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 4400 – Crisis 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 – Metal Health Services 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). Additionally, MSM Chapter 4400 will include the following new community-based crisis services: Mobile Crisis Team (MCT) and Intensive Crisis Stabilization Service (ICSS) facility.

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Material Transmitted	Material Superseded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 Crisis Services	MTL NEW Crisis Services

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
4400	**Crisis Services**	Added “Crisis Services” Section.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
4401	**Authority**	Added "Authority" Section, removing "temporary" Federal Medical Assistance Percentages (FMAP) language.
4402	**Definitions**	Added "Definitions" section, with reference to MSM Addendum for additional definitions.
4403	**Managed Care Members**	Added "Managed Care Members" section.
4404	**Crisis Intervention (CI) Services**	Added "Crisis Intervention" section.
4404.1		Added "Eligible Providers" section and added additional/missing PTs.
4404.2		Added "Eligible Members" section and added clarifying language.
4404.3		Added "Covered Services" section and added clarifying language and added reference to Telehealth.
4404.4		Added "Noncovered Services" section.
4404.5		Added "Authorization Requirements" section.
4404.6		Added "Billing" section, with additional clarifying language and a billing chart.
4405	**Designated Mobile Crisis Team (DMCT)**	Added "Designated Mobile Crisis Team" section summary and added a description of the two specialty types (87/31 DMCT (PT 87, Specialty 32) and Certified Community Behavioral Health Clinics (CCBHC) as DMCT) included under this service.
4405.1		Added "Eligible Providers" section with added language for clarity and for the addition of a Quality Assurance and Quality Improvement (QA/QI) Program and added language for DMCT delivered by a CCBHC.
4405.2		Added "Eligible Members" section with additional clarifying language.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
4405.3		Added "Covered Services" section with clarifying language for Telehealth usage.
4405.4		Added "Noncovered" section.
4405.5		Added "Authorization Requirements" section.
4405.6		Added "Billing" section, with additional clarifying language with a billing chart.
4406	**Mobile Crisis Team (MCT)**	Added "Mobile Crisis Team" section summary.
4406.1		Added "Eligible Providers" section.
4406.2		Added "Eligible Members" section.
4406.3		Added "Covered Services" section.
4406.4		Added "Noncovered Services" section.
4406.5		Added "Authorization Requirements" section.
4406.6		Added "Billing" section with a billing chart.
4407	**Intensive Crisis Stabilization Service (ICSS)**	Added "Intensive Crisis Stabilization Service" section summary.
4407.1		Added "Eligible Providers" section.
4407.2		Added "Eligible Members" section.
4407.3		Added "Covered Services" section.
4407.4		Added "Noncovered Services" section.
4407.5		Added "Authorization Requirements" section.
4407.6		Added "Billing" section with a billing chart.
4408	**Crisis Stabilization Center (CSC)**	Added "Crisis Stabilization Center" section summary.
4408.1		Added "Eligible Providers" section.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
4408.2		Added "Eligible Members" section.
4408.3		Added "Covered Services" section.
4408.4		Added "Noncovered Services" section.
4408.5		Added "Authorization Requirements" section.
4408.6		Added "Billing" section with a billing chart.
Appendix A	**Crisis Quality Assurance (QA) and Quality Improvement (QI) Guide**	Added "Crisis Quality Assurance and Quality Improvement Guide" as Appendix A to MSM Chapter 4400.
Appendix B	**Memorandum of Understanding (MOU) Toolkit**	Added "Memorandum of Understanding Toolkit" as Appendix B to MSM Chapter 4400.

4400 CRISIS SERVICES

4401 AUTHORITY

- Americans with Disabilities Act (ADA) of 1990 (P.L. 101-336), 42 United States Code (U.S.C.) 12101, and regulations adopted hereunder contained in 28 Code of Federal Regulations (CFR) §§ 36.101 through 36.999, inclusive
- "Advance Directives" are regulated by 42 CFR §489, Subpart I and Nevada Revised Statutes (NRS) Chapter 449A, Care and Rights of Patients
- Section 1902(a)(20) of the Social Security Act (SSA) (State Provisions for Mental Institution Patients 65 and Older)
- Section 1902(a)(20) of the SSA (Provision prohibiting States from making Medicaid payments to anyone but the provider)
- Section 1905(a)(13) of the SSA (Other Diagnostic Screening, Preventative and Rehabilitative Services)
- Section 1905(r)(5) of the SSA (Mental Health Services for Children as it relates to Early and Periodic Screening, Diagnosis and Treatment (EPSDT))
- Section 1947 of the SSA (Qualifying Community-Based Mobile Crisis Intervention (CI) Services)
- Section 504 of the Rehabilitation Act of 1973. (29 U.S.C. § 794)
- 42 CFR 440.2(a) (Specific Definitions of Services for Inpatient vs. Outpatient)
- 42 CFR, Part 440 (Services: General Provisions), 440.130 (Diagnostic, screening, preventive and rehabilitative services)
- Centers for Medicare and Medicaid Services (CMS) 2261-P, (Medicaid Program; Coverage for Rehabilitative Services)
- NRS 433.B.010 to 433.B.350 (Mental Health of Children)
- NRS 433.A.010 to 433.A.750 (Mental Health of Adults)
- NRS, Chapter 630 (Physicians, Physician Assistants (PA), and Practitioners of Respiratory Care)
- NRS 641 (Psychologists)

- NRS 641.A (Marriage and Family Therapists (MFT) and Clinical Professional Counselors)
- NRS 641B (Social Workers)
- NRS 695C.194 (Provision of Health Care Services to Recipients of Medicaid or enrollees in Children's Health Insurance Program (CHIP): Requirement for Health Maintenance Organizations (HMOs) to contract with hospitals with endorsements as Crisis Stabilization Centers (CSC)
- NRS 695G.320 (Provision of Health Care Services to Recipients of Medicaid or enrollees in CHIP: Requirement for Managed Care Organizations (MCOs) to contract with hospitals with endorsements as CSCs
- NRS 443.704(s) (Mobile Crisis Teams (MCT))
- NRS 449 (Medical and other Related Facilities)
- NRS 449.01566 (Peer Support Services (PSS) Defined)
- NRS 449.0915 Crisis Services (Endorsement of Hospital as a CSC)
- Nevada Medicaid State Plan 22-0005 Crisis Services, Attachment 3.1-A and Attachment 4.19-B
- Nevada Medicaid Inpatient Psychiatric and Substance Use Policy, Procedures and Requirements. The Joint Commission Restraint and Seclusion Standards for Behavioral Health.

4402 DEFINITIONS

Certified Community Behavioral Health Clinic (CCBHC) is a specially designated clinic that provides comprehensive mental health and substance use treatment services. These clinics are designed to offer integrated, person-centered care to individuals regardless of their ability to pay.

CI Services are Rehabilitative Mental Health (RMH) interventions that target urgent situations where recipients are experiencing acute psychiatric and/or personal distress. The goal of CI services is to assess and stabilize situations (through brief and intense interventions) and provide appropriate mental and behavioral health service referrals.

CSCs are a hospital-based facility that delivers Intensive Crisis Stabilization Services (ICSS) and holds endorsement as a CSC. It is a specialized facility providing immediate care and support to individuals experiencing severe emotional, psychological, or behavioral crises. CSCs focus on short-term, intensive crisis stabilization (23 hours and 59 minutes), ensuring the individual's safety and well-being while addressing urgent needs.

Emergency Medical Providers, for the purpose of this Medicaid Services Manual (MSM) Chapter, are meant to include Emergency Medical Services (EMS), Fire Departments (FD), Search and Rescue Teams, and Disaster Response Teams.

ICSS providers are a community-based specialized facility providing immediate care and support to individuals experiencing severe emotional, psychological, or behavioral crises. ICSSs focus on short-term, intensive crisis stabilization (23 hours and 59 minutes) ensuring the individual's safety and well-being while addressing urgent needs.

Psychiatric Advance Directive (PAD) is a legal document that allows individuals to outline their preferences for future mental health treatment if they are unable to make decisions for themselves due to a mental health crisis. This can include specifying preferred medications, treatments, and hospitalization preferences, as well as appointing a healthcare proxy to make decisions on their behalf. PADs are designed to ensure that a person's treatment preferences are respected and followed during times when they may not be able to communicate their wishes effectively.

Public Safety Access Point (PSAP) is a call center responsible for answering emergency calls, such as those made to 911. PSAPs are staffed by trained personnel who manage the intake of emergency calls and dispatch the appropriate emergency services, such as police, fire, and EMS.

Additional program definitions can be found in the MSM Addendum.

4403 MANAGED CARE MEMBERS

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.

4404 CRISIS INTERVENTION SERVICES

CI services are designed to provide immediate support and assistance to individuals who are experiencing acute emotional distress, trauma, or dangerous situations. The primary purpose is to stabilize the individual, reduce the intensity of their crisis, and help them regain control. These services focus on addressing urgent needs, ensuring safety, and connecting individuals to ongoing support or resources to address the underlying issues contributing to the crisis. CI aims to help people navigate difficult moments, prevent escalation and hospital admissions, and promote healing and recovery.

CIs may be provided in a variety of settings, including but not limited to psychiatric emergency departments, emergency rooms (ER), homes, foster homes, schools, homeless shelters, while in transit and telephonically.

4404.1 ELIGIBLE PROVIDERS

CI providers must be enrolled as a Nevada Medicaid provider.

The following may provide CI services:

A. Licensed Professionals

B. Qualified Mental Health Professional (QMHP).

If a multidisciplinary team is used with Medicaid enrolled QMHA, Qualified Behavioral Aids (QBA), or Peer Support Specialists, the team must be led by a QMHP or licensed professional. The team leader assumes professional liability over the CI services rendered.

4404.2 ELIGIBLE MEMBERS

A. Clinical documentation must demonstrate that the recipient meets any combination of the following:

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

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

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

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

5. Participants 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 (e.g., harm to self, harm to others, inability to care for oneself).

4404.3 COVERED SERVICES

A. CI services must include:

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

2. Situational risk-of-harm assessment; and

3. 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.

4. Culturally and linguistically appropriate care. Individuals with limited English proficiency or communication/language-based disabilities shall have timely access to interpretation/translation service(s), auxiliary aids, and ADA-compliant services (e.g., sign language interpreters, Telecommunications Device (TTY) lines).

B. Telehealth: Reference MSM Chapter 3400 related to telehealth modality. The use of telehealth shall be:

1. Dictated by client; and/or

2. Utilized when deemed medically and clinically appropriate; and/or

3. Utilized to provide follow-up services.

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

4404.4 NONCOVERED SERVICES

CI services not available for reimbursement under Nevada Medicaid include, but are not limited to:

A. Care coordination, and/or

B. Case management, and/or

C. Targeted case management (TCM) services (see MSM Chapter 2500, Targeted Case Management), and/or

D. CI services delivered without a risk-of-assessment, and/or

E. Room and Board.

4404.5 AUTHORIZATION REQUIREMENTS

Recipient may receive without prior authorization:

A. A maximum of four hours per day over a three-day period (one occurrence) without prior authorization

B. A maximum of three occurrences over a 90-day period without prior authorization.

Prior authorization is not required for CI Services unless they'll be exceeding the maximum allowable occurrences.

Emergency request for CI: Submit within five business days of the delivery of additional services, including the first date of service of the first occurrence.

4404.6 BILLING

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

B. Providers must adhere to Medicaid billing guidelines, which include the use of appropriate service codes, modifiers, and shadow billing practices. The following codes must be used to bill for Medicaid-covered CI Services:

Billing Code	Brief Description	Unit / Service Limitation	Prior Authorization Requirement
Crisis Intervention (CI)			
H2011	Crisis Intervention (**CI**) Individual Response	UNIT: Per 15 minutes. Maximum of four hours per day over a three-day period (one occurrence). Maximum of three occurrences over 90-day period.	No *Unless to exceed service limitations.
H2011 HT	Crisis Intervention (**CI**) Team Response	UNIT: Per 15 minutes. Maximum of four hours per day over a three-day period (one occurrence). Delivered by a team of providers. Must include modifier HT.	No *Unless to exceed service limitations.

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

C. 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)

D. 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.

4405 DESIGNATED MOBILE CRISIS TEAM (DMCT)

Nevada shall ensure that DMCTs respond in person to the location in the community or a family's location of choice where a crisis arises. In urban Clark and Washoe counties, mobile response will be conducted face-to-face and in-person, with an average response time within one hour; average response times for individuals in rural areas are within two hours and within three hours in frontier areas. Telehealth responses in these locations shall be initiated as soon as possible, with in-person team member(s) arriving within the above-mentioned timeframes. Nevada identifies these mobile crisis response teams that comply with ARPA and the US SSA as DMCTs.

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-hours a day, 7-days a week, 365-days of the year.

While a crisis episode is not defined outside of the individual experiencing the crisis, the dispatch of a DMCT indicates a higher Level of Care (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 "warm handoffs") and follow up by providers. Care coordination is inclusive of coordinating or scheduling transportation to other locations when recipients are determined to need a different LOC.

There are two DMCT models:

A. Mobile crisis response delivered by a DMCT is limited to Nevada governmental agencies and emergency medical providers (i.e.: Emergency Medical Service (EMS), Ambulance, Fire, and/or Rescue) delivering emergency services.

B. Mobile crisis response delivered by a CCBHC as a DMCT.

4405.1 ELIGIBLE PROVIDERS

DMCTs must adhere to all federal and state requirements, the regulations outlined in this MSM chapter, and all other applicable MSM chapters. This includes compliance with the provisions relevant to all providers.

To participate in the Nevada Medicaid Program, DMCTs must meet all specific requirements and remain compliant with any licensing, accreditation, and certification standards throughout their Medicaid enrollment.

A. Provider Eligibility Requirements:

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

2. 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.

3. DMCTs must be led by a:

    a. Licensed Professional

    b. QMHP under Direct Supervision of a Licensed Professional

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

    a. Physician

    b. PA

    c. APRN and Independent Nurse Practitioner (NP) with a focus on psychiatric mental health

    d. Psychologist

    e. Licensed Marriage and Family Therapist (LMFT), Licensed Clinical Social Worker (LCSW), and Licensed Clinical Professional Counselor (LCPC).

    f. Registered Nurse (RN)

    g. Substance Use Disorder (SUD) specialists: Licensed clinical alcohol and drug counselors (LCADCs), licensed alcohol and drug counselors (LADCs), and certified alcohol and drug counselors (CADCs).

    h. Certified Peer Support Specialist (PSS) (per Nevada Certification Board)

    i. Providers of EMS

    j. People with appropriate expertise in behavioral health, which may include QMHP, Qualified Mental Health Associate (QMHA), Qualified Behavioral Aide (QBA), community health workers (CHW), case management providers, or other similar paraprofessionals.

B. Provider Supervision:

All clinical supervision expectations shall align with existing requirements in MSM Chapter 400 Supervision Standards for an outpatient behavioral health delivery model. All Provider Eligibility Requirements shall be documented by DMCTs and made available upon request.

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

2. 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; and

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

    d. The supervisor reviews and co-signs with the rendering 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 supervisory 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 staff has the documented necessary training, competencies, and skills to conduct mental health screens.

C. Provider Training:

DMCT providers must develop a staff training and competency plan to be submitted as part of the DMCTs Annual QA/QI Report and whenever requested. The plan will include all required training listed below and other core competencies defined by the state. The training and competency plan will outline the process for ongoing review of clinical skills and supervision of staff.

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

a. Safety/risk screening: Training in safety and risk screening shall include methods to:

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

2. Select the appropriate screening tool; and

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

4. 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 records or other systems utilized in the provision, documentation, and/or reporting of mobile crisis services.

2. All DMCT staff shall receive training in trauma-informed care within 90 days of employment.

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

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

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

6. DMCTs shall maintain documentation to demonstrate satisfactory and timely completion of all required training.

D. Quality Assurance (QA) and Quality Improvement (QI) Program:

Until the DMCT receives certification from the Division of Public and Behavioral Health (DPBH), it must implement an ongoing QA/QI program.

This program is vital for reviewing and monitoring all services provided as well as individual recipients' experiences and feedback. The program ensures high-quality service delivery; addresses identified problems and guarantees expected outcomes. DMCTs must cooperate with authorized external review systems, including the state's licensing agency and the Division of Nevada Medicaid (DNM).

DMCTs may utilize MSM Chapter 4400 Appendix A - Crisis Quality Assurance and Quality Improvement Guide in the development of their QA/QI program and overall reporting requirements.

1. QA/QI plans must also include:

a. Collaborative Protocol Plan

1. List collaborative memorandums of understanding (MOU), etc., written agreement partners.

b. Staffing Plan

1. Organizational chart with the supervisory structure

c. Training and Competency Plan

1. Training logs, training schedules, post-test result of all staff.

2. QA/QI plans must be submitted:

a. Upon enrollment application.

b. Annually in the month of the original approval.

c. Whenever requested.

E. Operational Requirements:

DMCTs 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. Screening: DMCTs must establish policies and protocols to ensure consistent screening of all individuals, and documentation of all screenings and screening findings. Screenings are conducted by qualified team members functioning within their scope.

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

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

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

    d. DMCT's should reduce duplicative screening and assessments and must not rely only on self-reported instruments for screening and assessment purposes and supplement these measures, when possible, with clinical ratings made from observations by trained clinicians.

    e. Once DMCTs arrive on scene and once crisis stabilization interventions have been successfully deployed, DMCTs should begin the screening and assessment process.

2. Assessment: MCTs must ensure a qualified team member (as outlined above) completes a behavioral health assessment and documents the findings, when indicated. Selected assessments tools must be:

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

    b. 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. MCTs shall establish policies and protocols to ensure consistent application of assessment tools as appropriate to the age of the individual receiving mobile crisis services and the circumstances, and documentation of assessment results.

e. All individuals receiving crisis stabilization must undergo assessments for both their physical and mental health.

3. Crisis and Safety Plans: Crisis and safety plans shall be shared with the individual, their supportive family system, and documented in their clinical record, and as part of the crisis and safety planning, DMCTs must either complete an assessment indicating individual is able to stay in current placement/location or coordinate the transfer of the individual to an appropriate higher LOC.

4. Advance Directives (AD): DMCTs shall establish protocols regarding when to consider and assist with the completion of an AD and/or PAD, in accordance with state laws and regulations, and DMCTs must follow Nevada Medicaid guidance on ADs, as set forth in MSM Chapter 100.

5. Harm Reduction: When applicable, DMCTs shall educate individuals on harm reduction practices. DMCTs shall carry harm reduction supplies, including fentanyl test strips. DMCTs shall carry naloxone and have team members trained in its administration (as specified above).

6. Family Engagement: MCTs shall establish protocols to allow family members and other collateral contacts to represent an individual in crisis. DMCTs shall follow Nevada Medicaid guidance on supported decision-making, as set forth in MSM Chapter 100. Active family/guardian/significant other/natural supports involvement is necessary unless contraindicated.

a. 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.

7. Recovery Orientation: Promote hope, empowerment, respect, social connections, self-responsibility, and self-determination.

8. Trauma-Informed Care: Address the impact of past trauma on individuals experiencing behavioral health crises or substance use disorders.

9. Significant Use of Peer Staff: Include individuals with lived experiences to provide relatable support. It is the intent of policy that the DMCT include one team member

who is a certified PSS provider (per Nevada Certification Board), to the greatest extent possible and as recommended by Substance Abuse and Mental Health Services Administration (SAMHSA).

10. Coordination of Care: DMCT providers shall coordinate timely follow-up services and/or referrals with providers, social support, and other services as needed, including but not limited to:

    a. Assigned case managers.

    b. Primary Care Providers (PCP).

    c. Existing (or referral) behavioral health providers/care teams, including mental health and SUD support.

    d. Harm-reduction resources.

    e. Appropriately share 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.)

    f. Coordinate transport to another LOC, when deemed clinically and medically appropriate.

    g. Schedule outpatient follow-up appointments in a manner synonymous with a warm handoff, to support connection to ongoing care.

    h. At least one follow-up contact with recipient within 72 hours of discharge.

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

    a. Health Insurance Portability and Accountability Act (HIPAA) compliant identifier for the individual crisis response episode, and

    b. Date of crisis response episode, and

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

d. Mechanism of response (dispatch), and

e. Name and credentials of all team members involved in the response and the supervising Licensed Professional.

f. Utilizes a data management tool that is used to track admissions, discharges, diagnoses, and long-term outcomes, to inform and update the DMCT.

12. Discharge from episode of care: DMCTs shall document discharge of the individual from the crisis episode in situations where acute/emergent presentation of the crisis is resolved.

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

b. Ongoing or existing services, support, and linkages have been recommended and documented.

c. 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).

d. A plan for follow-up within 72 hours.

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.

13. DMCTs shall ensure they:

a. Never require the individual in crisis to travel to the DMCT.

b. Respond to the preferred location based on individual in crisis and/or caregiver preference. Respond with the least restrictive means possible, only involving law enforcement (LE) personnel when necessary.

c. Develop and maintain a strength-based, person-centered, trauma-informed, and culturally sensitive/respectful relationship with the individual.

d. Respond to dispatches through emergency and crisis call centers and shall advise the call centers of any changes to the DMCT's availability (i.e., in the event of self-dispatch to a crisis on-site).

e. Have Global Positioning System (GPS) devices linked to the call center(s) and a means of direct communication available with all partners (including the crisis call center, EMS, LE, ICSS providers, and other community partners), such as a cellular phone or radio for dispatch.

f. 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 PAD, hospital/provider bed availability, and appointment availability/scheduling).

g. Do not refuse a request for dispatch unless safety considerations warrant involvement of public safety.

h. Have established standardized safety protocols for community response and when emergency medical provider or LE involvement is needed (e.g., in instances of serious injury, overdose, medical emergency, and imminent risk of harm).

i. 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).

j. 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.

k. Provide culturally and linguistically appropriate care. 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. Have a commitment to Zero Suicide/Suicide Safer Care.

m. Utilize restraint and seclusion only when necessary to ensure safety.

n. Focus on Consumer and Staff Safety.

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

14. Collaborative protocols: DMCTs shall have formal, written, collaborative protocols, MOU, and other agreements with community partners, as necessary:

a. Local LE agencies

b. EMS providers

c. 988 crisis lines, designated crisis call centers, and dispatch centers providing service coordination among respondents (including Public Safety Answering Point (PSAP).

d. Medicaid MCO, as applicable in their coverage area.

e. First Responders are priority and whenever possible should receive expedited admission

DMCT's may utilize MSM Chapter 4400 Appendix B –Nevada Crisis Partnership – MOU Toolkit, for best practices in the development of their MOUs

15. Medical Records: Shall be kept in accordance with documentation standards set forth in MSM Chapters 100, 400, and 4400, and be 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.).

DMCTs should access and review existing medical records/treatment information when available to support CI activities (e.g., seeking and leveraging clinical information from an existing crisis or safety plan, if available).

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

A medical record must be maintained for each individual and should include the following items, when applicable:

a. Assessment by a mental health professional for SUD and co-occurring mental health/substance use disorders, including a mental status examination and risk assessment for harm to self, others, or property.

b. Coordination with the individual's current treatment provider, if applicable.

c. Safety plan, including follow-up details: Name, address, and contact information for follow-up providers. Follow-up appointment details, if known.

d. A collaboratively developed crisis stabilization plan, including Strategies and interventions to resolve the crisis in the least restrictive way. Language that is understandable to the individual and their support system. Measurable goals for resolving the crisis and restoring functioning.

16. Best Practices: In addition to the MSM, DMCTs may refer to SAMHSA for best practices in mobile crisis care delivery.

17. Privacy and Confidentiality Protocols:

a. Policies: 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 the applicable MSM.

b. Training: DMCT Clinical Supervision is responsible for the initial and ongoing training of staff in privacy and confidentiality practices and protocols.

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

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

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

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

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

5. Comply with recipient confidentiality laws and HIPAA.

18. DMCT Delivered by a CCBHC.

a. CCBHCs may bill mobile crisis separately and in addition to their CCBHC PPS daily rate if they deliver their mobile crisis following all DMCT regulations and policies, listed in MSM Chapter 4400, Section 4405.

b. CCBHCs must obtain endorsement for the CCBHC delivering mobile crisis as a DMCT issued by the DPBH.

c. Reference MSM Chapter 2700 related to all other CCBHC regulations and guidelines.

d. CCBHCs that deliver mobile crisis as a DMCT must also be enrolled as a DMCT.

4405.2 ELIGIBLE MEMBERS

A. DMCTs shall attempt to meet the needs of all Nevadans, with consideration given to the providers identified coverage 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.).

B. The individual served does not have to be a previous or existing client.

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

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

E. DMCT accepts all recipients, regardless of:

1. Race, ethnicity, gender, socioeconomic status, sexual orientation, or place of residence.

2. Social conditions affecting the recipient.

3. Whether the recipient is admitted voluntarily under NRS 433A.140 or through an emergency admission under NRS 433A.150.

F. DMCTs must ensure that no recipient is excluded from participation, denied benefits, or subjected to discrimination in service delivery or employment practices based on disability,

age, race, color, religion, sex, national origin, or any other classification protected by federal law, Nevada State Constitutional provisions, or statutory regulations. For further details, please refer to MSM Chapter 100.

G. Participants 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).

4405.3 COVERED SERVICES

A. Nevada Medicaid currently reimburses for services delivered by an appropriately enrolled DMCT. Any additional services associated with the crisis (also referred to as bridge services) shall be billed as individually reimbursed services under the applicable MSM by an appropriately enrolled Nevada Medicaid provider.

B. DMCT services shall be available for on-call coverage, and back-up availability, 24 hours per day, seven days per week, 365 days per year; services shall not be restricted to certain locations or days/times within the coverage area. DMCT is comprised of at least two providers, one who can deliver services at the time of the crisis episode, in-person at the location of the individual in crisis.

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

D. 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.

E. Services to be provided in accordance with the terms, conditions and requirements of the Americans with Disabilities Act of 1990 (P.L. 101-336), 42 U.S.C. 12101, and regulations adopted hereunder contained in 28 CFR §§ 36.101 through 36.999, inclusive.

G. Telehealth: Reference MSM Chapter 3400 related to telehealth modality. The use of telehealth shall be:

1. Dictated by client preference; and

2. Utilized when deemed clinically and medically appropriate; and

3. Utilized to include additional member(s) of the team not on-site; and

4. Utilized to provide follow-up services to the individual following an initial encounter with the DMCT; and

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

4405.4 NONCOVERED SERVICES

Services not eligible for reimbursement when rendered by a DMCT under Nevada Medicaid include but are not limited to:

A. Crisis services delivered without a screening or assessment.

B. Crisis services delivered solely via telehealth without the availability of an in-person response to the individual in crisis.

C. Mobile crisis services delivered by one-member teams or one individual provider only.

D. Mobile crisis delivered without documented follow-up contact within 72 hours after discharge.

E. Mobile crisis services delivered by a DMCT not enrolled with Nevada Medicaid at the time service is rendered.

F. Mobile crisis services delivered within a hospital or nursing facility setting.

G. Room and Board.

4405.5 AUTHORIZATION REQUIREMENTS

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.

4405.6 BILLING

Providers must adhere to Medicaid billing guidelines, which include the use of appropriate service codes, modifiers, and shadow billing practices. The following codes must be used to bill for Medicaid-covered DMCT Services:

Billing Code	Brief Description	Unit / Service Limitation	Prior Authorization Requirement
Designated Mobile Crisis Team (DMCT)			
H2011 HT	Mobile Crisis response delivered by a Designated Mobile Crisis Team **(DMCT)**	UNIT: Per 15 minutes. Must include modifier HT.	No
H2011 HT	Certified Community Behavioral Health Clinic **(CCBHC)** delivering mobile crisis as a Designated Mobile Crisis Team **(DMCT)**	UNIT: Per 15 minutes. Must include modifier HT.	No

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

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

A. Nevada Medicaid currently reimburses services delivered under an appropriately enrolled Certified Community Behavioral Health Center (CCBHC) who delivers Mobile Crisis as a Designated Mobile Crisis Team (DMCT). Any additional services associated with the crisis (also referred to as bridge services) shall be billed under the CCBHC encounter rate and guidelines, under MSM Chapter 2700, by an appropriately enrolled Medicaid provider.

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. 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, IHS, Ryan White Act programs, and Victims of Crime.

4406 MOBILE CRISIS TEAM (MCT)

Nevada shall ensure that MCTs respond to individuals in crisis. This response, whenever deemed clinically necessary, should be in-person at the location in the community or at a family's preferred location where the crisis arises. When MCTs are unable to respond in-person or when response times exceed one hour in urban areas, two hours in rural areas, or three hours in frontier areas, telehealth responses should be initiated immediately.

The primary objective of this Mobile Crisis Response service is to offer "someone to come" in the crisis care 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. MCTs shall be available to respond to an individual in crisis, 24 hours a day, 7-days a week, 365-days of the year. While a crisis episode is not defined outside of the individual experiencing the crisis, the dispatch of a MCT indicates a higher LOC is needed through an in-person response for the individual's acute/emergency 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 MCT includes care coordination (through active engagement "warm hand-offs") and follow-up by providers. Care coordination is inclusive of coordinated transportation to other locations when recipients are determined to need facility-based care.

4406.1 ELIGIBLE PROVIDERS

MCTs must adhere to all federal and state requirements, the regulations outlined in this MSM chapter, and all other applicable MSM chapters. This includes compliance with the provisions relevant to all providers.

To participate in the Nevada Medicaid Program, MCTs must meet all specific requirements and remain compliant with any licensing, accreditation, and certification standards throughout their Medicaid enrollment.

A. Provider Eligibility Requirements:

1. MCTs must be enrolled as a Nevada Medicaid provider

2. MCTs should include at least two team members, one who should be able to deliver the service at the location of the individual in crisis.

3. MCTs must be led by a:

   a. Licensed Professional, or

   b. QMHP under Direct Supervision of a Licensed Professional.

4. MCTs shall have a multidisciplinary team capable of addressing the needs of individuals experiencing all levels of crisis in the community. This team may include:

   a. Physician

   b. PA

   c. APRN and Independent NP with a focus on psychiatric mental health

   d. Psychologist

   e. LMFT, LCSW, or LCPC.

   f. QMHP, QMHA, or QBA - under clinical supervision.

   g. RN

   h. SUD specialists: LCADCs, LADCs, or certified alcohol and drug counselors (CADCs).

   i. Certified PSS (per Nevada Certification Board)

   j. LE Officer

   k. Emergency medical providers (Emergency Medical Technician (EMT), Paramedic)

   l. People with appropriate expertise in behavioral health, which may include CHW, case management providers, or other similar paraprofessionals.

B. Provider Supervision:

All clinical supervision expectations shall align with existing requirements in MSM Chapter 400 Supervision Standards for an outpatient behavioral health delivery model. All Provider Eligibility Requirements shall be documented by MCTs and made available upon request.

1. Real-time, in-person, or telephonic clinical consultation and supervision shall be available 24/7 to assist the MCT staff.

2. MCTs 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 MSM Chapter 400 Documentation standards; and

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

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

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

e. Documentation of supervisory contacts with all engaged MCT supervisee staff, including date of supervisory 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 staff has the documented necessary training, competencies, and skills to conduct mental health screens.

C. Provider Training:

MCT providers must develop a staff training and competency plan to be submitted as part of their Annual QA/QI Report. The plan will include all required training listed below and other core competencies defined by the state. The training and competency plan will outline the process for ongoing review of clinical skills and supervision of staff.

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

1. Safety/risk screening: 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.

2. 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.

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

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

   b. How to educate individuals at risk (and their supportive family system) about naloxone use; and/or

   c. How to educate individuals about harm reduction techniques and resources.

4. Crisis/safety planning

5. Appropriate privacy and confidentiality policies and procedures

6. Use of Telehealth equipment

7. Electronic health records or other systems utilized in the provision, documentation, and/or reporting of mobile crisis services.

8. All MCT staff shall receive training in trauma-informed care within 90 days of employment.

9. All MCT staff shall receive annual refresher training on the training topics identified in this section.

10. All MCT staff shall demonstrate competence in all post-tests, for each topic in which they have been trained.

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

12. MCTs shall maintain documentation to demonstrate satisfactory and timely completion of all required training.

D. QA/QI Program:

Until the MCT receives certification from the DPBH, it must implement an ongoing QA/QI program.

This program is vital for reviewing and monitoring all services provided as well as individual recipients' experiences and feedback. The program ensures high-quality service delivery; addresses identified problems and guarantees expected outcomes. MCTs must cooperate with authorized external review systems, including the state's licensing agency and Nevada Medicaid

MCTs may utilize MSM Chapter 4400 Appendix A - Crisis Quality Assurance and Quality Improvement Guide in the development of their QA/QI program and overall reporting requirements.

1. QA/QI plans must also include:

    a. Collaborative Protocol Plan

        1. List written collaborative (MOU, etc.) written agreement partners.

    b. Staffing Plan

        1. Organizational chart with the supervisory structure

    c. Training and Competency Plan

        1. Training logs, training schedules, post-test result of all staff.

2. QA/QI plans must be submitted:

    a. Upon enrollment application.

    b. Annually in the month of the original approval.

    c. Whenever requested.

E. Operational Requirements:

1. Screening: MCTs must establish policies and protocols to ensure consistent screening of all individuals, and documentation of all screenings and screening finding. Screenings are conducted only by qualified team members functioning within their scope.

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

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

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

d. MCTs should reduce duplicative screening and assessments and aim to not overly rely on self-reported instruments for screening and assessment purposes and supplement these measures, when possible, with clinical ratings made from observations by trained clinicians.

2. Assessment: MCTs must ensure a qualified team member (as outlined above) completes a behavioral health assessment and documents the findings, when indicated. Selected assessments tools must be:

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

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

c. Selected assessment tools may include the CAMS and other tools that meet state requirements.

d. MCTs shall establish policies and protocols to ensure consistent application of assessment tools as appropriate to the age of the individual receiving mobile crisis services and the circumstances, and documentation of assessment results.

3. Crisis and Safety Plans: Crisis and safety plans shall be shared with the individual, their supportive family system, and documented in their clinical record, and as part of the crisis and safety planning, MCTs must either complete an assessment indicating individual is able to stay in current placement/location or coordinate the transfer of the individual to an appropriate higher LOC.

4. ADs: MCTs shall establish protocols regarding when to consider and assist with the completion of an AD and/or PAD, in accordance with state laws and regulations, and MCTs must follow Nevada Medicaid guidance on advanced directives, as set forth in MSM Chapter 100.

5. Harm Reduction: When applicable, MCTs shall educate individuals on harm reduction practices. MCTs shall carry harm reduction supplies, including Fentanyl test strips. MCTs shall carry naloxone and have team members trained in its administration (as specified above).

6. Family Engagement: MCTs shall establish protocols to allow family members and other collateral contacts to represent an individual in crisis. MCTs shall follow Nevada Medicaid guidance on supported decision-making, as set forth in MSM Chapter 100. Active family/guardian/significant other/natural supports involvement is necessary unless contraindicated.

    a. Whenever possible, 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.

7. Recovery Orientation: Promote hope, empowerment, respect, social connections, self-responsibility, and self-determination.

8. Trauma-Informed Care: Address the impact of past trauma on individuals experiencing behavioral health crises or substance use disorders.

9. Significant Use of Peer Staff: Include individuals with lived experiences to provide relatable support. It is the intent of policy that the MCT should include one team member who is a certified PSS provider (per Nevada Certification Board), to the greatest extent possible as recommended by SAMHSA.

10. Coordination of Care: MCT providers shall coordinate timely follow-up services and/or referrals with providers, social support, and other services as needed, including but not limited to:

    a. Assigned case managers

    b. PCP

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

    d. Harm-reduction resources, where available

    e. Appropriately share 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.)

    f. Schedule outpatient follow-up appointments in a manner synonymous with a warm handoff, to support connection to ongoing care.

g. At least one follow-up contact with the recipient within 72 hours of discharge.

11. MCT Daily Log: MCTs shall maintain a daily log of all MCT responses, as dispatched by a crisis call center or self-dispatched, within and outside of their coverage area. Log will be made available upon request. The log will include up to and including:

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

b. Date of crisis response episode, and

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

d. Mechanism of response (dispatch, telephonic, individual or team), and

e. Name and credentials of all team members involved in the response and the supervising provider.

f. Utilizes a data management tool that is used to track admissions, discharges, diagnoses, and long-term outcomes, to inform and update the MCT.

12. Discharge from episode of care: MCTs shall document discharge of the individual from the crisis episode in situations where acute/emergency presentation of the crisis is resolved.

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

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

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

13. MCTs shall ensure they:
a. Focus on Consumer and Staff Safety.

b. Never requires the individual in crisis to travel to the MCT.

c. Respond based on the individual in crisis and/or caregiver preference, with the least restrictive means possible, only involving LE personnel when necessary.

d. Develop and maintain a strength-based, person-centered, trauma-informed, and culturally sensitive/respectful relationship with the individual.

e. Respond to dispatches through a call center and shall advise the call center of any changes to the MCT's availability (i.e., in the event of self-dispatch to a crisis on-site).

f. Have Global Positioning System (GPS) devices linked to the call center(s) and a means of direct communication available with all partners (including the crisis call center, EMS, LE, ICSS providers, and other community partners), such as a cellular phone or radio for dispatch.

g. 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 PAD, hospital/provider bed availability, and appointment availability/scheduling).

h. Have a commitment to Zero Suicide/Suicide Safer Care.

i. Use restraint and seclusion only when necessary to ensure safety.

j. 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).

k. 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).

l. 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.

m. Provide culturally and linguistically appropriate care. Individuals with limited English proficiency or communication/language-based disabilities shall have timely access to interpretation/translation service(s), auxiliary

aids, and ADA-compliant services (e.g., sign language interpreters, Telecommunications Device (TTY) lines).

14. Collaborative protocols: Have formal, written, collaborative protocols, MOU, and other agreements with community partners, as necessary:

    a. LE agencies.

    b. EMS providers.

    c. 988 crisis lines, crisis call centers, and dispatch centers providing service coordination among respondents (including Public Safety Answering Point (PSAP)).

    d. Medicaid MCO, as applicable in their coverage area.

    e. First Responders are priority and whenever possible should be given expedited admission.

    MCTs may utilize MSM Chapter 4400 Appendix B – Nevada Crisis Partnership – MOU Toolkit, for best practices in the development of their MOUs.

15. Medical Records:

    Medical records shall be kept in accordance with documentation standards set forth in MSM Chapters 100, 400, and 4400, and be 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.).

    MCTs should access and review existing medical records/treatment information when available to support CI activities (e.g., seeking and leveraging clinical information from an existing crisis or safety plan, if available).

    Documentation of MCT service by supervisor and at least one additional team member rendering the intervention/stabilization service on-site.
    A medical record must be maintained for each individual and should include the following items, when applicable:

    a. Assessment for SUD and co-occurring mental health/substance use disorders, including circumstances of admission/dispatch and admission/dispatch date/time.

b. Evaluation by a mental health professional, including a mental status examination and risk assessment for harm to self, others, or property.

c. Review of the individual's current crisis plan.

d. Admission diagnosis with supporting documentation.

e. Coordination with the individual's current treatment provider, if applicable.

f. Discharge plan, including follow-up details: Name, address, and contact information for follow-up providers. Follow-up appointment details, if known.

g. A collaboratively developed crisis stabilization plan, including Strategies and interventions to resolve the crisis in the least restrictive way. Language that is understandable to the individual and their support system. Measurable goals for resolving the crisis and restoring functioning.

h. Documentation of informed consent attempts and reasons for administering antipsychotic medication over objection, if applicable.

16. Best Practices:

In addition to the MSM, MCTs should refer to SAMHSA for best practices in mobile crisis care delivery.

17. Privacy and Confidentiality Protocols:

a. Policies: 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 Chapters 100, 400, 3300, and 4400.

b. Training: MCT Clinical Supervisor is responsible for the initial and ongoing training of staff in privacy and confidentiality practices and protocols.

c. Data Sharing: MCTs shall establish and maintain privacy and confidentiality policies and procedures to protect beneficiary information in accordance with State and Federal requirements.

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

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

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

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

5. Comply with recipient confidentiality laws and HIPAA.

4406.2 ELIGIBLE MEMBERS

MCTs shall attempt to meet the needs of all Nevadans, with consideration given to the providers identified coverage 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.).

MCTs shall accept all referrals from a crisis call center and the individual served does not have to be a previous or existing client. MCTs shall respond without reassessing the individual on-site if the call center has completed an initial safety screen and provided the screening information to the MCT.

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

A. MCT accepts all recipients, regardless of:

1. Race, ethnicity, gender, socioeconomic status, sexual orientation, or place of residence.

2. Social conditions affecting the recipient.

3. Whether the recipient is admitted voluntarily under NRS 433A.140 or through an emergency admission under NRS 433A.150.

B. MCTs must ensure that no recipient is excluded from participation, denied benefits, or subjected to discrimination in service delivery or employment practices based on disability, age, race, color, religion, sex, national origin, or any other classification protected by

federal law, Nevada State Constitutional provisions, or statutory regulations. For further details, please refer to MSM Chapter 100.

C. Participants 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).

4406.3 COVERED SERVICES

Nevada Medicaid currently reimburses for services delivered by an appropriately enrolled MCT. Any additional services associated with the crisis (also referred to as bridge services) shall be billed as individually reimbursed services under the applicable MSM by an appropriately enrolled Nevada Medicaid provider.

A. MCT services shall be available for on-call coverage, and back-up availability, 24 hours per day, 7 days per week, 365 days per year; services shall not be restricted to certain locations or days/times within the coverage area. MCT should be comprised of at least one provider who can deliver the services at the time of the crisis episode.

B. MCTs shall not refuse a request for dispatch within their coverage area, unless safety considerations warrant involvement of public safety.

1. MCTs 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.

C. MCTs shall provide culturally and linguistically appropriate care. Individuals with limited English proficiency or communication/language-based disabilities shall have timely access to interpretation/translation service(s), auxiliary aids, and ADA-compliant services (e.g., sign language interpreters, Telecommunications Device (TTY) lines).

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

E. MCTs shall provide timely services to individuals in crisis as defined by state and federal regulations, policy, and/or guidance.

F. Telehealth: Reference MSM Chapter 3400 related to telehealth modality. The use of telehealth shall be:

1. Dictated by client preference; and

2. Utilized when deemed clinically and medically appropriate; and

3. Utilized to include additional member(s) of the team not on-site; and

4. Utilized to provide follow-up services to the individual following an initial encounter with the MCT; and

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

4406.4 NONCOVERED SERVICES

Services not eligible for reimbursement when rendered by an MCT under Nevada Medicaid include, but are not limited to:

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

B. Mobile crisis services delivered without, at a minimum, one documented follow-up contact within 72 hours of discharge and/or

C. Crisis services delivered by a MCT that is not enrolled with Nevada Medicaid at the time service is rendered, and/or

D. Crisis services delivered within a hospital or nursing facility setting, and/or

E. Room and Board.

4406.5 AUTHORIZATION REQUIREMENTS

No prior authorization is required for the delivery of crisis services by an MCT.

4406.6 BILLING

Providers must adhere to Medicaid billing guidelines, which include the use of appropriate service codes, modifiers, and shadow billing practices. The following codes must be used to bill for Medicaid-covered MCT Services:

Billing Code	Brief Description	Unit / Service Limitation	Prior Authorization Requirement
Mobile Crisis Team			
H2011 HT	Mobile Crisis Team (MCT) Community-based	UNIT: Per 15 minutes. Must include modifier HT.	No

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

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

A. 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. 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, IHS, Ryan White Act programs, and Victims of Crime.

4407 INTENSIVE CRISIS STABILIZATION SERVICE

Crisis stabilization refers to unplanned, expedited crisis services provided to or on behalf of individuals to address urgent conditions requiring immediate attention—conditions that cannot be adequately or safely managed in a community setting. The goal of an ICSS facility is to deliver stabilization services to avoid the need for inpatient care. If untreated, the individual's condition or symptoms may pose an imminent threat to themselves or others or substantially increase the risk of them becoming gravely disabled.

ICSSs serve as an emergency healthcare alternative, offering those with acute behavioral health challenges (including co-occurring disorders) prompt action, compassionate care, and effective support in a respectful environment. They operate on a "no-wrong-door" policy for crisis care. ICSSs provide short-term, subacute care to stabilize individuals and help them return to active participation in the community. Key elements of this model include a welcoming and accepting atmosphere that fosters hope, empowerment, choice, and a sense of higher purpose.

The ICSS model is designed for interventions lasting less than 24 hours. ICSSs are part of a broader continuum of crisis services aimed at stabilizing individuals and alleviating symptoms of distress.

The primary objective of ICSS is to conduct a prompt and comprehensive assessment of the individual and develop a treatment plan that emphasizes CI. This approach aims to restore the individual's functioning to a level manageable at a lower level of care.

ICSSs encompass behavioral health interventions designed to:

A. De-escalate or stabilize a behavioral health crisis, including crises occurring alongside a substance use disorder.

B. When appropriate, prevent admission to inpatient mental health facilities or hospitals and connect individuals with ongoing care providers tailored to their unique needs.

4407.1 ELIGIBLE PROVIDERS

A. Provider Eligibility Requirements: To participate in the Nevada Medicaid Program, ICSSs must meet all specific requirements and remain compliant with licensing, accreditation, and certification standards throughout their Medicaid enrollment.

1. Proof that the ICSS provider meets the requirements specified in NRS 449.0915.

2. ICSSs must adhere to all federal and state requirements, the regulations outlined in this MSM chapter, and all other applicable MSM chapters. This includes compliance with the provisions relevant to all providers.

3. Must be enrolled as a Nevada Medicaid provider.

4. ICSSs must establish policies to ensure:

   a. A mental health professional is on-site 24/7.

   b. Licensed physicians, PAs, or psychiatric APRNs are available for consultation to direct care staff 24/7.

   c. RNs, LPNs, social workers, CHWs, and PSS (as defined by Chapter 449 of the NRS) adequately meet recipients' needs.

   d. Restraint and seclusion are only used when necessary to ensure safety.

   e. ICSS are available to all individuals, including walk-ins or those brought by LE or MCTs.

5. ICSSs must:.

   a. Adhere to best practices and utilize evidence-based practices.

   b. In a way that incorporates recovery concepts for individuals with behavioral health issues, such as hope, empowerment, respect, social connections, self-responsibility, and self-determination.

6. ICSSs must have the necessary equipment and personnel to conduct medical examinations pursuant to NRS 433A.165, including:

   a. Medical triage and screening.

   b. Suicide risk screening and comprehensive suicide risk assessments and planning, when clinically indicated.

   c. Violence risk screening and comprehensive violence risk assessments and planning, when clinically indicated.

   d. SUD triage and screening, as well as co-occurring substance use disorder/medication-assisted treatment initiation.

   e. Medical backup services must be available on-site or through written agreements with a general acute care hospital, ensuring immediate access within reasonable proximity for medical emergencies.

B. Provider Supervision:

ICSS's must maintain 24/7/365 staffing with a multidisciplinary team capable of addressing the needs of individuals experiencing all levels of crisis in the community.

1. Real-time clinical consultation and supervision shall be available 24/7/365 to assist the ICSS staff.

2. All clinical supervision expectations shall align with existing requirements in MSM Chapter 400 Supervision Standards for an outpatient behavioral health delivery model. ICSSs must be led by a:

    a. Licensed Professional, or

    b. QMHP under Direct Supervision of a Licensed Professional.

3. The ICSS multidisciplinary team may include:

    a. Physician

    b. PA

    c. Advanced Practice Registered Nurse (APRN) or Independent NP with a focus on psychiatric mental health

    d. Psychologist

    e. LMFT, LCSW, or LCPC

    f. RN

    g. SUD specialists: LCADCs, LADCs, or CADCs.

    h. QMHP, QMHA, or QBA - under clinical supervision.

    i. Qualified PSS, as defined by NRS 433.627

4. ICSSs 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 MSM Chapter 400 Documentation standards; and

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

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

d. The supervisor reviews and co-signs with the rendering supervised staff the documented screening; and

e. Documentation of supervisory contacts with all engaged ICSS supervisee staff, including date of supervisory 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 staff has the documented necessary training, competencies, and skills to conduct mental health screens.

g. Clinical Supervisors operate within the scope of their license and expertise and have written policies and procedures to document the prescribed process.

C. Provider Training:

1. ICSSs must develop a staff training and competency plan to be submitted as part of the QA/QI Report. The plan will include all required training and other core competencies defined by the state. The plan will outline the process for ongoing review of clinical skills and supervision of staff.

a. All ICSS staff shall receive annual refresher training on the training topics identified in this section.

b. All ICSS staff shall demonstrate competence in all post-tests, for each topic in which they have been trained.

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

d. ICSSs shall maintain documentation to demonstrate satisfactory and timely completion of all required training. Annually with their QA/QI Report and when requested by the state, ICSSs must submit training logs, training schedules, and post-test results for monitoring purposes.

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

   a. Safety/risk screening: Training in safety and risk screening shall include methods to:

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

      2. Select the appropriate screening tool; and

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

      4. 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. Electronic health records or other systems utilized in the provision, documentation, and/or reporting of crisis services.

D. Operational Requirements:

Operates in accordance with established administrative protocols, evidence-based protocols. These centers adhere to best practices and utilize evidence-based practices for delivering CSSs and follow a 23-hour, 59-minute delivery model.

1. Screening: ICSSs must establish policies and protocols to ensure consistent screening of all individuals, and documentation of all screenings and screening findings, and screenings are conducted qualified team members functioning within their scope.

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

   a. Tools chosen must be nationally accepted or evidenced based, peer-reviewed tools, and Screening tools include the Columbia Suicide Screening Tool (Columbia) and other tools that meet state requirements.

2. Assessment: ICSS teams must ensure a qualified team member (as outlined above) completes a behavioral health assessment and documents the findings. ICSSs perform an initial assessment for all presenting at the center, regardless of the severity of their behavioral health issues.

   a. All individuals receiving crisis stabilization must undergo assessments of both their physical and mental health. Appropriate staff will provide the necessary assessment and stabilization services. If external services are required, referrals will be made according to the recipient's specific needs.

   b. ICSS's 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.

      3. Comprehensive assessment and development of a treatment plan is conducted promptly with emphasis on services necessary to stabilize and restore the individual to a level that can be managed at a lower level of care.

   c. 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.
      3. Selected assessment tools may include the CAMS and other tools that meet state requirements.

3. Crisis and Safety Plans: Crisis and safety plans shall be shared with the individual, their supportive family system, and documented in their clinical record, and as part of the crisis and safety planning, ICSSs 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.

4. ADs: ICSSs shall establish protocols regarding when to consider and assist with the completion of an AD and/or a PAD, in accordance with state laws and regulations, and ICSSs must follow Nevada Medicaid guidance on advanced directives, as set forth in MSM Chapter 100.

5. Harm Reduction: When applicable, ICSSs shall educate individuals on harm reduction practices. ICSSs shall carry harm reduction supplies, including fentanyl test strips. ICSSs shall carry naloxone and have team members trained in its administration (as specified above).

6. Family Engagement: ICSSs shall establish protocols to allow family members and other collateral contacts to represent an individual in crisis. ICSSs shall follow Nevada Medicaid guidance on supported decision-making, as set forth in MSM 100. Active family/guardian/significant other/natural supports involvement is necessary unless contraindicated.

7. Coordination of Care: ICSS providers shall coordinate timely follow-up services and/or referrals with providers, social support, and other services as needed, including but not limited to:

    a. Assigned case managers

    b. PCP

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

    d. Harm-reduction resources, where available

    e. Appropriately share 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.).

    f. ICSSs 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 PAD, hospital/provider bed availability, and appointment availability/scheduling).

g. At least one follow-up contact with a recipient not later than 72 hours after the recipient is discharged.

8. Discharge from episode of care: ICSSs shall document discharge of the individual from the crisis episode, in situations where acute/emergent presentation of the crisis is resolved.

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

b. The ICSS must make every effort to stabilize the recipient's condition and ensure expeditious discharge to either an appropriate community setting with aftercare services or psychiatric hospital or general hospital with a psychiatric unit.

c. A plan for follow up.

d. Recipients in an ICSS may transition to inpatient admission whenever acute care services are required. When transitioning a recipient, documentation should include, but is not limited to:

1. Outreach efforts to inpatient hospitals, including reasons for delays in transitioning to an inpatient level of care.

2. Denial reasons, if applicable, and outreach efforts within the community to establish appropriate aftercare services.

3. Reasons for delays in obtaining aftercare services.

9. Recovery Orientation: Promote hope, empowerment, respect, social connections, self-responsibility, and self-determination.

10. Trauma-Informed Care: Address the impact of past trauma on individuals experiencing behavioral health crises or substance use disorders.

11. Significant Use of Peer Staff: Include individuals with lived experiences to provide relatable support.

12. Commitment to Zero Suicide/Suicide Safer Care.

13. Focus on Consumer and Staff Safety.

14. Uses a data management tool to collect and maintain data relating to admissions, discharges, diagnoses and long-term outcomes for recipients.

15. Medical Records: Shall be kept in accordance with documentation standards set forth in MSM Chapters 100, 400, and 4400, and be 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.).

    A medical record must be maintained for each individual and include the following items, when applicable:

    a. Assessment for SUD and co-occurring mental health/SUDs, including circumstances of admission and admission date/time.

    b. Evaluation by a mental health professional, including a mental status examination and risk assessment for harm to self, others, or property.

    c. Review of the individual's current crisis plan.

    d. Admission diagnosis with supporting documentation.

    e. Coordination with the individual's current treatment provider, if applicable.

    f. Discharge plan, including follow-up details: Name, address, and contact information for follow-up providers. Follow-up appointment details, if known.

    g. A collaboratively developed crisis stabilization plan, including strategies and interventions to resolve the crisis in the least restrictive way. Language that is understandable to the individual and their support system. Measurable goals for resolving the crisis and restoring functioning.

    h. Documentation of informed consent attempts and reasons for administering antipsychotic medication over objection, if applicable.

    i. Documentation of follow-up contact.

16. Collaboration: Have formal, written, collaborative protocols, MOU, and other agreements with community partners, as necessary:

    a. Local LE agencies
    b. EMS providers

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

d. Medicaid MCO, as applicable in their coverage area.

e. First responders are priority and whenever possible should receive expedited admission.

ICSS's may utilize MSM Chapter 4400 Appendix B – Nevada Crisis Partnership – MOU Toolkit, for best practices and to assist in the development of their MOU's.

E. QA/QI Program:

Until the ICSS facility receives certification from the DPBH, it must implement an ongoing QA/QI program.

This program is vital for reviewing and monitoring all services provided as well as individual recipients' experiences and feedback. The program ensures high-quality service delivery; addresses identified problems and guarantees expected outcomes. ICSSs must cooperate with authorized external review systems, including the state's licensing agency and Nevada Medicaid

ICSSs may utilize MSM 4400 Appendix A - Crisis Quality Assurance and Quality Improvement Guide in the development of their QA/QI program and overall reporting requirements.

1. QA/QI plans must also include:

a. Collaborative Protocol Plan

1. List written collaborative (MOU, etc.) written agreement partners.

b. Staffing Plan

1. Organizational chart with the supervisory structure

c. Training and Competency Plan

1. Training logs, training schedules, post-test result of all staff.

2. QA/QI plans must be submitted:

a. Upon enrollment application.

b. Annually in the month of the original approval.

c. Whenever requested.

F. ICSS Best Practices: In addition to the MSM, ICSS providers may refer to SAMHSA.

G. Privacy And Confidentiality Protocols

1. Policies: 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, 3300, and Chapter 4400.

2. Training: ICSS Clinical Supervisor is responsible for the initial and ongoing training of staff in privacy and confidentiality practices and protocols.

3. Data Sharing: ICSSs shall establish and maintain privacy and confidentiality policies and procedures to protect beneficiary information in accordance with State and Federal requirements.

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

b. Share screening and assessment information with the receiving clinical/medical provider, including crisis plans and AD and/or PAD.

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

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

e. Comply with recipient confidentiality laws and HIPAA

4407.2 ELIGIBLE MEMBERS

A. ICSS accepts all, regardless of:

1. Race, ethnicity, gender, socioeconomic status, sexual orientation, or place of residence.

2. Social conditions affecting the participant.

3. Whether the participant is admitted voluntarily under NRS 433A.140 or through an emergency admission under NRS 433A.150.

B. ICSS services are available to all Medicaid eligible individuals who are outside of a hospital or other facility setting and are experiencing a behavioral health crisis (including mental health and SUD-related crises).

C. ICSSs shall attempt to meet the needs of all Nevadans, with consideration given to the providers identified coverage 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. ICSSs must ensure that no recipient is excluded from participation, denied benefits, or subjected to discrimination in service delivery or employment practices based on disability, age, race, color, religion, sex, national origin, or any other classification protected by federal law, Nevada State Constitutional provisions, or statutory regulations. For further details, please refer to MSM Chapter 100.

4407.3 COVERED SERVICES

A. Services covered when delivered by an ICSS include, but are not limited to:

1. CI
2. Screenings/Assessments
3. Medical Clearance
4. Observation/Monitoring
5. Treatment Planning
6. Harm Reduction Strategies
7. Family Engagement
8. Peer Support
9. AD or PAD
10. Telehealth Services in accordance with MSM Chapter 3400.
11. Case Management

12. Referral Services

13. Discharge Planning

14. Coordination of Aftercare, including at least one follow-up contact with participant within 72 hours of their discharge (crisis stabilization).

B. To qualify for Nevada Medicaid's ICSS Bundled encounter rate, ICSS providers must deliver each of the following services to the participant:

1. CI: Immediate care to de-escalate and stabilize the situation. Services may include evaluations, screenings, assessments, therapy, testing, etc.

2. Screening and Assessment: Evaluating the individual's mental health, substance use, and co-occurring conditions.

3. Observation and Monitoring: Ensuring the individual's safety and stability during their stay.

4. Treatment Planning: Developing a plan tailored to the individual's needs and diagnosis, including safety measures.

5. Harm Reduction: Including therapy, peer support and medication management.

6. Case Management/Referral Services: Case management services include, without limitations, services to assist in obtaining housing, food, primary health care, and other basic needs. Referral services connect individuals to ongoing treatment and support systems.

7. Medical Clearance: Ensuring individuals are medically stable and referring them to appropriate medical facilities, if needed.

8. Discharge Planning and Coordination of Aftercare: ICSS providers are required to provide at least one documented follow-up contact with the participant no later than 72 hours after discharge.

C. If ICSS providers are unable to deliver all of the bundled CSSs, they may utilize the Crisis Intervention (H2011) HCPCS code as an alternative to the bundled rate (S9485).

D. ICSSs are available to all individuals, including walk-ins or those brought by LE or MCTs.

E. Telehealth: Reference MSM Chapter 3400 related to telehealth modality. The use of telehealth shall be:

1. Dictated by client preference

2. Utilized when deemed clinically and medically appropriate

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

4. Utilized to provide follow-up services to the individual following an initial encounter with the ICSS

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

4407.4 NONCOVERED SERVICES

Services not eligible for reimbursement when rendered by an ICSS under Nevada Medicaid include, but are not limited to:

A. CI/stabilization services delivered without a screening or assessment.

B. CI /stabilization services delivered solely via telehealth.

C. CI/stabilization services provided without at least one documented follow-up contact within 72 hours of discharge.

D. Medical conditions that require care and services beyond what can be safely provided within the ICSS facility. In such cases, the ICSS facility is responsible for coordinating transfer to an appropriate facility.

E. Room and board.

4407.5 AUTHORIZATION REQUIREMENTS

ICSS do not require prior authorization.

4407.6 BILLING

A. Providers must adhere to Medicaid billing guidelines, which include the use of appropriate service codes, modifiers, and shadow billing practices. The following codes must be used to bill for Medicaid-covered ICSS Services:

Billing Code	Brief Description	Unit / Service Limitation	Prior Authorization Requirement
Intensive Crisis Stabilization Services (ICSS)			
S9485	Intensive Crisis Stabilization Services (ICSS)	UNIT: One per crisis encounter/episode. Must be "shadow billed" with S9484.	No
S9484	Intensive Crisis Stabilization Services (ICSS) Community-based facility	UNIT: Per hour. S9484 is "shadow billed" and is reimbursed at $0. Must be billed with S9485 on the same claim.	No
H2011	Crisis Intervention (CI) Individual Response	UNIT: Per 15 minutes. Maximum of four hours without prior authorization (PA). Cannot be billed on the same day as S9485.	No *Unless to exceed service limitations.
H2011 HT	Crisis Intervention (CI) Team Response	UNIT: Per 15 minutes. Maximum of four hours without prior authorization. Cannot be billed on the same day as S9485. Delivered by a team of providers. Must include modifier HT.	No *Unless to exceed service limitations.

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

B. To qualify for the ICSS Bundled Rate (S9485), providers must deliver all the ICSS Bundled Services. The bundled rate is payable one per crisis encounter/episode, regardless of the duration of care.

C. When providers are unable to provide all the ICSS bundled services, they may utilize the appropriate HCPCS code for CI service(s).

D. Encounters with more than one health practitioner and multiple encounters with the same health practitioner that take place on the same day and that share the same or like crisis episode constitute a single billable encounter.

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

F. 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. 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, IHS, Ryan White Act programs, and Victims of Crime.

4408 CRISIS STABILIZATION CENTER

Crisis stabilization refers to unplanned, expedited services provided to or on behalf of individuals to address urgent conditions requiring immediate attention—conditions that cannot be adequately or safely managed in a community setting. The goal of a CSC is to deliver ICSS to avoid the need for inpatient care. If untreated, the individual's condition or symptoms may pose an imminent threat to themselves or others or substantially increase the risk of them becoming gravely disabled.

CSCs serve as an emergency healthcare alternative, offering those with acute behavioral health challenges (including co-occurring disorders) prompt action, compassionate care, and effective support in a respectful environment. They operate on a "no-wrong-door" policy for crisis care, ensuring accessibility for all. CSCs provide short-term, subacute care to stabilize individuals and help them return to active participation in the community. Key elements of this model include a welcoming and accepting atmosphere that fosters hope, empowerment, choice, and a sense of higher purpose.

The CSC model is designed for interventions lasting less than 24 hours. If stabilization cannot be achieved within this period, individuals are referred to an appropriate LOC~~)~~ at an inpatient facility. CSCs are part of a broader continuum of crisis services aimed at stabilizing individuals and alleviating symptoms of distress. Recipients who are stabilized at a CSC are typically discharged to a lower LOC.

CSSs encompass behavioral health interventions designed to:

A. De-escalate or stabilize a behavioral health crisis, including crises occurring alongside a substance use disorder.

B. When appropriate, prevent admission to inpatient mental health facilities or hospitals and connect individuals with ongoing care providers tailored to their unique needs.

4408.1 ELIGIBLE PROVIDERS

A. Provider Eligibility Requirements:

To participate in the Nevada Medicaid Program, CSCs must meet all specific requirements and remain compliant with licensing, accreditation, and certification standards throughout their Medicaid enrollment.

1. CSCs must adhere to all federal and state requirements, the regulations outlined in this MSM chapter, and all other applicable MSM chapters. This includes compliance with the provisions relevant to all providers.

2. Proof that the CSC provider meets the requirements specified in NRS 449.0915.

3. Proof that the hospital qualifies as a rural hospital or holds accreditation from the Commission on Accreditation of Rehabilitation Facilities (CARF), the Center for Improvement in Healthcare Quality, DNV GL Healthcare, the Accreditation Commission for Health Care, the Joint Commission, or their successor organizations.

4. Nevada State hospital licensure showing endorsement as a CSC. In Nevada, licensure is obtained through the Bureau of Health Care Quality and Compliance (BHCQC) within the DPBH.

5. The endorsement as a CSC must be renewed concurrently with the license to which the endorsement applies.

6. Must be enrolled as a Nevada Medicaid provider

7. CSCs must maintain 24/7/365 staffing with a multidisciplinary team capable of addressing the needs of individuals experiencing all levels of crisis in the community.

   CSCs must establish policies to ensure:

   a. A mental health professional is on-site 24/7.

   b. Licensed physicians, PAs, or psychiatric APRNs are available for consultation to direct care staff 24/7.

   c. RNs, LPNs, social workers, CHWs, and PSS (as defined by Chapter 449 of the NRS) adequately meet recipients' needs.

   d. Restraint and seclusion are only used when necessary to ensure safety.

   e. CSCs are available to all individuals, including walk-ins or those brought by LE or MCTs.

8. CSCs must provide ICSSs:

   a. Following a 23-hour, 59-minute delivery model. If recipients cannot be stabilized in this period, the next step would be to refer them to an appropriate LOC at an inpatient facility. Recipients who can be stabilized in an intensive crisis stabilization service provider are anticipated to be discharged to a lower LOC.

b. In designated areas for intensive crisis stabilization or detoxification before releasing the recipient into the community, referring and/or transferring them to another facility.

c. Operate in alignment with established administrative protocols, evidence-based treatment practices, and evidence-based documentation standards.

d. Adhere to best practices and utilize evidence-based practices.

e. In a way that incorporates recovery concepts for individuals with behavioral health issues, such as hope, empowerment, respect, social connections, self-responsibility, and self-determination.

9. CSCs must have the necessary equipment and personnel to conduct medical examinations pursuant to NRS 433A.165, including:

a. Medical triage and screening.

b. Suicide risk screening and comprehensive suicide risk assessments and planning, when clinically indicated.

c. Violence risk screening and comprehensive violence risk assessments and planning, when clinically indicated.

d. SUD triage and screening, as well as co-occurring substance use disorder/medication-assisted treatment initiation.

e. Medical backup services must be available on-site or through written agreements with a general acute care hospital, ensuring immediate access within reasonable proximity for medical emergencies.

B. Provider Supervision:

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

1. Real-time clinical consultation and supervision shall be available 24/7/365 to assist the CSC staff. CSCs must be led by a:

a. Licensed Professional, or

b. QMHP under Direct Supervision of a Licensed Professional.

2. The CSC multidisciplinary team may include:

a. Physician

b. PA

c. APRN or Independent NP with a focus on psychiatric mental health

d. Psychologist

e. LMFT, LCSW, LCPC.

f. RN

g. QMHP, QMHA, or QBA - under clinical supervision.

h. SUD specialists: LCADCs, LADCs, or CADCs.

i. Qualified PSS, as defined by NRS 433.627, whenever appropriate.

3. CSCs 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 MSM Chapter 400 Documentation standards; and

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

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

d. The supervisor reviews and co-signs with the rendering staff the documented screening; and

e. Documentation of supervisory contacts with all engaged CSC supervisee staff, including date of supervisory 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 staff has the documented necessary training, competencies, and skills to conduct mental health screens.

g. Clinical Supervisors operate within the scope of their license and expertise and have written policies and procedures to document the prescribed process.

C. Provider Training:

1. CSCs must develop a staff training and competency plan. The plan will include all required training and other core competencies defined by the state. The plan will outline the process for ongoing review of clinical skills and supervision of staff.

a. All CSC staff shall receive annual refresher training on the training topics identified in this section.

b. All CSC staff shall demonstrate competence in all post-tests, for each topic in which they have been trained.

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

d. CSCs shall maintain documentation to demonstrate satisfactory and timely completion of all required training.

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

a. Safety/risk screening: Training in safety and risk screening shall include methods to:

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

2. Select the appropriate screening tool; and

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

4. 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. Electronic health records or other systems utilized in the provision, documentation, and/or reporting of crisis services.

D. Operational Requirements:

CSCs must operate in alignment with established administrative protocols, evidence-based treatment practices, and evidence-based documentation standards. These centers adhere to best practices and utilize evidence-based practices for delivering ICSSs and follow a 23-hour, 59-minute delivery model.

1. Screening: CSCs must establish policies and protocols to ensure consistent screening of all individuals, and documentation of all screenings and screening findings, and screenings are conducted only by qualified team members functioning within their scope.

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

a. Tools chosen must be nationally accepted or evidenced based, peer-reviewed tools, and Screening tools include the Columbia Suicide Screening Tool (Columbia) and other tools that meet state requirements.

2. Assessment: CSC teams must ensure a qualified team member (as outlined above) completes a behavioral health assessment and documents the findings. CSCs promptly perform an initial assessment for every recipient presenting at the center, regardless of the severity of their behavioral health issues.

a. All individuals receiving crisis stabilization must undergo assessments of both their physical and mental health. Appropriate staff will provide the

necessary assessment and stabilization services. If external services are required, referrals will be made according to the recipient's specific needs.

b. CSCs 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.

3. Comprehensive assessment and development of a treatment plan is conducted promptly with emphasis on services necessary to stabilize and restore the individual to a level that can be managed at a lower LOC.

c. 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.

3. Selected assessment tools may include the CAMS and other tools that meet state requirements.

3. Crisis and Safety Plans: Crisis and safety plans shall be shared with the individual, their supportive family system, and documented in their clinical record, and as part of the crisis and safety planning, CSCs 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.

4. ADs: CSCs shall establish protocols regarding when to consider and assist with the completion of an AD and/or PAD, in accordance with state laws and regulations, and CSCs must follow Nevada Medicaid guidance on advanced directives, as set forth in MSM Chapter 100.

5. Harm Reduction: When applicable, CSCs shall educate individuals on harm reduction practices. CSCs shall carry harm reduction supplies, including Fentanyl test strips. CSCs shall carry Naloxone and have team members trained in its administration (as specified above).

6. Family Engagement: CSCs shall establish protocols to allow family members and other collateral contacts to represent an individual in crisis. CSCs shall follow Nevada Medicaid guidance on supported decision-making, as set forth in MSM Chapter 100. Active family/guardian/significant other/natural supports involvement is necessary unless contraindicated.

7. Coordination of Care: CSC providers shall coordinate timely follow-up services and/or referrals with providers, social support, and other services as needed, including but not limited to:

    a. Assigned case managers

    b. PCP

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

    d. Harm-reduction resources, where available

    e. Appropriately share 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.).

    f. At least one documented follow-up contact with a recipient not later than 72 hours after the recipient is discharged.

    g. CSCs 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 PAD, hospital/provider bed availability, and appointment availability/scheduling).

8. Discharge from episode of care: CSCs shall document discharge of the individual from the crisis episode:

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

    b. The CSC must make every effort to stabilize the recipient's condition and ensure expeditious discharge to either an appropriate community setting with aftercare services or psychiatric hospital or general hospital with a psychiatric unit.

c. A plan for follow up

d. Recipients in a CSC may transition to inpatient admission whenever acute care services are required. When transitioning a recipient, documentation should include, but is not limited to:

1. Outreach efforts to inpatient hospitals, including reasons for delays in transitioning to an inpatient LOC.

2. Denial reasons, if applicable, and outreach efforts within the community to establish appropriate aftercare services.

3. Reasons for delays in obtaining aftercare services.

9. Recovery Orientation: Promote hope, empowerment, respect, social connections, self-responsibility, and self-determination.

10. Trauma-Informed Care: Address the impact of past trauma on individuals experiencing behavioral health crises or substance use disorders.

11. Significant Use of Peer Staff: Include individuals with lived experiences to provide relatable support.

12. Commitment to Zero Suicide/Suicide Safer Care.

13. Restraint and seclusion are only used when necessary to ensure safety.

14. Focus on Consumer and Staff Safety.

15. Collaborative protocols with community partners, Medicaid MCO, and collaboration with 988 crisis lines, LE, PSAP, and other first responders, as applicable in their coverage area. First responders are priority and whenever possible should receive expedited admission. CSCs must collaborate with LE.

16. Uses a data management tool to collect and maintain data relating to admissions, recipient demographics, discharges, diagnoses and long-term outcomes for recipients.

17. Medical Records: Shall be kept in accordance with documentation standards set forth in MSM Chapter 100, 400 and MSM Chapter 4400, and be 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.).

A medical record must be maintained for each individual and include but not limited to the following items, when applicable:

a. Assessment for SUD and co-occurring mental health/substance use disorders, including circumstances of admission/dispatch and admission/dispatch date/time.

b. Evaluation by a mental health professional, including a mental status examination and risk assessment for harm to self, others, or property.

c. Review of the individual's current crisis plan.

d. Admission diagnosis with supporting documentation.

e. Coordination with the individual's current treatment provider, if applicable.

f. Discharge plan, including follow-up details: Name, address, and contact information for follow-up providers. Follow-up appointment details, if known.

g. A collaboratively developed crisis stabilization plan, including Strategies and Interventions to resolve the crisis in the least restrictive way. Language that is understandable to the individual and their support system. Measurable goals for resolving the crisis and restoring functioning.

h. Documentation of informed consent attempts and reasons for administering antipsychotic medication over objection, if applicable.

i. Document follow-up contact.

E. Best Practices: In addition to the MSM, CSC providers may refer to SAMHSA.

F. Privacy And Confidentiality Protocols

1. Policies: 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 the applicable MSM Chapters.

2. Training: CSC Clinical Supervisor is responsible for the initial and ongoing training of staff in privacy and confidentiality practices and protocols.

3. Data Sharing: CSCs shall establish and maintain privacy and confidentiality policies and procedures to protect beneficiary information in accordance with State and Federal requirements.

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

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

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

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

e. Comply with recipient confidentiality laws HIPAA.

4408.2 ELIGIBLE MEMBERS

A. Participants 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).

B. CSCs accept all, regardless of:

1. Race, ethnicity, gender, socioeconomic status, sexual orientation, or place of residence.

2. Social conditions affecting the recipient.

3. The recipient's ability to pay.

4. Whether the recipient is admitted voluntarily under NRS 433A.140 or through an emergency admission under NRS 433A.150.

C. CSCs shall attempt to meet the needs of all Nevadans, with consideration given to the providers identified coverage 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. CSCs must ensure that no recipient is excluded from participation, denied benefits, or subjected to discrimination in service delivery or employment practices based on disability, age, race, color, religion, sex, national origin, or any other classification protected by federal law, Nevada State Constitutional provisions, or statutory regulations. For further details, please refer to MSM Chapter 100.

4408.3 COVERED SERVICES

A. Services covered when delivered by an CSC include, but are not limited to:

1. CI
2. Screenings/Assessments
3. Medical Clearance
4. Observation/Monitoring
5. Treatment Planning
6. Harm Reduction Strategies
7. Family Engagement
8. Peer Support
9. AD or PAD
10. Telehealth Services in accordance with MSM Chapter 3400.
11. Case Management
12. Referral Services
13. Discharge Planning
14. Coordination of Aftercare, including at least one follow-up contact with participant within 72 hours of their discharge (crisis stabilization).

B. To qualify for Nevada Medicaid's ICSS Bundled encounter rate, CSC providers must deliver each of the following services to the participant:

1. CI: Immediate care to de-escalate and stabilize the situation. Services may include evaluations, screenings, assessments, therapy, testing, etc.
2. Screening and Assessment: Evaluating the individual's mental health, substance use, and co-occurring conditions.
3. Observation and Monitoring: Ensuring the individual's safety and stability during their stay.

4. Treatment Planning: Developing a plan tailored to the individual's needs and diagnosis, including safety measures.

5. Harm Reduction: Including therapy, peer support and medication management.

6. Case Management/Referral Services: Case management services include, without limitations, services to assist in obtaining housing, food, primary health care, and other basic needs. Referral services connect individuals to ongoing treatment and support systems.

7. Medical Clearance: Ensuring individuals are medically stable and referring them to appropriate medical facilities, if needed.

8. Discharge Planning and Coordination of Aftercare: CSC providers are required to provide at least one documented follow-up contact with the recipient no later than 72 hours after the recipient is discharged.

C. CSSs are available to all individuals, including walk-ins or those brought by LE or by MCTs.

D. Telehealth: 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 CSC

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.

4408.4 NONCOVERED SERVICES

Services not eligible for reimbursement when rendered by an CSC under Nevada Medicaid include, but are not limited to:

A. CI/stabilization services delivered without a screening or assessment.

B. CI/stabilization services delivered solely via telehealth.

C. CI/stabilization services provided without at least one documented follow-up contact with the recipient within 72 hours of discharge.

D. Services provided beyond the 23-hour, 59-minute service delivery model.

E. Medical conditions that require care and services beyond what can be safely provided within the CSC facility. In such cases, the CSC facility is responsible for ensuring the recipient is transferred to an appropriate facility.

F. Room and board.

4408.5 AUTHORIZATION REQUIREMENTS

CSC services do not require prior authorization.

4408.6 BILLING

A. Providers must adhere to Medicaid billing guidelines, which include the use of appropriate service codes, modifiers, and shadow billing practices. The following codes must be used to bill for Medicaid-covered CSC Services:

Billing Code	Brief Description	Unit / Limitations	Prior Authorization Requirement
Crisis Stabilization Center (CSC) delivering ICSS			
S9485	Crisis Stabilization Center (**CSC**) Hospital-based facility	UNIT: One per crisis encounter/episode. Must be "shadow billed" with S9484.	No
S9484	Crisis Stabilization Center (**CSC**) Hospital-based facility	UNIT: Per hour. S9484 is "shadow billed" and is reimbursed at $0. Must be billed with S9485 on the same claim.	No
H2011	Crisis Intervention (CI) Individual Response	UNIT: Per 15 minutes. Maximum of four hours without prior authorization (PA). Cannot be billed on the same day as S9485.	No *Unless to exceed service limitations use emergency request.
H2011 HT	Crisis Intervention (CI) Team Response	UNIT: Per 15 minutes. Maximum of four hours without prior authorization. Cannot be billed on the same day as S9485. Must include modifier HT	No *Unless to exceed service limitations use emergency request.

Refer to the Nevada Medicaid Billing Manual for additional claims submission details. If you need further clarification, please contact the Medicaid QIO-like vendor.

B. To qualify for the ICSS Bundled Rate (S9485), CSC providers must deliver all the ICSS Bundled Services. The bundled rate is payable one per crisis encounter/episode, regardless of the duration of care.

C. When CSC providers are unable to provide all the ICSS bundled services, they may utilize the appropriate HCPCS code for CI service(s).

D. Encounters with more than one health practitioner and multiple encounters with the same health practitioner that take place on the same day and that share the same or like crisis episode constitute a single billable encounter.

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

F. 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. 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, IHS, Ryan White Act programs, and Victims of Crime.

A. Crisis Quality Assurance (QA) and Quality Improvement (QI) Guide

A QA/QI program is a structured approach organizations use to enhance processes, systems, or services over time. The goal is to create an environment where improvements are ongoing and driven by data, feedback, and collaboration.

1. Key Components a QA/QI Program should include:

   a. Goals and Objectives:

      1. Clearly defined, measurable goals aligned with Medicaid's mission and SAMSHA's guidelines to enhance care quality and accessibility.

      2. Targets for improving specific services, health outcomes, or patient experiences.

   b. Stakeholder Engagement:

      1. Inclusion of input from beneficiaries, providers, and community organizations.

      2. Mechanisms for collaborative decision-making and feedback loops.

   c. Process and Methodology:

      1. A structured framework like Plan-Do-Study-Act (PDSA) or Six Sigma for implementing and assessing changes.

      2. Regularly updated policies and strategies based on data insights.

   d. Monitoring and Reporting:

      1. A process for tracking performance metrics, identifying trends, and addressing issues.

      2. Transparent reporting to regulators, providers, and the public.

   e. Sustainability and Scalability:

      1. Strategies to ensure long-term improvement and adaptability to new challenges or regulations.

2. Necessary Data for QA/QI planning:

   a. Clinical Data:

      1. Patient health outcomes (e.g., hospital readmission rates, vaccination rates, chronic disease management indicators).

2. Quality of care metrics (e.g., adherence to evidence-based practices).

b. Utilization Data:

1. Service usage rates (e.g., emergency department visits, primary care visits).

2. Data on underutilization or overutilization of services.

c. Beneficiary Data:

1. Demographics (e.g., age, gender, socioeconomic status) to identify disparities in care.

2. Patient satisfaction surveys and feedback.

d. Cost Data:

1. Healthcare expenditure details to balance cost-efficiency with quality improvement.

2. Analyses of cost savings from implemented changes.

e. Process and Workflow Metrics:

1. Data on administrative processes (e.g., claims, processing times).

2. Organizational chart with supervisory structure.

3. Training logs, training schedules, and post-test results.

4. Timeliness and accuracy of eligibility determinations.

3. Template: Creating a QA/QI report involves ensuring it is both comprehensive and actionable. Here's a template and questions to guide the outline of such a report:

a. Purpose and Scope

1. What are the objectives of this QA/QI report?

2. Which Medicaid crisis services are being evaluated?

3. What is the time frame covered by the data in this report?

b. Service Overview

1. What services were provided during the evaluation period?

2. How many individuals were served, and what were the demographics of the population?

3. Were there any specific challenges encountered during service delivery?

c. Performance Metrics

1. What are the key performance indicators (KPIs) used to evaluate crisis services?

2. What benchmarks or targets were set for these indicators?

3. How does current performance compare to past reports or benchmarks?

d. Outcome Measures

1. What were the clinical/non-clinical outcomes for patients (e.g., hospitalization, follow-up care compliance)?

2. Were there any adverse events or significant incidents reported?

3. How do these outcomes align with Medicaid's quality expectations?

e. Provider and Staff Performance

1. Were staff adequately trained and equipped to deliver crisis services?

2. Are there patterns in service delays, cancellations, or escalations?

3. What feedback was collected from staff regarding service delivery? Training & competency plan?

f. Patient Feedback and Satisfaction

1. Was patient feedback collected? How?

2. What were the main themes or findings from patient surveys or interviews?

3. How did patient satisfaction scores compare to previous periods?

g. Challenges and Barriers

1. What operational challenges were encountered (e.g., staffing shortages, resource limitations)?

2. Were there external factors that impacted service delivery (e.g., policy changes, funding issues)?

3. How were these challenges addressed or mitigated?

h. Opportunities for Improvement

1. What areas were identified for quality improvement?
2. What specific interventions or changes are recommended?
3. How will these changes be implemented and monitored?

i. Data and Methods

1. What data sources were used to evaluate performance (e.g., training, patient records, incident reports)?
2. What methods were used to analyze the data?
3. Are there any limitations or biases in the data that should be noted?

j. Conclusion and Next Steps

1. What are the key takeaways from this QA/QI report?
2. What are the priorities for the next evaluation period?
3. How will the findings of this report be shared with stakeholders?

A. MEMORANDUM OF UNDERSTANDING Toolkit

Many entities are working towards improving Nevada's continuum of crisis care including the development and expansion of community-based crisis services. The importance of reciprocal relationships in crisis care is supported by various frameworks and initiatives. For instance, the SAMHSA emphasizes interconnected systems in its guidelines for behavioral health crisis care. Additionally, coordinated systems of care that integrate homeless outreach and emergency response services have been shown to enhance stabilization and recovery outcomes.

One key to delivering comprehensive crisis response is developing partnerships formalized in a MOU. Partners should include local community-based organizations, local LE agencies, local emergency medical response services, local fire departments, community health centers, hospital associations, and many others. SAMHSA highlights the importance of integrated systems in behavioral health crisis care. These systems often include MCTs, crisis stabilization units, and crisis hotlines, which work together to provide comprehensive support. Programs like the 988 Suicide and Crisis Lifeline demonstrate how partnerships enable crisis care providers to connect individuals in distress with the appropriate behavioral health services at every stage of a crisis.

1. What is a MOU?

An MOU is a document that outlines the terms and details of a mutual agreement between two or more parties. Unlike a formal contract, an MOU is typically less binding and may serve as a precursor to a more detailed agreement. However, depending on its wording and the jurisdiction, it can be legally enforceable, which is why legal counsel is often recommended before implementation.

MOUs are often used in collaborations, partnerships, or joint ventures to define shared goals, roles, responsibilities, and expectations. They help ensure all parties are on the same page.

2. Why use a MOU?

An MOU defines shared goals and the authority and responsibilities of each partner, helping to create sustainable pathways to mental health services that can endure staffing transitions. It clarifies decision-making processes, conflict resolution methods, and data-sharing agreements to ensure compliance with HIPAA and Family Educational Rights and Privacy Act (FERP). Acting as a roadmap for collaboration, MOUs outline roles and responsibilities to meet staffing needs, provide appropriate referrals, and address local mental health needs by establishing partnerships with community health centers, hospitals, and law enforcement.

3. What services should the MOU cover?

Identifying the services needed in your catchment area will guide your choice of partners. Your MOU can outline which services will be delivered or supported through the partnership. You may already have a specific service in mind, or you can collaborate with county departments and community agencies to explore available options

B. MOU Best Practices:

1. Define Clear Objectives: Clearly outline the purpose of the MOU, such as improving crisis response, enhancing coordination, or addressing specific community needs.

2. Identify Roles and Responsibilities: Specify the roles and responsibilities of each party involved, ensuring accountability and clarity in the partnership.

3. Include Key Stakeholders: Engage all relevant stakeholders, such as crisis stabilization units, MCTs, law enforcement, EMS, and community organizations, to ensure comprehensive input.

4. Establish Communication Protocols: Develop clear communication channels and protocols to facilitate effective collaboration during crisis situations.

5. Legal and Privacy Concerns: Include provisions for data sharing and confidentiality, ensuring compliance with laws like HIPAA and FERPA.

6. Set Measurable Outcomes: Define specific goals and metrics to evaluate the effectiveness of the partnership and the services provided.

7. Plan for Sustainability: Include strategies for maintaining the partnership over time, such as regular reviews, updates, and training sessions.

8. Draft a Dissolution Clause: Outline the process for terminating the agreement, if necessary, to avoid conflicts in the future.

9. Consult Legal Counsel: Have the MOU reviewed by legal experts to ensure it is legally sound and aligns with all applicable regulations.

10. Customize to Local Needs: Tailor the MOU to address the unique needs and resources of the community it serves.

C. MOU Benefits:

An MOU offers several benefits, particularly when formalizing a collaboration or partnership. Some key advantages include:

1. Clarity: It clearly defines the roles, responsibilities, and expectations of each party, reducing misunderstandings.
2. Flexibility: Unlike contracts, MOUs are less rigid, allowing for adjustments as the partnership evolves.
3. Collaboration and Commitment: It encourages mutual understanding and demonstrates each party's commitment to the shared goals.
4. Cost-Effective: Since it doesn't always require extensive legal drafting, it can be a more cost-effective way to outline an agreement.

Important: This document is intended for informational purposes only. An MOU is a legally binding document that should be reviewed by legal counsel prior to implementation.

Additional MOU Resources:

Creating a Memorandum of Agreement | SAMHSA
Writing Guide for Memorandum of Understanding (Homeland Security)
MOU_Formalizing_Partnerships.pdf (Jobs for the Future Organization)