Medicaid Services Manual
Transmittal Letter

September 30, 2025

To: Custodians of Medicaid Services Manual

From: Casey Angres
Chief of Division Compliance

Subject: Medicaid Services Manual Changes
Chapter 400 – Mental Health Services

Background And Explanation

Revisions to Medicaid Services Manual (MSM) Chapter 400 - Mental Health Services are being proposed to add Coordinated Specialty Care (CSC) for beneficiaries experiencing their first episode of psychosis. CSC is the standard of care for treatment for individuals, typically in late adolescence to mid-20s experiencing their first episode of psychosis (FEP). It is an evidence-based, recovery-focused, team-based early intervention model that promotes access to care and shared decision-making among specialists, the person experiencing psychosis, and family member.

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

Entities Financially Affected: The proposed changes affect all Medicaid-enrolled providers delivering outpatient behavioral health treatment, case management, peer support, medication management, supportive employment and education, and crisis type of services. Those provider types (PT) include but are not limited to Behavioral Health Outpatient Treatment (PT 14), Physician, Osteopath (PT 20), Certified Registered Nurse Practitioner, Nurse (PT 24), Psychologist (PT 26), Behavioral Health Rehabilitative Treatment (PT 82), Crisis Services (PT 87), and Peer Support Services (PT 97).

Financial Impact on Local Government: An estimated increase in annual aggregate expenditures for state fiscal years (SFY)

SFY 2026:	$3,904,660
SFY 2027:	$3,915,943

These changes are effective July 1, 2025.

Material Transmitted	Material Superseded
MTL OL Chapter 400 – Mental Health Services	MTL 14/24, 02/25 Chapter 400 – Mental Health Services

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
403.4(D)(4)	**OMH Services**	Added CSC service definition.
403.4(D)(4)(a)		Added "Eligible Providers" section for CSC.
403.4(D)(4)(b)		Added "Eligible Member" section for CSC.
403.4(D)(4)(c)		Added "Covered Services" section for CSC.
403.4(D)(4)(d)		Added "Non-Covered Services" section for CSC.
403.4(D)(4)(e)		Added "Authorization Requirements" section for CSC.
403.4(D)(4)(f)		Added "Billing" section for CSC.
403.4(D)(4)(g)		Added "Managed Care Members" section for CSC.

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Subject: Medicaid Services Manual Changes
Chapter 400 – Mental Health Services

Background And Explanation

Proposed revisions to Medicaid Services Manual (MSM) Chapter 400 - Mental Health Services include the addition of Assertive Community Treatment (ACT) for individuals with serious and persistent mental illness. ACT is a team-based, community-focused treatment approach that provides comprehensive psychiatric treatment, rehabilitation, and support. Its goal is to improve functioning and help individuals remain in their communities, avoiding inpatient treatment.

ACT services are delivered assertively, meaning team members go above and beyond to support and empower individuals to achieve their goals. It is a service-delivery model, not a case management program. ACT is designed for individuals with the most severe and persistent symptoms of mental illness, who struggle with basic daily activities, safety, self-care, and maintaining safe and affordable housing. These individuals require intensive interventions that traditional, less intensive services have not effectively addressed.

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

Entities Financially Affected: The proposed changes affect all Medicaid-enrolled providers delivering outpatient behavioral health treatment, case management, peer support, medication management, supportive employment and education, and crisis type of services. Those provider types (PTs) include but are not limited to: Behavioral Health Outpatient Treatment (PT 14), Physician, Osteopath (PT 20), Certified Registered Nurse Practitioner, Nurse (PT 24), Psychologist (PT 26), Behavioral Health Rehabilitative Treatment (PT 82), Crisis Services (PT 87), and Peer Support Services (PT 97).

Financial Impact on Local Government: An estimated increase in annual aggregate expenditures for state fiscal years (SFY):

SFY 2026: $12,040,087
SFY 2027: $14,147,982

These changes are effective July 1, 2025.

Material Transmitted	Material Superseded
MTL OL MSM Chapter 400 - Mental Health Services	MTL 02/25, 14/25 MSM Chapter 400 - Mental Health Services

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
403.6D	**Assertive Community Treatment (ACT)**	Added ACT program definition.
403.6D(1)		Added "Eligible Providers" section, revised and removed duplicative details for ACT.
403.6D(2)		Added "Eligible Member" section, revised and removed duplicative details for ACT.
403.6D(3)		Added "Covered Services" section for ACT.
403.6D(4)		Added "Non-Covered Services" section ACT.
403.6D(5)		Added "Authorization Requirements" section ACT.
403.6D(6)		Added "Billing" section ACT.
403.6D(7)		Added "Managed Care Members" section ACT.

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Subject: Medicaid Services Manual Changes
Chapter 400 – Mental Health Services

Background And Explanation

Creation of Medicaid Services Manual (MSM) Chapter 4400 – Crisis Services are being proposed. The following crisis services are being removed from MSM Chapter 400 and being moved with revisions and updates to the new MSM Chapter 4400: Crisis Intervention (CI), Designated Mobile Crisis Team (DMCT), and Crisis Stabilization Center (CSC).

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

Entities Financially Affected: The proposed changes affect all Medicaid-enrolled providers delivering Crisis Services. The provider types (PT) include, but is not limited to: Behavioral Health Outpatient Treatment (PT 14), Mobile Crisis delivered by a DMCT (PT 87, Specialty 31), Mobile Crisis delivered by a Certified Community Behavioral Health Clinic (CCBHC) as a DMCT (PT 87, Specialty 32), and CSC (PT 87, Specialty 250).

Financial Impact on Local Government: The financial impact or potential impact of the proposed regulation on local government is unknown at this time.

These changes are effective October 1, 2025.

Material Transmitted	Material Superseded
MTL OL MSM Chapter 400 – Mental Health Services	MTL 14/24, 02/25, 14/25 MSM Chapter 400 – Mental Health Services

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
403.6G	**Crisis Intervention Services**	Removed entire section, reworded, revised, and placed it into the new MSM Chapter 4400 dedicated to Crisis Services.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
403.6H	**Mobile Crisis Response Delivered by Designated Mobile Crisis Team (DMCT)**	Removed entire section, reworded, revised, and placed it into the new MSM Chapter 4400 dedicated to Crisis Services.
403.6I	**Crisis Stabilization Center (CSC)**	Removed entire section, reworded, revised, and placed it into the new MSM Chapter 4400 dedicated to Crisis Services.

testing, and results shall be maintained in the provider personnel record by the BHCN, Behavioral Health Rehabilitative Treatment, or other behavioral health entity. TB screening, testing, and results must be completed for initial enrollment and thereafter as indicated by NAC 441A.375. For further information, contact the CDC or the Nevada TB Control Office at DHHS.

D. Licensed Psychologists – An individual independently licensed through the Nevada Board of Psychological Examiners.

1. Psychologists licensed in Nevada through the Board of Psychological Examiners may supervise Psychological Assistants, Psychological Interns and Psychological Trainees pursuant to NRS and NAC 641. A Supervising Psychologist, as defined by NRS and NAC 641, may bill on behalf of services rendered by those they are supervising within the scope of their practice and under the guidelines outlined by the Psychological Board of Examiners. Assistants, Interns and Trainees must be linked to their designated Supervising Psychologist, appropriate to the scope of their practice, under which their services are billed to Medicaid.

2. Psychological Assistants registered through the Nevada Board of Psychological Examiners and have a designated licensed Psychologist through the Board of Psychological Examiners may render and their supervisor may bill for their services pursuant to NRS and NAC 641.

3. Psychological Interns registered through the Nevada Board of Psychological Examiners and have a designated licensed Psychologist through the Board of Psychological Examiners may render and their supervisor may bill for their services pursuant to NRS and NAC 641.

4. Psychological Trainees registered through the Nevada Board of Psychological Examiners and have a designated licensed Psychologist through the Board of Psychological Examiners may render and their supervisor may bill for their services pursuant to NRS and NAC 641.

403.4 OMH SERVICES

These services include assessment and diagnosis, testing, basic medical and therapeutic services, crisis intervention, mental health therapies, and therapeutic interventions (partial hospitalization and intensive outpatient), medication management and medication training/support, and case management services. For case management services, refer to MSM Chapter 2500 for Non-SED and Non-SMI definitions, service requirements, service limitations, provider qualifications, and documentation requirements.

A. Assessments are covered for problem identification (diagnosis) and to establish measurable treatment goals and objectives by a QMHP or designated QMHA in the case of a Mental

Health Screen.

1. Mental Health Screen – A behavioral health screen to determine eligibility for admission to treatment program.

2. Comprehensive Assessment – A comprehensive evaluation of a recipient's history and functioning which, combined with clinical judgment, is to include a covered, current ICD diagnosis and a summary of identified rehabilitative treatment needs. Health and Behavior Assessment – Used to identify the psychological, behavioral, emotional, cognitive, and social factors important to the prevention, treatment, or management of physical health needs. The focus of the assessment is not on the mental health needs, but on the biopsychosocial factors important to physical health needs and treatments. The focus of the intervention is to improve the recipient's health and well-being utilizing cognitive, behavioral, social and/or psycho-physiological procedures designed to ameliorate specific disease related needs. This type of assessment is covered on an individual basis, family with the recipient present or family without the recipient present.

3. Psychiatric Diagnostic Interview – Covered once per calendar year without prior authorization. If there is a substantial change in condition, subsequent assessments may be requested through a prior-authorization from the QIO-like vendor for Nevada Medicaid. A psychiatric diagnostic interview may consist of a clinical interview, a medical and mental history, a mental status examination, behavioral observations, medication evaluation and/or prescription by a licensed psychiatrist. The psychiatric diagnostic interview is to conclude with a written report which contains a current ICD diagnosis and treatment recommendations.

4. Psychological Assessment – Covered once per calendar year without prior authorization. If there is a substantial change in condition, subsequent assessments may be requested through a prior-authorization from the QIO-like vendor for Nevada Medicaid. A psychological assessment may consist of a clinical interview, a biopsychosocial history, a mental status examination and behavioral observations. The psychological assessment is to conclude with a written report which contains a current ICD diagnosis and treatment recommendations.

5. Functional Assessment – Used to comprehensively evaluate the recipient's skills, strengths and needs in relation to the skill demands and supports required in the particular environment in which the recipient wants or needs to function; as such, environment is consistent with the goals listed in the recipient's ITP. A functional assessment is used to assess the presence of functional strengths and needs in the following domains: vocational, education, self- maintenance, managing illness and wellness, relationships, and social.

A person-centered conference is covered as part of the functional assessment to collaboratively develop and communicate the goals and objectives of the ITP. The conference must include the recipient, a QMHP, family or legal representative, significant others and case manager(s). The case manager(s) or lead case manager, if there are multiple case managers, shall provide advocacy for the recipient's goals and independence, supporting the recipient's participation in the meeting and affirming the recipient's dignity and rights in the service planning process.

6. Intensity of Needs Determination - A standardized mechanism to determine the intensity of services needed based upon the severity of the recipient's condition. The Intensity of Needs determination is to be utilized in conjunction with the clinical judgment of the QMHP and/or trained QMHA. This assessment was previously known as a LOC assessment. Currently, DHCFP recognizes LOCUS for adults and CASII for children and adolescents. There is no LOC assessment tool recognized by DHCFP for children below age six; however, providers must utilize a tool comparable to the CASII and recognized as a standard of practice in determining the Intensity of Needs for this age group.

7. SED Assessment - Covered annually or if there is a significant change in functioning. The SED assessment is a tool utilized to determine a recipient's eligibility for higher levels of care and Medicaid service categories.

8. SMI Assessment - Covered annually or if there is a significant change in functioning. The SMI assessment is a tool utilized to determine a recipient's eligibility for higher levels of care and Medicaid service categories.

B. Neuro-Cognitive, Psychological, and Mental Status Testing

1. Neuropsychological testing with interpretation and report involves assessment and evaluation of brain behavioral relationships by a neuropsychologist. The evaluation consists of qualitative and quantitative measurement that consider factors such as the interaction of psychosocial, personality/emotional, intellectual, environmental, neurocognitive, biogenetic, and neurochemical aspects of behaviors in an effort to understand more fully the relationship between physiological and psychological systems. This service requires prior authorization from the QIO-like vendor.

2. Neurobehavioral testing with interpretation and report involves the clinical assessment of thinking, reasoning and judgment, acquired knowledge, attention, memory, visual spatial abilities, language functions, and planning. This service requires prior authorization.

3. Psychological testing with interpretation and report is the administration, evaluation and scoring of standardized tests which may include the evaluation of

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

C. Mental Health Therapies

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

1. Family Therapy

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

2. Group Therapy

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

3. Individual Therapy Services

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

4. Neurotherapy

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

b. Prior authorizations through the QIO-like vendor are required for all neurotherapy services exceeding the below identified session limits for the following covered ICD Codes:

1. Attention Deficit Disorders (ADD) – 40 sessions
Current ICD Codes: F90.0, F90.8, and F90.9

2. Anxiety Disorders – 30 sessions
Current ICD Codes: F41.0 and F34.1

3. Depressive Disorders – 25 sessions
Current ICD Codes: F32.9, F33.40, F33.9, F32.3, and F33.3

4. Bipolar Disorders – 50 sessions
Current ICD Codes: F30.10, F30.9, F31.0, F31.10, F31.89, F31.30, F31.60, F31.70, F31.71, F31.72, F31.9, and F39

5. Obsessive Compulsive Disorders (OCD) – 40 sessions
Current ICD Codes: F42

6. Opposition Defiant Disorders (ODD) and/or Reactive Attachment Disorders – 50 sessions
Current ICD Codes: F93.8, F91.3, F94.1, F94.2, F94.9, and F98.8

7. Post-Traumatic Stress Disorders (PTSD) – 35 sessions
Current ICD Codes: F43.21, F43.10, F43.11, and F43.12

8. Schizophrenia Disorders – 50 sessions
Current ICD Codes: F20.89, F20.1, F20.2, F20.0, F20.81, F20.89, F20.5, F25.0, F25.1, F25.8, F25.9, F20.3, and F20.9

Prior authorization may be requested for additional services based

upon medical necessity.

D. Mental Health Therapeutic Interventions

1. Partial Hospitalization Program (PHP) – A restorative program encompassing mental and behavioral health services and psychiatric treatment services designed for recipients who require a higher intensity of coordinated, comprehensive, and multidisciplinary treatment for mental health disorders. These services are furnished under a medical model by a hospital in an outpatient setting or by a Federally Qualified Health Center (FQHC) that assumes clinical liability and meets the criteria of a Certified Mental Health Clinic (CMHC). A hospital or an FQHC may choose to offer PHP through an enrolled Substance Abuse Prevention and Treatment Agency (SAPTA)-certified clinic or an enrolled BHCN agency/entity/group, and the hospital or FQHC must enter into a contract with this provider which specifically outlines the roles and responsibilities of both parties in providing this program. The contract must be submitted to DHCFP and reported to its fiscal agent prior to the delivery of these services to the recipient. These 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 and/or substance use disorder (SUD). PHP services include active therapeutic treatment and must be targeted to meet the goals of alleviating impairments and maintaining or improving functioning to prevent relapse or hospitalization. PHP is provided to individuals who are determined as SED or SMI.

a. Scope of Services - PHP services may include:

1. Individual Therapy
2. Group Therapy
3. Family Therapy
4. Medication Management
5. Behavioral Health Assessment
6. BST
7. Psychosocial Rehabilitation
8. Peer Support Services
9. Crisis Services

PHP requires around-the-clock availability of 24/7 psychiatric and psychological services. These services may not be billed separately by the same provider as PHP is an all-inclusive rate, however, the recipient may require additional medical services that are not provided by the PHP. To support the recipient in gaining access to the necessary medical services, coordination must be made by the PHP provider. These services are requested following established prior authorization and coding requirements.

b. Service Limitations: PHP services are direct services provided in a mental/behavioral health setting for at least three days per week and no more than five days per week; each day must include at least four hours of direct services as clinically indicated based on a patient-centered approach. If more/fewer hours and/or more/fewer days are indicated, the recipient should be reevaluated. PHP delivered through a BHCN will always require prior authorization and must be reauthorized every three weeks.

c. PHP Utilization Management: Evaluation of the patient's response to treatment interventions and progress monitoring toward Treatment Plan goals must include ongoing patient assessments, including Intensity of Needs determinations using American Society of Addiction Medicine (ASAM)/LOCUS/CASII at regularly scheduled intervals and whenever clinically indicated.

d. Provider Qualifications: Direct services are face-to-face interactive services led by licensed staff and components of this service can be performed by qualified, enrolled health care workers practicing within their scope under the Direct Supervision of a QMHP-level professional, including Interns. Interns can provide PHP services under Clinical Supervision. Direct Supervision requires that a licensed professional practicing within the scope of their Nevada licensure be onsite where services are rendered. Each component of the PHP must be provided by enrolled and qualified individuals within the scope of their practice.

e. Documentation: Patient assessments must document the individual patient response to the Treatment Plan, progress toward goals, changes in identified goals and objective based on progress and substantiate continued stay at the current intensity/frequency of services. 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 be evidence-based and reflect best practices recognized by professional and advocacy organizations and ensure coordination of needed services, follow-up care and recovery supports. The direct provider of each service component must complete documentation

for that component. Further information on documentation standards is located within the section "Documentation" within this chapter.

f. Non-Covered Services in PHP include, but are not limited to:

1. Non-evidence-based models;

2. Transportation or services delivered in transit;

3. Club house, recreational, vocational, after-school, or mentorship program;

4. Routine supervision, monitoring or respite;

5. Participation in community-based, social-based support groups (e.g., Alcoholics Anonymous (AA), Narcotics Anonymous (NA));

6. Watching films or videos;

7. Doing assigned readings; and

8. Completing inventories or questionnaires.

2. Intensive Outpatient Program (IOP) – A comprehensive interdisciplinary program of direct mental/behavioral health services which are expected to improve or maintain an individual's condition and functioning level for prevention of relapse or hospitalization. IOP is provided to individuals who are determined as SED or SMI. IOP group sizes are required to be four to 15 recipients.

a. Scope of Services - IOP may include the following direct services:

1. Individual Therapy

2. Group Therapy

3. Family Therapy

4. Medication Management

5. Behavioral Health Assessment

6. BST

7. Psychosocial Rehabilitation

8. Peer Support Services

9. Crisis Services

IOP requires around-the-clock availability of 24/7 psychiatric and psychological services. These services may not be billed separately by the same provider as IOP is an all-inclusive rate, however, the recipient may require additional medical services that are not provided by the IOP. To support the recipient in gaining access to the necessary medical services, coordination must be made by the IOP provider. These services are requested following established prior authorization and coding requirements.

b. Service Limitations: IOP services delivered in a mental/behavioral health setting are direct services provided three days per week, each day must include at least three hours and no more than six hours of direct service delivery as clinically indicated based on a patient-centered approach. If more/fewer hours and/or more/fewer days are indicated, the recipient should be reevaluated. IOP delivered through a BHCN will always require prior authorization and must be reauthorized every three weeks.

c. IOP Curriculum and Utilization Management: A curriculum and a schedule for the program delivered through a BHCN must be submitted with each prior authorization request (PAR); this information may also be provided with enrollment and the description of IOP services. The curriculum must outline the service array being delivered including evidence-based practice(s), best practice(s), program goals, schedule of program and times for service delivery, staff delivering services, and population served in the program.

IOP program recipients must receive on-going patient assessments, at regularly scheduled intervals and whenever clinically indicated, including intensity of needs determinations using LOCUS/CASII to evaluate the recipient's response to treatment interventions and to monitor progress toward Treatment Plan goals. Recipient assessments must document the individual's response to the Treatment Plan, identify progress toward individual and program goals, reflect changes in identified goals and objectives, and substantiate continued stay at the current intensity/frequency of services. An updated Treatment Plan must be completed to justify a transfer to a higher or lower intensity/frequency of services or discharge from treatment as no longer meeting medical necessity at any level.

Provider Qualifications: Direct services are face-to-face interactive services

provided by qualified, enrolled providers, including both licensed staff. and other health care workers practicing within their scope under the Direct Supervision of a QMHP-level professional, including Interns. Interns can provide IOP services under Clinical Supervision. Direct Supervision requires that a licensed professional practicing within the scope of their Nevada licensure be onsite where services are rendered. Each component of the IOP must be provided by enrolled and qualified individuals within the scope of their practice.

d. Documentation: Patient assessments must document the individual patient response to the Treatment Plan, progress toward goals, changes in identified goals and objective based on progress and substantiate continued stay at the current intensity/frequency of services. 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 be evidence-based and reflect best practices recognized by professional and advocacy organizations and ensure coordination of needed services, follow-up care, and recovery supports. The direct provider of each service component must complete documentation for that component. Further information on documentation standards is located within the section "Documentation" within this chapter.

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

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

3. Medication Management – A medical treatment service using psychotropic medications for the purpose of rapid symptom reduction, to maintain improvement

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

4. Coordinated Specialty Care (CSC) – A recovery-focused, team-based early intervention model that promotes access to care and shared decision-making among specialists, the recipient, and family member(s). The comprehensive, multidisciplinary program of services are expected to improve or maintain condition and functioning level of individuals experiencing First Episode Psychosis (FEP).

   FEP is defined as an Early Serious Mental Illness (ESMI) and can be present with affective psychosis or non-affective psychosis. FEP is caused primarily by a mental health condition, and is not psychosis that stems from substance abuse, trauma, medical conditions, or traumatic brain injury (TBI).

   CSC programs must ensure high-fidelity implementation of an evidence-based, nationally recognized model approved by the Division of Public and Behavioral Health (DPBH). The program must hold certification from DPBH upon approval of their certification program. The general functions of CSC include but are not limited to: access to clinical providers with specialized training in FEP care; easy entry to the FEP specialty program through active outreach and engagement; provision of services in home, community, and clinic settings, as needed; acute care during or following a psychiatric crisis; transition to step-down services with the CSC team or discharge to regular care after 2-3 years, depending on the client's level of symptomatic and functional recovery; assurance of program quality through continuous monitoring of treatment fidelity.

   a. Eligible Providers

1. CSC services are provided by a multidisciplinary team of Licensed Professionals, QMHPs, Peer Support Specialists, Case Managers, and Supportive Employment and Education Specialists under the supervision of the Team Leader. Each component of CSC must be provided by enrolled and qualified providers within the scope of their practice.

    a. Team Leader: The CSC Team Leader is a Board-Certified Psychiatrist or a Licensed Professional. The Team Leader provides ongoing consultation to Team Members regarding the principles of early psychosis intervention and coordinates key services, including screening potential clients for admission into the program, leading weekly team meetings, overseeing treatment planning and case review conferences, and cultivating referral pathways to and from the CSC program.

    b. Licensed Professionals: Licensed Professionals operating within their scope of practice can include but are not limited to: Board-Certified Psychiatrists, Licensed Physicians, Licensed Physician Assistants (Psychiatry), Advanced Practice Registered Nurses (Psychiatry), Licensed Psychologists, Licensed Clinical Social Workers, Licensed Marriage and Family Therapists, and Licensed Clinical Professional Counselors.

    c. Qualified Mental Health Professionals (QMHP): QMHPs operating within their scope of practice can include Clinical Social Work Interns, Marriage and Family Therapist Interns, and Clinical Professional Counselor Interns.

    d. Peer Support Specialist (PSS): PSS have lived experience with mental illness and/or substance use disorders and hold peer certification. They assist individuals in achieving recovery, building self-advocacy skills, managing symptoms, and accessing community resources. Peer support services are person centered and designed to empower individuals toward independent and productive lives.

    e. Case Manager: Case management professionals assist clients with problem solving, offering solutions to address

practical problems, and coordinating social services across multiple areas of need. Case management involves frequent in-person contact between the clinician and the patient/client and their family, with sessions occurring in clinics, communities, and home settings, as required.

f. Supportive Employment and Education Specialist (SEES): The SEES strives to integrate vocational and mental health services, serves as the CSC team liaison with outside educators and employers, and frequently works with the client in the community to enhance school or job performance.

b. Eligible Members

1. Eligible members, typically between the ages of 15 and 45, who have experienced FEP within the last 18 months or who are experiencing early at-risk symptoms for psychosis and have been identified by a professional as having a documented need for CSC.

c. Covered Services

1. Behavioral Health Assessment
2. Individual Therapy
3. Group Therapy
4. Family Education and Support
5. Supported Employment and Education (SEE)
6. Case Management
7. Peer Support Services
8. Crisis Services
9. Primary Care Coordination
10. Medication Management
11. Psychiatry

Family education and support teaches relatives and/or other individuals providing support about psychosis and its treatments and strengthens their capacity to aid in the recipient's recovery. To the greatest extent possible, and consistent with the recipient's preferences, supportive individuals are included in all phases of treatment planning and decision-making.

SEE services facilitate the recipient's return to work or school, as well as attainment of expected vocational and educational milestones. SEE emphasizes rapid placement in the recipient's desired work or school setting and provides active and sustained coaching and support to ensure the individual's success.

Primary care coordination coordinates care between the identified behavioral health services and integrates other supportive services involved with a recipient's treatment.

Any additional services the recipient may require shall be billed as individually reimbursed services and coordination must be made by the CSC provider. These services are requested following established requirements and are reimbursable outside of the CSC weekly rate.

d. Non-Covered Services

1. Non-Evidence-Based Models
2. Documentation
3. Room and Board Expenditures
4. Transportation
5. Caregiver Services
6. Supervision

e. Authorization Requirements

1. CSC screening and introduction service can be used once per calendar year before a prior authorization is required. Prior authorizations must be based on the expected benefit to the eligible member as documented in the treatment plan. The weekly CSC services do not require prior authorization.

f. Billing

1. Providers must adhere to Medicaid billing guidelines using appropriate service codes. The following codes must be used to bill for Medicaid-covered CSC. Refer to the Nevada Medicaid Billing Manual for additional claims submission details.

Code	Brief Description	Unit	Service Limitations
H2040	CSC Screening and Introduction, team-based	Per screening	Once per calendar year before Prior Authorization
H2041	CSC, team-based	Per week	N/A

g. Managed Care Members

1. MCOs must ensure compliance with Medicaid guidelines for CSC services. Providers should verify coverage requirements with the recipient's MCO.

4. Medication Training and Support – This service must be provided by a professional other than a physician and is covered for monitoring of compliance, side effects, recipient education and coordination of requests to a physician for changes in medication(s). To be reimbursed for this service, the provider must be enrolled as: a QMHP, an LCSW, an LMFT, or a CPC. An RN enrolled as a QMHA may also provide this service if billed with the appropriate modifier. Medication Training and Support is a face-to-face documented review and educational session by a qualified professional, focusing on a member's response to medication and compliance with the medication regimen. The review must include an assessment of medication compliance and medication side effects. Vital signs must be taken including pulse, blood pressure, and respiration and documented within the medical or clinical record. A physician is not required to be present but must be available for consult. Medication Training and Support is designed to maintain the member on the appropriate level of the least intrusive medications, encourage normalization and prevent hospitalization. Medication Training and Support may not be billed for members who reside in Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) facilities.

a. Service Limitations: Cannot exceed two units per month (30 minutes), per recipient without a prior authorization.

b. Documentation Requirements: Documentation must include a description of the intervention provided and must include:

d. Organization and time management skills: Recipients are experiencing inappropriate deficits managing and prioritizing their daily activities; and/or

e. Transitional living skills: Recipients lack the skills to begin partial-independent and/or fully independent lives.

403.6D Assertive Community Treatment (~~P~~ACT) is a team-based, community-focused approach for individuals with serious and persistent mental illness. It provides comprehensive psychiatric treatment, rehabilitation, and support, aiming to improve functioning and help people stay in their communities and out of inpatient treatment.

ACT services are provided "assertively" meaning the team members go the extra mile to support and empower the individual to achieve their goals. ACT is a service-delivery model, not a case management program.

ACT is for individuals who have the most serious and intractable symptoms of a severe mental illness and who, consequently, have the greatest difficulty with basic daily activities, keeping themselves safe, caring for their basic physical needs or maintaining a safe and affordable place to live and require interventions that have not been effectively addressed by traditional, less intensive services.

1. Eligible Providers ~~A multi-disciplinary team-based approach of the direct delivering of comprehensive and flexible treatment, support, and services within the community. The team must be composed of at least one QMHP and one other QMHP, QMHA, or peer supporter.~~

a. ACT Teams:

1. All clinical supervision expectations shall align with existing requirements in MSM Chapter 400 Supervision Standards for an outpatient behavioral health delivery model.

a. Clinical consultation and supervision shall be available 24/7/365 to assist the ACT Team.

2. Each ACT Team member has the documented necessary training, competencies, and skills to conduct mental health screens within their scope.

3. Include 10-12 full-time employees (FTEs) per 100 participants, on average.

4. Each team must begin with at least six FTEs, irrespective of participant size,

and aim for a minimum staff-to-participant ratio of 1:10 in urban areas and 1:12 in rural areas.

5. Regardless of the size of the ACT team, it must include each of the following key personnel:
   a. Team Leader – One per ACT team.
      1. Full-time team leader/supervisor who serves as the clinical and administrative supervisor of the team, who also functions as a practicing clinician.
      2. The Team Leader must be a Licensed Professional and hold a valid Nevada clinical license in one of the following fields: nursing, social work, marriage and family therapy, certified professional counseling, psychiatry, clinical psychology, or be a psychiatric prescriber.
      3. If the Team Leader is not Co-occurring disorder (COD) qualified, then at least one of the remaining team members must be a master's level Substance Use Disorder (SUD) Treatment Specialist.
   b. Psychiatric Prescriber – Average one per 100 participants.
      1. A Psychiatric Prescriber on an ACT team is a healthcare professional responsible for managing the psychiatric medication needs of participants.
      2. May be a psychiatrist or a psychiatric nurse practitioner.
      3. May work part-time at 16 hours per week minimum per 50 participants.
   c. Registered Nurse (RN) – Average two per 100 participants.
      1. An RN on an ACT team plays a crucial role in providing comprehensive healthcare services to clients with severe mental illnesses. They provide a range of treatment, rehabilitation, and support services, with the primary responsibility being psychiatric, not medical.
      2. If an ACT program is unable to staff a full-time psychiatrist

and/or a full-time nurse, then they may hire these positions as part-time. When this happens, the ACT team must hire additional staff to complete a team composition equaling six full-time staff.

d. Supportive Employment and Education Specialist (SEES) - Average two per 100 participants.

1. A SEES on an ACT team plays a crucial role in helping individuals with severe mental illness find and maintain employment.

2. They should have strong interpersonal and communication skills, the ability to work collaboratively within a multidisciplinary team, and knowledge of local employment and educational resources are important.

3. They integrate vocational goals and services within the participants treatment plan.

4. They assess participant skills, interests, and employment history. They provide on-the-job support and advocate for participants' rights in the workplace, ensuring reasonable accommodations are made. They work closely with the ACT team to provide holistic support.

5. If an ACT program is unable to staff this position, then they may refer out to a provider they have a formal coordinated care agreement.

6. The remaining ACT Team Members may include a combination of the following:

a. Substance Use Disorder (SUD) Treatment Specialist.

1. A SUD Treatment Specialist on an ACT team is responsible for assessing and diagnosing substance use issues and co-occurring mental health conditions.

2. They create individualized treatment plans that address both substance use and mental health needs, provide individual and group counseling sessions, and offer immediate support

during substance use crises.

3. Additionally, they educate clients and their families about substance use disorders and relapse prevention, collaborate with other ACT team members to ensure comprehensive care, and advocate for clients' access to necessary resources and services.

4. Their ultimate goal is to help clients achieve sobriety, improve their mental health, and enhance their overall quality of life.

b. Case Manager.

1. A Case Manager typically holds a bachelor's degree in social work or behavioral health and has experience working with individuals who have serious mental illness.

2. The Case Manager provides direct support, such as helping participants access housing, healthcare, and social services, and they facilitate communication between participants and other service providers – providing a central point of contact for all aspects of a participants care.

c. Certified Peer Support Specialist (PSS)

1. Having personal experience with mental health challenges, demonstrating that recovery is possible. Can provide a unique form of empathy and support that compliments the clinical expertise of the other team members.

2. They are certified in peer support and have training in mental health and substance use recovery.

3. A PSS on an ACT team typically has lived experience with mental illness and/or substance use disorders and has successfully navigated recovery.

4. Serves as a role model, provides education on self-help techniques, coping strategies, symptom management, and assists with creating community support systems.

5. They use their personal experiences to provide hope, support, and mentorship to clients, helping them engage in their own recovery process

b. Operational Requirements:

ACT Team's must operate in alignment with established administrative protocols, evidence-based treatment practices, and evidence-based documentation standards. Continuity of operations and disaster plans shall comply with state standards and Nevada Medicaid requirements for enrollment.

1. Admission criteria – ACT teams to have explicit admission criteria and intake rate to limit the number of admissions in any given month.

   a. Ensuring that new participants meet specific criteria helps maintain the safety and stability of the program, both for the participants and the team members.

   b. Gradual admissions help ensure that new participants receive thorough assessments and tailored treatment plans, promoting better outcomes and stability.

   c. A steady, manageable flow of new admissions helps maintain team cohesion and effectiveness, as the team can integrate new participants without overwhelming existing processes

2. Team meetings:

   a. ACT Team meetings should be held daily, but no less than four (4) times per week.

   b. The daily team meeting includes team members from various disciplines dedicated to team cohesiveness, collaboration, and the recovery of individuals with severe mental illness.

   c. Team members update each other on each participants' experiences and recovery over the past and upcoming 24 hours. The team leader ensures the meeting stays focused on the 24-hour cycle by reviewing the roster of ACT participants, maintaining the meeting's momentum.

3. Individualized Treatment Plans are collaboratively developed by the entire

ACT team, the participant, and any family or natural supports.

4. Service Delivery:

   a. The majority of ACT services (more than 50%) are delivered in vivo, meaning services are provided in the community where participants live and work, rather than in a clinical or office setting. This approach is designed to help participants by integrating treatment into their daily lives, making it more accessible and relevant to their real-world experiences.

   b. Team members go the extra mile to support and empower participants to achieve their individual goals.

   c. The ACT team carries a small, shared caseload, providing person-centered care with shared decision making amongst the team.

   d. Intensity: Average of two or more contacts per participant per week, averaging two hours per participant per week. With no less than one contact, per participant, every two weeks.

   e. Services are provided directly by the ACT Team. Team members share responsibility for all participants served by the Team.

   f. Services are available 24 hours a day, seven days per week.

   g. In rural areas, participants may experience less frequent but longer individual contacts due to geographical constraints.

   h. Team members may interact with a participant with acute needs multiple times a day. As the participant stabilizes, contacts decrease.

Best Practices, reference SAMHSA's Assertive Community Treatment EBP Kit and for other resources, reference Case Western Reserve University's EBP ACT Resources.

2. Eligible Members

   a. Eligibility for Assertive Community Treatment (ACT) services requires that the participant has a confirmed diagnosis of Serious Mental Illness (SMI), or SMI with co-occurring conditions, for which ACT services are deemed medically necessary. ACT is primarily intended for individuals diagnosed with SMI who meet at least one of the criteria listed in section (a) and one or more of the conditions outlined in

section (b):

1. Major depression
2. Schizophrenia
3. Bipolar disorder
4. Obsessive compulsive disorder (OCD)
5. Panic disorder
6. Post-traumatic stress disorder (PTSD)
7. Borderline personality disorder (BPD)
8. Co-occurring substance use/mental health disorders

b. ACT is designed to assist individuals with SMI and/or SMI with co-occurring disorders who also have high-service needs, including at least one of the following:

1. High utilization of emergency services, which may include crisis phone lines, emergency room, psychiatric hospitalization, and other crisis intervention.
2. Housing instability, including substandard housing, homelessness, or high risk of homelessness.
3. Legal issues, including arrest and incarceration related to mental illness.
4. Been unsuccessful with traditional treatment methods.
5. Struggle with living independently within the community, including personal hygiene and nutritional needs.
6. Inability to maintain self-sustaining employment.

3. Covered Services

a. ACT services include, but are not limited to:

1. Crisis Assessment and Intervention

2. Comprehensive Evaluation for mental health and co-occurring care
3. Psychiatric Care: psychotherapy, psychosocial rehabilitation
4. Individual supportive therapy
5. Medication Administration and Management
6. Substance Use Treatment
7. Illness Management and Recovery Skills
8. Case Management
9. Supportive Employment and Education
10. Referrals and Linkages
11. Peer Support Services
12. Family and natural supports Intervention, including psychoeducation
13. Assistance with daily living activities (household, transportation, personal hygiene, money management, medical and dental care, community resources, and accessing other applicable benefits)

b. Time unlimited: There is no predetermined end date for the services provided. Participants can receive support for as long as necessary. This approach ensures that individuals with severe mental illness have continuous access to the care and support needed to maintain stability, enhance their quality of life, and prevent relapse.

4. Noncovered Services

a. Non-evidence-based models

b. Caregiver Services

c. Documentation

d. Room and Board

5. Authorization Requirements

Prior Authorization is not required for ACT services delivered to eligible Medicaid participants.

6. Billing

Providers must adhere to Medicaid billing guidelines using a service code and place of service (POS) code. The following code must be used to bill for Medicaid-covered Assertive Community Treatment.

Code Modifier	Brief Description	Unit/ Service Limitation	Prior Authorization Requirement
H0040	Assertive Community Treatment (ACT) Daily Rate	1 unit per day Must include Place of Service (POS) code to indicate where the service was delivered.	No

Refer to the Nevada Medicaid Billing Manual for additional claims submission details.

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

b. In accordance with federal law, Medicaid is the payer of last resort where other resources may be responsible for payment. These prior resources include, but are not limited to:

1. Medicare
2. Labor unions
3. Worker's Compensation Insurance Carriers
4. Private/group insurance
5. Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)
6. Exceptions to this rule occur in cases where Medicaid is considered primary, such as services funded by the Bureau of Family Health Services, Indian Health Services (IHS), Ryan White Act programs, and Victims of

Crime.

7. Managed Care Members

Managed Care Organizations (MCOs) must ensure compliance with Medicaid guidelines. Providers are responsible for enrolling with each MCO and verifying coverage requirements directly with the recipient's MCO.

~~2. PACT is for individuals who have the most serious and intractable symptoms of a severe mental illness and who, consequently, have the greatest difficulty with basic daily activities, keeping themselves safe, caring for their basic physical needs or maintaining a safe and affordable place to live and require interventions that have not been effectively addressed by traditional, less intensive services.~~

~~3. Services are available 24 hours a day, seven days per week. Team members may interact with a person with acute needs multiple times a day. As the individual stabilizes, contacts decrease. This team approach is facilitated by daily team meetings in which the team is briefly updated on each individual. Activities for the day are organized and team members are available to one another throughout the day to provide consultation or assistance. This close monitoring allows the team to quickly adjust the nature and intensity of services in response to individuals' changing needs. PACT is reimbursed as unbundled services.~~

403.6E RESERVED

403.6F PSYCHOSOCIAL REHABILITATION

1. Scope of Service: PSR services are RMH interventions designed to reduce psychosocial dysfunction (i.e., interpersonal, cognitive, behavioral, development, etc.) and restore recipients to their highest level of functioning. PSR services target psychological functioning within a variety of social settings.

PSR services may include any combination of the following interventions:

a. Behavior management: Recipients learn how to manage their interpersonal, emotional, cognitive, and behavioral responses to various situations. They learn how to positively reflect anger, manage conflicts, and express their frustrations verbally. They learn the dynamic relationship between actions and consequences;

b. Social competency: Recipients learn interpersonal-social boundaries and gain confidence in their interpersonal-social skills;

c. Problem identification and resolution: Recipients learn problem resolution

techniques and gain confidence in their problems solving skills;

d. Effective communication: Recipients learn how to genuinely listen to others and make their personal, interpersonal, emotional and physical needs known;

e. Moral reasoning: Recipients learn culturally relevant moral guidelines and judgment;

f. Identity and emotional intimacy: Recipients learn personal and interpersonal acceptance. They learn healthy (appropriate) strategies to become emotionally and interpersonally intimate with others;

g. Self-sufficiency: Recipients learn to build self-trust, self-confidence and/or self-reliance;

h. Life goals: Recipients learn how to set and achieve observable specific, measurable, achievable, realistic, and time-limited life goals; and/or

i. Sense of humor: Recipients develop humorous perspectives regarding life's challenges.

2. Provider Qualifications:

a. QMHP: QMHPs may provide PSR services.

b. QMHA: QMHAs may provide PSR services under the Clinical Supervision of a QMHP.

c. QBA: QBAs may not provide PSR services.

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

Service Limitations	Children: CASII	Adults: LOCUS
Levels I & II	No services authorized	No services authorized
Level III	Maximum of two hours per day	Maximum of two hours per day
Levels IV & V	Maximum of three hours per day	Maximum of three hours per day

Level VI	Maximum of four hours per day	Maximum of four hours per day

4. Admission Criteria: At least one parent or a legal guardian (in the case of legal minors) with whom the recipient is living must be willing to participate in home and community-based services; and the recipient must have substantial deficiencies in any combination of the following criteria:

   a. Behavior management: Recipients are experiencing severe deficits managing their responses (viz., interpersonal, emotional, cognitive, and behavioral) to various situations. Recipients cannot age appropriately manage conflicts, positively channel anger, or express frustration verbally. They do not understand the relationship between actions and consequences;

   b. Social competency: Recipients are experiencing severe deficits navigating interpersonal-social boundaries. They lack confidence in their social skills;

   c. Problem identification and resolution: Recipients are experiencing severe deficits resolving personal and interpersonal problems;

   d. Effective communication: Recipients need to learn how to listen to others and make their needs known to others. They cannot effectively communicate their personal, interpersonal, emotional and physical needs;

   e. Moral reasoning: Recipients are experiencing severe deficits in culturally relevant moral judgment;

   f. Identity and emotional intimacy: Recipients are experiencing severe deficits with personal and interpersonal acceptance. They avoid and/or lack the ability to become emotionally and interpersonally intimate with other people;

   g. Self-sufficiency: Recipients are experiencing severe deficits with self-confidence, self-esteem, and self-reliance; recipients express feelings of hopelessness and helplessness; dealing with anxiety: Recipients are experiencing severe deficits managing and accepting anxiety, they are fearful of taking culturally normal and healthy rehabilitative risks;

   h. Establishing realistic life goals: Recipients are experiencing severe deficits setting and achieving realistic life goals; and/or

   i. Sense of humor: Recipients are experiencing severe deficits seeing or understanding the various humorous perspectives regarding life's challenges.

~~403.6G CRISIS INTERVENTION SERVICES~~

~~1. Scope of Services: CI services are RMH interventions that target urgent situations where recipients are experiencing acute psychiatric and/or personal distress. The goal of CI services is to assess and stabilize situations (through brief and intense interventions) and provide appropriate mental and behavioral health service referrals. The objective of CI services is to reduce psychiatric and personal distress, restore recipients to their highest level of functioning and help prevent acute hospital admissions. CI interventions may be provided in a variety of settings, including but not limited to psychiatric emergency departments, emergency rooms, homes, foster homes, schools, homeless shelters, while in transit and telephonically. CI services do not include care coordination, case management, or targeted case management (TCM) services (see MSM Chapter 2500, TCM).~~

~~CI services must include the following:~~

~~a. Immediate and intensive interventions designed to help stabilize the recipient and prevent hospitalization;~~

~~b. Conduct situational risk-of-harm assessment;~~

~~c. Follow-up and de-briefing sessions to ensure stabilization, continuity of care, and identification of referral resources for ongoing community mental and/or behavioral health services.~~

~~2. Provider Qualifications: 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.~~

~~403.6H MOBILE CRISIS RESPONSE DELIVERED BY DESIGNATED MOBILE CRISIS TEAM (DMCT)~~

~~On September 17, 2021, per Section 9813 of the American Rescue Plan Act (ARPA), the Nevada DHHS was awarded a state planning grant by the US CMS to assist in the development and implementation of qualifying community-based mobile crisis intervention services under its Medicaid state plan. In addition, Section 9813 of the ARPA established Section 1947 of the US SSA, which authorizes optional state plan coverage and reimbursement for qualifying mobile crisis intervention services with a temporarily enhanced 85 percent federal medical assistance percentage (FMAP) for 12 quarters during the timeframe of April 2022 to March 2027. Section 1947 also waives standard state plan requirements for state wideness, comparability, and provider choice, in addition to providing definition for qualifying community-based mobile crisis services.~~

~~The following policy is contingent upon State Plan Amendment (SPA) approval by CMS.~~

~~1. Scope of Services~~

~~Nevada shall ensure that MCRT respond in person at the location in the community where a crisis arises or a family's location of choice. For individuals 18 years of age and younger, responses in urban Clark and Washoe counties will be conducted face-to-face and in-person, with an average response time within one hour; average response times for these individuals in rural areas are within two hours. For adults, responses in urban areas shall be within one hour and within two hours in rural areas. Telehealth responses in these locations shall be initiated as soon as possible, within one hour, with face-to-face and in-person team members arriving within one hour in urban areas and within two hours in rural areas. Nevada identifies these MCRTs that comply with ARPA and the US SSA as DMCT.~~

~~The primary objective of this Mobile Crisis Response service is to offer "someone to come" in the crisis continuum, established through Senate Bill (SB) 390 (during the 81st Nevada Legislative Session (2021)) and subsequent legislation that formulates a comprehensive safety net of crisis services for all Nevadans. DMCTs will respond to an individual in crisis~~

~~at the individual's location, 24/7/365.~~

~~While a crisis episode is not defined outside of the individual experiencing the crisis, the dispatch of a DMCT indicates a higher LOC is needed through an in-person response for the individual's acute/emergent episode of crisis. An assessment, including the evaluation of suicidality, is required to be delivered by a qualified and/or licensed behavioral health professional. The resulting intervention and stabilization of the crisis by the DMCT includes care coordination (through active engagement and "warm hand-off") and follow-up by providers. Care coordination is inclusive of coordinated transportation to other locations when recipients are determined to need facility-based care.~~

~~2. DMCT Access and Accessibility~~

~~a. DMCT services shall be available 24/7/365 for in-person response and ensure 24 hour/seven days per week on-call coverage and back-up availability.~~

~~b. DMCT services shall not be restricted to certain locations or days/times within the covered area. DMCTs shall:~~

~~1. Respond to wherever the recipient is in the community outside of a hospital or other facility settings.~~

~~2. Never require the individual in crisis to travel to the DMCT.~~

~~3. Respond to the preferred location based on individual in crisis and/or caregiver preference.~~

~~4. Respond with the least restrictive means possible, only involving public safety personnel when necessary.~~

~~5. DMCTs are expected to respond to dispatch through a designated call center and shall advise the designated call center of any changes to the DMCT's availability (i.e., in the event of self-dispatch to a crisis on-site).~~

~~c. DMCTs shall attempt to meet the needs of all Nevadans, with consideration given to the providers' identified catchment area and including specific populations (i.e., Tribal communities and multicultural communities, LGBTQ+, children and adolescents, aging populations, individuals with disabilities, individuals experiencing substance use, etc.).~~

~~d. For all DMCT providers, the individual served does not have to be a previous or existing client.~~

~~e. Continuity of operations and disaster plans shall comply with state standards and DHCFP requirements for enrollment.~~

~~f. DMCTs shall have Global Positioning System (GPS) devices linked to the designated call center(s) and a means of direct communication available at all times with all partners (including the crisis call center, Emergency Medical Services (EMS), Law Enforcement, Intensive Crisis Stabilization Service providers, and other community partners), such as a cellular phone or radio for dispatch.~~

~~g. DMCTs shall not refuse a request for dispatch unless safety considerations warrant involvement of public safety.~~

~~1. In such cases, DMCTs shall have established standardized safety protocols for community response and when public safety involvement is needed (e.g., in instances of serious injury, overdose, medical emergency, and imminent risk of harm).~~

~~2. Policies shall appropriately balance a willingness to help those in crisis with the team's personal safety and not involve broad rules that would exclude whole populations (i.e., individuals actively using substances or those with a criminal history).~~

~~3. Ensure all interventions are offered in a clinically appropriate manner that respects the preferences of the individual in crisis and their supportive family systems while recognizing the need to maintain safety.~~

~~h. DMCTs shall accept all referrals from a designated call center and shall respond without reassessing the individual on-site only if the designated call center has completed an initial safety screen and provided the screening information to the DMCT.~~

~~i. DMCTs shall use available technology to support care coordination activities and to determine access to available post-crisis care options (e.g., through health information technology, prior treatment information through crisis including safety plans, and psychiatric advance directive (PAD), hospital/provider bed availability, and appointment availability/scheduling).~~

~~j. DMCTs shall provide culturally and linguistically appropriate care.~~

~~k. Individuals with limited English proficiency or communication/language-based disabilities shall have timely access to interpretation/translation service(s), auxiliary aids, and Americans with Disabilities Act (ADA) compliant services (e.g., sign language interpreters, Telecommunications Device (TTY) lines).~~

~~l. Services to children and youth up to 18 years old shall adhere to DHHS Division of Child and Family Services (DCFS) System of Care core values and guiding principles.~~

~~m. DMCTs shall provide timely services to individuals in crisis as defined by state and federal regulations, policy, and/or guidance, including the DMCT Certification Criteria.~~

~~3. DMCT Operational Requirements~~

~~a. Inclusive Services~~

~~1. Screening~~

~~a. DMCTs must establish policies and protocols to ensure:~~

~~1. Consistent screening of all individuals, and~~

~~2. Documentation of all screenings and screening findings, and~~

~~3. Screenings are conducted only by QMHPs and QMHAs who have continuous access to a QMHP for consultation.~~

~~b. Selected screening tools must include use of adopted tools for evaluation of risk, violence, and suicidality.~~

~~1. Tools chosen must be nationally accepted or evidenced-based, peer-reviewed tools, and~~

~~2. Screening tools include the Columbia Suicide Screening Tool (Columbia) and other tools that meet state requirements.~~

~~1. Assessment~~

~~a. Mobile crisis teams must ensure a qualified team member (as outline in MSM 403.6I Provider Qualifications) completed a behavioral health assessment and documents the findings, when indicated.~~

~~b. Selected assessments tools must be:~~

~~1. Nationally accepted or evidenced-based, peer reviewed tools, and~~

~~2. Support evaluations necessary for an involuntary hold, when a hold is initiated.~~

~~c. Selected assessment tools may include the Collaborative Assessment and Management of Suicidality (CAMS) and other tools that meet state requirements.~~

~~d. Mobile crisis teams shall establish policies and protocols to ensure:~~

~~1. Consistent application of assessment tools as appropriate to the age of the individual receiving mobile crisis services and the circumstances, and~~

~~2. Documentation of assessment results.~~

~~e. Crisis and Safety Plans~~

~~1. Crisis and safety plans shall be shared with the individual, their supportive family system, and documented in their clinical record, and~~

~~2. As part of the crisis and safety planning, DMCTs must either complete an assessment indicating individual is able stay in current placement/location or coordinate the transfer of the individual to an appropriate higher LOC.~~

~~2. Medical Records~~

~~a. Medical records shall be kept in accordance with documentation standards set forth in MSM Chapter 100 and MSM Chapter 400, and~~

~~b. Shared with whomever is providing the services (the follow-up provider where the individual is being discharged) to support coordination of care (i.e., triggering words, specific circumstances of individual, etc.)~~

~~3. Advance Directives~~

~~a. DMCTs shall establish protocols regarding when to consider and assist with the completion of a PAD, in accordance with state laws and regulations, and~~

~~b. DMCTs must follow Nevada Medicaid guidance on advance~~

~~directives, as set forth in MSM Chapter 100.~~

~~4. Harm Reduction~~

~~a. When applicable, DMCTs shall educate individuals on harm reduction practices,~~

~~b. DMCTs shall carry harm reduction supplies, including Fentanyl test strips, and~~

~~c. Mobile crisis teams shall carry Naloxone and have team members trained on its administration (as specified in MSM Chapter 400 Section 403.6I Provider Training).~~

~~5. Family Engagement~~

~~a. Mobile crisis teams shall establish protocols to allow family members and other collateral contacts to represent an individual in crisis, and~~

~~b. DMCTs shall follow Nevada Medicaid guidance on supported decision-making, as set forth in MSM Chapter 100.~~

~~6. Coordination of Care~~

~~a. DMCT providers shall coordinate timely follow-up services and/or referrals with providers, social supports, and other services as needed, including but not limited to:~~

~~1. Assigned case managers~~

~~2. Primary Care Providers (PCP)~~

~~3. Existing (or referral) behavioral health providers/care teams, including mental health and SUD support, where available~~

~~4. Harm-reduction resources, where available~~

~~5. Appropriately shared information with whomever is providing the services, the follow-up provider, to where the individual is being discharged to support coordination of care (i.e., triggering words, specific circumstances to individual, etc.)~~

~~b. Discharge from episode of care~~

~~1. DMCTs shall document discharge of the individual from the crisis episode in situations where~~

~~a. Acute/emergent presentation of the crisis is resolved~~

~~b. Appropriate referral(s) and service engagement(s) to stabilize the crisis are completed, including transfer to a Crisis Stabilization Center (CSC) or other LOC~~

~~c. Ongoing or existing services, supports, and linkages have been recommended and documented~~

~~d. Services provided (in-person or via telehealth) up to 72 hours following the initial engagement with the DMCT are considered part of the crisis episode (i.e., pre-discharge)~~

~~e. DMCTs may continue to provide bridge services and support to the individual for up to 45 days for continued stabilization in an outpatient setting; these covered services rendered after 72 hours shall be billed to Medicaid by appropriately enrolled providers. with the appropriate outpatient billing codes~~

~~7. Telehealth~~

~~a. Reference MSM Chapter 3400 related to telehealth modality. The use of telehealth shall be~~

~~1. Dictated by client preference~~

~~2. Utilized to include additional member(s) of the team not on-site~~

~~3. Utilized to provide follow-up services to the individual following an initial encounter with the DMCT~~

~~4. Utilized to include highly trained members of the team, such as psychiatrists, psychiatric nurse practitioners, or others who can prescribe and/or administer medications~~

~~b. Best Practices~~

~~1. An individual in crisis is to be represented in screening/assessment, crisis planning, and follow-up by a family member or other collateral contact that has knowledge of the individual's capabilities and functioning, especially when working with children and youth.~~

~~2. Reduce duplicative screening and assessments.~~

~~3. Access and review existing medical records/treatment information when available to support crisis intervention activities (e.g., seeking and leveraging clinical information from an existing crisis or safety plan, if available).~~

~~4. Providers are expected to develop and maintain a strengths-based, person-centered, trauma-informed, and culturally sensitive/respectful relationship with the individual.~~

~~5. Co-creation of a safety/crisis plan, when applicable.~~

~~6. Education for the individual on harm reduction practices, when applicable.~~

~~Regarding Peer Support Services, it is the intent of policy that the DMCT may include one team member who is a certified Peer Support Specialist provider (per Nevada Certification Board), to the greatest extent possible as recommended by Substance Abuse and Mental Health Services Administration (SAMHSA).~~

~~c. Privacy and Confidentiality Protocols~~

~~1. Policies~~

~~a. Providers shall have established/written policies in compliance with State and Federal privacy and confidentiality laws (e.g., HIPAA), as well as established protocols set forth in accordance with MSM Chapter 100, Chapter 400, and Chapter 3300.~~

~~2. Training~~

~~a. DMCT Clinical Supervision is responsible for the initial and ongoing training of staff on privacy and confidentiality practices and protocols.~~

~~3. Collaboration and Data Sharing~~

a. DMCTs shall establish and maintain privacy and confidentiality policies and procedures to protect beneficiary information in accordance with State and Federal requirements.

b. Address what can and cannot be shared, especially in emergency situations.

c. Share screening and assessment information with the receiving clinical/medical provider, including crisis plans and PADs.

d. Develop and implement appropriate data-sharing agreements with partners, ensuring partners are also securing any data covered by state and federal privacy regulations.

e. Develop data sharing protocols and member information release authorizations to support collaboration practices in accordance with state and federal requirements.

f. Have formal, written, collaborative protocols, memorandums of understanding (MOU), and other agreements with community partners, as necessary:

1. Local Law Enforcement agencies

2. Emergency Medical Services (EMS) providers

3. 988 crisis lines, designated crisis call centers, and dispatch centers providing service coordination among respondents

4. Medicaid Managed Care Organizations (MCO), as applicable in their catchment area.

d. Excluded Services

1. Services not eligible for reimbursement when rendered by a DMCT under Nevada Medicaid include:

a. Crisis services delivered without a screening or assessment, and/or

b. Crisis services delivered solely via telehealth without the availability of an in-person response to the individual in crisis, and/or

c. Crisis services delivered by one-member teams or one individual provider only, and/or

~~d. Crisis services delivered by a DMCT that is not enrolled under Provider Type and Specialty in Nevada Medicaid at the time service is rendered, and/or~~

~~e. Crisis services delivered by a Law Enforcement officer, and/or~~

~~f. Crisis services delivered within a hospital or nursing facility setting.~~

~~4. DMCT Provider Eligibility Requirements~~

~~a. DMCTs must be enrolled as a Nevada Medicaid provider~~

~~b. DMCTs must include at least two team members, one of which shall be able to deliver the service at the location of the individual in crisis. DMCTs must be led by a:~~

~~1. QMHP-level Independent Professional, or~~

~~2. QMHP-level Intern under Direct Supervision of a QMHP-level Independent Professional, or~~

~~3. QMHA-level paraprofessional under the Direct Supervision of a QMHP-level Independent Professional.~~

~~c. DMCT members shall fall into one of the following categories:~~

~~1. Physician~~

~~2. PA~~

~~3. APRN and Independent NP with a focus in psychiatric mental health~~

~~4. Psychologist~~

~~5. LMFT, LCSW, LCPC, and qualified Post-Graduate Interns (under clinical supervision)~~

~~6. RN and QMHA-level~~

~~7. SUD specialists: Licensed clinical alcohol and drug counselors (LCADCs), licensed alcohol and drug counselors (LADCs), certified alcohol and drug counselor (CADCs), and/or associated interns of these specialties (under supervision)~~

~~8. Certified Peer Support Specialist (per Nevada Certification Board) and QBA-level~~

~~d. Provider Supervision~~

~~1. All clinical supervision expectations shall align with existing requirements in MSM Chapter 400 Supervision Standards for an outpatient behavioral health delivery model~~

~~2. All Chapter 400 Provider Eligibility Requirements shall be documented by DMCTs and made available upon request~~

~~3. Real-time clinical consultation and supervision shall be available 24/7/365 to assist the DMCT~~

~~4. DMCTs shall have policies and procedures in place for Clinical Supervision, including a staffing plan that identifies the supervisory structure with the employees' names and positions within the agency, and must ensure:~~

~~a. Case records are kept updated in accordance with Chapter 400 Documentation standards; and~~

~~b. Protocols are regularly updated on when and how to engage the on-call clinician in the crisis episode responded to by the DMCT; and~~

~~c. Supervisors review in-person or via telehealth the response to crisis episode with all involved QMHP-level Intern and QMHA-level staff, and shall appropriately document the time and content of that supervisory discussion; and~~

~~d. The supervisor reviews and co-signs with the rendering QMHP-level Intern and QMHA-level staff the documented screening within 24 hours or next business day; and~~

~~e. Documentation of supervisory contacts with all engaged DMCT supervisee staff, including date of supervisor review, date of observation of individual staff, log of indirect supervision contacts (e.g., paperwork reviewed), as well as date, agenda, and action plan for all conferences with supervisee staff; and~~

f. Each engaged QMHP-level Intern and QMHA-level staff has the documented necessary training, competencies, and skills to conduct mental health screens.

e. Provider Training

1. DMCT providers must develop a staff training and competency plan to be reviewed annually as requested.

a. The plan will include all required training listed in Chapter 400 Provider Eligibility Requirements and other core competencies defined by the state.

b. The plan will outline the process for ongoing review of clinical skills and supervision of staff.

2. All engaged DMCT staff shall receive training in the following areas prior to participating in a mobile response to a crisis episode:

a. Safety/risk screening

1. Training in safety and risk screening shall include methods to:

a. Adapt to cultural and linguistic needs of individuals during the screening process; and

b. Select the appropriate screening tool; and

c. Engage with supportive family system and collateral contacts; and

d. Interpret screening tool results.

b. Stabilization and verbal de-escalation techniques shall be culturally competent, including when and how to adjust response based on the circumstances of the individual in crisis, the site of the crisis response, and the severity of the situation.

c. Harm reduction strategies for individuals with SUD should include:

1. Use of naloxone in the field; and/or

2. How to educate individuals at risk (and their supportive

~~family system) about Naloxone use; and/or~~

~~3. How to educate individuals about harm reduction techniques and resources.~~

~~d. Crisis/safety planning~~

~~e. Appropriate privacy and confidentiality policies and procedures~~

~~f. Use of Telehealth equipment~~

~~g. Electronic health record or other systems utilized in the provision, documentation, and/or reporting of mobile crisis services.~~

~~3. All DMCT staff shall receive training on trauma-informed care within 90 days of employment as a DMCT staff.~~

~~4. All DMCT staff shall receive annual refresher trainings on the training topics identified in this section.~~

~~5. All DMCT staff shall demonstrate competency on all post-tests, for each topic in which they have been trained.~~

~~6. Each training topic shall be covered in separate training modules dedicated to specific topics.~~

~~7. DMCTs shall maintain documentation to demonstrate satisfactory and timely completion of all required trainings.~~

~~a. When requested by the state, DMCTs must submit training logs, training schedules, and post-test results for monitoring purposes.~~

~~5. DMCT Recipient Eligibility Requirements~~

~~a. DMCT services are available to all Medicaid eligible individuals who are: 1. outside of a hospital or other facility setting, and 2. experiencing a behavioral health crisis (including mental health and SUD-related crises).~~

~~b. Symptoms are indicative of a crisis which requires coordinated clinical response, through the implementation of intervention and stabilization services, for the safety and protection of the individual in crisis and others involved on-site (e.g., harm to self, harm to others, inability to care for oneself).~~

~~c. Referral from a designated call center or self-referral by a DMCT.~~

6. Authorization Process And Clinical Documentation Of Service

a. Documentation of DMCT service by 1. a QMHP-level Independent Professional supervising and/or delivering service and 2. at least one additional team member rendering the intervention/stabilization service on-site.

b. No prior authorization is required for the delivery of services by a DMCT, unless an outpatient service requiring prior authorization (according to service limitations) is delivered in association with but separate from the crisis episode lasting 72 hours.

c. DMCTs shall maintain a daily log of all DMCT responses, as dispatched by a crisis call center and self-dispatched, within and outside of catchment area. Log will be made available upon request. The log will include up to and including

1. HIPAA compliant identifier for the individual crisis response episode, and

2. Date of crisis response episode, and

3. Start and end time of crisis response episode (for the recipient on that day), and

4. Mechanism of response (dispatch), and

5. Name and credentials of all team members involved in response and supervising QMHP-level Independently Licensed provider.

403.6I CRISIS STABLIZATION CENTER (CSC)

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 individual or others, or substantially increase the risk of the individual becoming gravely disabled.

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

~~LOC 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 LOC.~~

~~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 LOC. Active family/guardian/significant other/natural supports involvement is necessary unless contraindicated. Crisis stabilization services mean behavioral health services designed to:~~

~~a. De-escalate or stabilize a behavioral health crisis, whether this is occurring concurrently with a SUD; 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 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 NRS) 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 SUD 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 individual and

~~shall contain, including but not limited to the following. Please also consult medical documentation requirements listed in Section 403.9B(2):~~

~~1. An assessment for SUD and co-occurring mental health and SUD, 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 individual 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 individual 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:~~

~~a. All recipients in a CSC may be rolled over for inpatient admission any time the patient requires acute care services.~~

~~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 LOC, 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 (IHS), Ryan White Act, and Victims of Crime, when Medicaid is primary. Benefits available free of charge to recipients from other sources must be provided free of charge to Nevada Medicaid recipients.~~

403.7 PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY (PRTF) SERVICES

A. Nevada Medicaid reimburses for services provided in a PRTF when rendered to eligible recipients in accordance with this Section.

B. A PRTF is a psychiatric facility, other than a hospital, that provides active treatment, as defined under 42 CFR 441.154, on an inpatient basis, seven days per week, under the direction of a physician.

C. PRTFs serve recipients under the age of 21 years with complex mental health needs and their families, based on medical necessity. PRTF treatment is intended to help recipients