer services provided:
1. DSM IV diagnosis (see DSM DIAGNOSIS definition), GAF Score of 50 or less, and CASII/LOCUS Level IV; or
 2. DC:0-3 Axis I diagnosis or DC:0-3 Axis II PIR-GAS score of 40 or less; and
 3. SED or SMI determination; and
 4. Clinical judgment; and
 5. The overall combination does not exceed a maximum of 6 hours per day; and
 6. The services provided in combination may not exceed the maximum individual daily limits established for each RMH service.
- d. Intensity of Need Levels V & VI: Recipients may receive any combination of BST, PSR, Day Treatment, and/or Peer-to-Peer services provided:
1. DSM IV diagnosis (see DSM DIAGNOSIS definition), GAF score of 40 or less, and CASII/LOCUS Levels V or VI; or
 2. DC:0-3 Axis I diagnosis or DC:0-3 Axis II PIR-GAS score of 30 or less; and
 3. SED or SMI determination; and
 4. Clinical judgment; and
 5. The overall combination does not exceed a maximum of 8 hours per day; and
 6. The services provided in combination may not exceed the maximum individual daily limits established for each RMH service.
- e. Additional RMH Service Authorizations: Recipients may receive any combination of additional medically necessary RMH services beyond established

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daily maximums. Additional RMH services must be prescribed on the recipient's Rehabilitation Plan and must be prior authorized by Medicaid's QIO-Like vendor. Additional RMH services authorizations may only be authorized for 30-day periods. These requests must include:

1. A lifetime history of the recipient's inpatient psychiatric admissions; and
 2. A 90-day history of the recipient's most recent outpatient psychiatric services; and
 3. Progress notes for RMH services provided over the most current two-week period.
7. Continuing Service Criteria: In order to receive prior authorization for continued RMH services (with the exception of Crisis Intervention), all of the following must be demonstrated in the Rehabilitation Plan and progress notes.
- a. The recipient will reasonably benefit from the RMH service or services requested;
 - b. The recipient continues to meet the specific RMH service admission criteria;
 - c. The recipient possesses the ability to achieve established treatment goals and objectives;
 - d. The recipient and/or their family/legal guardian (in the case of legal minors) desire to continue the service;
 - e. The recipient's condition and/or level of impairment does not require a more intensive level of service;
 - f. The recipient does not require a level of structure, intensity, and/or supervision beyond the scope of the RMH service or services requested; and
 - g. The retention of the RMH service or services will reasonably help prevent the discomposure of the recipient's mental and/or behavioral health and overall wellbeing.
8. Exclusion and Discharge Criteria: Prior authorization will not be given for RMH services if any of the following apply:
- a. The recipient will not reasonably benefit from the RMH service or services requested;

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- b. The recipient does not continue to meet the specific RMH service admission criteria;
- c. The recipient does not possess the ability to achieve established rehabilitation goals and objectives;
- d. The recipient demonstrates changes in condition, which warrants a more or less intensive level of services;
- e. The recipient and/or their family/legal guardian (in the case of legal minors) do not desire to continue the service;
- f. The recipient presents a clear and imminent threat of serious harm to self and/or others (recipient presents the intent, capability, and opportunity to harm themselves and others);
- g. The recipient's condition and/or level of impairment requires a more intensive level of service; and
- h. The retention of the RMH service or services will not reasonably help prevent the discomposure of the recipient's mental and/or behavioral health and overall wellbeing.

403.6C BASIC SKILLS TRAINING (BST) SERVICES

- 1. Scope of Service: Basic Skills Training (BST) services are Rehabilitative Mental Health (RMH) interventions designed to reduce cognitive and behavioral impairments and restore recipients to their highest level of functioning. BST services are provided to recipients with age and developmentally inappropriate cognitive and behavioral skills. BST services help recipients acquire (learn) constructive cognitive and behavioral skills through positive reinforcement, modeling, operant conditioning, and other training techniques. BST services teach recipients a variety of life skills. BST services may include the following interventions:
 - a. Basic living and self-care skills: Recipients learn how to manage their daily lives, recipients learn safe and appropriate behaviors;
 - b. Social skills: Recipients learn how to identify and comprehend the physical, emotional, and interpersonal needs of others—recipients learn how to interact with others;

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- c. Communication skills: Recipients learn how to communicate their physical, emotional, and interpersonal needs to others—recipients learn how to listen and identify the needs of others;
- d. Parental training: Parental training teaches the recipient’s parent(s) and/or legal guardian(s) BST techniques. The objective is to help parents continue the recipient’s RMH care in home and community based settings. Parental training must target the restoration of recipient’s cognitive and behavioral mental health impairment needs. Parental training must be recipient centered;
- e. Organization and time management skills: Recipients learn how to manage and prioritize their daily activities; and/or
- f. Transitional living skills: Recipients learn necessary skills to begin partial-independent and/or fully independent lives.

2. Provider Qualifications:

- a. Qualified Mental Health Professionals (QMHP): QMHPs may provide BST services.
- b. Qualified Mental health Associates (QMHA): QMHAs may provide BST services under the Clinical Supervision of a QMHP.
- c. Qualified Behavioral Aides (QBA): QBAs may provide BST services under the Clinical Supervision of QMHP and the Direct Supervision of a QMHP or QMHA.

3. Service Limitations: BST services require prior authorization by Medicaid’s QIO-Like vendor. Prior authorizations may not exceed 90-day intervals. BST services are based on the below daily maximums:

Service Limitations	Children: CASII	Adults: LOCUS
Levels I, II, & III	Maximum of 2 hours per day	Maximum of 2 hours per day
Levels IV & V	Maximum of 3 hours per day	Maximum of 3 hours per day
Level VI	Maximum of 4 hours per day	Maximum of 4 hours per day

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4. Admission Criteria: The recipient and at least one parent and/or legal guardian (in the case of legal minors) with whom the recipient is living must be willing to participate in home and community based services; and assessment documentation must indicate that the recipient has substantial impairments in any combination of the following areas:
 - a. Basic living and self-care skills: Recipients are experiencing age inappropriate deficits in managing their daily lives and are engaging in unsafe and inappropriate behaviors;
 - b. Social skills: Recipients are experiencing inappropriate deficits in identifying and comprehending the physical, emotional, and interpersonal needs of others;
 - c. Communication skills: Recipients are experiencing inappropriate deficits in communicating their physical, emotional, and interpersonal needs to others;
 - d. Organization and time management skills: Recipients are experiencing inappropriate deficits managing and prioritizing their daily activities; and/or
 - e. Transitional living skills: Recipients lack the skills to begin partial-independent and/or fully independent lives.

403.6D PROGRAM FOR ASSERTIVE COMMUNITY TREATMENT (PACT)

1. A multi-disciplinary team-based approach of the direct delivering of comprehensive and flexible treatment, support, and services within the community. The team must be composed of at least one QMHP and one other QMHP, QMHA, or Peer Supporter.
2. PACT is for individuals who have the most serious and intractable symptoms of a severe mental illness and who, consequently, have the greatest difficulty with basic daily activities, keeping themselves safe, caring for their basic physical needs, or maintaining a safe and affordable place to live and require interventions that have not been effectively addressed by traditional, less intensive services.
3. Services are available 24 hours a day, 7 days per week. Team members may interact with a person with acute needs multiple times a day. As the individual stabilizes, contacts decrease. This team approach is facilitated by daily team meetings in which the team is briefly updated on each individual. Activities for the day are organized and team members are available to one another throughout the day to provide consultation or assistance. This close monitoring allows the team to quickly adjust the nature and intensity of services in response to individuals' changing needs. PACT is reimbursed as unbundled services.

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403.6E DAY TREATMENT SERVICES

1. **Scope of Service:** Day Treatment services are Rehabilitative Mental Health (RMH) interventions designed to reduce emotional, cognitive, and behavioral problems and restore recipients to their highest level of functioning. Day Treatment services target emotional, cognitive, and behavioral functioning within a variety of actual and/or simulated social settings. Day Treatment services provide recipients opportunities to implement and expand upon (trial and error) what they previously learned/gained from other mental and/or behavioral health therapies and interventions in safe settings. The goal of Day Treatment services is to prepare recipients for reintegration back into home and community based settings. Day treatment services are facility based and out of home services. Day Treatment services may not be provided in the recipient’s home or home-like setting. Day Treatment services do not include routine supervision and monitoring. Day Treatment includes, as part of its service package, a fluid combination of all the Rehabilitative Mental Health (RMH) services. Therefore, providers may not bill separately for Basic Skills Training (BST), Psychosocial Rehabilitation (PSR), Peer-to-Peer, and Crisis Intervention (CI) services during the same time of day and day they bill for Day Treatment services. Outpatient Mental Health assessments and therapies may be billed separately.
2. **Provider Qualifications:**
 - a. **Qualified Mental Health Professionals (QMHP):** QMHPs may provide Day Treatment services.
 - b. **Qualified Mental Health Associates (QMHA):** QMHAs may provide Day Treatment services under the Clinical Supervision of a QMHP.
 - c. **Qualified Behavioral Aides (QBA):** QBAs may not provide Day Treatment services.
3. **Service Limitations:** Day Treatment services require prior authorization by Medicaid’s QIO-Like vendor. Prior authorizations may not exceed 90-day intervals. Day Treatment services are based on the below daily maximums:

Service Limitations	Children: CASII	Adults: LOCUS
Levels I & II	No Services Authorized	No Services Authorized
Level III	Maximum of 4 hours per day	Maximum of 4 hours per day

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Level IV	Maximum of 5 hours per day	Maximum of 5 hours per day
Levels V & VI	Maximum of 6 hours per day	Maximum of 6 hours per day

4. Admission Criteria: Clinical documentation must demonstrate that the recipient meets all of the following:
 - a. Recipient requires (and would benefit from) opportunities to test their acquired emotional, cognitive, and behavioral skills in settings that emulate their normal home and community based environments; and/or recipient is experiencing an acute disorder, crisis, or transitioning from an inpatient to community setting.
 - b. There is clinical evidence that the recipient's condition requires a structured program with treatment that cannot be provided in a less intensive outpatient setting;
 - c. There is an adequate social support system available to provide the stability necessary for maintenance in the program or the recipient demonstrates willingness to assume responsibility for their own safety outside program hours;
 - d. Recipient has primary emotional, cognitive and behavioral health issues which are incapacitating, interfering with daily activities or places others in danger to the point that it causes anguish or suffering;
 - e. Recipient's emotional, cognitive, and behavioral issues require intensive, coordinated, multifaceted intervention within a therapeutic milieu;
 - f. Recipient's level of functioning identifies deficits in basic living skills; and
 - g. Recipient demonstrates reasonable expectation that the recipient can improve demonstrably within 6 months.

403.6F PEER-TO-PEER SERVICES

1. Scope of Service: Peer-to-Peer Support services are Rehabilitative Mental Health (RMH) interventions designed to reduce social and behavioral impairments and restore recipients to their highest level of functioning. Peer-to-Peer supporters (e.g. peer supporters) help the recipient live, work, learn, and participate fully in their communities. Peer-to-Peer services must be delivered directly to recipients and must directly contribute to the restoration of recipient's diagnosis mental and/or behavioral health condition. Peer-to-Peer services may include any combination of the following:

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- a. Helping stabilize the recipient;
 - b. Helping the recipient access community based mental and/or behavioral health services;
 - c. Assisting during crisis situations and interventions;
 - d. Providing preventative care assistance; and/or
 - e. Providing personal encouragement, self-advocacy, self-direction training, and peer mentoring.
2. **Provider Qualifications:** A peer supporter is a qualified individual who is currently or was previously diagnosed with a mental and/or behavioral health disorder and who possess the skills and abilities to work collaboratively with and under the Clinical and Direct Supervision of a QMHP. The selection of the supporter is based on the best rehabilitation interest of the recipient. A peer supporter cannot be the legal guardian or spouse of the recipient. At a minimum, a peer supporter must meet the qualifications for a Qualified Behavioral Aide (QBA). Peer supporters are contractually affiliated with a Behavioral Health Community Network, Independent Professional (Psychologists and Psychiatrists), or Individual Rehabilitative Mental Health (RMH) providers may provide services to any eligible Medicaid-recipient, if determined appropriate in the treatment planning process.
 3. **Service Limitation:** All Peer-to-Peer services require prior authorization by Medicaid's QIO-Like vendor. Prior authorizations may not exceed 90-day intervals. Peer-to-Peer service limits are based on the below 30-day maximums.

Service Limitations	Children: CASII	Adults: LOCUS
Levels I to II	Maximum of 6 hour per 90 day period	Maximum of 6 hour per 90 day period
Level III	Maximum of 9 hour per 90 day period	Maximum of 9 hours per 90 day period
Levels IV to VI	Maximum of 12 hours per 90 day period	Maximum of 12 hours per 90 day period

4. **Admission Criteria:** Clinical documentation must demonstrate that the recipient meets all of the following:

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- a. The recipient would benefit from the peer supporter's understanding of the skills needed to manage their mental and/or behavioral health symptoms and for utilization of community resources;
- b. The recipient requires assistance to develop self-advocacy skills;
- c. The recipient requires peer modeling in order to take increased responsibilities for his/her own recovery; and
- d. Peer-to-Peer support services would be in the best interest of the recipient and would most likely improve recipient's mental, behavioral, and overall health.

403.6G PSYCHOSOCIAL REHABILITATION (PSR) SERVICES

1. Scope of Service: Psychosocial Rehabilitation (PSR) services are Rehabilitative Mental Health (RMH) interventions designed to reduce psychosocial dysfunction (i.e., interpersonal cognitive, behavioral development, etc.) and restore recipients to their highest level of functioning. PSR services target psychological functioning within a variety of social settings. PSR services may include any combination of the following interventions:
 - a. Behavior management: Recipients learn how to manage their interpersonal, emotional, cognitive, and behavioral responses to various situations. They learn how to positively reflect anger, manage conflicts, and express their frustrations verbally. They learn the dynamic relationship between actions and consequences;
 - b. Social competency: Recipients learn interpersonal-social boundaries and gain confidence in their interpersonal-social skills;
 - c. Problem identification and resolution: Recipients learn problem resolution techniques and gain confidence in their problems solving skills;
 - d. Effective communication: Recipients learn how to genuinely listen to others and make their personal, interpersonal, emotional, and physical needs known;
 - e. Moral reasoning: Recipients learn culturally relevant moral guidelines and judgment;
 - f. Identity and emotional intimacy: Recipients learn personal and interpersonal acceptance. They learn healthy (appropriate) strategies to become emotionally and interpersonally intimate with others;

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- g. Self-sufficiency: Recipients learn to build self-trust, self-confidence, and/or self-reliance;
 - h. Life goals: Recipients learn how to set and achieve observable specific, measurable, achievable, realistic, and time-limited life goals; and/or
 - i. Sense of humor: Recipients develop humorous perspectives regarding life's challenges.
2. Provider Qualifications:
- a. Qualified Mental Health Professionals (QMHP): QMHPs may provide PSR services.
 - b. Qualified Mental Health Associates (QMHA): QMHAs may provide PSR services under the Clinical Supervision of a QMHP.
 - c. Qualified Behavioral Aides (QBA): QBAs may not provide PSR services.
3. Service Limitations: All PSR services require prior authorization by Medicaid's QIO-Like vendor. Prior authorizations may not exceed 90-day intervals. PSR services are based on the below daily maximums.

Service Limitations	Children: CASII	Adults: LOCUS
Levels I & II	No services authorized	No services authorized
Level III	Maximum of 2 hours per day	Maximum of 2 hours per day
Levels IV & V	Maximum of 3 hours per day	Maximum of 3 hours per day
Level VI	Maximum of 4 hours per day	Maximum of 4 hours per day

4. Admission Criteria: At least one parent or a legal guardian (in the case of legal minors) with whom the recipient is living must be willing to participate in home and community based services; and the recipient must have substantial deficiencies in any combination of the following criteria:
- a. Behavior management: Recipients are experiencing severe deficits managing their responses (viz., interpersonal, emotional, cognitive, and behavioral) to

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various situations. Recipients cannot age appropriately manage conflicts, positively channel anger, or express frustration verbally. They do not understand the relationship between actions and consequences;

- b. Social competency: Recipients are experiencing severe deficits navigating interpersonal-social boundaries. They lack confidence in their social skills;
- c. Problem identification and resolution: Recipients are experiencing severe deficits resolving personal and interpersonal problems;
- d. Effective communication: Recipients need to learn how to listen to others and make their needs known to others. They cannot effectively communicate their personal, interpersonal, emotional, and physical needs;
- e. Moral reasoning: Recipients are experiencing severe deficits in culturally relevant moral judgment;
- f. Identity and emotional intimacy: Recipients are experiencing severe deficits with personal and interpersonal acceptance. They avoid and/or lack the ability to become emotionally and interpersonally intimate with other people;
- g. Self-sufficiency: Recipients are experiencing severe deficits with self-confidence, self-esteem, and self-reliance; recipients express feelings of hopelessness and helplessness;
- h. Dealing with anxiety: Recipients are experiencing severe deficits managing and accepting anxiety, they are fearful of taking culturally normal and healthy rehabilitative risks;
- i. Establishing realistic life goals: Recipients are experiencing severe deficits setting and achieving realistic life goals; and/or
- j. Sense of humor: Recipients are experiencing severe deficits seeing or understanding the various humorous perspectives regarding life's challenges.

403.6H CRISIS INTERVENTION (CI) SERVICES

1. Scope of Services: Crisis Intervention (CI) services are Rehabilitative Mental Health (RMH) interventions that target urgent situations where recipients are experiencing acute psychiatric and/or personal distress. The goal of CI services is to assess and stabilize situations (through brief and intense interventions), and provide appropriate mental and behavioral health service referrals. The objective of CI services is to reduce psychiatric and personal distress, restore recipients to their highest level of functioning, and help

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prevent acute hospital admissions. CI interventions may be provided in a variety of settings, including but not limited to psychiatric emergency departments, emergency rooms, homes, foster homes, schools, homeless shelters, while in transit, and telephonically. CI services do not include care coordination, case management, or targeted case management services (see Chapter 2500, Targeted Case Management, of the Medicaid Service Manual). CI services must include the following:

- a. Immediate and intensive interventions designed to help stabilize the recipient and prevent hospitalization;
 - b. Conduct situational risk-of-harm assessment;
 - c. Follow-up and de-briefing sessions to ensure stabilization, continuity of care, and identification of referral resources for ongoing community mental and/or behavioral health services.
2. **Provider Qualifications:** Qualified Mental Health Professionals (QMHP) may provide CI services. If a multidisciplinary team is used, the team must be lead by a QMHP. The team leader assumes professional liability over the CI services rendered.
 3. **Service Limitations:** Recipients may receive a maximum of 4 hours per day over a 5-day period (one occurrence). A single occurrence may not exceed 5 days. Recipients may receive a maximum of three occurrences over a 90-day period. CI services must be post authorized by Medicaid’s QIO-Like vendor. Providers have seven days to submit a post authorization request. Post authorization requests must be accompanied with an updated Rehabilitation Plan that addresses the recipient’s acute psychiatric and personal distress. The submission procedures for post authorization service utilization requests are the same as prior authorization requests.

Service Limitations	Children: CASII	Adults: LOCUS
Levels I to VI	<ul style="list-style-type: none"> • Maximum of 4 hours per day over a 5-day period (one occurrence) • Maximum of 3 occurrences over a 90-day period 	<ul style="list-style-type: none"> • Maximum of 4 hours per day over a 5-day period (one occurrence) • Maximum of 3 occurrences over a 90-day period

4. **Admission Criteria:** Clinical documentation must demonstrate that the recipient meets any combination of the following:

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- a. Recipient's behavior requires immediate and intensive interventions to help stabilize the current situation and prevent hospitalization;
 - b. Recipient presents a moderate risk of danger to themselves and others (or to deteriorate to this dysfunctional level);
 - c. Recipient's immediate behavior is unmanageable by family and/or community members; and/or
 - d. Recipient will benefit from the stabilization, continuity of care, and the referrals for ongoing community mental and/or behavioral health services.
5. Exclusion Criteria: Post authorization will not be given for RMH services if any of the following apply:
- a. Recipient meets criteria for acute inpatient care and would distinctly benefit from acute inpatient care;
 - b. Recipient presents a clear and present danger (extreme risk) to themselves and others;
 - c. Recipient demonstrates a history (more than three occurrences over a 90-day period) of not benefiting from CI services (as documented on their Rehabilitation Plan); and/or
 - d. Recipient who would not therapeutically benefit from CI services.

403.7 OUTPATIENT ALCOHOL AND SUBSTANCE ABUSE SERVICES POLICY

Outpatient substance abuse services may be provided by a Qualified Mental Health Professional (QHMP) within the scope of their practice under state law and expertise.

403.7A COVERAGE AND LIMITATIONS

1. Nevada Medicaid may reimburse for:
 - a. Outpatient alcohol/substance abuse treatment services within the context of services discussed in Section 403.4 of this Chapter (individual and family therapy is limited to one hour per session. Group therapy is limited to two (2) hours per session).
 - b. Psychiatrist (MD) - Office and clinic visits provided by a psychiatrist are a Medicaid benefit. There are no limitations to services, and prior authorization is

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not required.

- c. Psychologist - Initial office and clinic visits for psychological evaluation and testing require a signed referral from a physician, licensed QMHP, or a signed referral through a Healthy Kids (EPSDT) screening. All services (psychological evaluation, testing, and subsequent individual, group, and family therapies) provided by psychologists must be prior authorized using the PAR form. For children under age 21 only services beyond 26 sessions per calendar year may be provided if 1) prior authorized by the QIO-like vendor, or 2) resulted from an EPSDT referral.

Testing services may also include an initial psychological evaluation.

- d. Advanced Practitioner of Nursing (APN) - Office and clinic visits provided by an APN are a Medicaid benefit. There are no limitations to services, and prior authorization is not required.
- e. Psychiatric/Psychological Evaluations - This service is covered once, at the onsite of an illness or suspected illness. It may be utilized for the same recipient but only if a new episode or illness occurs after a hiatus, or admission or readmission to inpatient status due to complications of an underlying condition. Individual therapy services require prior authorization. The sessions are limited to a maximum of one hour per session, and 26 sessions per calendar year, unless it is the result of a Healthy Kids (EPSDT) screening. When requesting the therapy the provider needs to submit a psychological evaluation or summary with a treatment plan and requested frequency. Approval is usually given for three months at a time.

When requesting additional therapy the provider needs to submit a progress report and include the number of attended sessions. It is the responsibility of the provider to keep track of the sessions.

- f. Group Therapy Services - Group therapy services require prior authorization. These sessions are limited to a maximum of two hours. Each session counts against the 26 hours per calendar year unless there is a Healthy Kids (EPSDT) screening. Group therapy sessions may be requested on an alternate schedule with individual therapy. The provider needs to document what the recipient did, how the focus of the group applies to the diagnosis in their progress report and how the plan of therapy is being met. The provider will need to include the number of attended sessions.
- g. Family Therapy Services - Family therapy services require prior authorization

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and are a benefit only when the recipient is present during the therapy. These sessions are limited to a maximum of one hour and count against the 26 sessions per calendar year unless there is a Healthy Kids (EPSDT) screening. Family therapy may be requested with individual therapy but frequency must be included for each therapy. If additional therapy is requested after the initial request and approval, the provider needs to submit a progress report, number of attended sessions, and plan of treatment.

- h. Individual Therapy Services - Individual therapy services require prior authorization. The sessions are limited to a maximum of one hour, and to 26 sessions in a calendar year, unless it is the result of a Healthy Kids (EPSDT) screening. When requesting the therapy the provider needs to submit a psychological evaluation or summary with a treatment plan and requested frequency. Approval is usually given for three months at a time. When requesting additional therapy the provider needs to submit a progress report and include the number of attended sessions. It is the responsibility of the provider to keep track of the sessions.

2. Other Covered Services

Please consult Section 403.12A.2 of this Chapter for other covered services.

3. Non-Covered Services

Please consult Section 403.7 of this Chapter for all non-covered services.

4. Billing

Reference appendix for code coverage.

403.7B PROVIDER RESPONSIBILITIES

Providers are responsible for:

- 1. Verifying Medicaid eligibility.
- 2. Submitting PARs to Medicaid's QIO-like vendor for purposes of obtaining prior authorization.
- 3. Appropriate billing procedures and code usage.

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403.7C RECIPIENT RESPONSIBILITIES

1. Medicaid recipients are required to provide their Medicaid card to their service providers.
2. Medicaid recipients are expected to comply with the service provider's treatment, care, and service plans, including making and keeping medical appointment.

403.7D AUTHORIZATION PROCESS

Prior authorization for psychological services is secured through Medicaid's QIO-like vendor by submitting a PA with substantiating documentation which must include the diagnosis, an evaluation or problem summary denoting the severity of presenting problems or functional disability. Specific, realistically attainable and measurable goals, and anticipated frequency and duration of treatment must be documented. Authorizations may be granted for a period of 90 days (i.e., once per week times 12 weeks). To continue the payment process necessitates a new payment authorization request and approval, progress notes, and number of sessions seen.

Psychiatrist/Psychologist led group therapy counts as an office visit and meets the same limitation criteria. Reimbursement for individuals age 21 years and older are limited to 26 individual, group and/or family sessions in a calendar year for psychiatrists and psychologists.

All other specific authorization requirements are addressed earlier in this Chapter in Section 403.10.A, Coverage and Limitations.

403.8 RESIDENTIAL TREATMENT CENTER (RTC) SERVICES

1. Residential Treatment Center (RTC) services are delivered in psychiatric, medical-model facilities, in- or out-of-state, that are accredited by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), the Commission on Accreditation of Rehabilitation Facilities, or the Council on Accreditation of Services for Families and Children, and licensed as a Residential Treatment Facility within their state. The objective of RTC services is to assist recipients who have behavioral, emotional, psychiatric and/or psychological disorders, or conditions, who are no longer at or appropriate for an acute level of care, or who cannot effectively receive services in a less restrictive setting and who meet medical necessity and admission criteria for RTC services.

RTCs are part of the mental health continuum of care and are an integral part of Nevada Medicaid's behavioral health system of care. Recipients who respond well to treatment in an RTC are anticipated to be discharged to a lower level of care, such as intensive home and community-based services, or to the care of a psychiatrist, psychologist, or other Qualified Mental Health Professional (QMHP).

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All Medicaid policies and requirements (such as prior authorization, etc.) are the same for Nevada Check Up, with the exception of the four areas where Medicaid and Nevada Check Up policies differ as documented in the Nevada Check Up Manual, Chapter 1000.

2. Medicaid Behavioral Health Intensity of Needs for Children and Adolescents:

Child and Adolescent Service Intensity Instrument (CASII)	Children: CASII	Adults: LOCUS
Levels I to V	Not Authorized	Not Authorized
Level VI Secure, 24 Hour, Services with Psychiatric Management	Accredited Residential Treatment Center (RTC)	Not Authorized

403.8A COVERAGE AND LIMITATIONS

1. Nevada Medicaid's all-inclusive RTC daily rate includes room and board, active treatment, psychiatric services, psychological services, therapeutic and behavioral modification services, individual, group, family, recreation and milieu therapies, nursing services, all medications (for Axis I, II and III diagnoses), quarterly RTC-sponsored family visits, psycho-educational services, and supervised work projects.
2. The all-inclusive daily rate does not include general physician (non-psychiatrist) services, neuropsychological, some dental, optometry, durable medical equipment, radiology, lab, and therapies (physical, speech and occupational). All of these services are Medicaid benefits, which must be billed separately by the particular service provider. Some may require prior authorization (see Section 405.1 for applicable MSM Chapters).
3. The QIO-like vendor may authorize all RTC stays, both fee for service and Health Maintenance Organization (see MSM Chapter 3600) Medicaid in three-month (or less) increments. For Medicaid recipients to remain in RTCs longer than three months, the RTC must, prior to the expiration of each authorization, submit a Continuing Stay Request to the QIO-like vendor for authorization. It is the RTC's responsibility to contact the QIO-like vendor no later than the 15th day of the month in which the current authorization expires.
4. For recipients under the age of 21 in the custody of a public child welfare agency, Nevada Medicaid will reimburse for prior authorized RTC services only when the public child welfare agency has also approved the admission.

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5. Criteria for Exclusion from RTC Admission

One or more of the following must be met which prohibit the recipient from benefiting rehabilitatively from RTC treatment or involve the RTC's inability to provide a necessary specialized service or program (clinical decisions will be made individually on a case-by-case basis):

- a. Psychiatric symptoms requiring acute hospitalization;
- b. The following conditions which limits the recipient's ability to fully participate in RTC services and cannot be reasonably accommodated by the RTC;
 1. Physical Disability
 2. Learning Capacity
 3. Traumatic Brain Injury (TBI)
 4. Organic brain syndrome;
- c. Pregnancy, unless the RTC can appropriately meet the needs of the adolescent, including obtaining prenatal care while in the facility, and, in the case of the birth of the infant while the recipient is at the RTC, the infant's care is included in the Discharge Plan. (In such an instance the infant would be covered individually by Medicaid for medically necessary costs associated with medical care);
- d. Chronic unmanageable violent behavior incompatible with RTC services which poses unacceptable and unsafe risks to other clients or staff for any reason (i.e., a danger to self, others or property);
- e. Medical illness which limits the recipient's ability to fully participate in RTC services and is beyond the RTC's capacity for medical care;
- f. Drug and/or alcohol detoxification is required as a primary treatment modality before a recipient can benefit rehabilitatively from RTC services; or
- g. A diagnosis of Oppositional Defiant Disorder (ODD) and/or Conduct Disorder, alone and apart from any other DSM Axis I or Axis II diagnosis.

6. RTC Therapeutic Home Passes

RTC Therapeutic Home Passes are to be utilized to facilitate a recipient's discharge back to their home or less restrictive setting. RTC recipients **are allowed** to utilize Therapeutic

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Home Passes based on individualized treatment planning needs and upon the recommendations of the RTC clinical treatment team. A total of **three Therapeutic Home Passes** are allowed per calendar year **and** Therapeutic Home Passes cannot be accumulated beyond a **calendar year** period. Duration per pass is no greater than 72 hours unless there is a documented medically necessary reason for a longer-term pass. **The QIO-like vendor must be notified by the RTC of all therapeutic home passes at least 14 days prior to the pass being issued to the recipient. The notification form can be located on the QIO-like vendor website. All passes which exceed 72 hours must be prior authorized by the QIO-like vendor.**

- a. The following guidelines must be adhered to for reimbursement. Failure to follow these guidelines will result in non-payment to RTCs during the time the recipient was away on a **Therapeutic Home Pass**:
 1. A physician's order is required for all **Therapeutic Home Passes**. If it is clinically appropriate for the recipient to travel alone, this must be specified in the physician's order.
 2. **A Therapeutic Home Pass will only occur within 90 days of the recipient's planned discharge and in coordination with their discharge plan. The recipient must have demonstrated a series of successful incremental day passes before the Therapeutic Home Pass occurs. The recipient must also be in the final phase of treatment in the RTC program.**
 3. Therapeutic Home Pass information which verifies days used must be documented in the recipient's case file and must include: dates for each pass, location of the pass, treatment objectives to be met by use of each pass, and the total number of days used per calendar year. A copy of the physician order for each pass must also be maintained in the recipient's clinical case file.
 4. The RTC must track the number of Therapeutic Home Passes used as **the QIO-like vendor** will not reimburse RTCs for pass days for any recipient exceeding a total of **three passes** per calendar year.
 5. If the recipient leaves without issuance of a Therapeutic Home Pass **the recipient will be considered discharged and the QIO-like vendor must be notified of the discharge and date the recipient left the facility.**
 6. In the event a recipient unexpectedly does not return to the RTC from a Therapeutic Home Pass or family emergency, and such an absence has been properly documented by the RTC, the RTC may utilize the day the recipient was expected to return from leave as the discharge date as long

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as the period does not exceed 72 hours. In the case of a family emergency or an extended pass which has been approved by the QIO-like vendor this period cannot exceed 120 hours.

7. Any recipient who is formally discharged from an RTC and is readmitted is considered to be a new admission, regardless of the length of time away from the facility. Prior authorization and a **Certificate of Need (CON) signed by a physician**, is required for payment.
 8. The **three passes** per calendar year Therapeutic Home Pass policy applies to all RTC recipients, regardless of the recipient's custody status.
 9. Therapeutic Home Passes include the day the pass begins, and ends the day before the recipient returns (prior to midnight).
7. Transportation

Nevada Medicaid may reimburse the following RTC travel related services for an eligible recipient and attendant when determined to be medically necessary for:

- a. Initial travel to the RTC upon admission;
- b. Travel for an RTC Therapeutic Home Pass; and
- c. Travel upon discharge from the RTC.

Transportation must be coordinated in accordance with Chapter 1900 of the Medicaid Services Manual.

8. RTC Interns/Psychological Assistant
 - a. RTC providers may be reimbursed for services provided by Interns/Psychological Assistants within the all-inclusive daily rate if they meet the requirements as prescribed in Section 403.3(6)(d) of this Chapter.
 - b. Approved out-of-state RTC providers must comply with the Interns/Psychological Assistants requirements in their own state for those Interns/Psychological Assistants in the categories listed in 403.3(6)(d).

403.8B PROVIDER RESPONSIBILITIES

1. All RTCs must comply with the regulations in this MSM Chapter and all other applicable MSM Chapters.

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2. Critical Events Reporting Requirements

RTCs are required to notify:

- a. The QIO-like vendor of any critical event or interaction involving any RTC patient, within 48 hours of the occurrence. Information which must be reported includes, but is not limited to, deaths, injuries, assaults, suicide attempts, police or sheriff's investigations, and physical, sexual, or emotional abuse allegations.
- b. The state Medicaid agency and state-designated client protection and advocacy agency of a resident's death, serious injury, or suicide attempt;
 1. Upon notification of a critical event, Nevada Medicaid may make an adverse decision against the RTC. In the event of a death, suicide attempt, or very serious injury (injury requiring hospitalization) of a patient, Nevada Medicaid may make an administrative decision to impose a ban on future Medicaid-eligible admissions and/or remove recipients currently at the RTC, if they are believed to be in danger.
 2. If a ban is imposed, Medicaid must receive and review HIPAA compliant documents requested from the RTC, including but not limited to, police, autopsy, state licensing, social services, and internal death or serious injury reports before a decision is made to remove or continue the imposed ban or terminate the contractual relationship with the RTC; AND
- c. Their local Centers for Medicare and Medicaid Services (CMS) office of the death of any resident, no later than the close of business the next business day after the resident's death per 42 CFR 483.374(c).

3. RTC Regulatory and Compliance Requirements

The RTC must also ensure on-going compliance with accreditation requirements. The RTC must also ensure on-going JCAHO accreditation and comply with all JCAHO requirements.

4. Letter of Attestation

The RTC must comply with 42 CFR 483.374 (a) and submit a Letter of Attestation to Medicaid, by the individual having legal authority to do so (i.e., facility director, CEO, or administrator), which confirms the facility is in compliance with CMS standards governing the use of restraint and seclusion. The Letter of Attestation must be submitted at the time of enrollment as a Medicaid provider and at anytime there is a change in the legal authority.

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5. Quality Assurance/Quality Improvement

The RTC must have a Quality Assurance/Quality Improvement program in place at the time of enrollment and a process to submit an annual QA report to DHCFP.

6. Quarterly Family Visits

Quarterly Family Visits are based on clinical appropriateness and are utilized to support person- and family- centered treatment planning. It is the responsibility of out-of-state and in-state RTCs, as part of the all-inclusive daily rate, to bring families (up to two people) to the facility on a quarterly basis when the family resides 200 miles or more from the RTC. This includes the RTC providing travel, lodging, and meals, to the family.

For Medicaid-eligible recipients in the custody of a public child welfare agency, prior to arranging the visit, the RTC must consult with and obtain approval from the agency's clinical representative pertaining to the appropriateness of such a visit.

7. Discharge Accompaniments

RTCs must ensure the following is provided to the legal representative upon discharge of a Medicaid-eligible recipient:

- a. Supply or access to current prescribed medications;
- b. The recipient's Medicaid-eligibility status;
- c. All pertinent medical records and post discharge plans to ensure coordination of and continuity of care.

8. Clinical Requirements

- a. The RTC must have a Medical Director who has overall medical responsibility for the RTC program. The Medical Director must be a board-certified/board eligible psychiatrist with specific experience in child and adolescent psychiatry.
- b. Psychiatric/Medical Services
 1. Medicaid-eligible children and adolescents must receive, at a minimum, two monthly face-to-face/one-on-one sessions with a child and adolescent psychiatrist and a psychiatrist must be available 24 hours a day.
 2. The RTC must provide routine medical oversight to effectively coordinate all treatment, manage medication trials and/or adjustments to minimize

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serious side effects, and provide medical management of all psychiatric and medical issues.

- c. Clinical psychotherapy (Individual, Group, or Family Therapy) must be provided by a licensed Qualified Mental Health Professional (QMHP). All Rehabilitative Mental Health (RMH) services may also be provided by a QMHP, a Qualified Mental Health Associate (QMHA), or a Qualified Behavioral Aide (QBA) within the scope of their practice under state law and expertise. Consultation by a licensed clinical psychologist must be available when determined medically necessary.

9. Patient Rights

RTCs must protect and promote Patient's Rights in accordance with all applicable Federal and State regulations.

10. Federal Requirements

At 42 CFR 441.151 to 441.156 addresses certification of need, individual plan of care, active treatment and the composition of the team developing the individual plan of care. RTCs must comply with all Federal and State Admission Requirements.

403.8C AUTHORIZATION PROCESS

1. Admission Criteria

All RTC admissions must be prior authorized by the QIO-like vendor. RTCs must submit the following documentation to the QIO-like vendor no less than five (5) days prior to the admission/transfer:

- a. RTC Prior Authorization Request Form which includes a comprehensive psychiatric assessment current within six months of the request for RTC admission; and
- b. A Certification of Need (CON) signed by a physician which includes:
 - 1. The current functioning of the recipient;
 - 2. The strengths of the recipient and their family;
 - 3. DSM diagnosis;

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4. Psychiatric hospitalization history;
 5. Medical history; and
 6. Current medications.
- c. An initial individualized Treatment Plan; and
 - d. A proposed Discharge Plan.
2. The QIO-like vendor must verify the medical necessity for all RTC services and verify:
 - a. The Level of Intensity of Needs for RTC services;
 - b. The ability for the recipient to benefit rehabilitatively from RTC services;
 - c. The Treatment Plan includes active participation by the recipient and their family (when applicable); and
 - d. The Discharge Plan is viable and includes coordinated case management services.
 3. All RTCs must notify the QIO-like vendor of the transfer of a recipient to an acute psychiatric hospital or unit within 24 hours following an emergent transfer. If the transfer is not emergent, the hospital must prior authorize the transfer. For transfers to an acute psychiatric hospital or unit, the QIO-like vendor must verify the medical necessity for acute inpatient psychiatric services and verify:
 - a. The Level of Intensity of Needs for acute inpatient psychiatric services;
 - b. The ability for the recipient to benefit rehabilitatively from acute inpatient psychiatric services;
 - c. Effective care coordination is in place for pre- and post-transfer service; and
 - d. One of the following admission criteria has been met:
 1. Active suicidal ideation accompanied by a documented suicide attempt or documented history of a suicide attempt within the past 30 days; or

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2. Active suicidal ideation within the past 30 days accompanied by physical evidence (e.g., note) or means to carry out the suicide threat (e.g., gun, knife, or other deadly weapon); or
3. Documented aggression within the 72-hour period before admission which:
 - a. Resulted in harm to self, others or property;
 - b. Manifests that control cannot be maintained outside of inpatient hospitalization; and
 - c. Is expected to continue if no treatment is provided.
4. The RTC must request prior authorization from the QIO-like vendor to return a recipient to the RTC from acute psychiatric services. The prior authorization request must include a Discharge Summary of the acute psychiatric inpatient services.
5. Prior authorization is required prior to transferring a recipient from one RTC to another for unanticipated specialized treatment services not available at the initial RTC placement.
6. RTCs may request a retro-eligibility authorization review from the QIO-like vendor for reimbursement for an RTC patient who was not Medicaid-eligible at the time of admission and later becomes eligible for Medicaid for the period RTC services were provided.
7. The QIO-like vendor will process prior authorization requests for RTC admissions within five (5) working days of receipt of all required information. Incomplete requests will be technically denied within 10 days if the requested information is not received.
8. RTC non-emergent admissions and transfers to acute psychiatric services not prior authorized will not be reimbursed by Medicaid.
9. Continuing Stay Criteria
 - a. The RTC must submit a Continuing Stay Request to the QIO-like vendor 15 days prior to the expiration of a current authorization.
 - b. The QIO-like vendor will process Continuing Stay Requests for RTC services within 14 days of receipt of all required information. Authorization will be issued for up to three months based on clinical appropriateness and medical necessity.

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- c. The RTC must notify the QIO-like vendor of all Medicaid recipient discharges within 24 hours of the discharge and provide a Discharge Summary within 30 days for a planned discharge and within 45 days of an unplanned discharge. In the case of a recipient's transfer to another program, a verbal summary must be given at the time of transition and followed with a written summary within seven (7) calendar days of the transfer.
- d. Continued Stays Requests not authorized by the QIO-like vendor will not be reimbursed by Medicaid. The RTC must submit a request for reconsideration to the QIO-like vendor within 90 days of receipt of the denial. Reconsideration requests received after 90 days will not be reviewed and will remain denied.

10. Retro-Eligibility

- a. If a client becomes Medicaid-eligible after admission to a RTC, the RTC must initiate the Continuing Stay Review process and submit all required information to the QIO-like vendor within 30 days from the date of the eligibility determination.
- b. The QIO-like vendor will process Continuing Stay Review requests for retro-eligible recipients within 30 days of receipt of all requested information.

11. Discharge Criteria

The QIO-like vendor will issue a denial or partial denial for RTC services based on review of medical necessity and admission or continuing stay criteria. Denials may be issued for, but are not limited to:

- a. RTC services are not shown to be medically necessary;
- b. The service exceeds Medicaid program limitations;
- c. Level 6 of Intensity of Needs is not met and services may be provided in a less restrictive setting;
- d. Specialized RTC services are not required;
- e. The legal guardian for the Medicaid recipient has requested the services be withdrawn or terminated;
- f. The services are not a Medicaid benefit; and/or

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- g. A change in federal or state law has occurred (the Medicaid recipient is not entitled to a hearing in this case; see MSM Chapter 3100).

12. Reimbursement

Nevada Medicaid reimburses RTCs an all-inclusive daily rate negotiated through DHCFP's Rates and Cost Containment Unit.

- a. An analysis by the Division of Health Care Financing and Policy's Rates and Cost Containment Unit of the most current cost report information filed by the RTC (HCFA 2252 or equivalent).
- b. The average or mean rate Nevada Medicaid reimburses its current RTC providers, both in-state and out-of-state.
- c. For out-of-state RTC service providers, the rate the RTC receives, if any, from its own state Medicaid program or public child welfare agency.

403.9

INPATIENT MENTAL HEALTH SERVICES POLICY

- 1. Inpatient mental health services are those services delivered in freestanding psychiatric hospitals or general hospitals with a specialized psychiatric unit which include a secure, structured environment, 24-hour observation and supervision by mental health professionals and provide a multidisciplinary clinical approach to treatment.

Inpatient mental health services includes treatments or interventions provided to an individual who has an acute, clinically identifiable DSM Axis I psychiatric diagnosis to ameliorate or reduce symptoms for improved functioning and return to a less restrictive setting.

- 2. Medicaid Behavioral Health Intensity of Needs for Children and Adolescents:

Child and Adolescent Service Intensity Instrument (CASII)	Children: CASII	Adults: LOCUS
Levels I to V	Not Authorized	Not Authorized
Level VI Secure, 24 Hour, Services with Psychiatric Management	Inpatient Hospitalization Authorized	Inpatient Hospitalization Authorized

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403.9A COVERAGE AND LIMITATIONS

1. Admissions

a. Certification Requirement:

1. A physician must issue a written order for admission or provide a verbal order for admission, which is later countersigned by the same physician. The order must be issued:

a. During the hospital stay;

b. At the time acute care services are rendered; or

c. The recipient has been transferred, or is awaiting transfer to an acute care bed from an emergency department, operating room, admitting department, or other hospital service.

2. The physician's order must be based one:

a. The recipient meeting Level 6 criteria on the Intensity of Needs grid (see Appendix A) and must include:

1. The date and time of the order and the status of the recipient's admission (i.e., inpatient, observation, same day surgery, transfer from observation, etc.)

b. Admission Date and Time:

The admission date and time must be reflected on the certification as the date and time the admission order was written prior to or during hospitalization. If the date and time of the physician admission orders are not clear or available, the QIO-like vendor applies the documentation most relevant to the admission determination contingent upon provision of acute care services.

c. Transfers and Planned Admissions:

For those instances in which a physician's admission order was issued for a planned admission and before the recipient arrives at the hospital the order must be signed by the physician and indicate the anticipated date of admission.

A physician's order must also be issued for transfers from another acute care hospital.

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d. Responsibilities:

1. The admission must be certified by the QIO-like vendor based on:
 - a. Medical necessity;
 - b. Clear evidence of a physician's admission order; and the
 - c. Recipient meeting Level 6 on the Intensity of Needs grid (see Appendix A).
2. The hospital must submit all required documentation including:
 - a. The physician's order which is signed by a physician and reflects the admission date and time; and
 - b. All other pertinent information requested by the QIO-like vendor.

e. Observation:

1. Observation status cannot exceed a maximum of 48 hours.
 2. Observation begins when the physician issues an observation status order and ends when the recipient is discharged from the hospital.
 3. A new admissions order must be issued and signed by a physician when a recipient is admitted to inpatient status post discharge from an observation stay.
2. Nevada Medicaid reimburses for admissions certified by the QIO-like vendor to a:
 - a. Psychiatric unit of a general hospital, regardless of age; or
 - b. Psychiatric hospital (Institution for Mental Diseases) for recipients under age 21 or 65 or older.
 3. For recipients under age 21 in the custody of the public child welfare agency, Nevada Medicaid reimburses for inpatient mental health services only when:
 - a. The child welfare agency also approves the admission/placement (this does not apply to placements at State-owned and operated facilities); and
 - b. The admission is certified by the QIO-like vendor.

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4. Reimbursement

- a. Nevada Medicaid reimburses for services for recipients admitted with a mental health or psychiatric condition to a general hospital without a psychiatric unit only under one of the following conditions:
 1. The admission is an emergency and is certified by the QIO-like vendor. The hospital must the QIO-like vendor within 24 hours of the first working day of the admission and make all efforts to stabilize the recipient's condition and discharge the recipient to a psychiatric hospital or general hospital with a psychiatric unit in as expeditiously as possible; or
 2. The recipient has been dually diagnosed as having both medical and mental diagnoses which warrant inpatient general hospital services, as determined by the QIO-like vendor.
- b. Nevada Medicaid does not reimburse for:
 1. Medicaid recipients between 21 and 64 years of age for inpatient mental health services unless the services are provided in a general hospital with a psychiatric unit (or in the event of (a)(1) or (a)(2) above occurs); or for
 2. Services not authorized by the QIO-like vendor.
- c. If a recipient is initially admitted to a hospital for acute care and is then authorized by the QIO-like vendor to receive mental health services, the acute care is paid at the medical/surgical rate.
- d. Authorized substance abuse services are paid at the substance abuse service rate.

5. Absences

- a. In special circumstances, Nevada Medicaid may allow up to an eight-hour pass from the acute hospital without denial of payment. Absences may include, but are not limited to, a trial home visit, a respite visit with parents (in the case of a child), a death in the immediate family, etc. The hospital must request prior authorization from the QIO-like vendor for an absence if the absence is expected to last longer than eight (8) hours.
- b. There must be a physician's order that a recipient is medically appropriate to leave on pass and the therapeutic reason for the pass must be clearly documented in the chart prior to the issuance of the pass. Upon the recipient's return, the pass

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must be evaluated for therapeutic effect and the results clearly documented in the recipient's chart.

6. Non-Covered Services

Reference 403.6

403.9B PROVIDER RESPONSIBILITIES

1. Authorization by the QIO-like vendor must be obtained prior to admission. A tentative treatment plan will be required for the QIO-like vendor's authorization. The only exception is in the event of an emergency admission, in which the child may be admitted and the QIO-like vendor must be notified of the admission within 24 hours or the first working day.

In the event authorization is not obtained, the admission will not be authorized and/or certified by the QIO-like vendor for payment.

2. Medical Records

A medical record shall be maintained for each recipient and shall contain the following items:

- a. An initial assessment of the recipient's clinically identifiable psychiatric disorder, which should include a chief complaint or equivalent, a history of the disorder, a statement of the circumstances which led to the request for services, a mental status examination and observations, a diagnosis or differential diagnosis, and a statement of treatment goals and objectives and method of treatment.
- b. A written, individualized treatment plan (ITP) to address the problems documented during the intake evaluation. The plan shall include the frequency, modality, and the goals of treatment interventions planned. It also shall include the type of personnel that will furnish the service.
- c. Dated progress notes are required for each treatment encounter to include the amount of time services were rendered, the type of service rendered, the progress of the recipient with respect to resolution of the presenting symptoms or problems, any side effects or necessary changes in treatment, and the interval to the next treatment encounter.

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The provider shall make available to Nevada Medicaid or Medicaid's Quality Improvement Organization (QIO-like vendor) copies of the medical record, progress notes, or summary documents which reflect the ongoing need for treatment and support any additional services requested.

For inpatient and outpatient services, the provider is responsible to meet Healthy Kids (EPSDT) and QIO-like vendor authorization guidelines, as discussed previously in this chapter.

3. Patient Self-Determination Act (Advance Directives) Compliance Pursuant to the Omnibus Budget Reconciliation Act of 1990 (OBRA 90), and federal regulations at 42 CFR 489.100, hospitals which participate in and receive funding from Medicare and/or Medicaid must comply with The Patient Self-Determination Act (PSDA) of 1990, including Advance Directives.

Specifically, the PSDA requires all Medicare and Medicaid hospital providers to do the following:

- a. Provide written information to all adult (age 18 and older) patients upon admission concerning:
 1. The individual's rights under state law to make decisions concerning their medical care, including the right to accept or refuse medical or surgical treatment, and the right to formulate advance directives (declarations and durable powers of attorney for health care decisions).
 2. The written policies of the provider or organization respecting implementation of such rights, including a clear and precise statement of limitation if the provider cannot implement an advance directive on the basis of conscience. At a minimum, a provider's or organization's statement of limitation must: 1) clarify any differences between institution-wide conscience objections and those that may be raised by individual physicians; 2) identify the state legal authority permitting such objections (which in Nevada is NRS 449.628); and 3) describe the range of medical conditions or procedures affected by the conscience objection.
- b. Document in the individual's medical record whether the individual has an advance directive.
- c. Not to condition the provision of care or otherwise discriminate against an individual based on whether the individual has executed an advance directive.

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- d. Ensure compliance with the requirements of state law respecting advance directives. The hospital must inform individuals any complaints concerning the advance directives requirements may be filed with the state survey and certification agency (which in Nevada is the Nevada State Health Division, Bureau of Licensure and Certification).
- e. Provide education of staff concerning its policies and procedures on advance directives (at least annually).
- f. Provide for community education regarding issues concerning advance directives (at least annually). At a minimum, education presented should define what constitutes an advance directive, emphasizing that an advance directive is designed to enhance an incapacitated individual's control over medical treatment, and describe applicable state law concerning advance directives. A provider must be able to document and verify its community education efforts. Nevada Medicaid is responsible for monitoring/reviewing hospitals periodically to determine whether they are complying with federal and state Advance Directive requirements.

4. Quality Assurance Medical Care Evaluation Studies

The purpose of medical care evaluation studies is to promote the most effective and efficient use of available health facilities and services consistent with patient needs and professionally recognized standards of care (42 CFR 456.141 to 456.145). As part of the conditions of participation in the Medicaid Title XIX program, a minimum of one Medical Care Evaluation Study must be in progress at anytime. Additionally, one study must be completed each year. The completed study must be submitted to the QIO-like vendor at the end of each calendar year along with the study in progress topic. (A report summarizing the study topics will be submitted to Nevada Medicaid, by the QIO-like vendor). Hospitals may design and choose their own study topic, or at the request of Medicaid perform a topic designated by Medicaid, and forward a copy of the completed study to the QIO-like vendor office within the specified time frames.

5. Medicaid Form NMO 3058 (Admit/Discharge/Death Notice)

All hospitals are required to submit Form NMO - 3058 to their local Welfare District Office whenever a hospital admission, discharge, or death occurs. Failure to submit this form could result in payment delay or denial. To obtain copies of Form NMO - 3058, please contact Medicaid's fiscal agent.

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6. Patient Rights

Pertaining to the acute psychiatric hospital's responsibilities of protecting and promoting each patient's rights, please consult the following authorities:

- a. 42 Code of Federal Regulations (CFR) 482.13.
- b. Nevada Revised Statutes (NRS) 449.730.
- c. Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) "Restraint and Seclusion Standards for Behavioral health." (Available at the following website: www.JCAHO.org).

7. Non-Emergency Admissions

Non-emergency admissions for Medicaid eligible recipients must be prior authorized by the QIO-like vendor within one (1) business day of the admission. Physicians may call them during normal business hours. (Non-emergency admissions not prior authorized by the QIO-like vendor will not be reimbursed by Nevada Medicaid.)

8. Claims for Denied Admissions

Hospitals are not permitted, after having an inpatient service denied by the QIO-like vendor, to submit the claim to Medicaid's fiscal agent as an outpatient service. The only exception to this is if an outpatient or non-inpatient related service was truly rendered prior to the inpatient admission order by the physician but the inpatient stay was denied by the QIO-like vendor (i.e., admit from ER or rollover from observation days).

9. Hospital Responsibilities for Outside Services

Any hospital receiving authorization from the QIO-like vendor to admit and provide services for a recipient is responsible for that recipient service and treatment needs. If a hospital does not have the proper or functional medical equipment or services, and must transfer a recipient temporarily to another hospital or other medical service provider (generally for only a portion of that day) for testing/evaluation/treatment, etc., it is the transferring hospital's responsibility, not Medicaid's, to fund the particular services, and if necessary, transportation.

10. Acute Psychiatric Admission Requirements

- a. 42 CFR 441.152 addresses Certification of Need requirements.
- b. 42 CFR 441.155 addresses Individual Plan of Care requirements.

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- c. 42 CFR 441.156 addresses the requirements of the composition of the team developing the individual plan of care.

11. Patient Liability

IMD's/freestanding psychiatric hospitals are exempt from Patient Liability (PL) requirements.

403.9C AUTHORIZATION PROCESS

The QIO-like vendor contracts with Medicaid to provide utilization and quality control review (UR) of Medicaid inpatient psychiatric hospital admissions. Within the range of the QIO-like vendors UR responsibilities are admission and length of stay criteria development, prior authorization, concurrent and retrospective review, certification and reconsideration decisions. The QIO-like vendor must approve both emergency and non-emergency inpatient psychiatric inpatient admissions. Any hospital which alters, modifies or changes any QIO-like vendor certification in any way, will be denied payment.

1. For purposes of Medicaid mental health services, an emergency inpatient psychiatric admission to either a general hospital with a psychiatric unit or freestanding psychiatric hospital, is defined as meeting at least one of the following three criteria:
 - a. Active suicidal ideation accompanied by a documented suicide attempt or documented history of a suicide attempt(s) within the past 30 days; or
 - b. Active suicidal ideation within the past 30 days accompanied by physical evidence (e.g. note) or means to carry out the suicide threat (e.g., gun, knife, or other deadly weapon); or
 - c. Documented aggression within the 72-hour period before admission:
 1. Which resulted in harm to self, others, or property;
 2. Which manifests that control cannot be maintained outside an inpatient hospitalization; and
 3. Which is expected to continue without treatment.

2. Concurrent Reviews

For non-emergency admissions, the prior authorization request form and Certification of Need (CON) must be submitted at least one business day prior to admission. For emergency admissions, the prior authorization request form and CON must be submitted

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no later than one business day following admission. Prior authorization requests, if medically and clinically appropriate, will be authorized up to seven days. If a provider wishes for the client to remain longer than seven days, the provider must submit, prior to the expiration of the initial prior authorization, a second, or Concurrent (Continuing Stay) Authorization Request Form. If, upon notification that additional information is needed for clinical review, the provider has two business days to provide the additional information (concurrent review procedures also apply to inpatient substance abuse detoxification and treatment services).

During this time of the initial authorization the psychiatric assessment, discharge plan, and written treatment plan, with the attending physician's involvement, must be initiated. For the recipient to remain hospitalized longer than seven days, the attending physician, who must be involved with the recipient's treatment plan, must, on a daily basis, also document the medical and acute necessity of why any additional inpatient days are necessary. QIO-like vendor authorization and approval of medical necessity is required for the entire stay.

3. Nevada Medicaid will reimburse for services for recipients admitted with a mental health or psychiatric condition to a general hospital without a psychiatric unit only under one of the following conditions:
 - a. The admission is an emergency admission and is certified by the QIO-like vendor (who must be contacted within 24 hours or the first working day after the admission). The hospital must make all efforts to stabilize the recipient's condition and discharge the recipient to a psychiatric hospital or general hospital with a psychiatric unit as expeditiously as possible; or
 - b. The recipient has been dually diagnosed as having both medical and mental conditions/diagnoses which warrant inpatient general hospital services, as determined by the QIO-like vendor.

Also, if a recipient is initially admitted to a hospital for acute care and is then authorized to receive mental health services, the acute care is paid at the medical/surgical tiered rate. The substance abuse services are paid at the substance abuse service rate. Hospitals are required to bill Medicaid separately for each of the types of stays. The QIO-like vendor must certify the two types of stays separately.

4. Acute inpatient admissions authorized by the QIO-like vendor do not require an additional authorization for physician ordered psychological evaluations and testing. The psychologist must list the "Inpatient Authorization Number" on the claim form when billing for services.

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5. Prior Resources

Pursuant to federal law, Medicaid is payer of last resort whenever any other resources may be responsible for payment. Prior resources include but are not limited to: Medicare, labor unions, Worker's Compensation Insurance carriers, private/group insurance, and CHAMPUS. Exceptions to this regulation are Bureau of Family Health Services, Indian Health Services (IHS), Ryan White Act, and Victims of Crime, when Medicaid is primary.

Benefits available free of charge to recipients from other sources must be provided free of charge to Nevada Medicaid recipients.

6. Reimbursement

Inpatient freestanding psychiatric and/or alcohol/substance abuse hospitals, and general acute hospitals with a psychiatric and/or substance abuse unit are reimbursed a per diem, all inclusive prospective daily rate determined and developed by the Nevada Division of Health Care Financing Policy's Rate Development and Cost Containment Unit. (Days certified as administrative are paid at the all-inclusive prospective administrative day rate.)

For claims involving Medicare crossover, Medicaid payment is the lower of the Medicare deductible amount or the difference between the Medicare payment and the Medicaid per diem prospective payment. (Medicare crossover claims involving recipient's ages 21 to 64 in freestanding psychiatric hospitals are reimbursable only if the recipient is a Qualified Medicare Beneficiary (QMB).) Also, additional Medicaid reimbursement is not made when the Medicare payment exceeds the Medicaid prospective rate. Service claims denied by Medicare are also denied by Medicaid.

403.10 INPATIENT ALCOHOL/SUBSTANCE ABUSE DETOXIFICATION AND TREATMENT SERVICES POLICY

Inpatient substance abuse services are those services delivered in freestanding substance abuse treatment hospitals or general hospitals with a specialized substance abuse treatment unit which includes a secure, structured environment, 24-hour observation and supervision by mental health substance abuse professionals, and a structured multidisciplinary clinical approach to treatment. These hospitals provide medical detoxification and treatment services for individuals suffering from acute alcohol and substance abuse conditions.

403.10A COVERAGE AND LIMITATIONS

1. Hospital inpatient days may be considered a Medicaid benefit when detoxification and treatment for acute alcohol and/or other substance abuse necessitates the constant

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availability of physicians and/or medical services found in the acute hospital setting. Medicaid reimburses for admissions to substance abuse units of general hospitals (regardless of age), or freestanding psychiatric and substance abuse hospitals for recipients age 65 and older, or those under age 21. The QIO-like vendor must prior authorize and certify all hospital admissions for both detoxification and treatment services to verify appropriateness of placement and justify treatment and length of stay.

Prior authorization is required for all Medicaid and pending Medicaid recipients, and Medicaid recipients covered through primary insurance, except Medicare Part A. If this is the case then authorization may need to be sent through Medicare.

Medicaid reimburses only for the following hospital alcohol/substance abuse detoxification and treatment services:

a. Detoxification

1. Recipients (under age 21) - Medicaid reimburses for up to five (5) hospital inpatient detoxification days with unlimited lifetime admission services (Medicaid covers stays beyond five days only if additional detoxification services are deemed medically necessary by the QIO-like vendor).
2. Recipients age 21 years and older - Medicaid reimburses for up to five (5) hospital inpatient detoxification days with unlimited lifetime admission services.
3. For recipients of all ages, results of a urine drug screen or blood alcohol test must be provided at the time of the request for authorization.

b. Treatment

1. Recipients (under age 21) - Medicaid reimburses for up to 21 hospital inpatient treatment days with unlimited lifetime admission services until the recipient reaches age 21 (stays beyond 21 days are covered only if additional treatment services are deemed medically necessary by the QIO-like vendor).
2. Recipients age 21 years and older - Medicaid reimburses for up to 21 hospital treatment days with unlimited lifetime admissions only if the recipient is deemed amenable for treatment, and has the potential to remain sober, and as determined by the physician.

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To measure the recipient's ability to be amenable to treatment and the potential to remain sober, he/she must:

- a. Be currently attending, or willing to attend during treatment and upon discharge, and actively participate in Alcoholics Anonymous (AA) and/or Narcotics Anonymous (NA) meetings.
- b. Develop, over the duration of treatment, a support system to assist sobriety efforts and a substance abuse-free lifestyle.
- c. Seek employment, employment training, or return to past employment if still available, or attend or remain in an educational program (i.e., college, vocational training).

It is the hospital's responsibility to assist the recipient during hospitalization to assure the above mentioned post discharge resources will be utilized.

Prior to inpatient admission, the referring or admitting physician must document discussing the above three “amenable to treatment” issues with the recipient, including the recipient's response to each. This documentation must be part of the recipient's inpatient hospital record. Prior to authorizing the admission, the QIO-like vendor will: 1) per discussion with the physician, verify the physician-patient communication did occur and the recipient accepts his/her responsibility toward maintaining sobriety and/or a drug free lifestyle after treatment; and 2) verify appropriateness of admission, treatment and length of stay.

A psychiatric screening must also be completed within 72 hours of any inpatient detoxification or treatment admission.

3. Absences

Please consult Section 403.12.A.5, of this Chapter regarding absences.

4. All Other Inpatient Services Coverage and Limitations. Please consult

Section 403.12A, of this Chapter for all other Coverage and Limitations.

5. Non-Covered Services

Please consult section 403.6 for non-covered services.

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403.10B PROVIDER RESPONSIBILITIES

1. The need for hospital alcohol/substance abuse detoxification and/or treatment services must be prior authorized by the QIO-like vendor. The only exception is in the event of an emergency, where a delay in treatment of more than 24 hours could result in severe pain, loss of life, limb, eyesight, or hearing, injury to self, or bodily harm to others. In this instance, the recipient may be admitted and the QIO-like vendor must be contacted for authorization purpose within 24 hours or the first working day of the admission.
2. Please consult Section 403.12.1-12, of this Chapter for additional provider responsibilities.

403.10C RECIPIENT RESPONSIBILITIES

1. Medicaid recipients are required to provide a valid monthly Medicaid eligibility card to their service providers.
2. Medicaid recipients are expected to comply with the service provider’s treatment, care, and service plans, including making and keeping medical appointments.

403.10D AUTHORIZATION PROCESS

The QIO-like vendor must certify all inpatient substance abuse detoxification and treatment admissions. Transfers to and from substance abuse detoxification/treatment services require prior authorization by the QIO-like vendor.

1. For recipients under age 21 in the custody of the public agency, Nevada Medicaid reimburses for alcohol/substance abuse detoxification and treatment services only when the following criteria are met:
 - a. DCFS’ Regional Resource Council (RRC), Utilization Review Team (URT) or Family Programs Office (FPO) (entities responsible for reviewing, recommending and authorizing appropriate placement and treatment services) approves the admission/placement (does not apply to placements at Desert Willow Treatment Center).
 - b. The admission is prior authorized and certified by the QIO-like vendor. For recipients under age 21 not in the custody of the public agency, only “b” applies.
2. Nevada Medicaid reimburses for services for recipients admitted with an alcohol/substance abuse condition/diagnosis to a general hospital without a specialized alcohol/substance abuse unit only under one of the following conditions:

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- a. The admission is an emergency and is certified by the QIO-like vendor (who must be contacted, for authorization purposes, within 24 hours or the first working day of the admission) and the hospital, as determined by the QIO-like vendor, makes all efforts to stabilize the recipient's condition and discharge the recipient to a substance abuse/psychiatric hospital or general hospital with a substance abuse/psychiatric unit as expeditiously as possible; or
- b. The recipient is dually diagnosed as having both medical and substance abuse conditions which warrant inpatient general hospital services, as determined by the QIO-like vendor; or
- c. The admission is certified by the QIO-like vendor for medical detoxification only.

Medicaid recipients between 21 and 64 years of age are covered for inpatient alcohol/substance abuse detoxification and treatment services only in a general hospital with a specialized alcohol/substance abuse unit. Those Medicaid recipients age 20 and under and age 65 and older are covered for inpatient substance abuse detoxification and treatment services in a freestanding psychiatric and/or alcohol/substance abuse hospital, as well as a general hospital with a specialized alcohol/substance abuse unit.

All transfers from detoxification to treatment require prior authorization. This applies to all Medicaid recipients, regardless of age.

Also, if a recipient is initially admitted to a hospital for acute care and is then authorized to receive alcohol/substance abuse services, the acute care is paid at the appropriate medical/surgical tier rate. The alcohol/substance abuse services are paid at the substance abuse service rate. Hospitals are required to bill Medicaid separately for each of the types of stays. The QIO-like vendor must certify the two types of stays separately.

3. Acute inpatient admissions authorized by the QIO-like vendor do not require an additional PA for physician ordered psychological evaluations and testing. The psychologist must list the QIO-like vendors "Inpatient's authorization number" on the claim form when billing for services.
4. Retrospective Reviews

The QIO-like vendor authorizes only Medicaid eligible clients, not pending eligible. Should a client become Medicaid eligible while in the facility, a retrospective review must be requested by the provider to the QIO-like vendor:

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- a. The medical record must be submitted to the QIO-like vendor within 30 days from the date of the eligibility determination.
- b. If the information submitted is not complete, a technical denial for service will be issued.
- c. The QIO-like vendor will complete the review and issue a final determination within 30 days of receipt of all requested information.

5. Determination Letters (Notices)

a. Approvals

The RTC provider is sent a “Notice of Medical Necessity Determination.”

b. Denials

The RTC provider is sent a “Notice of Medical Necessity Determination” and “Request for Reconsideration” form. The Medicaid client is sent a “Notice of Decision (NOD) for Authorization Form” and “Hearing Information and Hearing Request Form.” Denials may be due to technical/administrative (e.g. the provider did not obtain prior authorization) or clinical (e.g. client did not meet medical or clinical necessity) reasons.

6. Reimbursement

Please consult Section 403.12.D.6 of this Chapter regarding reimbursement.

7. Patient Liability

Please consult Section 403.12.B.11 of this Chapter regarding patient liability.

403.11 ADMINISTRATIVE DAYS POLICY

The primary purpose and function of administrative days is to assist hospitals, which, through no fault of their own, cannot discharge a recipient who no longer requires acute level services, due to lack of, or a delay in, an alternative appropriate setting, which includes the adequate and comprehensive documentation of discharge planning efforts. Administrative Days are reimbursed on a retrospective, not cost settlement, basis.

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403.11A COVERAGE AND LIMITATIONS

Administrative days are those inpatient days which have been certified for payment by the QIO-like vendor, based on physician advisement, at the Skilled Nursing Level (SNL) or Intermediate Care Level (ICL).

1. Skilled Nursing Level (SNL) is a unique payment benefit of the Nevada Medicaid program. These reimbursement levels provide for ongoing hospital services for those recipients who do not require acute care. Discharge to a nursing facility is not required. Issuance of this level is a reflection of the hospital services required by and provided to the recipient. SNL days may be authorized when one or more of the following apply, or as determined by physician review:
 - a. Recipient is awaiting placement, or evaluation for placement, at a nursing facility/extended care facility, group home, or other treatment setting, for continuity of medical services, e.g.:
 1. Transfers to other facilities;
 2. Rehabilitation or independent living;
 3. Hospice etc.
 - b. Recipient is to be discharged home and is awaiting home equipment set up/availability, nursing services and/or other caretaker requirements, e.g.:
 1. Home Health Nursing;
 2. Public Health Nursing;
 3. Durable Medical Equipment;
 4. Family preparation;
 5. Respite care.
 - c. Conditions which may prevent a non-acute recipient from leaving the hospital (e.g., recipient's labs must be monitored, cultures taken for staph infection, or any treatment/work up that could not be safely and effectively accomplished in another setting).
 - d. Recipient is awaiting placement at a residential treatment center, group home, or psychiatric treatment center for continuity of psychiatric services., e.g.:

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1. Partial hospitalization
 2. Therapeutic foster care
 3. Day treatment
 4. Rural mental health follow-up services
 5. Set up for wrap around services
- e. Recipient has mental disabilities that prevent nursing facility placement (e.g., failed PASRR screening), and the recipient will eventually go to an institution of mental diseases.
3. Intermediate Care Level (ICL), is a unique payment benefit of the Nevada Medicaid program, which provides reimbursement for ongoing hospital services, for those recipients who cannot be discharged due to social reasons. ICL days are authorized when one or more of the following apply, or as determined by physician review:
 - a. Stable child awaiting adoption or discharge home when the mother is discharged;
 - b. Ready for discharge and is awaiting transportation;
 - c. ICL at a nursing home or alternate setting;
 - d. Victim of crime in need of assessment and evaluation.
 4. Administrative days are denied when:
 - a. A recipient, recipient's family, or physician refuses a Nursing Facility (NF) placement.
 - b. A recipient, family, or physician refuses a psychiatric Residential Treatment Center (RTC) placement, group home, or psychiatric treatment center.
 - c. There is insufficient documentation (Monday through Friday contacts and results) in the chart reflecting adequate discharge planning.

403.11B PROVIDER RESPONSIBILITIES

Please consult Section 403.12.B of this Chapter for provider responsibilities.

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403.11C RECIPIENT RESPONSIBILITIES

1. Medicaid recipients are required to provide a valid monthly Medicaid eligibility card to their service providers.
2. Medicaid recipients are expected to comply with the service provider's treatment, care, and service plans, including making and keeping medical appointments.

403.11D AUTHORIZATION PROCESS

If appropriate, the QIO-like vendor certifies administrative days at either an SNL or ICL level of care.

403.12 ELECTROCONVULSIVE THERAPY (ECT)

Effective Date 03/01/2004. ECT is a treatment for mental disorders, primarily depression, but also acute psychotic episodes in Schizophrenia and Bipolar Disorder. A low voltage alternating current is used to induce a generalized seizure that is monitored electrographically while under general anesthesia and muscle relaxation.

Medicaid will reimburse medically necessary ECT treatments when administered by a Board Certified Psychiatrist in a qualified acute care general hospital, contracted acute care psychiatric hospital, or in a hospital outpatient surgery center/ambulatory surgery center. Recipients receiving outpatient ECT do not require a global treatment program provided in the inpatient setting prior to outpatient services.

Prior Authorization is required.

403.12A COVERAGE AND LIMITATIONS

ECT is generally used for treatment of affective disorders unresponsive to other forms of treatment. It has also been used in schizophrenia, primarily for acute schizophrenic episodes.

1. Prior authorization requires documentation of the following medically necessary indicators:
 - a. Severe psychotic forms of affective disorders
 - b. Failure to respond to other therapies
 - c. Medical preclusion to use of drugs
 - d. Need for rapid response

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- e. Uncontrolled agitation or violence to self or others
- f. Medically deemed for probable preferential response to ECT
- 2. Recipients (under 16) years of age must have all of the above indicators and:
 - a. Two prior medication trials predetermined by a physician
 - b. Two concurring opinions by a Board Certified Psychiatrist
 - c. Informed written consent by custodial parent(s)/legal guardian
- 3. Covered ICD-9-CM Codes:
 - 295.00 – 295.94 Schizophrenic disorders
 - 296.00 – 296.90 Affective psychoses
 - 298.00 – 298.9 Depressive type psychosis, and other nonorganic psychoses
- 4. Covered CPT Codes:
 - 90870 – Electroconvulsive therapy (includes necessary monitoring); single seizure
- 5. Reasons for Denial
 - a. Continuing use of ECT without evidence of recipient improvement.
 - b. Diagnostic codes not encompassed in the foregoing list.
- 6. Coding Guidelines
 - a. Anesthesia administration for ECT is a payable service only if provided by a physician other than the one administering ECT.
 - b. If billing is received for ECT and a visit on the same day, the latter will be denied if rendered by the physician administering ECT.
- 7. Documentation Requirements

Medical records should include recipient symptoms, physical findings, and diagnosis to document the medical necessity of performing ECT.

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404 HEARINGS

Please reference Medicaid Services Manual, Chapter 3100 Hearings, for hearings procedures.

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405 MEDICAID'S ANNUAL REVIEW

DHCFP has in place a formal system in which an annual review may be conducted to assure recipient satisfaction and provider compliance with the provisions of this chapter and any applicable Division chapter.

All providers must comply with this review process and submit all documentation as requested.

405.1 REFERENCES and CROSS REFERENCES

Please consult other Medicaid Services Manuals which may correlate with Chapter 400, Mental Health and Alcohol/Substance Abuse Services.

Medicaid Service Manuals:

Chapter 100	Eligibility, Coverage and Limitations
Chapter 200	Hospital Services
Chapter 600	Physician Services
Chapter 1000	Dental Services
Chapter 1100	Ocular Services
Chapter 1300	Durable Medical Equipment Services
Chapter 1500	EPSDT (Healthy Kids)
Chapter 1700	Therapy Services
Chapter 1900	Medical Transportation Services
Chapter 2500	Targeted Case Management
Chapter 3100	Medicaid Hearings Procedure
Chapter 3300	Surveillance and Utilization Review Section (SURS)
Chapter 3600	Managed Care Organizations

Nevada Check Up Manuals:

Chapter 1000	Nevada Check Up Program
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405.2 CONTACTS

1. STATE OFFICES

a. Central Office

Division of Health Care Financing and Policy
Nevada Medicaid Office
1100 E. Williams Street
Carson City, Nevada 89701
Telephone: (775) 684-3600

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b. District Offices

Nevada Division of Health Care Financing and Policy, Medicaid District Offices (DOS) are listed in various Medicaid pamphlets. Local telephone numbers are:

Carson City	(775) 684-3651
Elko	(775) 753-1191
Las Vegas	(702) 668-4200
Reno - Bible Way	(775) 687-1900

c. State of Nevada DCFS Child and Adolescent Services

For more information and how to apply for services contact:

In Northern Nevada:
2655 Enterprise Road
Reno, Nevada 89512
Telephone (775) 688-1600

In Southern Nevada:
6171 West Charleston Blvd.
Las Vegas, Nevada 89158
Telephone (702) 486-6100

All subcontractors of DCFS must also be contractors with Medicaid.

d. State of Nevada MHDS

For more information and how to apply for services contact:

Southern Nevada Adult Mental Health Services
6161 West Charleston Boulevard
Las Vegas, NV 89146-1126
Telephone: (702) 486-6000

Northern Nevada Adult Mental Health Services
480 Galletti Way
Sparks, NV 89431-5573
Telephone: (775) 688-2001

Rural Clinics Community Outpatient Services
503 North Division Street
Carson City, Nevada 89703-4104

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Telephone: (775) 687-1000

All subcontractors of MHDS must also be contractors with Medicaid.

2. PROVIDER RELATIONS UNITS

Provider Relations Department
 First Health Services Corporation
 PO Box 30026
 Reno, Nevada 89520-3026
 Toll Free within Nevada (877) NEV-FHSC (638-3472)
 Email: nevadamedicaid@fhsc.com

3. PRIOR AUTHORIZATION DEPARTMENTS

First Health Services Corporation
 Nevada Medicaid and Nevada Check Up
 HCM
 4300 Cox Road
 Glen Allen, VA 23060
 (800) 525-2395

4. PHARMACY POINT-OF-SALE DEPARTMENT

First Health Services Corporation
 Nevada Medicaid Paper Claims Processing Unit
 PO Box C-85042
 Richmond, VA 23261-5042
 (800) 884-3238

405.3 FORMS

1. CMS (HCFA) 1500 - Health insurance billing form. Forms following the sequence of the CMS (HCFA) 1500 are acceptable.

Provider may order this form from a private printer or purchase from:
 Government Printing Office
 Superintendent of Documents
 Room C 836, Building G
 Washington, DC 20401