MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

March 29, 2022

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: CASEY ANGRES
MANAGER OF DIVISION COMPLIANCE

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

BACKGROUND AND EXPLANATION

Revisions to MSM Chapter 400 – Mental Health and Alcohol and Substance Abuse Services are being proposed to ensure that crisis stabilization services provided at hospitals with a crisis stabilization center endorsement are covered and reimbursable services under Nevada Medicaid pursuant to Senate Bill 156 proposed during the 2021 legislative session. The goal of this legislation is to add a place to go as a critical element of the crisis continuum of care to support an array of crisis services critical in caring for individuals experiencing a behavioral health crisis. New proposed policy documentation for Section 403.6I includes scope of services for crisis stabilization centers, their primary objective, requirements, best practices, provider responsibilities, admission criteria and authorization process. Crisis stabilization centers best patient outcomes may be better immediate care and a more positive behavioral health crisis response. State Plan Amendment (SPA) changes within 4.19-B, 4a and 4b, proposed how providers will be reimbursed a daily default rate and after an individual and complete fiscal year of providing services, will be allowed to complete a cost report, of which an individual rate will be calculated.

Entities Financially Affected: This proposed change affects all Medicaid-enrolled providers delivering crisis stabilization services. Those Provider Types (PTs) include but are not limited to: Hospital, Inpatient (PT 11), Hospital, Outpatient (PT 12) and Psychiatric Hospital, Inpatient (PT 13).

Financial Impact on Local Government: The estimated financial impact is anticipated to result in a savings of:

SFY 2022: (816,333)
SFY 2023: ($12,122,807)

These changes are effective March 30, 2022.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
MTL OL MSM 400 – Mental Health and Alcohol/Substance Abuse Services	MTL 21/15, 08/21 MSM 400 – Mental Health and Alcohol/Substance Abuse Services

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
403.6I	**Crisis Stabilization Center**	New Policy section for Crisis Stabilization Centers.
403.6I(1)		New language for Scope of Service and primary objection for Crisis Stabilization Centers.
403.6I(2)		New language for Requirements for Crisis Stabilization Centers.
403.6I(3)		New language for Provider Responsibilities for Crisis Stabilization Centers.
403.6I(4)		New language for Admission Criteria for Crisis Stabilization Centers.
403.6I(5)		New language for Authorization Process for Crisis Stabilization Centers.

identification of referral resources for ongoing community mental and/or behavioral health services.

2. Provider Qualifications: QMHPs may provide CI services. If a multidisciplinary team is used, the team must be led by a QMHP. The team leader assumes professional liability over the CI services rendered.

3. Service Limitations: Recipients may receive a maximum of four hours per day over a three-day period (one occurrence) without prior authorization. Recipients may receive a maximum of three occurrences over a 90-day period without prior authorization.

Service Limitations	Children: CASII	Adults: LOCUS
Levels I to VI	• Maximum of four hours per day over a three-day period (one occurrence) • Maximum of three occurrences over a 90-day period	• Maximum of four hours per day over a three-day period (one occurrence) • Maximum of three occurrences over a 90-day period

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

a. Recipient's behavior requires immediate and intensive interventions to help stabilize the current situation and prevent hospitalization;

b. Recipient presents a moderate risk of danger to themselves and others (or to deteriorate to this dysfunctional level);

c. Recipient's immediate behavior is unmanageable by family and/or community members; and/or

d. Recipient will benefit from the stabilization, continuity of care and the referrals for ongoing community mental and/or behavioral health services.

403.6I CRISIS STABLIZATION CENTER

1. Scope of Service: Crisis stabilization is an unplanned, expedited service, to, or on behalf of, an individual to address an urgent condition requiring immediate attention that cannot be adequately or safely addressed in a community setting. The goal of crisis stabilization is to avoid the need for inpatient services, which, if the condition and symptoms are not treated, present an imminent threat to the recipient or others, or substantially increase the risk of the recipient becoming gravely disabled.

Crisis Stabilization Centers (CSCs) are considered an emergency healthcare alternative, providing persons with an acute behavioral health problem (including co-occurring disorders) with prompt action, gentle response, and effective support in a respectful environment. CSCs are a no-wrong-door access. CSCs are a short-term, subacute care for recipients which support an individual's stabilization and return to active participation in the community. Key elements include a welcoming and accepting environment, which conveys hope, empowerment, choice, and higher purpose. This model is traditionally meant to last 24 hours or less. If recipients cannot be stabilized in this period, the next step would be to refer them to an appropriate level of care at an inpatient facility. CSCs are part of a continuum of crisis services designed to stabilize and improve symptoms of distress. Recipients who can be stabilized in a CSC are anticipated to be discharged to a lower level of care.

The primary objective of the crisis stabilization service is to promptly conduct a comprehensive assessment of the individual and to develop a treatment plan with emphasis on crisis intervention services necessary to stabilize and restore the individual to a level of functioning that can be managed at a lower level of care. Active family/guardian/significant other/natural supports involvement is necessary unless contraindicated. Crisis stabilization services means behavioral health services designed to:

a. De-escalate or stabilize a behavioral health crisis, whether this is occurring concurrently with a substance use disorder; and

b. When appropriate, avoid admission of a patient to another inpatient mental health facility or hospital and connect the patient with providers of ongoing care as appropriate for the unique needs of the patient.

2. Requirements: CSCs must operate in accordance with established administrative protocols, evidenced-based protocols for providing treatment and evidence-based standards for documenting information concerning services rendered to recipients of such services in accordance with best practices for providing crisis stabilization services. Has a policy structure in place that establishes, including but not limited to:

a. Procedures to ensure that a mental health professional is on-site 24 hours a day, seven days a week;

b. Procedures to ensure that a licensed physician, physician assistant, or psychiatric Advanced Practice Registered Nurse (APRN) is available for consultation to direct care staff 24 hours a day, seven days a week;

c. Procedures to ensure RNs, Licensed Practical Nurses (LPNs), social workers, community health workers, and peer support specialists (as defined per Chapter 449 of the Nevada Revised Statutes) are available to adequately meet the needs of

recipients;

d. Procedures to assure that restraint and seclusion are utilized only to the extent necessary to ensure the safety of patients and others;

e. Delivers crisis stabilization services:

1. To all persons who come in the door, whether as walk-ins or drop-offs from law enforcement or a mobile crisis team.

f. Uses a data management tool to collect and maintain data relating to admissions, discharges, diagnoses, and long-term outcomes for recipients of crisis stabilization services;

g. Operating in accordance with best practices for the delivery of crisis stabilization services, CSCs must include:

1. Recovery Orientation

a. In a manner that promotes concepts that are integral to recovery for persons with behavioral health issues, including, without limitation, hope, personal empowerment, respect, social connections, self-responsibility, and self-determination.

2. Trauma-informed care

a. Many individuals experiencing a behavioral health crisis or substance use disorder have experienced some sort of trauma in the past.

3. Significant use of peer staff

a. People with lived experience who have something in common with the recipients needing help.

4. Commitment to Zero Suicide/Suicide Safer Care.

5. Strong commitments to safety for consumers/staff.

6. Collaboration with law enforcement.

3. Provider Responsibilities:

a. An endorsement as a CSC must be renewed at the same time as the license to

which the endorsement applies. An application to renew an endorsement as a CSC must include, without limitation:

1. Proof that the applicant meets the requirements per NRS 449.0915; and

2. Proof that the hospital is a rural hospital or is accredited by the Commission on Accreditation of Rehabilitation Facilities, the Center for Improvement in Healthcare Quality, DNV GL Healthcare, the Accreditation Commission for Health Care, or the Joint Commission, or their successor organizations.

b. Medical Records: A medical record shall be maintained for each recipient and shall contain, including but not limited to the following. Please also consult medical documentation requirements listed in 403.9B(2):

1. An assessment for substance use disorder and co-occurring mental health and substance abuse disorder, including a statement of the circumstances under which the person was brought to the unit and the admission date and time;

2. An evaluation by a mental health professional to include at a minimum:

   a. Mental status examination; and

   b. Assessment of risk of harm to self, others, or property.

3. Review of the person's current crisis plan;

4. The admission diagnosis and what information the determination was based upon;

5. Coordination with the person's current treatment provider, if applicable;

6. A plan for discharge, including a plan for follow up that includes, but is not limited to:

   a. The name, address, and telephone number of the provider of follow-up services; and

   b. The follow up appointment date and time, if known.

7. The clinical record must contain a crisis stabilization plan developed collaboratively with the recipient and/or guardian that includes, but is not

limited to:

a. Strategies and interventions to resolve the crisis in the least restrictive manner possible;

b. Language that is understandable to the recipient and members of the recipient's support system; and

c. Measurable goals for progress toward resolving the crisis and returning to an optimal level of functioning.

8. If antipsychotic medications are administered, the clinical record must document:

a. The physician's attempt to obtain informed consent for antipsychotic medication; and

b. The reasons why any antipsychotic medication is administered over the recipient's objection or lack of consent.

4. Admission Criteria: Accepts all patients, without regard to:

a. Race, ethnicity, gender, socioeconomic status, sexual orientation or place of residence of the patient;

b. Any social conditions that affect the patient;

c. The ability of the patient to pay; or

d. Whether the patient is admitted voluntarily to the hospital pursuant to NRS 433A.140 or admitted to the hospital under an emergency admission pursuant to NRS 433A.150;

e. Performs an initial assessment on any patient who presents at the hospital, regardless of the severity of the behavioral health issues that the patient is experiencing.

1. All beneficiaries receiving Crisis Stabilization shall receive an assessment of their physical and mental health. Assessment and stabilization services will be provided by the appropriate staff. If outside services are needed, a referral that corresponds with the recipient's needs shall be made.

2. Has the equipment and personnel necessary to conduct a medical

examination of a patient pursuant to NRS 433A.165.

a. Medical backup services must be available either on site or by written contract or agreement with a general acute care hospital. Medical backup means immediate access within reasonable proximity to health care for medical emergencies.

3. Considers whether each patient would be better served by another facility and transfers a patient to another facility when appropriate.

f. Crisis stabilization services that may be provided include but are not limited to:

1. Case management services, including, without limitation, such services to assist patients to obtain housing, food, primary health care and other basic needs;

2. Services to intervene effectively when a behavioral health crisis occurs and address underlying issues that lead to repeated behavioral health crises;

3. Treatment specific to the diagnosis of a patient; and

4. Coordination of aftercare for patients, including, without limitation, at least one follow-up contact with a patient not later than 72 hours after the patient is discharged.

5. Authorization Process: The QIO-like vendor contracts with Medicaid to provide utilization and quality control review (UR) of Medicaid prior authorization submissions. Within the range of the QIO-like vendor's UR responsibilities are admission and length of stay criteria development, prior authorization, concurrent and retrospective review, certification, and reconsideration decisions. Any facility which alters, modifies, or changes any QIO-like vendor certification in any way, will be denied payment.

a. All recipients in a CSC may be rolled over for inpatient admission any time the patient requires acute care services. All rollovers to inpatient care require the QIO-like vendor's authorization within 24 hours of the admission/rollover. CSC stays which do not rollover to inpatient status are limited to 24 hours.

b. When transitioning a recipient, documentation should include but is not limited to: outreach efforts to inpatient hospitals including reasons for delays in transitioning to an inpatient Level of Care, including any denial reasons and/or outreach efforts within the community to establish appropriate aftercare services and reasons for any delay in obtaining this. The CSC must make all efforts to stabilize the recipient's condition and discharge to an appropriate community setting with

aftercare services or to a psychiatric hospital or general hospital with a psychiatric unit as expeditiously as possible.

c. Pursuant to federal law, Medicaid is payer of last resort whenever any other resources may be responsible for payment. Prior resources include but are not limited to: Medicare, labor unions, Worker's Compensation Insurance Carriers, private/group insurance and CHAMPUS. Exceptions to this regulation are Bureau of Family Health Services, Indian Health Services (HIS), Ryan White Act and Victims of Crime, when Medicaid is primary. Benefits available free of charge to recipients from other sources must be provided free of charge to Nevada Medicaid recipients.

403.7 OUTPATIENT ALCOHOL AND SUBSTANCE ABUSE SERVICES POLICY

Outpatient substance abuse services may be provided by a QHMP within the scope of their practice under state law and expertise.

403.7A COVERAGE AND LIMITATIONS

1. Nevada Medicaid reimburses the following:

a. Outpatient alcohol/substance abuse treatment services within the context of services discussed in Section 403.4 of this Chapter (individual and family therapy is limited to one hour per session. Group therapy is limited to two hours per session).

b. Psychiatrist (MD) – Office and clinic visits provided by a psychiatrist are a Medicaid benefit. There are no limitations to services and prior authorization is not required.

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

1. prior authorized by the QIO-like vendor; or

2. resulted from an EPSDT referral.

Testing services may also include an initial psychological evaluation.

d. APN – Office and clinic visits provided by an APN are a Medicaid benefit. There