State/Territory: Nevada

AMOUNT, DURATION, AND SCOPE OF MEDICALAND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

1. Inpatient hospital services other than those provided in an institution for mental diseases.

   Provided: ___ No limitations X With limitations*

2. a. Outpatient hospital services.

   ___ Provided: ___ No limitations X With limitations*

   b. Rural health clinic services and other ambulatory services furnished by a rural health clinic (which are otherwise included in the State plan).

   X Provided: ___ No limitations X With limitations*

   ___ Not provided.

   c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with Section 4231 of the State Medicaid Manual (HCFA-Pub. 45-4).

   X Provided: ___ No limitations X With limitations*

3. Other laboratory and x-ray services.

   Provided: X No limitations ___ With limitations*

*Description provided on Attachment.

1. Inpatient hospital services are limited to admissions certified for payment by Nevada Peer Review Organization.

2.a. Outpatient hospital services are limited to the same extent as physicians' services, prescribed drugs, therapy and other specific services listed in this Attachment (see 2.c.).

2.b. Rural health clinic services are subject to the same limitations listed for specific services elsewhere in this Attachment.

Rural Health Clinic (RHC) Services are defined in Section 1905(a)(2)(B) of the Social Security Act (the Act). RHC services include services provided by physicians (MD/DO), dentist, advanced practice registered nurse, physician assistants, nurse anesthetist, nurse midwives, psychologist, licensed clinical social workers, dental hygienist, podiatrist, radiology, optometrist, opticians (including eyeglasses dispensed), visiting nurses, clinical laboratory and other ambulatory services included in the state plan. RHC services also include services and supplies that are furnished as an incident to professional services furnished by a physician, physician assistant, nurse practitioner or nurse midwife, and related medical supplies other than drugs and biologicals. Limitations on other ambulatory services furnished in the RHC are the same limitations as defined for those services in the State Plan.

2.c. Federally qualified health center services are subject to the same limitation as those of rural health clinics.

Federally Qualified Health Center (FQHC) Services as defined in Section 1905(a)(2)(C) of the Act. FQHC services include services provided by physicians (MD/DO), dentist, advanced practice registered nurse, physician assistants, nurse anesthetist, nurse midwives, psychologist, licensed clinical social workers, dental hygienist, podiatrist, radiology, optometrist, opticians (including eyeglasses dispensed), visiting nurses, clinical laboratory and other ambulatory services included in the state plan. FQHC services also include services and supplies that are furnished as an incident to professional services furnished by a physician, physician assistant, nurse practitioner or nurse midwife, and related medical supplies other than drugs and biologicals. Limitations on other ambulatory services furnished in the FQHC are the same limitations as defined for those services in the State Plan.

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AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

4.a. Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.

Provided: __ No limitations X With limitations*

4.b. Early and periodic screening, diagnostic and treatment services for individuals under 21 years of age, and treatment of conditions found.*

4.c. Family planning services and supplies for individuals of child-bearing age.

Provided: __No limitations X With limitations*

4.d.1 Face-to-face tobacco cessation counseling services.
4.d.2 Face-to-face tobacco cessation counseling services for pregnant women.

1. Provided: (i) X By or under supervision of a physician;

(ii) X By any other health care professional who is legally authorized to furnish such services under State law and who is authorized to provide Medicaid coverable services other than tobacco cessation services; or

(iii) Any other health care professional legally authorized to provide tobacco cessation services under State law *and* who is specifically *designated* by the Secretary in regulations. (none are designated at this time)

2. Provided: _ No limitations X With limitations*

Please describe any limitations

Benefits allow for 24 counseling sessions per 12-month period. These limitations can be exceeded if determined medically necessary by the state.

5. a. Physicians' services whether furnished in the office, the patient's home, a hospital, a nursing facility or elsewhere.

Provided: __No limitations _X_With limitations*

b. Medical and surgical services furnished by a dentist (in accordance with Section 1905(a)(5)(B) of the Act).

Provided: __ No limitations X With limitations*

6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.

a. Podiatrists' services are available for all eligible recipients.

Provided: X No limitations __ With limitations*

*Description provided on Attachment.

4.a. Nursing facility services require prior authorization from the Nevada Medicaid Office.

4.b. Early Periodic Screening, Diagnostic, and Treatment (EPSDT) services as defined in 42 CFR 440.40(b). All medically necessary diagnostic and treatment services will be provided to EPSDT recipients to treat conditions detected by periodic and interperiodic screening services, even if the services are not included in the "State Plan."

Services in a school-based setting must be performed by qualified providers as set forth in the State Plan for the services they are providing and shall meet applicable qualifications under 42 CFR Part 440.

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Applied Behavior Analysis (ABA) Services

Services:

The ABA services must be medically necessary to develop, maintain, or restore to the maximum extent practical the functions of an individual with a diagnosis of Autism Spectrum Disorder (ASD) or other condition for which ABA is recognized as medically necessary. All services must be provided under a treatment plan based on evidence-based assessment criteria and include realistic and obtainable treatment goals.

Services must be rendered according to the written orders of the Physician, Physician's Assistant or an Advanced Practitioner Registered Nurse (APRN) and be directly related to the active treatment regimen designed by the healthcare professional that is clinically responsible for the treatment plan. Treatment services must be delivered by a qualified healthcare professional as defined in provider qualifications and acting within their scope of practice according to state law. 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, or in the recipient's home.

Prior authorization and service limits are applicable for treatment services based on the individual's treatment needs as determined through and medical necessity in accordance with EPSDT. Service limits may be exceeded based upon medical necessity.

Service Limitations:

a. Services which do not meet medical necessity requirements.

b. Educational services being provided under an Individualized Education Program (IEP) pursuant to the federal Individuals with Disabilities Education Act (IDEA).

c. Custodial care, child care, and/or respite care services.

d. Treatment whose purpose is vocational or recreational.

e. Services, supplies or procedures performed in a non-conventional setting including but not limited to Resorts, Spa and Camps.

f. Care coordination and treatment planning.

g. Duplicative services.

Provider Qualifications

To be recognized and reimbursed for ABA, the provider must be one of the following:

a. Licensure as a Physician by the Nevada State Board of Medical Examiners and acting within their scope of practice.

b. A doctoral degree in psychology obtained from an approved doctoral program in psychology edited by the American Psychological Association (APA) or a doctoral program in psychology accredited individually or as part of an institutional accreditation by another private or governmental accrediting agency, when the association's or agency's standards and procedures have been approved by the Nevada State Board of Psychologist Examiners. Licensed in the state in which they perform the functions or actions and acting within their scope of practice.

a. A qualified Behavior Analyst (BCBA/D) is an individual who has earned a master's degree level and/or doctorate from an accredited college or university in a field of social science or special education and holds a current certification as a Board-Certified Behavior Analyst by the Behavior Analyst Certification Board, Inc., and licensed by the appropriate Nevada State Board or qualifying state agency per Nevada Revised Statute (NRS) 437.200 – 437.335, and acting within their scope of practice as defined by state law.

b. A qualified Assistant Behavior Analyst (BCaBA) is an individual who has earned a bachelor's degree from an accredited college or university in a field of social science or special education approved by the Board and holds a current certification as a Board Certified Assistant Behavior Analyst by the Behavior Analyst Certification Board, Inc., and licensed by the appropriate Nevada State Board or qualifying state agency per NRS 437.200 – 437.335, and acting within their scope of practice. All BCaBAs must practice under the supervision of a Licensed Psychologist or BCBA/D. The Physician, Psychologist, BCBA/D will be the billing provider (they are licensed) and the BCaBA and RBT will be the servicing provider on the claim.

c. A Registered Behavior Technician (RBT) is an individual who has earned a high school diploma or equivalent, completed training and testing as approved and credentialed by the Behavior Analyst Certification Board, and registered by the appropriate Nevada State Board or qualifying state agency per NRS 437.200 – 437.335, and acting within their scope of practice. All RBTs must practice under the supervision of a Licensed Psychologist, BCBA/D, or BCaBA. The Physician, Psychologist, BCBA/D will be the billing provider (they are licensed) and the BCaBA and RBT will be the servicing provider on the claim.

4.c. Family planning services are not covered for individuals whose age or physical condition prohibits reproduction. Sterilization procedures including tubal ligations and vasectomies to permanently prevent conception are covered in accordance with 42 CFR Part 441 Subpart F.

5.a. Physician Services are only covered when deemed medically necessary. Cosmetic surgery that does not meaningfully promote the proper function of the body; does not prevent or treat illness or disease and is primarily directed at improving the appearance of a person is not covered.

5.b. Medical and surgical services provided by a dentist are limited to providers who are a Doctor of Dental Medicine or dental surgery. Reference 42 CFR 440.50 (b) for further information

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b. Optometrists' services.

XX Provided: ___ No limitations X With limitations*

___ Not provided.

c. Chiropractors' services.

XX Provided: ___ No limitations X With limitations*

___ Not provided.

d. Other practitioners' services.

XX Provided: Identified on attached sheet with description of limitations, if any.

___ Not provided.

7. Home health services.

a. Intermittent or part-time nursing services provided by a home health agency or by a registered nurse when no home health agency exists in the area.

Provided: ___ No limitations X With limitations*

b. Home health aide services provided by a home health agency.

Provided: ___ No limitations X With limitations*

c. Medical supplies, equipment, and appliances.

___ Provided: ___ No limitations X With limitations*

d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility.

XX Provided: ___ No limitations X With limitations*

___ Not Provided.

8. Private duty nursing services.

XX Provided: ___ No limitations X With limitations*

___ Not Provided.

*Description provided on Attachment 3a.

6.b. Optometrist services require prior authorization from the Nevada Medicaid Office. Refractions are limited to one in 24 months except for those required as a result of an EPSDT examination.

6.c. Chiropractor services are limited to individuals under the age of 21 and referred as a result of a Healthy Kids (EPSDT) screening.

6.d. Other practitioner services

Services of a licensed Physician Assistant within their scope of practice according to state law.

- Physician Assistants assume professional liability for services furnished by a certified community health worker effective February 1, 2022.

Services of a licensed Advanced Practice Registered Nurse within their scope of practice according to state law.

- Advanced Practice Registered Nurses assume professional liability for services furnished by a certified community health worker effective February 1, 2022.

Services of a licensed Psychologist within their scope of practice according to state law.

Services of a licensed Registered Nurse within their scope of practice according to state law.

Services of a licensed Pharmacist within their scope of practice according to state law effective July 1, 2022.

Services of a licensed Emergency Medical Technician (EMT) within their scope of practice according to state law. An EMT must have a community paramedicine endorsement to render community paramedicine services.
Services of a licensed Advanced EMT within their scope of practice according to state law. An Advanced EMT must have a community paramedicine endorsement to render community paramedicine services.

Services of a licensed Paramedic within their scope of practice according to state law. A Paramedic must have a community paramedicine endorsement to render community paramedicine services.

7. Home health care services

Services: As regulated under 42 CFR 484, 42 CFR 440.70 and other applicable state and federal law or regulation.

Home health services are certified by a physician and provided under a physician approved Plan of Care. These services may be provided in any setting where normal life activities occur. The provider must be enrolled as a Medicare Certified Home Health Agency licensed and authorized by state and federal laws to provide health care services in the home. Home health services include the following services and items:

a. Physical therapy.
(Reference Section 11 “a” of Attachment 3.1-A)

b. Occupational therapy.
(Reference Section 11 “b” of Attachment 3.1-A)

c. Speech therapy.
(Reference Section 11 “c” of Attachment 3.1-A)

d. Skilled nursing services (RN/LPN visits)

Services of a registered or licensed practical nurse that may be provided to recipients in a home setting include:

"Skilled nursing" means assessments, judgments, interventions, and evaluations of intervention, which require the training, and experience of a licensed nurse. Skilled nursing care includes but is not limited to performing assessments to determine the basis for action or a need for action; monitoring fluid and electrolyte balance; suctioning of the airway; central venous catheter care; mechanical ventilation; and tracheotomy care.

Provider Qualifications:
A "qualified registered nurse" is an individual who has met the requirements outlined in NAC 632.150 and NRS 632.

1. In addition to those requirements contained in NRS 632, an applicant for a license to practice as a registered nurse must:
   a. Have graduated from a nursing program approved by the Board.
   b. Have successfully completed courses on the theory of and have clinical experience in medical-surgical nursing, maternal and child nursing and psychiatric nursing if the applicant graduated from an accredited school of professional nursing after January 1, 1952.
   c. On or after July 1, 1982, obtain a passing score as determined by the Board on the examination for licensure.

   A "qualified licensed practical nurse" is an individual who has met the requirements outlined in NAC 632.150 and NRS 632.

2. An applicant for a license to practice as a licensed practical nurse must:
   a. Have graduated from high school or passed the general educational development test.
   b. Have graduated or received a certificate of completion from a program for registered nurses or practical nurses approved by the Board.
   c. Have successfully completed a course of study on the theory of and have clinical practice in medical-surgical nursing, maternal and child health nursing and principles of mental health if the applicant graduated from an accredited school of practical or vocational nursing after January 1, 1952.
   d. Obtain a passing score as determined by the Board on the examination for licensure.

f. Home health aide services.

Home health aides may provide assistance with:

1. Personal care services, such as bathing
2. Simple dressing changes that do not require the skills of a licensed nurse
3. Assistance with medications that are self-administered
4. Assistance with activities that are directly supported of skilled therapy services but do not require the skills of a therapist, such as, routine maintenance exercise
5. Routine care of prosthetic and orthotic device

6. Monitoring of vital signs
7. Reporting of changes in recipient condition and needs
8. Any task allowed under NRS 632 and directed in the physician's approved plan of care.

Provider Qualifications:
A person who:

- has successfully completed a state-established or other training program that meets the requirements of 42 CFR 484.36(a); and
- a competency evaluation program or state licensure program that meets the requirements of 42 CFR 484.36(b), or
- a competency evaluation program or state licensure program that meets the requirements of 42 CFR 484.36(b) or (e).

An individual is not considered to have completed a training and competency evaluation program, or a competency evaluation program if, since the individuals most recent completion of this program(s), there has been a continuous period of 24 consecutive months during none of which the individual furnished services described in 42 CFR 409.40 for compensation.

g. Medical supplies, equipment and appliances.

Services:
Equipment and appliances are defined as items which are primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of disability, illness or injury, can withstand repeated use and can be reusable and removable.

Medical supplies are those health care related items which are consumable or disposable or cannot withstand repeated use by more than one individual, that are required to address an individual medical disability, illness or injury.

Service limitations:
Nevada Medicaid covers standard medical equipment that meets the basic medical need of the recipient. Deluxe equipment will not be authorized when it is determined a standard model will meet the basic medical needs of the recipient. Items classified as educational or rehabilitative by nature are not covered under this benefit. The DME provider is required to have documentation of physician's orders prior to the dispensing of any equipment or supplies.

DME services are typically not covered under this program benefit for recipients in an inpatient setting. Customized seating systems may be covered under this benefit to a recipient in a nursing facility if the item is unique to their medical needs. Disposable services are not covered in an inpatient setting under this benefit.

Prior authorization and service limitations are applicable for some equipment and supplies. Specific limitations can be found in Chapter 1300 of the Medicaid Services Manual.

Provider Qualifications:
Providers are required to have a Medical Device Equipment and Gas licensure from the Nevada Board of Pharmacy

8. Private duty nursing services

Private duty nursing services means nursing services provided by a registered nurse or licensed practical nurse under the direction of the recipient's physician. These services may be provided in the recipient's home and other settings where normal life activities occur. To qualify for these services, a recipient must require more individual and continuous care than is available from a visiting nurse or routinely provided by the nursing staff of the hospital or skilled nursing facility. These services are provided in accordance with 42 CFR 440.80 and other applicable state and federal law or regulation. These services are offered through a home health provider that is enrolled as a Medicare Certified Home Health Agency licensed and authorized by state and federal laws to provide health care services in the home.

Provider Qualifications:
(Reference Section 7 "e" of Attachment 3.1-A)

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9. Clinic services.

X Provided: __ No limitations X With limitations*

__ Not provided.

10. Dental services.

X Provided: __ No limitations X With limitations*

__ Not provided.

11. Physical therapy and related services.

a. Physical therapy.

X Provided: __ No limitations X With limitations*

__ Not provided.

b. Occupational therapy.

X Provided: __ No limitations X With limitations*

__ Not provided.

c. Services for individuals with speech, hearing, and language disorders (provided by or under the supervision of a speech pathologist or audiologist).

X Provided: __ No limitations X With limitations*

__ Not provided.

*Description provided on Attachment.

9. Clinic services are subject to the same limitations listed elsewhere in this Attachment, e.g., limits on prescriptions and physician office visits.

Cancer and Rare Disease clinic: services provided to children with cancer and/or other rare diseases in an enrolled specialty clinic.

Clinics eligible for this enrollment must screen, evaluate, diagnose, and treat pediatric patients with cancer, hemophilia, or another known rare disease. Nevada DHCFP allows reimbursement of such services in a clinic setting when medically appropriate to the setting and medically necessary for the patient.

For a clinic to meet criteria and be enrolled into this specialty, 85% of its population must be children under the age of 21, diagnosed and/or treated with cancer, hemophilia, or another known rare disease.

Family Planning Clinics: Educate, counsel, and provide birth control methods to patients to decrease the number of unwanted pregnancies, or to help patients prepare for a healthy pregnancy and baby.

Genetic Clinics: Offer programs that test symptomatic or asymptomatic individuals, including prospective parents, for possible genetic conditions or provide prospective or retrospective counseling regarding genetic concerns.

Methadone Clinic: "A Facility for treatment with narcotics" which means any person or any public or private facility that provides a narcotic treatment program described in 42 C.F.R. Part 8.

Public Health: Provide preventive, diagnostic, therapeutic, rehabilitative, or palliative services. Services may include EPSDT screenings, maternal support services, family planning services, laboratory services, dental services, as well as child health, prenatal and primary care services and immunizations. Must be a county entity.

School Based Health Centers (SBHC): Provide primary and preventive medical services to Medicaid and Nevada Check Up recipients. SBHCs are health centers located on or near a school facility of a school district, independent school, or board of an Indian tribe or tribal organization. All services that are provided must be medically necessary to be considered covered SBHC services.

Comprehensive Outpatient Rehabilitation Facilities (CORF): Provide coordinated outpatient diagnostic, therapeutic, and restorative services, at a single fixed location, to outpatients for the rehabilitation of injured, disabled, or sick individuals.

Community Health Clinics – State Health Division: Provide preventive, diagnostic, therapeutic, rehabilitative, or palliative services. Services may include EPSDT screenings, maternal support services, family planning services, laboratory services, dental services, as well as child health, prenatal and primary care services and immunizations. Must be a state entity.

Special Children's Clinic: Provides services to children and their families with developmental delays or disabilities. These clinics are part of Nevada state agencies.

Tuberculosis (TB) Clinic: Works with its community partners to provide coordinated treatment and services to TB patients which includes case management, evaluations to recipients in need of TB care, contact investigations and education of TB treatment and control.

HIV: Provides care and support services to individuals living with HIV/AIDS

Substance Use Agency Model: Provides services for prevention and treatment for recipients who have been diagnosed or at risk of substance use disorders. American Society of Addiction Medicine (ASAM) patient placement criteria is used to establish guidelines for level of care placements within the substance use treatment continuum.

10. Dental services are limited to emergency care only. For those individuals referred for diagnosis/treatment under the Early Periodic Screening, Diagnosis and Treatment Program dental services are not so limited, and the full range of dental care is provided without authorization. Orthodontics through EPSDT require prior authorization.

11a. Physical therapy provided in an outpatient setting

Services: As regulated under 42 CFR §440.110(a) and other applicable state and federal law or regulation.

Physical therapy means services prescribed by a physician or other licensed practitioner of the healing arts within the scope of practice under state law and provided to a recipient by or under the direction of a qualified physical therapist to ameliorate/improve neuromuscular, musculoskeletal and cardiopulmonary disabilities which can respond or improve as a result of the prescribed treatment plan in a reasonable, predicable period of time. Services related to the general health and welfare of recipients, such as general exercises and play/recreational therapy to promote overall fitness and flexibility and activities to provide diversion or general motivation is not covered. Service limits may be exceeded based on medical necessity.

Physical Therapy Evaluations and Treatments: includes assessing, preventing or alleviating movement dysfunction and related functional problems; obtaining and interpreting information; and coordinating care and integrating services relative to the recipient receiving treatment such as:

a. Evaluation and diagnosis to determine the existence and extent of motor delays, disabilities and/or physical impairments affecting areas such as tone, coordination, movement, strength, and balance;
b. Therapeutic exercise;
c. Application of heat, cold, water, air, sound, massage, and electricity;
d. Measurements of strength, balance, endurance, range of motion;
e. Individual or group therapy.

Maintenance Therapy means services provided by or under the direction of a qualified therapist to develop and safely implement a maintenance program to maintain functional status at a level consistent with the patient's physical or mental limitations or to prevent decline in function. Services must be established during the last rehabilitative treatment visit. Services must be medically necessary and require the management of a qualified therapist.

Maintenance Therapy Evaluations and Treatments: includes establishing a plan, assuring patient safety, training the patient, family members and/or unskilled personnel to maintain functional status or prevent decline in function, and making necessary reevaluations of the plan such as:

a. Ongoing evaluation of patient performance;
b. Adjustment to the maintenance program to achieve appropriate functional goals;
c. Prevent decline of function;
d. Provide interventions, in the case of a chronic or progressive limitation, to improve the likelihood of independent living and quality of life; and
e. Provide treatment interventions for recipients who are making progress, but not at a rate comparable to the expectations of restorative care.

Provider Qualifications:

A "qualified physical therapist" is an individual who is a graduate of a program of physical therapy approved by both the Committee on Allied Health Education and Accreditation of the American Medical Association and the American Physical Therapy Association or its equivalent; and where applicable, licensed by the State.

Physical therapy assistant is a person who is licensed as a physical therapist assistant, if applicable, by the State in which practicing (NRS 640.260), and has graduated from a 2-year college-level program approved by the American Physical Therapy Association; or has 2 years of appropriate experience as a physical therapist assistant, and has achieved a satisfactory grade on a proficiency examination conducted, approved, or sponsored by the U.S. Public Health Service, except that these determinations of proficiency do not apply with respect to persons initially licensed by a State or seeking initial qualification as a physical therapy assistant after December 31, 1977. PTA works under the direct supervision of the PT and is not receiving direct reimbursement.

All personnel who are involved in the furnishing of outpatient physical therapy services directly by or under arrangements with an organization must be legally authorized (licensed or, if applicable, certified or registered) to practice by the State in which they perform the functions or actions and must act only within the scope of their State license or State certification or registration.

The physical therapist must be present or readily available to supervise a physical therapist assistant for prescribed supervised CPT modalities that do not require direct (one-on-one), patient contact by the licensed therapist.

11b. Occupational therapy services provided in an outpatient setting

Services: As regulated under 42 CFR §440.110(b) and other applicable state and federal law or regulation.

Occupational therapy means services prescribed by a physician or other licensed practitioner of the healing arts within the scope of practice under state law and provided to a recipient by or under the direction of a qualified occupational therapist to ameliorate/improve functional disabilities which can respond or improve as a result of the prescribed treatment plan in a reasonable, predicable period of time. Services related to the general health and welfare of recipients, such as general exercises and play/recreational therapy to promote overall fitness and flexibility and activities to provide diversion or general motivation is not covered. Service limits may be exceeded based on medical necessity.

Occupational Therapy Evaluations and Treatments: Include assessing, improving, developing, or restoring functions impaired or lost through illness, injury or deprivation, improving ability to perform tasks for independent functioning when functions are lost or impaired, preventing through early intervention, initial or further impairment or loss of function; and obtaining and interpreting information; and coordinating care and integrating services, such as:

a. Evaluation and diagnosis to determine the extent of disabilities in areas such as sensorimotor skills, self-care, daily living skills, play and leisure skills, and use of adaptive or corrective equipment;
b. Task-oriented activities to prevent or correct physical or emotional deficits to minimize the disabling effect of these deficits;
c. Exercise to enhance functional performance;
d. Individual and group therapy.

Maintenance Therapy means services provided by or under the direction of a qualified therapist to develop and safely implement a maintenance program to maintain functional status at a level consistent with the patient's physical or mental limitations or to prevent decline in function. Services must be established during the last rehabilitative treatment visit. Services must be medically necessary and require the management of a qualified therapist.

Maintenance Therapy Evaluations and Treatments: includes establishing a plan, assuring patient safety, training the patient, family members and/or unskilled personnel to maintain functional status or prevent decline in function, and making necessary reevaluations of the plan such as:

a. Ongoing evaluation of patient performance;
b. Adjustment to the maintenance program to achieve appropriate functional goals;
c. Prevent decline of function;
d. Provide interventions, in the case of a chronic or progressive limitation, to improve the likelihood of independent living and quality of life; and
e. Provide treatment interventions for recipients who are making progress, but not at a rate comparable to the expectations of restorative care.

Provider Qualifications:

A "qualified occupational therapist" is an individual who is a graduate of a program in occupational therapy approved by the Committee on Allied Health Education and Accreditation of the American Medical Association and engaged in the supplemental clinical experience required before registration by the American Occupational Therapy Association.

Occupational therapy assistant is a person who has satisfied the academic requirement of an educational program approved by the Board of Occupational Therapy and the American Occupational Therapy Association and is authorized (licensed or certified) to practice by the State in which they perform the functions or actions and must act only within the scope of their State license or State certification or registration. OTA works under the direct supervision of the OT and is not receiving direct reimbursement.

All personnel who are involved in the furnishing of outpatient occupational therapy services directly by or under arrangements with an organization must be legally authorized (licensed or, if applicable, certified or registered) to practice by the State in which they perform the functions or actions and must act only within the scope of their State license or State certification or registration.

The occupational therapist must be present or readily available to supervise an occupational therapist assistant for prescribed supervised CPT modalities that do not require direct (one-on-one), patient contact by the licensed therapist.

11c. Services for individuals with speech, hearing, and language disorders provided in an outpatient setting

Services: as regulated under 42 CFR §440.110(c) and other applicable state and federal law or regulation.

Speech and language pathology services are those services necessary for the diagnosis and treatment of speech and language disorders that result in communication disabilities and for the diagnosis and treatment of swallowing disorders with or without the presence of a communication disability. The services must be of such a level of complexity and sophistication or the condition of the patient must be such that the services required can be safely and effectively performed only by a qualified therapist. Services are provided to a recipient to ameliorate/improve functional disabilities which can respond or improve as a result of the prescribed treatment plan in a reasonable, predicable period of time. Service limits may be exceeded based on medical necessity.

The practice of audiology consists of rendering services for the measurement, testing, appraisal, prediction, consultation, counseling, research or treatment of hearing and hearing impairment for the purpose of modifying disorders in communication involving speech, language and hearing. Audiology services must be performed by a certified and licensed audiologist. Treatment services such as:

a. Speech and language evaluations and diagnosis of delay and/or disabilities to include voice, communication, fluency, articulation, or language development;
b. Individual treatment and therapeutic modalities and/or group treatment (therapy);
c. Audiological evaluation and diagnosis to determine the presence or extent of hearing impairments;
d. Complete hearing and/or hearing aid evaluation, hearing aid fittings or re-evaluations, and audiograms.

Maintenance Therapy means services provided by or under the direction of a qualified therapist to develop and safely implement a maintenance program to maintain functional status at a level consistent with the patient's physical or mental limitations or to prevent decline in function. Services must be established during the last rehabilitative treatment visit. Services must be medically necessary and require the management of a qualified therapist.

Maintenance Therapy Evaluations and Treatments: includes establishing a plan, assuring patient safety, training the patient, family members and/or unskilled personnel to maintain functional status or prevent decline in function, and making necessary reevaluations of the plan such as:

a. Ongoing evaluation of patient performance;
b. Adjustment to the maintenance program to achieve appropriate functional goals;
c. Prevent decline of function;
d. Provide interventions, in the case of a chronic or progressive limitation, to improve the likelihood of independent living and quality of life; and
e. Provide treatment interventions for recipients who are making progress, but not at a rate comparable to the expectations of restorative care.

Provider Qualifications:

Speech and language pathologists are required to have a State license or State certification or registration and have a certificate of clinical competence from the American Speech and Hearing Association (ASHA); have completed the equivalent educational requirements and work experience necessary for the certificate; or has completed the academic program and is acquiring supervised work experience to qualify for the certificate;

A qualified audiologist has a master's or doctoral degree in audiology which meets State licensure requirements. Per NRS 637B.160 they are licensed by the Board of Examiners for Audiology and Speech Pathology.

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12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

a. Prescribed drugs.

_X_ Provided __ No limitations _X_ With limitations*

___ Not Provided

b. Dentures.

_X_ Provided __ No limitations _X_ With limitations*

___ Not Provided

c. Prosthetic devices.

_X_ Provided __ No limitations _X_ With limitations*

___ Not Provided

d. Eyeglasses.

_X_ Provided __ No limitations _X_ With limitations*

___ Not Provided

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.

a. Diagnostic services.

_X_ Provided __ No limitations _X_ With limitations*

___ Not Provided

*Description provided on Attachment.

12.a.

1. Nevada Medicaid will meet all reporting and provision of information requirements of Section 1927(b)(2) and the requirements of Subsections (d) and (g) of Section 1927.

2. Covered outpatient drugs are those of any manufacturer who has entered into and complies with an agreement under Section 1927(a), which are prescribed for a medically accepted indication (as defined in Subsection 1927(k)(6)) of Title XIX of the Social Security Act.

1935(d)(1) 3. Effective January 1, 2006, the Medicaid agency will not cover any Part D drug for full-benefit dual eligible individuals who are entitled to receive Medicare benefits under Part A or Part B.

1927(d)(2)
1935(d)(2) a. Other Drugs Not Covered:

1) Pharmaceuticals designated "ineffective" or "less than effective" (including identical, related, or similar drugs) by the Food and Drug Administration (FDA) as to substance or diagnosis for which prescribed.
2) Pharmaceuticals considered "experimental" as to substance or diagnosis for which prescribed.
3) Pharmaceuticals manufactured by companies not participating in the Medicaid Drug Rebate Program unless rated "1-A" by the FDA.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Agency

MEDICAID PROGRAM: REQUIREMENTS RELATING TO COVERED OUTPATIENT DRUGS FOR THE CATEGORICALLY NEEDY

12.a. Prescribed Drugs: Description of Service Limitation

Citation(s)	Provision(s)
1935(d)(1)	Effective January 1, 2006, the Medicaid agency will not cover any Part D drug for full-benefit dual eligible individuals who are entitled to receive Medicare benefits under Part A or Part B.
1927(d)(2) and 1935(d)(2)	The Medicaid agency provides coverage for the following excluded or otherwise restricted drugs or classes of drugs, or their medical uses to all Medicaid recipients, including full benefit dual eligible beneficiaries under the Medicare prescription Drug Benefit – Part D. ☐ **The following excluded drugs are covered:** *("All" drugs categories covered under the drug class)* ☐ *("Some" drugs categories covered under the drug class* ☐ *-List the covered common drug categories not individual drug products directly under the appropriate drug class)* *("None" of the drugs under this drug class are covered)* ☐ ☐ (a) agents when used for anorexia, weight loss, weight gain ☐ (b) agents when used to promote fertility ☐ (c) agents when used for cosmetic purposes or hair growth ☒ (d) agents when used for the symptomatic relief of cough and colds

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Agency _____

MEDICAID PROGRAM: REQUIREMENTS RELATING TO COVERED OUTPATIENT DRUGS FOR THE CATEGORICALLY NEEDY

12.a. Prescribed Drugs: Description of Service Limitation

Citation(s)	Provision(s)
	☒ (e) prescription vitamins and mineral products, except prenatal vitamins and fluoride
	☒ (f) nonprescription drugs
	☐ (g) covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee (see specific drug categories below)

3. The State will not pay for covered outpatients' drugs of a non-participating manufacturer, except for drugs rated "1-A" by the FDA. If such a medication is essential to the health of a recipient and a physician has obtained approval for use of the drugs in advance of its dispensing, it may be covered by the program pursuant to Section 1927(a)(3).

4. The Medicaid program restricts coverage of certain covered outpatient drugs through the operation of a prior authorization program. The prior authorization process provides for a turn-around response by either telephone or other telecommunications device within twenty-four hours of receipt of a prior authorization request. In emergency situations, providers may dispense at least a seventy-two-hour supply of medication in accordance with the provisions of §1927 (d)(5) of the (SSA).

5. Pursuant to 42 U.S.C. Section 1396r-8, the state is establishing a preferred drug list with prior authorization for drugs not included on the preferred drug list. The state, or the state in consultation with a contractor, may negotiate supplemental rebate agreements that will reclassify any drug not designated as preferred in the baseline listing for as long as the agreement is in effect.

6. Pursuant to Section 1927(d)(6), the State has established a maximum quantity of medication per prescription as a 34-day supply; maintenance drugs per prescription as a 100-day (three month) supply; and contraceptives per prescription as a 12-month supply.

    a. In those cases where less than a 30-day supply of maintenance drug is dispensed without reasonable medical justification, the professional fee may be disallowed.

    b. In nursing facilities if the prescriber fails to indicate the duration of therapy for maintenance drug, the pharmacy must estimate and provide at least a 30-day supply.

7. The state will meet the requirements of Section 1927 of the SSA. Based on the requirements for Section 1927 of the act, the state has the following policies for the supplemental rebate program for Medicaid recipients:

    a. CMS has authorized the State of Nevada to enter into direct agreements with pharmaceutical manufacturers for a supplemental drug rebate program. The supplemental rebate agreement effective July 1, 2014 amends the original, January 1, 2012 version, which is effective through their expiration dates. Additionally, CMS has authorized the State of Nevada to enter into the Michigan multi-state pooling agreement (MMSPA) also referred as the National Medicaid Pooling Initiative (NMPI) for drugs provided to Medicaid beneficiaries. The NMPI Supplemental Rebate Agreement (SRA) was submitted to CMS on March 30, 2022 and has been reviewed and authorized by CMS.

    b. Supplemental rebates received by the State under these agreements by the State that are in excess of those required under the national drug rebate agreement will be shared with the federal government on the same percentage basis as applied under the national rebate agreement.

    c. All drugs covered by the program, irrespective of a supplemental agreement, will comply with provisions of the national drug rebate agreement.

d) The unit rebate amount is confidential and cannot be disclosed for purposes other than rebate invoicing and verification, in accordance with Section 1927 (b)(3)(D).

e) Acceptance of supplemental rebates for products covered in the Medicaid program does not exclude the manufacturers' product(s) from prior authorization or other utilization management requirements.

f) Rebates paid under CMS-approved Supplemental Rebate Agreement for the Nevada Medicaid population does not affect AMP or best price under the Medicaid program.

g) Rebates paid under CMS-approved Supplemental Rebate Agreement for the Nevada Medicaid population does not affect AMP or best price under the Medicaid program.

8. The Medicaid program restricts coverage of certain covered outpatient drugs through the operation of a prior authorization program. The prior authorization process provides for a turn-around response by either telephone or other telecommunications device within 24 hours of receipt of a prior authorization request. In emergency situations, providers may dispense at least a 72-hour supply of medication in accordance with the provisions of §1927 (d)(5) of the SSA.

9. Pursuant to Section 1927(d)(6), the State has established a maximum quantity of medication per prescription as a 34-day supply; maintenance drugs per prescription as a 100-day (three month) supply; and contraceptives per prescription as a 12-month supply.

   a) In those cases where less than a 30-day supply of maintenance drug is dispensed without reasonable medical justification, the professional fee may be disallowed.

   b) In nursing facilities if the prescriber fails to indicate the duration of therapy for maintenance drug, the pharmacy must estimate and provide at least a 30-day supply.

12. b. Dentures are allowed every five years.

c. Prosthetic devices must be prescribed by a physician or osteopath and must be prior authorized by the Nevada Medicaid Office on Form NMO-3.

d. Eyeglasses are limited to those prescribed to correct a visual defect of at least 0.5 diopters or 10 degrees in axis deviation for recipients for recipients of all ages once in 12 months, or with prior authorization if program limitations are exceeded. In addition, they are available on the periodicity schedule established for EPSDT.

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

b. Screening services.

_X_ Provided ___ No limitations _X_ With limitations*

___ Not Provided

c. Preventive services.

_X_ Provided ___ No limitations _X_ With limitations*

___ Not Provided

d. Rehabilitative services.

_X_ Provided ___ No limitations _X_ With limitations*

___ Not Provided

14. Services for individuals age 65 or older in institutions for mental diseases.

a. Inpatient hospital services.

_X_ Provided ___ No limitations _X_ With limitations*

___ Not Provided

b. Nursing facility services.

_X_ Provided ___ No limitations _X_ With limitations*

___ Not Provided

*Description provided on Attachment.

A. Diagnostic Services. Provided under the EPSDT program.

B. Screening Services. Annual mammography provided to women aged 40 and over. Screening services also provided under the EPSDT program.

C. Preventive Services. Services provided are according to the United States Preventive Services Task Force (USPSTF) A and B recommendations along with approved vaccines and their administration recommended by the Advisory Committee on Immunization Practices (ACIP). Documentation is available to support claiming of FMAP for such services. As changes are made to the USPSTF and/or ACIP, coverage and billing codes will be updated to comply with the changes. Cost sharing is not applied to any of these services.

Medical Nutrition Therapy (MNT): Medical nutrition therapy services are designed to provide medically necessary, diagnostic, therapy and counseling services for the management of nutrition related disease states. MNT involves the assessment of an individual's overall nutritional status followed by an individualized course of treatment to prevent or treat medical illness. Services must be provided under a treatment plan based on evidence-based assessment criteria and include realistic and obtainable goals.

Services:

The following services are covered when provided by a Licensed and Registered Dietician and must include coordination with the referring provider:

a. An initial nutrition and lifestyle assessment
b. One on one or group nutrition counseling
c. Follow-up intervention visits to monitor progress in managing diet
d. Subsequent visits in the following years
e. Services may be provided in a group setting with the same service limitations

Service limits may be exceeded based on medical necessity. Prior authorization is required

Service Limitations:

MNT services are rendered by a Licensed and Registered Dietitian (RD) working in a coordinated, multidisciplinary team effort with a Physician, Physician's Assistant (PA) or Advanced Practice Registered Nurse (APRN). Treatment services must be ordered by the recipient's referring provider and delivered by a Registered Dietitian as defined in provider qualifications and acting within the scope of their licensure.

Provider Qualifications:

a. Licensure as a Registered Dietitian by the Nevada State Board of Health.
b. The individual must hold a bachelor's degree or higher education from an accredited college or university in human nutrition, nutrition education or equivalent education and completed the required training.
c. Registered dietitians are not authorized to supervise any non-licensed practitioners to provide medical nutrition therapy services.

Doula Services:

A doula is a non-medically trained professional who provides education, emotional and physical support during pregnancy, labor/delivery, and postpartum period.

Services:
The following doula services are covered beginning April 1, 2022:

a. Emotional support, including bereavement support
b. Physical comfort measures during peripartum (i.e. labor and delivery)
c. Facilitates access to resources to improve health and birth-related outcomes
d. Advocacy in informed decision making
e. Evidence-based education and guidance

Service Limitations:
Pursuant to 42 CFR Section 440.130(c), doula services are preventive services and must be recommended by a physician or other licensed practitioner of the healing arts within their scope of practice under state law. Referral or prior authorization is not required.

Any services requiring medical or clinical licensure are not covered.

Provider Qualifications:
Approved certification from the Nevada Certification Board as a doula must be obtained prior to rendering services.

D. Rehabilitative Services:

1. Mental Health Rehabilitation Services

Mental health rehabilitation assists individuals to restore 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 appropriate.

The services must be recommended by a physician or other licensed practitioner of the healing arts, within their scope of practice and prescribed on an individualized treatment plan to achieve maximum reduction of a mental disability and restore the recipient to their optimal level of functioning.

13D. Rehabilitative Services

The following Practitioners and Qualifications chart is applicable to each of the Mental Health Rehabilitation Services that follow in this section.

Licensed Professionals		
Provider Type/Qualifications	**Services Provided**	**Supervisions Requirements**
• Licensed Marriage and Family Therapist (LMFT) • 42 CFR 440.60 • Licensed Clinical Social Worker (LCSW) • 42 CFR 440.60 • Licensed Clinical Professional Counselor (CPC) • 42 CFR 440.60 • Licensed Clinical Alcohol and Drug Counselor (LCADC) • 42 CFR 440.60 • Licensed Alcohol and Drug Counselor (LADC) • 42 CFR 440.60	• Individual counseling • Group counseling • Medication Assisted Treatment • Family therapy • Behavioral Health Assessment • Basic Skills Training • Psychosocial Rehabilitation • Peer-to-Peer Support Services • Crisis Services •	Services must be within the scope of the providers licensure.
• Licensed Psychologist 42 CFR 440.60	• Individual counseling • Group counseling • Family Therapy • Behavioral Health Assessment • Psychological Testing	NA
• Licensed Psychiatrist 42 CFR 440.50	• Evaluation • Medication management • Individual counseling • Group counseling • Medication Assisted Treatment • Family therapy	NA

• Registered Nurse	• Behavioral Health Assessments • Crisis Services	NA
• Advanced Practice Registered Nurse (psychiatry)	• Medication Management • Behavioral Health Assessments • Crisis Services	N/A
• Certified Alcohol and Drug Counselor (CADC) NRS 641C.390	• Individual counseling • Group counseling • Medication Assisted Treatment • Behavioral Health Assessment • Basic Skills Training • Psychosocial Rehabilitation • Peer-to-Peer Support Services • Crisis Services	CADCs do not require supervision and can function on their own within their scope of practice as referenced in NRS 641C.390. They are not licensed, but certified.
Qualified Mental Health Professional (QMHP)		
Provider Type/Qualifications	**Services Provided**	**Supervision Requirements**
• Licensed Marriage and Family Therapist (LMFT) 42 CFR 440.60 • Licensed Clinical Social Worker (LCSW) 42 CFR 440.60 • Licensed Clinical Professional Counselor (CPC) 42 CFR 440.60 • Licensed Psychologist 42 CFR 440.60 • Advanced Practice Registered Nurse The following licensed interns are covered as a QMHP	• Individual counseling • Group counseling • Medication Assisted Treatment • Family therapy • Behavioral Health Assessment • Basic Skills Training • Psychosocial Rehabilitation • Peer-to-Peer Support Services • Crisis Services	Practitioners acting in the QMHP capacity must practice within the scope of their license. Interns or those not licensed independently must be supervised by a licensed clinician appropriate to their scope/board in accordance with State regulations. The DHCFP understand that the supervising licensed clinician assumes responsibility for licensed intern supervisees.

• Licensed Marriage and Family Therapist Intern (LMFT-Intern) 42 CFR 440.60 • Licensed Clinical Social Worker Intern (LCSW-Intern) 42 CFR 440.60 • Licensed Clinical Professional Counselor Intern (CPC-Intern) 42 CFR 440.60		
Qualified Mental Health Associates (QMHA)		
Provider Type/Qualification	**Services Provided**	**Supervisions Requirements**
• Registered nurse; or • A person who meets the following minimum documented qualifications; ○ Holds a bachelor's degree in a social services field with ○ Additional understanding of mental health rehabilitation services, and case file documentation requirements; AND ○ Education and experience demonstrate the competency under clinical supervision to direct and provide professional therapeutic interventions within the scope of their practice and limits of their expertise,	• Basic Skills Training • Psychosocial Rehabilitation • Crisis Services • Peer-to-Peer Support Services	Staff acting in the QMHA capacity must be supervised by a licensed clinician appropriate to their scope/board as listed under Licensed Professionals. The DHCFP understand that the supervising licensed clinician assumes responsibility for unlicensed supervisees.

identify presenting problems, participate in treatment plan development and implementation, coordinate treatment, provide parenting skills, training, facilitate discharge plans, and effectively provide verbal and written communication on behalf of the recipient to all involved parties, AND o FBI background check in accordance with the provider qualifications of a QBA.		
Qualified Behavioral Aide (QBA)		
Provider Type/Qualifications	**Services Provided**	**Supervisions Requirements**
• A person who has an educational background of a high-school diploma or GED equivalent. • A QBA must have the documented competencies to assist in the provision of individual and group rehabilitation services which are under the direct supervision of a QMHP or QMHA o Read, write and follow written or oral instructions o Perform mental health	• Basic Skills Training • Peer-to-Peer Support Services	Staff acting in the QBA capacity must be supervised by a licensed clinician appropriate to their scope/board as listed under Licensed Professionals. The DHCFP understand that the supervising licensed clinician assumes responsibility for unlicensed supervisees. QBAs are required to participate in and successfully complete an approved training program which includes basic training, periodic and continuing in service training. Training must be interactive and not solely based on self-study guides or

rehabilitation services as documented in the treatment plan o Identify emergency situations and respond accordingly, o Communicate effectively, o Document services provided o Maintain confidentiality, o Successfully complete approved training program o CPR certification, • FBI criminal background check to ensure no convictions of applicable offenses have been incurred.		videotapes and should ensure that a QBA will be able to interact appropriately with individuals with mental health disorders. Training must also include: ▪ Case file documentation; ▪ Recipient's rights; ▪ HIPAA compliance; ▪ Communication skills; ▪ Problem solving and conflict resolution skills; ▪ Communication techniques for individuals with communication or sensory impairments; and ▪ CPR certification The entity that is providing supervision over the QBA shall provide annually a minimum of eight hours of service training for each QBA. 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 entity. Training requirements may be waived if the QBA can provide written verification of comparable education and training. The entity must document this validation.

Peer Supporter		
Provider Type/Qualifications	Services Provided	Supervision Requirements
• A qualified individual currently or previously diagnosed with a mental health disorder who has the skills and abilities to work collaboratively with and under the direction of a QMHP; • Qualified Behavioral Aide (QBA);	• Peer-to-Peer Support Services	• Peer-to-Peer Support services are delivered under Clinical Supervision, provided by an independently licensed mental health professional QMHP-level mental health professional, Licensed Clinical Social Worker (LCSW), Licensed Marriage and Family Therapist (LMFT), or Clinical Professional Counselor (CPC). Supervision by the QMHP, LCSW, LMFT, or CPC, that must be provided and documented at least monthly; and • Quarterly In-Service Training: i. Specific to Peer-to-Peer Support Service delivery, the training must include any single or any combination of the following competencies: 1. The ability to help stabilize the recipient; 2. The ability to help the recipient access community-based mental health and/or behavioral health services; 3. The ability to assist during crisis situations and interventions; 4. The ability to provide preventative care assistance; and 5. The ability to provide personal encouragement, peer mentoring, self-

		direction training, and self-advocacy; and ii. Includes two hours of training in any single or any combination of the following competencies: 1. Basic living and self-care skills; 2. Social skills; 3. Communication skills 4. Parental training; 5. Organizational and time management skills; and 6. Transitional living skills.

2. Mental Health Rehabilitation Services

Mental health rehabilitation assists individuals to restore 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 appropriate.

The services must be recommended by a physician or other licensed practitioner of the healing arts, within their scope of practice and prescribed on an individualized treatment plan to achieve maximum reduction of a mental disability and restore the recipient to their optimal level of functioning.

Each individual service must be identified on a written rehabilitation plan. This is also referenced as the treatment plan. Providers are required to maintain case records. Components of the rehabilitation plan and case records must be consistent with the federal rehabilitation regulations. Rehabilitation services may only be covered by Medicaid if they are not the responsibility of other programs and if all applicable requirements of the Medicaid program are met. Services covered under the Title IV-E program are not covered under the rehabilitation program. Room and Board is not an allowable service under the mental health rehabilitative program. Services are not provided to recipients who are inmates of a public institution.

These services require utilization review according to the individual intensity of need and are time limited.

Rehabilitative mental health services may be provided in a community-based, outpatient services, home-based, and school-based environment. Depending on the specific services they may be provided in a group or individual setting. All collateral services that are delivered to a person that is an integral part of the recipient's environment such as medically necessary training, counseling and therapy, must directly support the recipient.

Services are based on an intensity of needs determination. The assessed level of need specifies the amount, scope and duration of mental health rehabilitation services required to improve, 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) and is based on several components related to person- and family-centered treatment planning. These components include:

- A comprehensive assessment of the recipient's level of functioning;
- The clinical judgment of the QMHP; or
- The clinical judgment of the case manager working under clinical supervision who is trained and qualified in mental health intensity of services determinations; and
- A proposed Treatment Plan.

A re-determination of the intensity of needs must be completed every 90 days or anytime there is a substantial change in the recipient's clinical status.

Nevada Medicaid utilizes an intensity of needs grid to determine the amount and scope of services based upon the clinical level of care of the recipient. The grid is based upon the current level of care assessments: Level of Care Utilization System (LOCUS) for adults and Child and Adolescent Services Intensity Instrument (CASII) for children. The determined level on the grid guides the interdisciplinary team in planning treatment.

Within each level there are utilization standards for the amount of services to be delivered. The six levels are broken out by the following categories in order from less intense to more intense;

Level of Care Utilization System (LOCUS)

- Level 1- Recovery maintenance and health management,
- Level 2- Low intensity community-based services,
- Level 3- High intensity community-based services,
- Level 4- Medically monitored non-residential services,
- Level 5- Medically monitored residential services, and
- Level 6 -Medically managed residential services.

Child and Adolescent Services Intensity Instrument (CASII)

- Level 1- Basic services, Recovery maintenance and health management,
- Level 2-Outpatient services,
- Level 3- Intensive outpatient services,
- Level 4- Intensive integrated services,
- Level 5- Non-secure, 24-hour services with psychiatric monitoring,
- Level 6- Secure, 24-hour services with psychiatric management.

All mental health rehabilitation services must meet the associated admission and continuing stay criteria and go through utilization management per the intensity of needs grid.

Service Array:

1. *Assessments: C*overed 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. An assessment is not intended for entry into each of the services. It is provided as an overall assessment of the recipient's needs. Assessments are limited to two per calendar year. Additional assessments may be prior authorized based upon medical necessity. Re-assessments utilizing the appropriate CPT codes are not subject to the initial assessment limitations.

2. *Mental Health Screens*: Determine eligibility for admission to treatment program. This is completed through a clinical determination of the intensity of need of the recipient. The objective of this service is to allow for the 90-day review for the intensity of needs determination and to determine either SED or SMI if it has not already been determined. The provider must meet the requirements of a QMHA.

3. *Neuro-cognitive/psychological and mental status testing:* This service is performed by a QMHP. Examples of testing are defined in the CPT; neuropsychological testing, neurobehavioral testing, and psychological testing. Each service includes both interpretation and reporting of the tests. This service requires prior authorization.

4. *Basic Skills Training*: Services in this category are rehabilitative interventions that target concrete skills training such as: monitoring for safety, basic living skills, household management, self-care, social skills, communication skills, parent education, organization skills, time management, and transitional living skills. This service is provided in a variety of settings including community-based, outpatient services, and the home environment. The level of professional providing the services is dependent upon the needs of the recipient and the utilization management criteria. This service is provided by a QMHP or QMHA, under the direction of a QMHP, or provided by a QBA under the direct supervision of a QMHP or QMHA. This may be provided in a group (four or more individuals) or in an individual setting. These services require utilization review according to the individual intensity of need and are time limited.

5. *Psycho-social Rehabilitation*: Services in this category are rehabilitative interventions that target specific behaviors. These services may include: behavioral management and counseling, conflict and anger management, interpersonal skills, collateral interventions with schools and social service systems, parent and family training and counseling, community transition and integration, and self-management. This service is provided in a variety of settings including, community-based, outpatient services, and the home environment. The level of professional providing the services is dependent upon the needs of the recipient and the utilization management criteria. This is provided on an individual basis or in a group consisting of at least four individuals. Service is provided by a QMHP or a QMHA. The services provided may be directly attributable to an individual provider. Recipients must either be severely emotionally disturbed or seriously mentally ill. The level of care of the recipient is consistent with the high intensity community-based services. These services require utilization review according to the individual intensity of need and are time limited. This service is reimbursed in 15-minute increments.

6. *Crisis Intervention*: A service provided by a QMHP to recipients who are experiencing a psychiatric crisis and a high level of personal distress. Crisis intervention services are brief, immediate and intensive interventions to reduce symptoms, stabilize the recipient, restore the recipient to his/her previous level of functioning, and to assist the recipient in returning to the community as rapidly as possible, if the recipient has been removed from their natural setting. The individual demonstrates an acute change in mood or thought that is reflected in the recipient's behavior and necessitates crisis intervention to stabilize and prevent hospitalization. The Individual is a danger to himself, others or property or is unable to care for self as a result of personal illness. These services may be mobile and may be provided in a variety of settings, including, but not limited to, psychiatric emergency departments, homes, hospital emergency rooms, schools, child protective custody and homeless shelters. Crisis intervention services include follow-up and de-briefing sessions to ensure stabilization and continuity of care.

The service may be provided telephonically, as long as the service meets the definition of crisis intervention. Face to face crisis intervention is reimbursable for either one QMHP or a team that is composed of at least one QMHP and another QMHP or QMHA. This service is allowable for all levels of care. These services require utilization review according to the individual intensity of need and are time limited. All service limitations may be exceeded with a prior authorization demonstrating medical necessity.

7. Intentionally left blank.

8. *Mental Health Therapy:* Provided by a QMHP for individual, group, and/or family therapy with the recipient present and for family therapy without the recipient present. Therapy delivered must be of a direct benefit to the recipient. Minimum size for group therapy is three individuals and a maximum therapist to participant ratio is one to ten. Mental health therapy is available at all levels of care. The intensity of the service increases based on the need of the recipient. These services require utilization review according to the individual intensity of need and are time limited. All service limitations may be exceeded with a prior authorization demonstrating medical necessity.

Level of Care	**Child & Adolescent**	**Adult**
Level 1	10 Total Sessions; Individual, Group and Family	6 Total Sessions; Individual, Group and Family
Level II	26 Total Sessions; Individual, Group and Family	12 Total Sessions; Individual, Group and Family
Level III	26 Total Sessions; Individual, Group and Family	12 Total Sessions; Individual, Group and Family
Level IV	26 Total Sessions; Individual, Group and Family	16 Total Sessions; Individual, Group and Family
Level V	26 Total Sessions; Individual, Group and Family	18 Total Sessions; Individual, Group and Family
Level VI	26 Total Sessions; Individual, Group and Family	18 Total Sessions; Individual, Group and Family

9. *Day Treatment Services*: A community-based psycho-social package of rehabilitative services designed to improve individual and group functioning for effective community integration. This is not an Institution for Mental Illness (IMD), a Residential Treatment Facility, nor is it an institution as defined under federal regulation. Admission to this program requires: severe emotional disturbance or serious mental illness and recipient's clinical and behavioral issues require intensive, coordinated, multi-disciplinary intervention within a therapeutic milieu. Day treatment is provided in a structured therapeutic environment which has programmatic objectives such as but not limited to: development of skills to promote health relationships and learn to identify ingredients that contribute to healthy relationships, development of coping skills and strategies, development of aggression prevention plans, problem identification and resolution, ability to learn respectful behaviors in social situations, development of the ability to demonstrate

self-regulation on impulsive behaviors, development of empathy for peers and family and develop a clear understanding of recipients cycles of relapse and a relapse prevention plan. Services must be provided by a QMHP or by a QMHA under the direct supervision of a QMHP. The services provided may be directly attributable to an individual provider. The staff ratio is one to five participants. The average time per day this program is offered is three hours per day. All service limitations may be exceeded with a prior authorization meeting medical necessity.

Level of Care	**Ages 3-6**	**Ages 7-18**	**Ages 19 and older**
Level I and II	No Services Authorized	No Services Authorized	No Services Authorized
Level III	Max. of 3 hrs per day	Max. of 4 hrs per day	No Services Authorized
Level IV	Max. of 3 hrs per day	Max. of 5 hrs per day	Max. of 5 hrs per day
Level V	Max. of 3 hrs per day	Max. of 6 hrs per day	Max. of 6 hrs per day
Level VI	Max. of 3 hrs per day	Max. of 6 hrs per day	Max. of 6 hrs per day

Mental health therapy and day treatment cannot be billed for the same time period. This service is consistent with intensive integrated outpatient services. These services require utilization review according to the individual intensity of need and are time limited.

10. *Peer-to-Peer Support Services*:

These services provide scheduled activities that encourage recovery, self-advocacy, developments of natural supports, and maintenance of community living skills. They promote skills for self-determination, community inclusion/participation, independence, and productivity. Peer Supporters model skills to help individuals meet their rehabilitative goals. Peer-to-Peer Support Services are for the direct benefit of the beneficiary and assist individuals and their families in the use of strategies for coping, resiliency, self-advocacy, symptom management, crisis support, and recovery.

Service Limitations – Services may be provided in an individual or group (requires five or more individuals) setting. The services are identified in the recipient's treatment plan and must be provided by a Peer Supporter working collaboratively with the case manager or child and family team/interdisciplinary team. The selection of a Peer Supporter is based on the best interest of the recipient. A Peer Supporter cannot be the legal guardian or spouse of the recipient. Services are offered based on the intensity/frequency of needs and are time limited. Additional hours may be granted when services are clinically indicated based on a recipient-centered approach and when determined medically necessary by the state.

11. *Intensive Outpatient Services:*

Service Definition (Scope) – A comprehensive array of direct mental health and rehabilitative services which are expected to restore an individual's condition and functioning level for prevention of relapse or hospitalization. These services are provided to individuals who meet the state's medical necessity criteria for the services. Intensive outpatient group sizes are required to be within four to 15 recipients. Intensive outpatient services require the availability of 24/7 psychiatric and psychological services.

Intensive outpatient services include:

- Individual counseling
- Group counseling
- Medication management
- Medication Assisted Treatment
- Drug Testing
- Family therapy

- Occupational therapy
- Behavioral Health Assessment
- Basic Skills Training
- Psychosocial Rehabilitation
- Peer-to-Peer Support Services
- Crisis Services

Service Limitations – Intensive Outpatient services may exceed minimum hours when services are clinically indicated based on a patient centered approach. Intensive Outpatient services are direct services provided no less than three days a week, with a minimum of three hours a day and not to exceed six hours a day. Individuals needing services that exceed this time frame should be reevaluated for referral to a higher intensity/frequency of services.

Utilization management must include on-going patient assessments, including intensity of needs determinations using ASAM/LOCUS/CASII, to evaluate patient's response to treatment interventions and to monitor progress toward treatment plan goals. On-going patient assessments must be completed at regularly scheduled intervals and whenever clinically indicated. Patient assessments must document the individual patients response to the treatment plan, progress towards goals, changes in identified goals and objectives based on progress and substantiate continued stay at the current intensity/frequency of services, or of response to the treatment plan and resolution of issues necessitates transfer to a higher or lower intensity/frequency of services or discharge from treatment as no longer meeting medical necessity at any level. Transfer and discharge planning must reflect best practices recognized by professional and advocacy organizations that ensure coordination of needed services, follow-up care and recovery supports.

12. *Partial Hospitalization Services:*

Service Definition (Scope) - Services furnished in an outpatient setting, at a hospital or an enrolled federally qualified health center (FQHC) that assumes clinical liability and meets the criteria of a Certified Mental Health Clinic (CMHC). Partial hospitalization services encompass a variety of psychiatric treatment services designed for recipients who require a higher intensity of coordinated, comprehensive and multidisciplinary treatment. These services are expected to restore the individual's condition and functional level and to prevent relapse or admission to a hospital. 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. Partial hospitalization services include active therapeutic treatment and must be targeted to meet the goals of alleviating impairments and restoring functioning.

Partial hospitalization services include:

- Individual counseling
- Group counseling
- Medication management
- Medication Assisted Treatment
- Drug Testing
- Family therapy
- Occupational therapy
- Behavioral Health Assessment
- Basic Skills Training
- Psychosocial Rehabilitation
- Peer-to-Peer Support Services
- Crisis Services

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

Service Limitations – Partial hospitalization may exceed minimum hours when services are clinically indicated based on a patient centered approach. PHP services are direct services provided no less than five days a week, with a minimum of four hours a day and not to exceed 23 hours a day. Individuals needing services that exceed this time frame should be reevaluated for referral to a higher intensity/frequency of services. Individuals who are not able to reside safely in the community with appropriate supports to actively engage in the PHP should not be considered appropriate for this intensity/frequency of services. Utilization management must include on-going patient assessments, including intensity of needs determinations using ASAM/LOCUS/CASII, to evaluate patient's response to treatment interventions and to monitor progress toward treatment plan goals. On-going patient assessments must be completed at regularly scheduled intervals and whenever clinically indicated. Patient assessments must document the individual patient response to the treatment plan, progress towards goals, changes in identified goals and objectives based on progress and substantiate continued stay at the current intensity/frequency of services, or of response to the treatment plan and resolution of issues necessitates transfer to a higher or lower intensity/frequency of services or discharge from treatment as no longer meeting medically necessity at any level. Transfer and discharge planning must reflect best practices recognized by professional and advocacy organizations that ensure coordination of needed services, follow-up care and recovery supports.

the following: a graduate degree in counseling and a license as a marriage and family therapist, or a clinical professional counselor, or is employed by the State of Nevada mental health agency and meets class specification qualifications of a Mental Health Counselor. The following licensed interns are covered as a QMHP: Licensed clinical social worker intern, licensed marriage and family therapist intern, licensed clinical professional counselor interns, or a Psychological Intern registered through the Psychological Board of Examiners defined in NAC 641.165. Interns must be supervised in accordance with state regulations and may only provide services within the scope of their licensure.

b. Qualified Mental Health Associate: A person who meets the following minimum documented qualifications; 1) Registered nurse OR 2) holds a bachelor's degree in a social services field with additional understanding of mental health rehabilitation services, and case file documentation requirements; AND 3) whose education and experience demonstrate the competency under clinical supervision to direct and provide professional therapeutic interventions within the scope of their practice and limits of their expertise, identify presenting problems, participate in treatment plan development and implementation, coordinate treatment, provide parenting skills, training, facilitate discharge plans, and effectively provide verbal and written communication on behalf of the recipient to all involved parties, AND 4) Has an FBI background check in accordance with the provider qualifications of a QBA.

c. Qualified Behavioral Aide: A person who has an educational background of a high-school diploma or GED equivalent. A QBA may only provide the following services: basic skills training and peer support services. A QBA must have the documented competencies to assist in the provision of individual and group rehabilitation services which are under the direct supervision of a QMHP or QMHA, read, write and follow written or oral instructions, perform mental health rehabilitation services as documented in the treatment plan, identify emergency situations and respond accordingly, communicate effectively, document services provided, maintain confidentiality, successfully complete approved training program, CPR certification, and have completed an FBI criminal background check to ensure no convictions of applicable offenses have been incurred. QBA's are required to participate in and successfully complete an approved training program which includes basic training, periodic and continuing in service training. Training must be interactive and 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. Training must also include:

- Case file documentation;
- Recipient's rights;
- HIPAA compliance;
- Communication skills;
- Problem solving and conflict resolution skills;
- Communication techniques for individuals with communication or sensory impairments; and
- CPR certification

The entity that is providing supervision over the QBA shall provide annually a minimum of eight hours of service training for each QBA. 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 entity. Training requirements may be waived if the QBA can provide written verification of comparable education and training. The entity must document this validation.

approved training program, CPR certification, and have completed an FBI criminal background check to ensure no convictions of applicable offenses have been incurred. QBA's are required to participate in and successfully complete an approved training program which includes basic training, periodic and continuing in service training. Training must be interactive and 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. Training must also include:

- Case file documentation;
- Recipient's rights;
- HIPAA compliance;
- Communication skills;
- Problem solving and conflict resolution skills;
- Communication techniques for individuals with communication or sensory impairments; and
- CPR certification

The entity that is providing supervision over the QBA shall provide annually a minimum of eight hours of service training for each QBA. 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 entity. Training requirements may be waived if the QBA can provide written verification of comparable education and training. The entity must document this validation.

Certified Community Behavioral Health Centers (CCBHC)

Certified Community Behavioral Health Center (CCBHC) is an entity that provides integrated, comprehensive health services with a focus on behavioral health. Certification indicates that the entity meets criteria as established by the State of Nevada, by the Division of Public and Behavioral Health's (DPBH) Health Care Quality and Compliance (HCQC) bureau. CCBHC's services must be provided under the philosophy of recovery and be informed by best practices for working with individuals from diverse cultural and linguistic backgrounds. Providers within the CCBHC model utilize pre-existing provider qualifications outlined under the current Rehabilitative section of the State Plan for behavioral health services and HCQC validates the appropriate policies and procedures are in place to operate as a CCBHC.

CCBHCs may also contract with Designated Collaborative Organization (DCO) that provide aspects of those services. Designated Collaborating Organization (DCO) is a distinct entity that is not under the direct supervision of a CCBHC but has a formal contractual relationship with a CCBHC to provide an authorized CCBHC service. The CCBHC must ensure the DCO provides the same quality of care as those required by the CCBHC certification. The CCBHC maintains ultimate clinical responsibility for the services provided to CCBHC recipients by the DCO under this agreement. To the extent that services are required that cannot be provided by either the CCBHC directly or by a DCO, referrals may be made to other providers or entities. The CCBHC retains responsibility for the overall coordination of a recipient's care including services provided by the DCO or those to which it refers a recipient. Providers within the DCO's utilize pre-existing provider qualifications outlined in the State Plan.

Service Array:

Nevada Medicaid offers the following services under a CCBHC delivery model. The services are currently covered services under the Rehabilitative Services benefit (13d.) of the State Plan.

- Crisis mental health services, including 24-hour mobile crisis teams, emergency crisis intervention services and crisis stabilization;
- Screening, assessment and diagnosis, including risk assessment;
- Patient-centered treatment planning or similar processes, including risk assessment and crisis planning;
- Outpatient mental health and substance use services;
- Outpatient clinic primary care screening and monitoring of key health indicators and health risk; targeted case management;
- Psychiatric rehabilitation services;
- Peer support and counselor services and family supports.

Service Limitations:

There are no limitations on the amount, duration, and scope for services furnished under a CCBHC delivery model. An individual's treatment plan defines the services they will receive.
Practitioner/Provider Qualifications:
Please refer to the chart located at the beginning of the 13d. Rehabilitative Service section.

14. Services for individuals age 65 or older in institutions for mental diseases

A. Inpatient hospital services are limited to recipients 65 and older if the admission is prior authorized by Medicaid's Peer Review Organization (PRO). The only exception for the recipient to be admitted without a prior authorization would be in the event of an emergency in which the PRO must be notified for certification purposes within five business days after the admission.

Inpatient psychiatric services are limited to seven days. Additional services may be authorized if accompanied by daily documentation from the attending physician and determined medically necessary by the state.

An emergency psychiatric admission must meet at least one of the following three criteria:

1. Active suicidal ideation accompanied by a documented suicide attempt or documented history of a suicide attempt(s) within the past 90 days; or

2. Active suicidal ideation accompanied by physical evidence (e.g., a note) or means to carry out the suicide threat (e.g., gun, knife or another deadly weapon); or

3. Documented aggression within the 72-hour period before admission:

   a. Which resulted in harm to self, others, or property;

   b. Which manifests that control cannot be maintained outside inpatient hospitalization; and

   c. Which is expected to continue if no treatment is provided.

B. Nursing facility services require prior authorization from the Medicaid office on Form NMO-49.

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND
REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

15. a. Intermediate care facility services for MR (other than such services as in an institution for mental diseases) for persons determined, in accordance with Section 1902(a)(31)(A) of the Act, to be in need of such care.

X Provided __ No limitations X With limitations*

___ Not provided

b. Including such services in a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions.

X Provided __ No limitations X With limitations*

___ Not provided

16. Inpatient psychiatric facility services for individuals under 22 years of age.

X Provided X No limitations __With limitations*

___ Not provided

17. Nurse-midwife services.

X Provided ___ No limitations X With limitations*

___ Not provided

18. Hospice care (in accordance with Section 2302 of the Affordable Care Act).

X Provided X No limitations ___ With limitations*

___ Not provided

*Description provided on Attachment.

15. a. Intermediate care facility services require prior authorization from the Institutional Care Unit on Form NMO-49.

16. Intentionally left blank.

17. Nurse-midwife services are limited to the same extent as are physicians' services.

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State/Territory: NEVADA

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

19. Case management services and Tuberculosis related services

a. Case management services as defined in, and to the group specified in, Supplement 1 to ATTACHMENT 3.1-A (in accordance with section 1905(a)(19) or section 1915(g) of the Act).

_X_ Provided: _X_ With limitations

___ Not provided.

b. Special tuberculosis (TB) related services under section 1902(z)(2)(F) of the Act.

___ Provided: ___ With limitations

_X_ Not provided.

20. Extended services to pregnant women.

a. Pregnancy-related and postpartum services for a 60-day period after the pregnancy ends and any remaining days in the month in which the 60th day falls.

___ Additional coverage ++

b. Services for any other medical conditions that may complicate pregnancy.

_X_ Additional coverage ++

++ Attached is a description of increases in covered services beyond limitations for all groups described in this attachment and/or any additional services provided to pregnant women only.

State/Territory: Nevada

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

21. Ambulatory prenatal care for pregnant women furnished during a presumptive eligibility period by an eligible provider (in accordance with Section 1920 of the Act).

__ Provided: __ No limitations __ With limitations*

_X_ Not provided.

22. Respiratory care services (in accordance with Section 1902(e)(9)(A) through (C) of the Act).

_X_ Provided: __ No limitations _X_ With limitations*

__ Not provided.

23. Certified pediatric or family nurse practitioners' services.

Provided: __ No limitations _X_ With limitations*

*Description provided on Attachment.

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

20. Extended services to pregnant women include all major categories of service provided for categorically needy recipients, except for services for individuals aged 65 or older in institutions for mental diseases, insofar as the services are medically necessary and related to the pregnancy. Services may require prior authorization from the Nevada Medicaid Office on Form NMO-3.

Expanded dental benefits are covered for pregnant women who are not normally covered for adult recipients ages 21 and older. In order to reduce the risk of premature birth due to periodontal disease, pregnant women will be allowed dental prophylaxes and certain periodontal services during pregnancy, as outlined within the Medicaid Services Manual, Chapter 1000, and the Provider Type 22 (Dentist) Fee Schedule, available on the Nevada Medicaid website, at http://dhcfp.nv.gov/.

21. All respiratory care services require prior authorization from the Medicaid Office on Form NMO-3.

22. Pediatric or family nurse practitioner services are limited to the same extent as physician services.

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

24. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

a.1. Transportation

☒ Provided: ☐ No Limitations ☒ With Limitations
☐ Not Provided.

a.2. Brokered Transportation

☒ Provided: Under Section 1902(a)(70) ☐ No Limitations ☒ With Limitations*
☐ Not Provided.

b. Services provided in Religious Health Care Institutions

☐ Provided: ☐ No Limitations ☐ With Limitations
☒ Not Provided.

c. Reserved

d. Nursing facility services for patients under 21 years of age

☒ Provided: ☐ No Limitations ☒ With Limitations*
☐ Not Provided.

e. Emergency hospital services.

☒ Provided: ☒ No Limitations ☐ With Limitations
☐ Not Provided.

f. Personal care services in recipient home, prescribed in accordance with a plan of treatment and provided by a qualified person under supervision of a registered nurse.

☐ Provided: ☐ No Limitations ☐ With Limitations
☒ Not Provided.

Covered under Item 26.

* Description provided on following pages

24.a.1. Transportation

General Transportation Operations and Requirements

Nevada has three types of transportation services. Emergency Transportation Services and Non-Emergency Secure Behavioral Health Transport Services are provided as optional medical services without a broker. Nevada uses the broker authority at 42 CFR 440.170(a)(4) for Non-Emergency Transportation called the Non-Emergency Medical Transportation (NEMT) Program.

All Medicaid transportation services must be:

1. Medically necessary;
2. Only to and from Nevada Medicaid covered services;
3. Provided by the least expensive means available which is in accordance with the recipient's medical condition and needs;
4. To the nearest appropriate Medicaid health care provider or medical facility.

Emergency Medical Transportation Services

Emergency medical transportation services are covered to the nearest, appropriate Medicaid health care provider or appropriate medical facility capable of meeting the recipient's medical needs, in an emergent situation, when other methods of transportation are contraindicated. Emergency medical transportation may be provided via ground ambulance or air ambulance which includes rotary or fixed wing transport. These services do not require prior authorization.

Medicaid does not reimburse the following for emergency transportation:

1. Transportation to non-covered medical services; or
2. Ambulance charges for waiting time, stairs, plane loadings and in-town mileage;
3. Deadheading;
4. Emergency transportation for recipients whose eligibility is pending at the time of transport.
5. Response with non-transport.

Non-Emergency Secure Behavioral Health Transport Services

Non-emergency secure behavioral health transport services means the use of a motor vehicle, other than an ambulance or other emergency response vehicle, that is specifically designed, equipped and staffed by an accredited agent to transport a person alleged to be in a mental health crisis or other behavioral health condition, including those individuals placed on a legal hold. All Nevada Medicaid recipients who meet the aforementioned criteria would be eligible for non-emergency secure behavioral health transports.

Accredited agents are licensed through the Division of Public and Behavioral Health (DPBH) which oversees issuance or renewal of a license and require the transport provider to develop and maintain certain operational policies. All requirements for the licensure are prescribed in Chapter 433 of the Nevada Administrative Code.

Before an employee of a non-emergency secure behavioral health transport provider may serve on a vehicle that transports patients or provide direct supportive services to patients, the employee must complete the following:

1. Four hours of evidence-based training concerning de-escalation of conflicts and obtain biennial recertification in de-escalation of conflicts.

2. Eight hours of evidence-based training concerning behavioral health which includes, without limitation, training concerning:

    a. Suicide prevention and intervention;
    b. The manner in which to respond when a person has overdosed on opioids; and
    c. Awareness of issues relating to mental health and substance use.

In addition to the required training above, each such employee must be currently certified in the techniques of administering cardiopulmonary resuscitation.

Vehicles used for non-emergency secure behavioral health transports must include a driver's compartment that is separated from the passenger compartment in a manner that allows the driver and passenger to communicate and prohibits the passenger from accessing the driver or any control for operating the vehicle. The passenger compartment must have two or more traditional vehicle seats with appropriate seat belt restraints, is free from exposed sharp edges, equipped with doors that automatically lock and are not capable of opening while the vehicle is in motion, and has space for a gurney or stretcher that is capable of being lifted to the comfort level of a patient.

Non-emergency secure behavioral health transports may be used for the following transports:

1. Facility-to-facility transport from a mental health facility or medical facility to another mental health facility or medical facility;

2. Transport to and from a facility arranged by individuals authorized by NRS 433A.160 to arrange for transportation; or

3. Transport of an individual seeking voluntary admission pursuant to NRS 433A.140 to a public or private mental health facility.

Recipients must be transported to the nearest, most appropriate Medicaid health care provider or medical facility. Family members or other unaccredited agents are not allowed to ride in the non-emergency secure behavioral health transport vehicle with the recipient. These services do not require prior authorization.

24.a.2. Brokered Transportation

☒ The State assures it has established a non-emergency medical transportation program in accordance with 1902(a)(70) of the Social Security Act in order to more cost-effectively provide transportation, and can document, upon request from CMS, that the transportation broker was procured in compliance with the requirements of 45 CFR 92.36 (b)-(i).

(1) The State will operate the broker program without the requirements of the following paragraphs of Section 1902(a);

☐ (1) state-wideness (indicate areas of State that are covered)

☒ (10)(B) comparability (indicate participating beneficiary groups)

☒ (23) freedom of choice (indicate mandatory population groups)

(2) Transportation services provided will include:

☒ wheelchair van
☒ taxi
☒ stretcher car
☒ bus passes
☒ tickets
☒ secured transportation
☒ other transportation (if checked describe below other transportation).

In addition to the modes described above, NET may also be provided by the following modes of transportation, excluding non-emergency secure behavioral health transports:

1. Ground ambulance;
2. Commercial air flight;
3. Gas Mileage Reimbursement
4. Paratransit- Public;
5. Transportation Network Companies; and
6. Private vehicles

(3) The State assures that transportation services will be provided under a contract with a broker who:

(i) is selected through a competitive bidding process based on the State's evaluation of the broker's experience, performance, references, resources, qualifications, and costs:

(ii) has oversight procedures to monitor beneficiary access and complaints and ensures that transportation is timely and transport personnel are licensed qualified, competent and courteous:

(iii) is subject to regular auditing and oversight by the State in order to ensure the quality and timeliness of the transportation services provided and the adequacy of beneficiary access to medical care and services:

(iv) complies with such requirements related to prohibitions on referrals and conflict of interest as the Secretary shall establish (based on prohibitions on physician referrals under Section 1877 and such other prohibitions and requirements as the Secretary determines to be appropriate.)

The State assures that the NET broker itself is not a provider of transportation. The NET broker may not hold ownership in any NET provider with whom the broker subcontracts or arranges NET through a non-contractual relationship. This prohibition applies to the corporation, if the broker is incorporated and to the owners, officers or employees of the broker.

The State of Nevada assures the availability of medically necessary transportation to and from medical providers for eligible Medicaid recipients in the following ways:

1. Eligible Medicaid program recipients are informed verbally and in writing of the availability of non-emergency transportation services by the Nevada Medicaid contracted transportation broker.

2. NET is contracted by a broker to provide transportation to medically necessary covered services statewide 24 hours a day, seven days per week, including weekends and holidays. The NET broker operates within all applicable Federal, State and local laws.

3. All NET services require prior authorization by DHCFP's NET broker with the exception of NET services provided by Indian Health Services (IHS) clinics. The NET broker is required to authorize the least expensive alternative conveyance available consistent with the recipient's medical condition and needs.

4. The NET broker will facilitate rides for recipients requiring door-to-door transport (Paratransit). The DHCFP will reimburse the Regional Transportation Commission (RTC) directly for any costs incurred for these services.

5. Eligible recipients may be reimbursed the cost of meals and lodging en route to and from medical care for long distance medical appointments.

6. An attendant's cost may be covered if an attendant is required to ensure the recipient receives the required medical services.

The following are not covered under NET services:

1. Transportation to and from non-covered services;
2. Travel to visit a recipient in an inpatient treatment facility except in the case of parents visiting a newborn that is in a facility;
3. Transportation between hospitals for outpatient or inpatient care or services;
4. Deadheading;
5. The cost of renting an automobile for private vehicle transport;
6. Wages or salary for escorts;
7. Charges for waiting time, stairs, plane loading;
8. Routine or special supplies including oxygen;
9. Recipients requiring any medical care or supervision during transport;
10. Transportation of a recipient in a personal care attendant's private vehicle;
11. Transportation from a Nursing Facility (NF) to an outpatient medical appointment. NET is the responsibility of the NF as NET is included in the NF all-inclusive per diem rates.
12. When multiple recipients make the same trip in a private vehicle, reimbursement is made for only one recipient; and
13. Basic life support (BLS), and advanced life support (ALS) transports.

(4) The broker contract will provide transportation to the following categorically needy mandatory populations:

☒ Low-income families with children (Section 1931)
☐ Deemed AFCD-related eligibles
☒ Poverty-level related pregnant women
☒ Poverty-level infants
☒ Poverty-level children 1 through 5
☒ Poverty-level children 6 – 18
☒ Qualified pregnant women AFDC – related
☒ Qualified children AFDC – related
☒ IV-E foster care and adoption assistance children
☒ TMA recipients (due to employment) (Section 1925)
☒ TMA recipients (due to child support)
☒ SSI recipients

(5) The broker contract will provide transportation to the following categorically needy optional populations:

☐ Optional poverty-level - related pregnant women
☐ Optional poverty-level - related infants
☐ Optional targeted low-income children

☒ Non-IV-E children who are under State adoption assistance agreements
☒ Non-IV-E independent foster care adolescents who were in foster care on their 18th birthday
☒ Individuals who meet income and resource requirements of AFDC or SSI
☐ Individuals who would meet the income & resource requirements of AFDC if child care costs were paid from earnings rather than by a State agency
☐ Individuals who would be eligible for AFDC if State plan had been as broad as allowed under Federal law
☐ Children aged 15-20 who meet AFDC income and resource requirements
☒ Individuals who would be eligible for AFDC or SSI if they were not in a medical institution
☐ Individuals infected with TB
☒ Individuals screened for breast or cervical cancer by CDC program
☐ Individuals receiving COBRA continuation benefit
☒ Individuals in special income level group, in a medical institution for at least 30 consecutive days, with gross income not exceeding 300% of SSI income standard
☒ Individuals receiving home and community-based waiver services who would only be eligible under State plan if in a medical institution
☒ Individuals terminally ill if in a medical institution and will receive hospice care
☐ Individuals aged or disabled with income not above 100% FPL
☐ Individuals receiving only an optional State supplement in a 209(b) State
☐ Individuals working disabled who buy into Medicaid (BBA working disabled group)
☒ Employed medically improved individuals who buy into Medicaid under TWWIIA Medical Improvement Group
☒ Individuals disabled age 18 or younger who would require an institutional level of care (TEFRA 134 kids).

(6) Payment Methodology

(A) The State will pay the contracted broker by the following method:

☒ (i) risk capitation

☐ (ii) non-risk capitation

☒ (iii) other (e.g., brokerage fee and direct payment to providers) (If checked describe any other payment methodology)

(B) Who will pay the transportation provider?

☒ (i) Broker

☐ (ii) State

☐ (iii) Other (if checked describe who will pay the transportation provider)

(C) What is the source of the non-Federal share of the transportation payments?

Describe below the source of the non-Federal share of the transportation payments proposed under the State plan amendment. If more than one source exists to fund the non-Federal share of the transportation payment, please separately identify each source of non-Federal share funding.

☒ (D) The State assures that no agreement (contractual or otherwise) exists between the State or any form of local government and the transportation broker to return or redirect any of the Medicaid payment to the State or form of local government (directly or indirectly). For instance, the NEMT broker will facilitate rides for recipients requiring door-to-door transport (Paratransit). The DHCFP will reimburse the Regional Transportation Commission (RTC) directly for any costs incurred for these services. This assurance is not intended to interfere with the ability of a transportation broker to contract for transportation services at a lesser rate and credit any savings to the program.

☒ (E) The State assures that payments proposed under this State plan amendment will be made directly to transportation providers and that the transportation provider payments are fully retained by the transportation providers and no agreement (contractual or otherwise) exists between the State or local government and the transportation provide to return or redirect any of the Medicaid payment to the State or form of local government (directly or indirectly).

☒ (7) The broker is a non-governmental entity:

☒ The broker is not itself a provider of transportation nor does it refer to or subcontract with any entity with which it has a prohibited financial relationship as described at 45 CFR 440.170(4)(ii).

☐ The broker is itself a provider of transportation or subcontracts with or refers to an entity with which it has a prohibited financial relationship; and

☐ Transportation is provided in a rural area as defined at 412.62(f) and there is no other available Medicaid participating provider or other provider determined by the State to be qualified except the non-governmental broker.

☐ Transportation is so specialized that there is no other available Medicaid participating provider or other provider determined by the State to be qualified except the non-governmental broker.

☐ The availability of other non-governmental Medicaid participating providers or other providers determined by the State to be qualified is insufficient to meet the need for transportation.

☐ (8) The broker is a governmental entity and provides transportation itself or refers to or subcontracts with another governmental entity for transportation. The governmental broker will:

☐ Maintain an accounting system such that all funds allocated to the Medicaid brokerage program and all costs charged to the Medicaid brokerage will be completely separate from any other program.

☐ Document that with respect to each individual beneficiary's specific transportation needs, the government provider is the most appropriate and lowest cost alternative.

☐ Document that the Medicaid program is paying no more for fixed route public transportation than the rate charged to the general public and no more for public para-transit services than the rate charged to other State human services agencies for the same service.

(9) Please describe below how the NEMT brokerage program operates. Include the services that will be provided by the broker. If applicable, describe any services that will not be provided by the broker and name the entity that will provide these services.

The NEMT broker provides transportation to and from medically necessary Nevada Medicaid covered services. Transportation is provided by the least expensive means available which is in accordance with the recipient's medical condition and needs and to the nearest appropriate Medicaid health care provider or medical facility. NEMT is available to all eligible Medicaid recipients with limitations.

Recipients call the NEMT broker for reservations. The NEMT broker verifies the recipient's eligibility and the existence of a medical services appointment. Recipients are screened for the most appropriate level of service. Recipients who use the system frequently or require high cost transportation may be further assessed by the Medicaid District Office to ensure appropriate utilization. The NET broker authorizes and schedules the rides with providers. The broker determines efficient routes.

The NEMT broker provides NEMT both statewide and out of state. Recipients traveling out of state may have the cost of meals and lodging en route to and from medical care, and while receiving medical care reimbursed. An attendant's costs may be covered if an attendant is required to ensure the recipient receives required medical services.

Medicaid does not reimburse the costs of non-emergency travel which had not been prior authorized or transportation to non-covered medical services. Ambulance charges for waiting time, stairs, plane loadings and in-town mileage and No shows, where a ride does not occur are also not reimbursable.

Full benefit dual eligible recipients may receive NEMT services to Access Medicaid only services.

Provider Qualifications

To be a NEMT provider, a vendor must have a current provider agreement with Nevada Medicaid NEMT broker, a State issued exemption from TSA regulation, proof of a liability insurance policy, pursuant to NRS 706.291 for a similar situated motor carrier, a criminal background check and an alcohol and substance abuse testing program in place for the drivers, and vehicles adequately maintained to meet the requirements of the contract. Vehicles shall comply with the Americans with Disabilities Act (ADA) regulations.

24.d. Nursing facility services for patients under 21 years of age require prior authorization from the Nevada Medicaid Office on Form NMO-49.

24.f. Personal care services covered under Item 26, Page 10a.

State: NEVADA

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

25. Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A, and Appendices A-G to Supplement 2 to Attachment 3.1-A.

___ Provided X Not Provided

26. Personal care services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for persons with mental retardation (ICF/MR), or institution for mental disease that are: (1) authorized for an individual in accordance with a service plan approved by the State; (2) provided by an individual who is qualified to provide such services and who is not a member of the individual's family; and (3) furnished in a home or other location.

X Provided: X State Approved (Not Physician Service Plan Allowed)

_____ Not Provided: X Services Outside the Home Also Allowed

X Limitations Described on Attachment

26a. Nevada Medicaid PERSONAL CARE SERVICES (PCS) assist, support, and maintain recipients living independently in their homes and in settings outside the home. These services are to be provided where appropriate, medically necessary, and consistent with program utilization control procedures. Personal Care Services may be an alternative to institutionalization. These services and hours are established based on medical necessity and must be prior authorized by Medicaid and established using a Medicaid defined functional assessment. Personal care services cannot exceed hours determined by a functional assessment conducted by State Medicaid staff or their designee. Services may be reassessed when a significant change in condition or circumstance occurs or annually as specified in policy.

Personal care services include a range of human assistance provided to persons with disabilities and chronic conditions of all ages, which enables them to accomplish tasks they would normally do for themselves if they did not have a disability. Assistance may be in the form of hands-on assistance (actually performing a personal care task for a person) or cuing so that the person performs the task by him/herself. Such assistance most often relates to performance of activities of daily living (ADLs) and instrumental activities of daily living (IADLs). ADLs include eating, bathing, dressing, toileting, transferring, and maintaining continence. IADLs capture more complex life activities and include light housework, laundry, meal preparation, transportation, and grocery shopping. Personal care services can be provided on a continuing basis or on episodic occasions. Skilled services that may be performed only by a health professional are not considered personal care services.

Personal care services may be provided by any willing and qualified provider through a Provider Agency (PA), Intermediary Service Organization (ISO), or by an Independent Contractor when a PA or ISO is not available in that area of the state. All providers must meet established qualifications of 16 hours of basic training, background checks, and TB testing. Legally responsible individuals (e.g. spouse, legal guardian, parent of minor child, legally responsible stepparent, or foster parent) may not be reimbursed for providing personal care services.

Coverage Template for Freestanding Birth Center Services

Attachment 3.1A: Freestanding Birth Center Services

28. (i) Licensed or Otherwise State-Approved Freestanding Birth Centers

Provided: ☐ No limitations ☒ With limitations ☐ None licensed or approved

Please describe any limitations:

1. Must meet applicable state licensing and/or certification requirements in the state in which the center is located. Services are limited to labor, delivery, post-partum, and immediate newborn care.

2. Accreditation by one of the following nationally recognized accreditation organizations:

   a. The Accreditation Association for Ambulatory Health Care, Inc.
   b. The Commission for the Accreditation of Birth Centers.
   c. The Joint Commission.

3. Service requirements are limited to care when the following pregnancy criteria are met:

   a. An uncomplicated low-risk prenatal course is reasonably expected to result in a normal and uncomplicated vaginal birth in agreement with licensed birth center protocol;
   b. Completion of at least 36 weeks' gestation and not more than 42 weeks' gestation.

28. (ii) Licensed or Otherwise State-Recognized covered professionals providing services in the Freestanding Birth Center

Provided: ☐ No limitations ☒ With limitations (please describe below)

☐ Not Applicable (there are no licensed or State Approved Freestanding Birth Centers)

Please describe any limitations:

Childbirth procedures are limited to labor, delivery, postpartum care and immediate newborn care.

Please check all that apply:

☒ (a) Practitioners furnishing mandatory services described in another benefit category and otherwise covered under the State plan (i.e., physicians and certified nurse midwives).

☐ (b) Other licensed practitioners furnishing prenatal, labor and delivery, or postpartum care in a freestanding birth center within the scope of practice under State law whose services are otherwise covered under 42 CFR 440.60 (e.g., lay midwives, certified professional midwives (CPMs) and any other type of licensed midwife). *

☐ (c) Other health care professionals licensed or otherwise recognized by the State to provide these birth attendant services (e.g., doulas, lactation consultant, etc.).*

*For (b) and (c) above, please list and identify below each type of professional who will be providing birth center services: N/A

State/Territory: _Nevada

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED

CATEGORICALLY NEEDY GROUP(S)

30. Coverage of Routine Patient Cost in Qualifying Clinical Trials

*The state needs to check each assurance below.

Provided: _X_____

I. General Assurances:

Routine Patient Cost – Section 1905(gg)(1)

_X__Coverage of routine patient cost for items and services as defined in section 1905(gg)(1) that are furnished in connection with participation in a qualified clinical trial.

Qualifying Clinical Trial – Section 1905(gg)(2)

_X__A qualified clinical trial is a clinical trial that meets the definition at section 1905(gg)(2).

Coverage Determination – Section 1905(gg)(3)

_X__A determination with respect to coverage for an individual participating in a qualified clinical trial will be made in accordance with section 1905(gg)(3).

PRA Disclosure Statement - This information is being collected to assist the Centers for Medicare & Medicaid Services in implementing Section 210 of the Consolidated Appropriations Act of 2021 amending section 1905(a) of the Social Security Act (the Act), by adding a new mandatory benefit at section 1905(a)(30). Section 210 mandates coverage of routine patient services and costs furnished in connection with participation by Medicaid beneficiaries in qualifying clinical trials effective January 1, 2022. Section 210 also amended sections 1902(a)(10)(A) and 1937(b)(5) of the Act to make coverage of this new benefit mandatory under the state plan and any benchmark or benchmark equivalent coverage (also referred to as alternative benefit plans, or ABPs). Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. An agency may notconduct or sponsor, and a person is not required to respond to, a collection of information unlessit displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0938-1148 (CMS-10398 #74). Public burden for all of the collection of information requirements under this control number is estimated to take about 56 hours per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 SecurityBoulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.