Medicaid Services Manual
Transmittal Letter

October 29, 2024

To: Custodians of Medicaid Services Manual

From: Casey Angres Casey Angres (Dec 19, 2024 13:26 PST)
Chief of Division Compliance

Subject: Medicaid Services Manual Changes MSM Chapter 400—Mental Health Services

Background And Explanation

Edits to Medicaid Service Manual (MSM) Chapter 400- Mental Health Services, Section 403.9B- Provider Responsibilities are being proposed to update the reference to align with previous policy, chapter and section numeration changes.

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: No financial impact.

Financial Impact on Local Government: No financial impact.

These changes are effective October 30, 2024.

Material Transmitted	Material Superseded
MTL18/24 MSM Chapter 400 – Mental Health Services	MTL 14/24 MSM Chapter 400 – Mental Health Services

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
403.9B	Provider Responsibilities	Update the section to align with previous chapter and section numeration changes. Added language from 403.8B and removed the reference. Policy will replace "Please consult Section 403.10B of this chapter for provider responsibilities" with the language from the reference section (which is now located in 403.8B).

MENTAL HEALTH SERVICES

400 INTRODUCTION

Nevada Medicaid reimburses for community-based and inpatient mental health services to both children and adults under a combination of mental health rehabilitation, medical/clinical and institutional authority. The services must be recommended by a physician or other licensed practitioner of the healing arts, within their scope of practice under State law for the maximum reduction of a physical or mental disability and to restore the individual to the best possible functioning level. The services are to be provided in the least restrictive, most normative setting possible and may be delivered in a medical professional clinic/office, within a community environment, while in transit and/or in the recipient's home. All services must be documented as medically necessary and appropriate and must be prescribed on an individualized Treatment Plan.

Mental health rehabilitation assists individuals to develop, enhance and/or retain psychiatric stability, social integration skills, personal adjustment and/or independent living competencies in order to experience success and satisfaction in environments of their choice and to function as independently as possible. Interventions occur concurrently with clinical treatment and begin as soon as clinically possible.

Alcohol and substance use treatment and services are aimed to assist recipients who struggle with alcohol and drug use to achieve mental and physical restoration. To be Medicaid reimbursable, while services may be delivered in inpatient or outpatient settings (inpatient substance use hospital, general hospital with a substance use unit, mental health clinic, or by an individual psychiatrist or psychologist), they must constitute a medical-model service delivery system.

All Medicaid policies and requirements (such as prior authorization, etc.) except for those listed in the Nevada Check Up (NCU) Chapter 1000, are the same for NCU. Medicaid Services Manual (MSM) Chapter 400 specifically covers behavioral health services and for other Medicaid services coverage, limitations and provider responsibilities, the specific MSM needs to be referenced.

Nevada Medicaid's philosophy assumes that behavioral health services shall be person-centered and/or family driven. All services shall be culturally competent, community supportive, and strength based. The services shall address multiple domains, be in the least restrictive environment, and involve family members, caregivers, and informal supports when considered appropriate per the recipient or legal guardian. Service providers shall collaborate and facilitate full participation from team members including the individual and their family to address the quality and progress of the individualized care plan and tailor services to meet the recipient's needs. In the case of child recipients, providers shall deliver youth guided effective/comprehensive, evidence-based treatments and interventions, monitor child/family outcomes through utilization of Child & Family Team meetings, and continuously work to improve services in order to ensure overall fidelity of recipient care. (Reference Addendum – MSM Definitions).

401 AUTHORITY

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

Other authorities include:

- Section 1902(a)(20) of the SSA (State Provisions for Mental Institution Patients 65 and Older)
- Section 1905(a)(13) of the SSA (Other Diagnostic Screening, Preventative and Rehabilitative Services)
- Section 1905(h) of the SSA (Inpatient Psychiatric Services to Individuals Under Age 21)
- Section 1905(i) of the SSA (Definition of an Institution for Mental Diseases)
- Section 1905(r)(5) of the SSA (Mental Health Services for Children as it relates to EPSDT)
- Section 1947 of the SSA (Qualifying Community-Based Mobile Crisis Intervention Services)
- 42 CFR 435.1009 (2) (Definition of Institution for Mental Diseases (IMD))
- 42 CFR 435.1010 (Definitions Relating to Institutional Status)
- 42 CFR 440.160 (Inpatient Psychiatric Services to Individuals Under Age 21)
- 42 CFR 440.2(a) (Specific Definitions of Services for Inpatient vs. Outpatient)
- 42 CFR 441.150 to 441.156 (Inpatient Psychiatric Services for Individuals under age 21 in Psychiatric Facilities or Programs)
- 42 CFR, Part 482 (Conditions of Participation for Hospitals)
- 42 CFR, Part 483 (Requirements for States and Long-Term Care Facilities)

- 42 CFR, PART 435 (Eligibility in the States, District of Columbia, the Northern Mariana Islands and American Samoa), 440.130 (Definitions relating to institutional status)
- 42 CFR, PART 440 (Services: General Provisions), 440.130 (Diagnostic, screening, preventive and rehabilitative services)
- CMS 2261-P, Centers for Medicare and Medicaid Services (CMS) (Medicaid Program; Coverage for Rehabilitative Services)
- CMS State Medicaid Manual, Chapter 4, Section 4390 (Requirements and Limits applicable to Specific Services (IMD))
- Nevada Revised Statute (NRS), Chapter 629 (Healing Arts Generally)
- NRS 432.B (Protection of Children from Abuse and Neglect)
- NRS, Chapter 630 (Physicians, Physician Assistants and Practitioners of Respiratory Care)
- NRS Chapter 632 (Nursing)
- NRS 433.B.010 to 433.B.350 (Mental Health of Children)
- NRS 433.A.010 to 433.A.750 (Mental Health of Adults)
- NRS 433.704(2) (Mobile Crisis Teams)
- NRS 449 (Medical and other Related Facilities)
- NRS 449.01566 (Peer Support Services Defined)
- NRS 449.0915 (Endorsement of Hospital as a Crisis Stabilization Center)
- NRS 641 (Psychologists)
- NRS 641.A (Marriage and Family Therapists 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: Requirement for Health Maintenance Organizations (HMOs) to contract with hospitals with endorsements as Crisis Stabilization Centers)
- NRS 695G.320 (Provision of Health Care Services to Recipients of Medicaid or enrollees in Children's Health Insurance Program: Requirement for Managed Care Organizations

(MCOs) to contract with hospitals with endorsements as Crisis Stabilization Centers)

- Nevada State Plan, Section 4.19-A, Page 4
- Nevada Medicaid Inpatient Psychiatric and Substance Use Policy, Procedures and Requirements. The Joint Commission Restraint and Seclusion Standards for Behavioral Health.

402 RESERVED

403 POLICY

403.1 OUTPATIENT SERVICE DELIVERY MODELS

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

A. Behavioral Health Community Networks (BHCN)

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

1. Outpatient Mental Health (OMH) services, such as assessments, therapy, testing and medication management, including specialized services for Nevada Medicaid recipients who are experiencing symptoms relating to a covered, current International Classification of Diseases (ICD) diagnosis or who are individuals with a mental illness and residents of its mental health service area who have been discharged from inpatient treatment;

2. 24-hour per day emergency response for recipients; and

3. Screening for recipients under consideration for admission to inpatient facilities.

BHCNs are a service delivery model and are not dependent on the physical structure of a clinic. BHCNs can be reimbursed for all appropriate services covered in this chapter and may make payment directly to the qualified provider of each service. BHCNs must coordinate care with individual Rehabilitative Mental Health (RMH) providers.

B. Independent Behavioral Health Professionals – are independently licensed in the State of Nevada as Psychiatrists, Psychologists, Advanced Practice Registered Nurses (APRN), Physician Assistants, Clinical Social Workers (LCSW), Marriage & Family Therapists (LMFT), and Licensed Clinical Professional Counselors (LCPC). These providers are directly reimbursed for the professional services they deliver to Medicaid-eligible recipients in accordance with their scope of practice, state licensure requirements, expertise, and enrollment with Nevada Medicaid.

C. Behavioral Health Rehabilitative Treatment providers must meet the provider qualifications for the specific behavioral health service. Individual RMH providers arrange for supervision with an independently licensed Behavioral Health Professional under an agency/entity/group. enrolled with Nevada Medicaid; only an individual RMH provider enrolled as a Qualified Mental Health Professional (QMHP) and functioning as a Clinical Supervisor is not required to have an arrangement for supervision. Individual RMH providers are not directly reimbursed by Nevada Medicaid and must contract with a BHCN,

Behavioral Health Rehabilitative Treatment, or other behavioral health provider to deliver services.

403.2 PROVIDER STANDARDS

A. All providers must:

1. Provide medically necessary services;

2. Adhere to the regulations prescribed in this chapter and all applicable Division chapters;

3. Provide only those services within the scope of their practice and expertise;

4. Ensure care coordination to recipients with higher intensity of needs;

5. Comply with recipient confidentiality laws and Health Insurance Portability and Accountability Act (HIPAA);

6. Maintain required records and documentation;

7. Comply with requests from the Qualified Improvement Organization (QIO)-like vendor;

8. Ensure client's rights; and

9. Cooperate with the Division of Health Care Financing and Policy's (DHCFP's) review process.

B. BHCN providers must also:

1. Have written policies and procedures to ensure the medical appropriateness of the services provided;

2. Operate under Clinical Supervision and ensure Clinical Supervisors operate within the scope of their license and expertise and have written policies and procedures to document the prescribed process;

3. Ensure access to psychiatric services, when medically appropriate, through a current written agreement, job description or similar type of binding document;

4. Utilize Clinical Supervision as prescribed in this chapter and have written policies and procedures to document the process to ensure Clinical Supervision is performed

on a regular, routine basis at least monthly and the effectiveness of the mental health treatment program is evaluated at least annually;

5. Work on behalf of recipients in their care to ensure effective care coordination and discharge planning within the state system of care among other community mental health providers and other agencies servicing a joint recipient;

C. Recipient and Family Participation and Responsibilities

1. Recipients or their legal guardians and their families (when applicable) must:

a. Participate in the development and implementation of their individualized treatment plan;

b. Keep all scheduled appointments; and

c. Inform their Medicaid providers of any changes to their Medicaid eligibility.

403.2A SUPERVISION STANDARDS

1. Clinical Supervision – The documented oversight by a Clinical Supervisor to assure the mental and/or behavioral health services provided are medically necessary and clinically appropriate. Clinical Supervision includes the on-going evaluation and monitoring of the quality and effectiveness of the services provided, under ethical standards and professional values set forth by state licensure, certification, and best practice. Clinical Supervision is intended to be rendered on-site. Clinical Supervisors are accountable for all services delivered and must be available to consult with all clinical staff related to delivery of service, at the time the service is delivered. LCSW, LMFT, Clinical Professional Counselors (CPC) and QMHP, excluding Interns, operating within the scope of their practice under state law, may function as Clinical Supervisors. Clinical Supervisors must have the specific education, experience, training, credentials and licensure to coordinate and oversee an array of mental and behavioral health services. Clinical Supervisors assume professional responsibility for the mental and/or behavioral health services provided by clinical staff, including Independent Professionals, QMHPs, and Individual RMH providers, including Qualified Mental Health Associates (QMHA) and Qualified Behavioral Aides (QBA). Clinical Supervisors can supervise other LCSWs, LMFTs, CPCs, QMHPs, QMHAs and QBAs. Clinical Supervisors may also function as Direct Supervisors.

Individual RMH providers, who are LCSWs, LMFTs, CPCs, and QMHPs, excluding Interns, may function as Clinical Supervisors over RMH services. However, Individual RMH providers, who are QMHPs, including interns, may not function as Clinical Supervisors over OMH services, such as assessments, therapy, testing and medication

management. Clinical Supervisors must assure the following:

a. An up to date (within 30 days) case record is maintained on the recipient; and

b. A comprehensive mental and/or behavioral health assessment and diagnosis is accomplished prior to providing mental and/or behavioral health services (with the exception of Crisis Intervention services); and

c. A comprehensive and progressive treatment plan is developed and approved by the Clinical Supervisor and/or a Direct Supervisor, who is a QMHP, LCSW, LMFT, or CPC; and

d. Goals and objectives are time specific, measurable (observable), achievable, realistic, time-limited, outcome driven, individualized, progressive, and age and developmentally appropriate; and

e. The recipient and their family/legal guardian (in the case of legal minors) participate in all aspects of care planning, the recipient and their family/legal guardian (in the case of legal minors) sign the treatment plan and the recipient and their family/legal guardian (in the case of legal minors) receive a copy of the treatment plan(s); and

f. The recipient and their family/legal guardian (in the case of legal minors) acknowledge in writing that they understand their right to select a qualified provider of their choosing; and

g. Only qualified providers provide prescribed services within scope of their practice under state law; and

h. Recipients receive mental and/or behavioral health services in a safe and efficient manner.

2. Direct Supervision – Independent Professionals, QMHPs, and/or QMHAs may function as Direct Supervisors within the scope of their practice. Direct Supervisors must have the practice-specific education, experience, training, credentials, and/or licensure to coordinate an array of OMH and/or RMH services. Direct Supervisors assure servicing providers provide services in compliance with the established treatment plan(s). Direct Supervision is limited to the delivery of services and does not include treatment and plan(s) modification and/or approval. If qualified, Direct Supervisors may also function as Clinical Supervisors. Direct Supervisors must document the following activities:

a. Their face-to-face and/or telephonic meetings with Clinical Supervisors.

1. These meetings must occur before treatment begins and periodically thereafter;

2. The documentation regarding this supervision must reflect the content of the training and/or clinical guidance; and

3. This supervision may occur in a group and/or individual settings.

b. Their face-to-face and/or telephonic meetings with the servicing provider(s).

1. These meetings must occur before treatment/rehabilitation begins and, at a minimum, every 30 days thereafter;

2. The documentation regarding this supervision must reflect the content of the training and/or clinical guidance; and

3. This supervision may occur in group and/or individual settings;

c. Assist the Clinical Supervisor with Treatment Plan reviews and evaluations.

403.2B DOCUMENTATION

1. Individualized Treatment Plan

a. A written individualized treatment plan, referred to as Treatment Plan, is a comprehensive, progressive, personalized plan that includes all prescribed Behavioral Health (BH) services, to include RMH and OMH services. A Treatment Plan is person- centered, rehabilitative and recovery oriented. The treatment plan addresses individualized goals and objectives. The objective is to reduce the duration and intensity of BH services to the least intrusive level possible while sustaining overall health. BH services are designed to improve the recipient's functional level based on achievable goals and objectives as determined in the Treatment Plan that identifies the amount and duration of services. The Treatment Plan must consist of services designed to achieve the maximum reduction of the BH services required to restore the recipient to a functional level of independence.

b. Each prescribed BH service within the Treatment Plan must meet medical necessity criteria, be clinically appropriate, and must utilize evidence-based practices.

c. The prescribed services within the plan must support the recipient's restoration of functioning consistent with the individualized goals and objectives.

d. A Treatment Plan must be integrated and coordinated with other components of

overall health care.

e. The person-centered treatment plan must establish strength-based goals and objectives to support the recipient's individualized rehabilitative process. The BH services are to accomplish specific, observable changes in skills and behaviors that directly relate to the recipient's individual diagnosed condition(s). BH services must be rehabilitative and meet medical necessity for all services prescribed.

2. Treatment Plan Development

a. The Treatment Plan must be developed jointly with a QMHP and:

1. The recipient or the recipient's legal representative (in the case of legal minors and when appropriate for an adult);

2. The recipient's parent, family member, guardian or legal representative with given consent from the recipient if determined necessary by the recipient;

b. All BH services requested must ensure that the goal of restoring a recipient's functional levels is consistent with the therapeutic design of the services to be provided under the Treatment Plan.

c. All requested BH services must ensure that all involved health professionals incorporate a coherent and cohesive developed treatment plan that best serves the recipient's needs.

d. Services should be developed with a goal that promotes collaboration between other health providers of the recipient, community supports including, but not limited to, community resources, friends, family or other supporters of the recipient and recipient identified stakeholders to ensure the recipient can receive care coordination and continuity of care.

e. The requested services are to be specific, measurable and relevant in meeting the goals and objectives identified in the Treatment Plan. The QMHP must identify within the Treatment Plan the scope of services to be delivered and are not duplicative or redundant of other prescribed BH services.

3. Required information contained in the Treatment Plan

a. Treatment Plans are required to include, but are not limited to, the following information:

1. Recipient's full name;

2. Recipient's Medicaid/Nevada Check Up billing number;

3. Intensity of Needs determination;

4. Severe Emotional Disturbance (SED) or Serious Mental Illness (SMI) determination;

5. Date of determination for SED or SMI;

6. The name and credentials of the provider who completed the determination.

b. Goals and Objectives of the Treatment Plan

1. The individualized treatment plan must demonstrate an improvement of the recipient's medical, behavioral, social, and emotional well-being of the effectiveness of all requested BH services that are recommended in meeting the plan's stated rehabilitative goals and objectives documenting the effectiveness at each reevaluation determined by the QMHP.

c. Requested Services:

1. Services: Identify the specific behavioral health service(s) (i.e., family therapy, individual therapy, medication management, basic skills training, day treatment, etc.) to be provided;

2. Scope of Services and Duration: Identify the daily amount, service duration, and therapeutic scope for each service to be provided;

3. Providers: Identify the provider or providers who are responsible for implementation of each of the plan's goals, interventions, and services;

4. Rehabilitative Services: Document that the services have been determined to be rehabilitative services consistent with the regulatory definition;

5. Care Coordination: When multiple providers are involved, the plan must identify and designate a primary care coordinator. The primary care coordinator develops the care coordination plan between the identified BH services and integration of other supportive services involved with a recipient's services;

6. Strength-Based Care: Collaboratively develop a treatment plan of care involving the strengths of the recipient and family (when applicable);

7. Declined Services: If the recipient declines recommended service(s), this act must be documented within the treatment plan.

d. Discharge Plan – A Treatment Plan must include a discharge plan that identifies:

1. The planned duration of the overall services to be provided under the Treatment Plan;

2. Discharge criteria;

3. Recommended aftercare services for goals that were both achieved and not achieved during duration of the Treatment Plan;

4. Identify available agency(ies) and independent provider(s) to provide aftercare services (i.e. community-based services, community organizations, nonprofit agencies, county organization(s), and other institutions) and the purpose of each for the recipient's identified needs under the Treatment Plan to ensure the recipient has access to supportive aftercare.

4. Required Signatures and Identified Credentials

a. Signatures, along with the identified credentials, are required on all treatment plans, modifications to treatment plans, and reevaluations of treatment plans include:

1. The clinical supervisor and their credentials;

2. The recipient, recipient's family, or their legal representative (in the case of legal minors and when appropriate for an adult);

3. The individual QMHP and their credentials responsible for developing and prescribing the plan within the scope of their licensure.

5. Treatment Plan Reevaluation: A QMHP must evaluate and reevaluate the Treatment Plan at a minimum of every 90 days, or a shorter period as determined by the QMHP. Every reevaluated Treatment Plan must include a brief analysis that addresses the services recommended, the services actually provided pursuant to the recommendations, a determination of whether the provided services met the developed goals and objectives of those services, and whether or not the recipient would continue to benefit from future services and be signed by the QMHP.

a. If it is determined that there has been no measurable restoration of functioning, a new recipient-centered treatment plan must be developed by the QMHP.

b. All recommendations and changes to the treatment goals, objectives, strategies, interventions, frequency, or duration; any change of individual providers, or any recommendation to change individual providers; and the expected duration of the medical necessity for the recommended changes must be identified in the new plan.

c. The new treatment plan must adhere to what is identified in Sections 403.2B(1) and 403.2B(2) under Individualized Treatment Plan and Treatment Plan Development.

6. Progress Notes: Progress notes for all BH services including RMH and OMH services are the written documentation of treatment services, or services coordination provided to the recipient pursuant to the Treatment Plan, which describes the progress, or lack of progress towards the goals and objectives of the Treatment Plan.

a. All progress notes documented with the intent of submitting a billable Medicaid behavioral health service claim must be documented in a manner that is sufficient to support the claim and billing of the services provided and must further document the amount, scope and duration of the service(s) provided as well as identify the provider of the service(s).

b. A Progress Note is required for each day the service was delivered, must be legible and must include the following information:

1. The name of the individual receiving the service(s). If the services are in a group setting, it must be indicated;

2. The place of service;

3. The date the service was delivered;

4. The actual beginning and ending times the service was delivered;

5. The name of the provider who delivered the service;

6. The credentials of the person who delivered the service;

7. The signature of the provider who delivered the service;

8. The goals and objectives that were discussed and provided during the time the services were provided; and

9. A statement assessing the recipient's progress towards attaining the identified treatment goals and objectives requested by the QMHP.

c. Temporary, but clinically necessary, services do not require an alteration of the treatment plan; however, these types of services, and why they are required, must be identified in a progress note. The note must follow all requirements for progress notes as stated within this section.

7. Discharge Summary: Written documentation of the last service contact with the recipient, the diagnosis at admission and termination, and a summary statement describing the effectiveness of the treatment modalities and progress, or lack of progress, toward treatment goals and objectives as documented in the Treatment Plan. The discharge summary documentation must include the reason for discharge, current intensity of needs level and recommendations for further treatment.

a. Discharge summaries are to be completed no later than 30 calendar days following a planned discharge and 45 calendar days following an unplanned discharge.

b. In the case of a recipient's transfer to another program, a verbal summary must be given by the current health professional at the time of transition and followed with a written summary within seven calendar days of the transfer. This summary will be provided with the consent from the recipient or the recipient's legal representative.

403.3 PROVIDER QUALIFICATIONS

A. QBA – an individual who has an educational background of a high-school diploma or General Education Development (GED) equivalent and has been determined competent by the overseeing Clinical Supervisor, to provide RMH services. These services must be provided under direct contract with a Behavioral Health Community Network (BHCN), a Behavioral Health Rehabilitative Treatment, or other behavioral health provider under which a QBA is able to deliver services. A QBA must have the documented competencies to assist in the provision of individual and group rehabilitative services, delivered under the Clinical Supervision of an Independent Behavioral Health Professional who may be enrolled as a QMHP and the Direct Supervision of a QMHP or QMHA; the supervising professional(s) assume(s) responsibility for their supervisees and shall maintain documentation on this supervision in accordance with MSM 403.2A Supervision Standards.

1. QBAs must also have experience and/or training in the provision of services to individuals diagnosed with mental and/or behavioral health disorders and have the ability to:

a. Read, write, and follow written and oral instructions; and

b. Perform RMH services as prescribed on the rehabilitative treatment plan;

and;

c. Identify emergency situations and respond appropriately; and

d. Communicate effectively with recipient and recipient's support system; and

e. Document services provided according to Chapter 400 Documentation requirements; and

f. Maintain recipient confidentiality.

2. For QBAs who will also function as Peer-to-Peer Service Specialists (hereinafter referred to as "Peer Supporters"), services are delivered under Clinical Supervision provided by an independently licensed QMHP-level mental health professional, LCSW, LMFT, or LCPC; this supervision shall be provided and documented at least monthly by the supervising professional.

a. Peer Supporter cannot be the legal guardian or spouse of the recipient.

b. The primary role of the Peer Supporter is to model skills based on lived experience to help individuals meet their rehabilitative goals.

3. Initial Competency Training

a. Before QBAs can enroll as Medicaid providers, they are required to successfully complete an initial 16-hour competency training program. This training must be interactive, not solely based on self-study guides or videotapes and ensures that a QBA will be able to interact appropriately with individuals with behavioral health disorders and their support systems. This training is intended to be delivered by the agency/entity/group providing supervision over the QBA. At a minimum, this training shall include the following core competencies:

1. Case file documentation (including Chapter 400 Documentation requirements for Progress Notes); and

2. Recipient rights (including rights of parents and guardians, as appropriate); and

3. Client confidentiality pursuant to state and federal regulations (including releases of information and mandated reporting); and

4. Communication skills (verbal, non-verbal, written with children and adults); and

5. Problem solving and conflict resolution skills (including mediation, de-escalation, crisis, suicidality); and

6. Communication techniques for individuals with communication or sensory impairments (citing evidence-based practice); and

7. Understanding the components of a rehabilitation plan; and

8. Cardiopulmonary resuscitation (CPR) certification (verification with certification card is necessary to fulfill requirement). Up to two hours of initial competency training may be used for CPR certification and must be outlined in enrollment documentation.

b. Certificates of initial competency must include all of the following information:

1. Name and signature of the enrolling QBA provider who received training; and

2. Name and signature of the individual trainer who provided the training; and

3. Name and signature of responsible Clinical Supervisor for the agency/entity/group; and

4. Date of training shall not be more than 365 days prior to the requested effective date of the submitted application for enrollment; and

5. Outline of all course content as indicated by the core competencies above. Note: The amount of time assigned to each competency must be identified separately and must add up to at least 16 hours.

4. In-Service Training

a. QBAs require two hours of in-service training per quarter for continued enrollment. The purpose of the in-service training is to facilitate the development of specialized skills or knowledge not included in the basic training and to review or expand skills or knowledge included in the initial competency training. Consideration must be given to topics suggested by

recipients. This training must include any single competency or combination of the following competencies:

1. Basic living and self-care skills – assisting recipients to regain skills to manage their daily lives, helping them to learn safe and appropriate behaviors; and/or

2. Social skills – assisting recipients to regain skills to identify and comprehend the physical, emotional, and interpersonal needs of themselves and of others, helping them to learn how to interact with others, and/or

3. Communication skills – assisting recipients to regain skills to communicate their physical, emotional, and interpersonal needs to others (expressive), helping them also learn listening skills and to identify the needs of others (receptive); and/or

4. Parental training – facilitating parent and guardian skills and abilities to maintain the recipient's RMH care in home and community-based settings; and/or

5. Organization and time management skills – assisting recipients to regain skills to manage and prioritize their daily activities; and/or

6. Transitional living skills – assisting recipients to regain necessary skills to establish partially-independent and fully-independent lives, as appropriate.

b. Documentation of all the completed in-service training and achieved competencies shall be maintained by the agency/entity/group providing supervision over the QBA. It is the intent that training be delivered by the agency/entity/group contracted to supervise the QBA. Training documentation must total eight hours annually. Documentation and/or certificates for in-service training are required for continued enrollment as a Medicaid provider. Documentation of competency training must include all the following information:

1. Name and original signature of the enrolling QBA provider who received training; and

2. Name and original signature of the Clinical or Direct supervisor of the training; also, must include the name and original signature of the individual who provided the training, if training is not delivered

by the agency/entity/group providing supervision over the QBA; and

3. Date of training must be within 365 days prior to the requested effective date of the submitted application for continued enrollment; and

4. Outline of course content related to the competencies above.

Official transcripts for education credits earned as in-service training (individually or as part of a degree program) must be submitted with additional explanation and correspondence to outline the course content related to the core competencies above.

c. QBAs serving as Peer Supporters, must complete the Initial Competency Training and the two hours of In-Service Training per quarter. Documentation of all the completed training and achieved competencies shall be maintained by the agency/entity/group providing supervision. Peer Supporters must submit training documentation, as listed above for the QBA, for initial and continued enrollment with Nevada Medicaid. Quarterly in-service training for Peer Supporters must also include any single competency or combination of the following competencies:

1. Helping to stabilize the recipient; and/or

2. Helping the recipient access community-based mental and/or behavioral health services; and/or

3. Assisting during crisis situations and with crisis interventions; and/or

4. Providing preventative care assistance; and/or

5. Providing personal encouragement, self-advocacy, self- direction training and peer mentoring.

5. All Applicants must have an FBI criminal background check before they can enroll with Nevada Medicaid. Applicants must submit the results of their criminal background checks to the BHCN, Behavioral Health Rehabilitative Treatment, or other applicable behavioral health entity providing supervision over the QBA. The BHCN, Behavioral Health Rehabilitative Treatment, and/or other applicable behavioral health entity must maintain both the requests and the results of the FBI criminal background check with the applicant's personnel records. Upon request,

the BHCN Behavioral Health Rehabilitative Treatment, and/or other applicable behavioral health entity must make the criminal background request and results available to Nevada Medicaid DHCFP for review.

a. Refer to MSM Chapter 100, Medicaid Program, under Conditions of Participation for all Providers. In addition, the following criteria will exclude applicants from becoming an eligible provider:

1. Conduct or practice detrimental to the health or safety of the occupants or employees of the facility or agency; and

2. Any other offense determined by DHCFP to be inconsistent with the best interest of all recipients.

b. The BHCN, Behavioral Health Rehabilitative Treatment, or other behavioral health entity, upon receiving information resulting from the FBI criminal background check, or from any other source, may not continue to employ a person who has been convicted of an offense as listed above, and as cited within MSM Chapter 100.

c. If an applicant believes that the information provided as a result of the FBI criminal background check is incorrect, they must immediately inform the BHCN, Behavioral Health Rehabilitative Treatment, or other behavioral health entity in writing with the incorrect information. The BHCN, Behavioral Health Rehabilitative Treatment, or other behavioral health entity must inform DHCFP within five days of the discovery of the incorrect information; DHCFP shall give the QBA provider a reasonable amount of time, but not more than 60 days from the date of discovery, to provide corrected information before denying an application, or terminating the contract of the QBA provider pursuant to this section.

6. All applicants shall have had tuberculosis (TB) screening or testing with negative results documented or medical clearance documented, as outlined in Nevada Administrative Code (NAC) 441A.375 and the Centers for Disease Control and Prevention (CDC), prior to the initiation of service delivery. Documentation of TB screening, testing, and results shall be maintained in the provider personnel record by the BHCN, Behavioral Health Rehabilitative Treatment, or other behavioral health entity. TB screening, testing, and results must be completed for initial enrollment and thereafter as indicated by NAC 441A.375. For further information, contact the CDC or the Nevada TB Control Office at the Department of Health and Human Services (DHHS).

B. QMHA - an individual who meets the following documented minimum qualifications:

1. Professional licensure as a Registered Nurse (RN) issued by the Nevada State Board of Nursing; and/or

2. Official documentation of a Bachelor's degree in Human Services from an accredited college or university with additional understanding of outpatient treatment services, rehabilitative treatment services, and case file documentation requirements; or

3. Official documentation of an Associate's degree in Human Services from an accredited college or university and additional understanding of outpatient treatment services, rehabilitative treatment services, and case file documentation requirements, demonstrated through four years of relevant professional experience by proof of past or current enrollment as a Nevada Medicaid provider delivering direct services to individuals with behavioral health disorders; or

4. Official documentation of a Bachelor's degree from an accredited college or university in a field other than Human Services and additional understanding of outpatient treatment services, rehabilitative treatment services, and case file documentation requirements, demonstrated by four years of relevant professional experience by proof of resume.

5. A QMHA with experience and training will demonstrate the ability to:

    a. Direct and provide professional therapeutic interventions within the scope of their practice and limits of their expertise; and

    b. Identify presenting problem(s); and

    c. Participate in treatment plan development and implementation; and

    d. Coordinate treatment; and

    e. Provide parenting skills training; and

    f. Facilitate discharge plans; and

    g. Effectively provide verbal and written communication on behalf of the recipient to all involved parties.

6. A QMHA delivers services under the Clinical and Direct Supervision of a mental health provider(s) within the appropriate scope of practice; the Supervisor(s) assume(s) responsibility for their supervisees and shall maintain documentation on supervision in accordance with MSM 403.2A Supervision Standards.

7. Initial Competency Training

a. Before QMHAs can enroll as Medicaid providers, they are required to successfully complete an initial 16-hour competency training program. This training must be interactive, not solely based on self-study guides or videotapes, and ensures that a QMHA will be able to interact appropriately with individuals with behavioral health disorders and their support systems. This training is intended to be delivered by the agency/entity/group providing supervision over the QMHA. At a minimum, this training must include the following core competencies:

1. Case file documentation (including Chapter 400 Documentation requirements for Progress Notes); and

2. Recipient rights (including rights of parents and guardians, as appropriate); and

3. Client confidentiality pursuant to state and federal regulations (including releases of information and mandated reporting); and

4. Communication skills (verbal, non-verbal, written with children and adults); and

5. Problem solving and conflict resolution skills (including mediation, de-escalation, crisis, suicidality); and

6. Communication techniques for individuals with communication or sensory impairments (citing evidence-based practice); and

7. Understanding the components of a rehabilitative treatment plan; and

8. CPR certification (verification with certification card is necessary to fulfill requirement). Up to two hours of initial competency training may be used for CPR certification and must be outlined in enrollment documentation.

b. Certificates of initial competency must include all the following information:

1. Name and signature of the enrolling QMHA provider who received training; and

2. Name and signature of the individual trainer who provided the training; and

3. Name and signature of responsible Clinical Supervisor for the agency/entity/group; and

4. Date of training shall not be more than 365 days prior to the requested effective date of the submitted application for enrollment; and

5. Outline of all course content as indicated by the core competencies above. Note: The amount of time assigned to each competency must be identified separately and must add up to at least 16 hours.

8. In-Service Training

a. QMHAs require two hours of in-service training per quarter for continued enrollment. The purpose of the in-service training is to facilitate the development of specialized skills or knowledge not included in the basic training and to review or expand skills or knowledge included in the initial competency training. Consideration must be given to topics suggested by recipients. This training must include any single competency or combination of the following competencies:

1. Basic living and self-care skills – assisting recipients to regain skills to manage their daily lives, helping them to learn safe and appropriate behaviors; and/or

2. Social skills – assisting recipients to regain skills to identify and comprehend the physical, emotional, and interpersonal needs of themselves and of others, helping them to learn how to interact with others; and/or

3. Communication skills – assisting recipients to regain skills to communicate their physical, emotional, and interpersonal needs to others (expressive), helping them also learn listening skills and to identify the needs of others (receptive); and/or

4. Parental training – facilitating parent and guardian skills and abilities to maintain the recipient's RMH care in "home" and community-based settings; and/or

5. Organization and time management skills – assisting recipients to regain skills to manage and prioritize their daily activities; and/or

6. Transitional living skills – assisting recipients to regain necessary skills to establish partially-independent and fully-independent lives, as appropriate.

b. Documentation of all the completed training and achieved competencies shall be maintained by the agency/entity/group providing supervision over the QMHA. It is the intent that training be delivered by the agency/entity/group contracted to supervise the QMHA. Training documentation must total eight hours annually. Documentation and/or certificates for in-service training required for continued enrollment as a Medicaid provider. Certificates of competency must include all the following information:

1. Name and original signature of the enrolling QMHA provider who received training; and

2. Name and original signature of the Clinical or Direct supervisor of the training; also, must include the name and original signature of the individual who provided the training, if training is not delivered by the agency/entity/group providing supervision over the QMHA; and

3. Date of training must be within 365 days prior to the requested effective date of the submitted application for continued enrollment; and

4. Outline of course content related to the competencies above.

Official transcripts for education credits (earned separately or as part of a degree program) must be submitted with additional explanation and correspondence to outline the course content related to the core competencies above.

9. All applicants must have an FBI criminal background check before they can enroll with Nevada Medicaid. Applicants must submit the results of their criminal background checks to the BHCN, Behavioral Health Rehabilitative Treatment, or

other applicable behavioral health entity providing supervision over the QMHA. The BHCN, Behavioral Health Rehabilitative Treatment, and/or other applicable behavioral health entity must maintain both the requests and the results of the FBI criminal background check with the applicant's personnel records. Upon request, the BHCN, Behavioral Health Rehabilitative Treatment, and/or other applicable behavioral health entity must make the criminal background request and results available to Nevada Medicaid (DHCFP) for review.

a. Refer to MSM Chapter 100, Medicaid Program, under Conditions of Participation for all Providers. In addition, the following criteria will exclude applicants from becoming an eligible provider:

   1. Conduct or practice detrimental to the health or safety of the occupants or employees of the facility or agency; and

   2. Any other offense determined by DHCFP to be inconsistent with the best interest of all recipients.

b. The BHCN, Behavioral Health Rehabilitative Treatment, or other behavioral health entity, upon receiving information resulting from the FBI criminal background check or from any other source, may not continue to employ a person who has been convicted of an offense as indicated above, and as cited within MSM Chapter 100.

c. If an applicant believes that the information provided as a result of the FBI criminal background check is incorrect, they must immediately inform the BHCN, Behavioral Health Rehabilitative Treatment, or other behavioral health entity in writing with the incorrect information. The BHCN, Behavioral Health Rehabilitative Treatment, or other behavioral health entity must inform DHCFP within five days of the discovery of the incorrect information; DHCFP shall give the QMHA provider a reasonable amount of time, but not more than 60 days from the date of discovery, to provide corrected information before denying an application or terminating the contract of the QMHA provider pursuant to this section.

10. All applicants shall have had TB screening or testing with negative results documented or medical clearance documented, as outlined in NAC 441A.375 and CDC, prior to the initiation of service delivery. Documentation of TB screening, testing, and results shall be maintained by the BHCN or Behavioral Health Rehabilitative Treatment provider personnel record. TB screening, testing, and results must be completed for initial enrollment and thereafter as indicated by NAC 441A.375 For further information, contact the CDC or the Nevada TB Control Office at DHHS.

C. QMHP - An individual who meets the definition of a QMHA and also meets the following documented minimum qualifications:

1. Holds any of the following independent licensure with educational degrees:

   a. Licensed Psychiatrist or Licensed Physician, M.D., Osteopath, D.O., with clinical experience in behavioral health treatment,

   b. Licensed Physician's Assistant with clinical experience in behavioral health treatment.

   c. Doctorate Degree in Psychology and Licensed Psychologist (Psychological Assistants, Interns, and Trainees are not able to deliver services under a psychologist enrolled as a QMHP).

   d. APRN with a focus in psychiatric-mental health.

   e. Independent Nurse Practitioner (NP) with a focus in psychiatric-mental health.

   f. Graduate degree in Social Work and licensed as a Clinical Social Worker.

   g. Graduate degree in Counseling and licensed as a Marriage & Family therapist or as a Clinical Professional Counselor.

2. Whose education and experience demonstrate the competency to identify precipitating events, conduct a comprehensive mental health assessment, diagnose a mental or emotional disorder and document a current ICD diagnosis, determine intensity of service needs using tools required by Nevada Medicaid (including Child and Adolescent Screening Intensity Instrument (CASII), Level of Care Utilization System (LOCUS), and service-specific assessment tools), establish measurable goals, objectives and discharge criteria, write and supervise a treatment plan and provide direct therapeutic treatment within the scope and limits of their expertise. Competency shall be supplemented by ongoing training provided through Clinical and Direct Supervision, per MSM 403.2A Supervision Standards.

3. Interns

   Reimbursement for clinical Interns is based upon the rate of a QMHP, which includes the Clinical and Direct supervision of services by an independently licensed supervisor of the entity/agency/group with which the QMHP is enrolling; this supervising clinician assumes responsibility for their licensed intern supervisees and shall maintain documentation on this supervision in accordance with MSM

403.2A Supervision Standards.

Interns are excluded from functioning as a clinical supervisor.
The following interns may enroll as QMHPs:

a. Clinical Social Work Interns are licensed as Master Social Work (LMSW) post-graduate interns and meet the requirements under a program of internship pursuant to the State of Nevada Board of Examiners for Social Workers (NAC 641B).

b. LMFT and LCPC Interns are licensed as Master-level Interns and meet the requirements under a program of internship pursuant to the State of Nevada Board of Examiners for Marriage and Family Therapists & Clinical Professional Counselors.

4. All applicants must have an FBI criminal background check before they can enroll with Nevada Medicaid. Applicants must submit the results of their criminal background checks to the BHCN, Behavioral Health Rehabilitative Treatment, or other applicable behavioral health entity providing supervision over the QMHP. The BHCN, Behavioral Health Rehabilitative Treatment, and/or other applicable behavioral health entity must maintain both the requests and the results of the FBI criminal background check with the applicant's personnel records. Upon request, the BHCN, Behavioral Health Rehabilitative Treatment, and/or other applicable behavioral health entity must make the criminal background request and results available to Nevada Medicaid (DHCFP) for review.

   a. Refer to MSM Chapter 100, Medicaid Program, under Conditions of Participation for all Providers. In addition, the following criteria will exclude applicants from becoming an eligible provider:

      1. Conduct or practice detrimental to the health or safety of the occupants or employees of the facility or agency; and

      2. Any other offense determined by DHCFP to be inconsistent with the best interest of all recipients.

   b. The BHCN, Behavioral Health Rehabilitative Treatment, or other behavioral health entity, upon receiving information resulting from the FBI criminal background check or from any other source, may not continue to employ a person who has been convicted of an offense as indicated above, and as cited within MSM Chapter 100.

   c. If an applicant believes that the information provided as a result of the FBI

criminal background check is incorrect, they must immediately inform the BHCN, Behavioral Health Rehabilitative Treatment, or other behavioral health entity in writing the incorrect information. The BHCN, Behavioral Health Rehabilitative Treatment, or other behavioral health entity must inform DHCFP within five days of the discovery of the incorrect information; DHCFP shall give the QMHP provider a reasonable amount of time, but not more than 60 days from the date of discovery, to provide corrected information before denying an application or terminating the contract of the QMHP provider pursuant to this section.

5. All applicants shall have had TB screening or testing with negative results documented or medical clearance documented, as outlined in NAC 441A.375 and the CDC, prior to the initiation of service delivery. Documentation of TB screening, testing, and results shall be maintained in the provider personnel record by the BHCN, Behavioral Health Rehabilitative Treatment, or other behavioral health entity. TB screening, testing, and results must be completed for initial enrollment and thereafter as indicated by NAC 441A.375. For further information, contact the CDC or the Nevada TB Control Office at DHHS.

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

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

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

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

4. Psychological Trainees registered through the Nevada Board of Psychological Examiners and has a designated licensed Psychologist through the Board of

Psychological Examiners may render and their supervisor may bill for their services pursuant to NRS and NAC 641.

403.4 OUTPATIENT MENTAL HEALTH (OMH) SERVICES

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

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

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

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

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

4. Psychological Assessment – Covered once per calendar year without prior authorization. If there is a substantial change in condition, subsequent assessments

may be requested through a prior-authorization from the QIO-like vendor for Nevada Medicaid. A psychological assessment may consist of a clinical interview, a biopsychosocial history, a mental status examination and behavioral observations. The psychological assessment is to conclude with a written report which contains a current ICD diagnosis and treatment recommendations.

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

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

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

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

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

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

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

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

3. Psychological testing with interpretation and report is the administration, evaluation and scoring of standardized tests which may include the evaluation of intellectual functioning, clinical strengths and needs, psychodynamics, insight, motivation and other factors influencing treatment outcomes.

C. Mental Health Therapies

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

1. Family Therapy

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

2. Group Therapy

Mental health treatment service facilitated by a QMHP within their scope of licensure or practice, which utilizes the interactions of more than one individual and the focus of the group to address behavioral health needs and interpersonal relationships. The therapy must be prescribed on the treatment plan and must have measurable goals and objectives. Group therapy may focus on skill development for learning new coping skills, such as stress reduction, or changing maladaptive behavior, such as anger management. Participation in group therapy must be documented on the clinical record. Minimum group size is three and maximum therapist to participant ratio is one to ten. Group therapy can be less than three but

more than one based on unforeseen circumstances such as a no-show or cancellation but cannot be billed as individual therapy. Group therapy may also include a family without the recipient present and/or multi-family groups.

3. Individual Therapy Services

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

D. Mental Health Therapeutic Interventions

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

a. Scope of Services: PHP services may include:

1. Individual Therapy

2. Group Therapy

3. Family Therapy

4. Medication Management

5. Occupational Therapy

6. Behavioral Health Assessment

7. Basic Skills Training

8. Psychosocial Rehabilitation

9. Peer-to-Peer Support Services

10. Crisis Services

PHP requires around-the-clock availability of 24/7 psychiatric and psychological services. These services may not be billed separately as PHP is an all-inclusive rate.

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

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

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

e. Documentation: Patient assessments must document the individual patient response to the treatment plan, progress toward goals, changes in identified goals and objective based on progress and substantiate continued stay at the current intensity/frequency of services. Resolution of issues necessitates transfer to a higher or lower intensity/frequency of services or discharge from treatment as no longer meeting medical necessity at any level. Transfer and discharge planning must be evidence-based and reflect best practices recognized by professional and advocacy organizations and ensure coordination of needed services, follow-up care and recovery supports. The direct provider of each service component must complete documentation for that component. Further information on documentation standards is located within the section "Documentation" within this chapter.

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

1. Non-evidence-based models;

2. Transportation or services delivered in transit;

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

4. Routine supervision, monitoring or respite;

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

6. Watching films or videos;

7. Doing assigned readings; and

8. Completing inventories or questionnaires.

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

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

1. Individual Therapy

2. Group Therapy

3. Family Therapy

4. Medication Management

5. Occupational Therapy

6. Behavioral Health Assessment

7. Basic Skills Training

8. Psychosocial Rehabilitation

9. Peer-to-Peer Support Services

10. Crisis Services

IOP requires around-the-clock availability of 24/7 psychiatric and psychological services. These services may not be billed separately as IOP is an all-inclusive rate.

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

c. IOP Curriculum and Utilization Management: A curriculum and a schedule for the program delivered through a BHCN must be submitted with each prior authorization request; this information may also be provided with enrollment and the description of IOP services. The curriculum must outline the service array being delivered including evidence-based practice(s), best practice(s), program goals, schedule of program and times for service delivery, staff delivering services, and population served in the program.
IOP program recipients must receive on-going patient assessments, at regularly scheduled intervals and whenever clinically indicated, including intensity of needs determinations using LOCUS/CASII to evaluate the recipient's response to treatment interventions and to monitor progress toward treatment plan goals. Recipient assessments must document the individual's response to the treatment plan, identify progress toward

individual and program goals, reflect changes in identified goals and objectives, and substantiate continued stay at the current intensity/frequency of services. An updated treatment plan must be completed to justify a transfer to a higher or lower intensity/frequency of services or discharge from treatment as no longer meeting medical necessity at any level.

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

d. Documentation: Patient assessments must document the individual patient response to the treatment plan, progress toward goals, changes in identified goals and objective based on progress and substantiate continued stay at the current intensity/frequency of services. Resolution of issues necessitates transfer to a higher or lower intensity/frequency of services or discharge from treatment as no longer meeting medical necessity at any level. Transfer and discharge planning must be evidence-based and reflect best practices recognized by professional and advocacy organizations and ensure coordination of needed services, follow-up care, and recovery supports. The direct provider of each service component must complete documentation for that component. Further information on documentation standards is located within the section "Documentation" within this chapter.

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

1. Non-evidence-based models;

2. Transportation or services delivered in transit;

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

4. Routine supervision, monitoring, or respite;

5. Participating in community based, social based support groups (i.e. Alcoholics Anonymous, Narcotics Anonymous);

6. Watching films or videos;

7. Doing assigned readings; and

8. Completing inventories or questionnaires.

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

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

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

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

1. If recipient was present or not;

2. Recipient's response to the medication;

3. Recipient's compliance with the medication regimen;

4. Medication benefits and side effects;

5. Vital signs, which include pulse, blood pressure, and respiration; and

6. Documented within the progress notes/medication record.

c. Non-covered services in Medication Training and Support include, but are not limited to:

1. Medication Training and Support is not allowed to be billed the same day as an evaluation and management (E/M) service provided by a psychiatrist.

2. If medication management, counseling or psychotherapy is provided as an outpatient behavioral health service, and medication management is a component, Medication Training and Support may not be billed separately for the same visit by the same provider.

3. Coaching and instruction regarding recipient self-administration of medications is not reimbursable under this service.

4. Medication Training and Support may not be provided for professional caregivers.

403.5 OUTPATIENT MENTAL HEALTH (OMH) SERVICES - UTILIZATION MANAGEMENT

A. INTENSITY OF NEEDS DETERMINATION

The assessed level of needs and the amount, scope and duration of RMH services required to improve or retain a recipient's level of functioning or prevent relapse. The determination cannot be based upon the habilitative needs of the recipient. Intensity of needs determination is completed by a trained QMHP or QMHA. Intensity of needs

determinations are based on several components consistent with person and family centered treatment/rehabilitation planning. Intensity of Needs redeterminations must be completed every 90 days or anytime there is a substantial change in the recipient's clinical status.

These components include:

1. A comprehensive assessment of the recipient's level of functioning; The clinical judgment of the QMHP; and

2. A proposed treatment and/or rehabilitation plan.

B. INTENSITY OF NEEDS GRID

1. The intensity of needs grid is an approved Level of Care (LOC) utilization system, which bases the intensity of services on the assessed needs of a recipient. The determined level on the grid guides the interdisciplinary team in planning treatment to improve or retain a recipient's level of functioning or prevent relapse. Each Medicaid recipient must have an intensity of needs determination completed prior to approval to transition to more intensive services (except in the case of a physician or psychologist practicing as independent providers). The intensity of needs grid was previously referred to as level of services grid.

2. Intensity of Need for Children:

CASII	Service Criteria
Level I Basic Services: Recovery Maintenance and Health Management	• Significant Life Stressors and/or current ICD Codes, Z55-Z65, R45.850 and R45.821 that does not meet SED criteria (excluding dementia, intellectual disabilities and related conditions or a primary diagnosis of a substance use disorder, unless these conditions co-occur with a mental illness).
Level II Outpatient Services	• Current ICD diagnosis in Mental, Behavioral and Neurodevelopmental Disorders that does not meet SED criteria (excluding Z55-Z65, R45.850 and R45.821 Codes, dementia, intellectual disabilities and related conditions, or a primary diagnosis of a substance use disorder, unless these conditions co-occur with a mental illness).

Level III Intensive Outpatient Services	• Current ICD diagnosis in Mental, Behavioral and Neurodevelopmental Disorders (excluding Z55-Z65, R45.850 and R45.821 Codes, dementia, intellectual disabilities and related conditions, or a primary diagnosis of a substance use disorder, unless these conditions co-occur with a mental illness); and • SED Determination.
Level IV Intensive Integrated Services	• Current ICD diagnosis in Mental, Behavioral and Neurodevelopmental Disorders (excluding Z55-Z65, R45.850 and R45.821 Codes, dementia, intellectual disabilities and related conditions, or a primary diagnosis of a substance use disorder, unless these conditions co-occur with a mental illness); and SED Determination.
Level V Non-secure, 24-hour Services with Psychiatric Monitoring	• Current ICD diagnosis in Mental, Behavioral and Neurodevelopmental Disorders (excluding Z55-Z65, R45.850 and R45.821 Codes, dementia, intellectual disabilities and related conditions, or a primary diagnosis of a substance use disorder, unless these conditions co-occur with a mental illness); and • SED Determination; and • Requires specialized treatment (e.g., sex offender treatment, etc.).
Level VI Secure, 24-hour Services with Psychiatric Management	• Current ICD diagnosis in Mental, Behavioral and Neurodevelopmental Disorders (excluding Z55-Z65, R45.850 and R45.821 Codes, dementia, intellectual disabilities and related conditions, or a primary diagnosis of a substance use disorder, unless these conditions co-occur with a mental illness); and • SED Determination; and • Requires inpatient/secured LOC.

3. Intensity of Needs for Adults:

LOCUS	Service Criteria
Level I Basic Services: Recovery Maintenance and Health Management	• Current ICD diagnosis in Mental, Behavioral and Neurodevelopmental Disorders, including Z55-Z65, R45.850 and R45.821 Codes, that do not meet SMI criteria (excluding dementia, intellectual disabilities and related conditions, or a primary diagnosis of a substance use disorder, unless these conditions co-occur with a mental illness).

Level II Low Intensity Community Based Services	• Current ICD diagnosis in Mental, Behavioral and Neurodevelopmental Disorders, including Z55-Z65, R45.850 and R45.821 Codes that do not meet SMI criteria (excluding dementia, intellectual disabilities and related conditions, or a primary diagnosis of a substance use disorder, unless these conditions co-occur with a mental illness).
Level III High Intensity Community Based Services (HCBS)	• Current ICD diagnosis in Mental, Behavioral and Neurodevelopmental Disorders (excluding Z55-Z65, R45.850 and R45.821 Codes, dementia, intellectual disabilities and related conditions, or a primary diagnosis of a substance use disorder, unless these conditions co-occur with a mental illness); and • SMI determination.
Level IV Medically Monitored Non-Residential Services	• Current ICD diagnosis in Mental, Behavioral and Neurodevelopmental Disorders (excluding Z55-Z65, R45.850 and R45.821 Codes, dementia, intellectual disabilities and related conditions, or a primary diagnosis of a substance use disorder, unless these conditions co-occur with a mental illness); and • SMI determination.
Level V Medically Monitored Residential Services	• Current ICD diagnosis in Mental, Behavioral and Neurodevelopmental Disorders (excluding Z55-Z65, R45.850 and R45.821 Codes, dementia, intellectual disabilities and related conditions, or a primary diagnosis of a substance use disorder, unless these conditions co-occur with a mental illness); and • SMI determination; and • Requires specialized treatment (e.g. sex offender treatment, etc.).
Level VI Medically Managed Residential Services	• Current ICD diagnosis in Mental, Behavioral and Neurodevelopmental Disorders (excluding Z55-Z65, R45.850 and R45.821 Codes, dementia, intellectual disabilities and related conditions, or a primary diagnosis of a substance use disorder, unless these conditions co-occur with a mental illness); and • SMI determination; and • Requires inpatient/secured LOC.

C. Utilization Management for outpatient mental health services is provided by the DHCFP QIO-like vendor as follows:

1. For BHCN, all service limitations are based upon the Intensity of Needs Grid in the definitions. The recipient must have an Intensity of Needs determination to supplement clinical judgment and to determine the appropriate service utilization. The provider must document in the case notes the level that is determined from the Intensity of Needs grid;

2. Independent psychologists are not subject to the service limitations in the Intensity of Needs Grid. The following service limitations are for psychologists:

   a. Assessments – two per calendar year, additional services require prior authorization from the QIO-like vendor; and

   b. Therapy (group, individual, family) – Up to 26 visits per calendar year are allowed without prior authorization. Additional services require prior authorization demonstrating medical necessity from the QIO-like vendor.

3. Independent psychiatrists are not subject to the service limitations in the Intensity of Needs grid. No prior authorization is required for this particular provider.

4. Medicaid Behavioral Health Intensity of Needs for Children and Adolescents.

CASII	Intensity of Services (Per Calendar Year[1])
Level I Basic Services: Recovery Maintenance and Health Management	• Assessment two total sessions (does not include Mental Health Screen) • Individual, Group or Family Therapy 10 total sessions; • Medication Management six total sessions
Level II Outpatient Services	• Assessments: four total sessions (does not include Mental Health Screen) • Individual, Group or Family Therapy: 26 total sessions • Medication Management: eight total sessions
Level III Intensive Outpatient Services	All Level Two Services Plus: • Assessments: four total sessions (does not include Mental Health Screen) • Individual, Group or Family Therapy: 26 total sessions • Medication Management: eight total sessions IOP
Levels IV Intensive Integrated Services	All Level Three Services • Assessments: four total sessions (does not include Mental Health Screen) • Individual, Group or Family Therapy: 26 total sessions • Medication Management: eight total sessions • PHP

Level V Non-secure, 24-Hour Services with Psychiatric Monitoring	All Level Four Services • Assessments: four total sessions (does not include Mental Health Screen) • Individual, Group or Family Therapy: 26 total sessions • Medication Management: eight total sessions • PHP
Level VI Secure, 24-Hour, Services with Psychiatric Management	All level Five services

A PA demonstrating medical necessity will be required and may be requested from the QIO-like vendor for additional services above the service limitations for all levels.

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

b. Sessions indicate billable codes for this service may include occurrence-based codes, time-based or a combination of both. Session = each time this service occurs regardless of the duration of the service.

5. Medicaid Behavioral Health Intensity of Needs for Adults.

Medicaid Behavioral Health Intensity of Needs for Adults. LOCUS	Intensity of Service (Per Calendar Year[1])
Level I Basic Services - Recovery Maintenance and Health Management	• Assessment: two total sessions (does not include Mental Health Screen) • Individual, Group or Family Therapy: six total sessions • Medication Management: six total sessions
Level II Low Intensity Community Based Services	• Assessment: (two assessments; does not include Mental Health Screen) • Individual, Group or Family Therapy: 12 total sessions • Medication Management: eight total sessions
Level III High Intensity Community Based Services	• Assessment (two assessments; does not include Mental Health Screen) • Individual, Group and Family therapy: 12 total sessions • Medication Management: 12 total sessions • IOP

Level IV Medically Monitored Non-Residential Services	• Assessment (two assessments; does not include Mental Health Screen) • Individual, Group and Family Therapy: 16 total sessions • Medication Management (12 sessions) • PHP
Level V Medically Monitored Residential Services	• Assessment (two assessments; does not include Mental Health Screen) • Individual, Group and Family therapy: 18 total sessions • Medication Management (12 sessions) • PHP
Level VI Medically Managed Residential Services	All Level Five Services

A PA demonstrating medical necessity will be required and may be requested from the QIO-like vendor for additional services above the service limitations for all levels.

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

b. Sessions indicate billable codes for this service may include occurrence-based codes, time-based or a combination of both. Session = each time this service occurs regardless of the duration of the service.

D. Non-Covered OMH Services

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

1. Services under this chapter for a recipient who does not have a covered, current ICD diagnosis;

2. Therapy for marital problems without a covered, current ICD diagnosis;

3. Therapy for parenting skills without a covered, current ICD diagnosis;

4. Therapy for gambling disorders without a covered, current ICD diagnosis;

5. Custodial services, including room and board;

6. Support group services other than Peer Support Services;

7. More than one provider seeing the recipient in the same therapy session;

8. Services not authorized by the QIO-like vendor if an authorization is required according to policy; and

9. Respite.

403.6 REHABILITATIVE MENTAL HEALTH (RMH) SERVICES

1. Scope of Service: RMH services must be recommended by a QMHP within the scope of their practice under state law. RMH services are goal-oriented outpatient interventions that target the maximum reduction of mental and/or behavioral health impairments and strive to restore the recipients to their best possible mental and/or behavioral health functioning. RMH services must be coordinated in a manner that is in the best interest of the recipient. RMH services may be provided in a variety of community and/or professional settings. The objective is to reduce the duration and scope of care to the least intrusive level of mental and/or behavioral health care possible while sustaining the recipient's overall health. All RMH services must be directly and medically necessary. RMH services cannot be reimbursed on the same day as Applied Behavior Analysis (ABA) services, refer to MSM Chapter 1500.

   Prior to providing RMH services, a QMHP must conduct a comprehensive assessment of an individual's rehabilitation needs including the presence of a functional impairment in daily living and a mental and/or behavioral health diagnosis. This assessment must be based on accepted standards of practice and include a covered, current ICD diagnosis. The assessing QMHP must approve a written Rehabilitation Plan. The rehabilitation strategy, as documented in the Rehabilitation Plan, must be sufficient in the amount, duration and scope to achieve established rehabilitation goals and objectives. Simultaneously, RMH services cannot be duplicative (redundant) of each other. Providers must ensure that the RMH services they provide are coordinated with other servicing providers. Case records must be maintained on recipients receiving RMH services. These case records must include and/or indicate:

   a. the recipient's name;

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

   c. the recipients and their families/legal guardians (in the case of legal minors)

acknowledgement of their freedom to select a qualified Medicaid provider of their choosing;

d. indications that the recipients and their families/legal guardians (in the case of legal minors) were involved in all aspects care planning;

e. indications that the recipients and their families/legal guardians (in the case of legal minors) are aware of the scope, goals, and objectives of the RMH services made available; and

f. the recipients and their families/legal guardians (in the case of legal minors) acknowledgement that RMH services are designed to reduce the duration and intensity of care to the least intrusive level of care possible while sustaining the recipient's overall health.

2. Inclusive Services: RMH services include Basic Skills Training (BST), Program for Assertive Community Treatment (PACT), Day Treatment, Peer-to-Peer Support, Psychosocial Rehabilitation (PSR), and Crisis Intervention (CI).

3. Provider Qualifications:

a. QMHP: QMHPs may provide BST, PACT, Day Treatment, Peer-to-Peer Support, PSR and CI services.

b. QMHA: QMHAs may provide BST, PACT, Day Treatment, Peer-to-Peer Support, PSR services under the Clinical Supervision of a QMHP.

c. QBA: QBAs may provide BST services under the Clinical Supervision of QMHP and the Direct Supervision of a QMHP/QMHA. QBAs may provide Peer-to-Peer Support services under the Clinical/Direct Supervision of a QMHP.

4. Therapeutic Design: RMH services are adjunct (enhancing) interventions designed to complement more intensive mental health therapies and interventions. While some rehabilitative models predominately utilize RMH services, these programs must demonstrate the comprehensiveness and clinical appropriateness of their programs prior to receiving prior authorization to provide RMH services. RMH services are time-limited services, designed to be provided over the briefest and most effective period possible. Service limitations are designed to help prevent rehabilitation diminishing return by remaining within reasonable age and developmentally appropriate daily limits. Also taken into consideration are other social, educational and intensive mental health obligations and activities. RMH services are planned and coordinated services.

5. Non-Covered Services: RMH services do not include (from CMS 2261-P):

a. RMH services are not custodial care benefits for individuals with chronic conditions but should result in a change in status;

b. custodial care and/or routine supervision: Age and developmentally appropriate custodial care and/or routine supervision including monitoring for safety, teaching or supervising hygiene skills, age appropriate social and self-care training and/or other intrinsic parenting and/or care giver responsibilities;

c. maintaining level of functioning: Services provided primarily to maintain a level of functioning in the absence of RMH goals and objectives, impromptu non-crisis interventions and routine daily therapeutic milieus;

d. case management: Conducting and/or providing assessments, care planning/ coordination, referral and linkage and monitoring and follow-up;

e. habilitative services;

f. services provided to individuals with a primary diagnosis of intellectual disabilities and related conditions (unless these conditions co-occur with a mental illness) and which are not focused on rehabilitative mental and/or behavioral health;

g. cognitive/intellectual functioning: Recipients with sub-average intellectual functioning who would distinctly not therapeutically benefit from RMH services;

h. transportation: Transporting recipients to and from medical and other appointments/services;

i. educational, vocational or academic services: General and advanced private, public and compulsory educational programs; personal education not related to the reduction of mental and/or behavioral health problem; and services intrinsically provided through the Individuals with Disabilities Education Improvement Act (IDEA);

j. inmates of public institutions: To include detention facilities, forestry camps, training schools or any other facility operated primarily for the detention of children who are determined to be delinquent;

k. room and board: Includes housing, food, non-medical transportation and other miscellaneous expenses, as defined below:

1. Housing expenses include shelter (mortgage payments, rent, maintenance and repairs and insurance), utilities (gas, electricity, fuel, telephone and water) and housing furnishings and equipment (furniture, floor coverings,

major appliances and small appliances);

2. Food expenses include food and nonalcoholic beverages purchased at grocery, convenience and specialty store;

3. Transportation expenses include the net outlay on purchase of new and used vehicles, gasoline and motor oil, maintenance and repairs and insurance;

4. Miscellaneous expenses include clothing, personal care items, entertainment and reading materials;

5. Administrative costs associated with room and board;

l. non-medical programs: Intrinsic benefits and/or administrative elements of non-medical programs, such as foster care, therapeutic foster care, child welfare, education, childcare, vocational and prevocational training, housing, parole and probation, and juvenile justice;

m. services under this chapter for a recipient who does not have a covered, current ICD diagnosis;

n. therapy for marital problems without a covered, current ICD diagnosis;

o. therapy for parenting skills without a covered, current ICD diagnosis;

p. therapy for gambling disorders without a covered, current ICD diagnosis;

q. support group services other than Peer Support services;

r. more than one provider seeing the recipient in the same RMH intervention with the exception of CI services;

s. respite care;

t. recreational activities: Recreational activities not focused on rehabilitative outcomes;

u. personal care: Personal care services intrinsic to other social services and not related to RMH goals and objectives; and/or

v. services not authorized by the QIO-like vendor if an authorization is required according to policy.

6. Service Limitations: All RMH services require prior authorization by Medicaid's QIO-Like vendor. RMH services may be prior authorized up to 90-days.

   a. Intensity of Need Levels I & II: Recipients may receive BST and/or Peer-to-Peer services provided:

      1. a covered, current ICD and CASII/LOCUS Levels I or II; and clinical judgment; and

      2. the overall combination does not exceed a maximum of two hours per day; and

      3. the services provided in combination may not exceed the maximum individual daily limits established for each RMH service.

   b. Intensity of Need Level III: Recipients may receive any combination of BST, PSR, Day Treatment and/or Peer-to-Peer services provided:

      1. a covered, current ICD and CASII/LOCUS Level III; and

      2. SED or SMI determination; and

      3. clinical judgment; and

      4. the overall combination does not exceed a maximum of four hours per day; and

      5. the services provided in combination may not exceed the maximum individual daily limits established for each RMH service.

   c. Intensity of Need Level IV: Recipients may receive any combination of BST, PSR, Day Treatment and/or Peer-to-Peer services provided:

      1. a covered, current ICD and CASII/LOCUS Level IV; and

      2. SED or SMI determination; and

      3. clinical judgment; and

      4. the overall combination does not exceed a maximum of six hours per day; and

      5. the services provided in combination may not exceed the maximum individual daily limits established for each RMH service.

d. Intensity of Need Levels V & VI: Recipients may receive any combination of BST, PSR, day treatment and/or peer-to-peer services provided:

1. a covered, current ICD and CASII/LOCUS Levels V or VI; and

2. SED or SMI determination; and

3. clinical judgment; and

4. the overall combination does not exceed a maximum of eight hours per day; and

5. the services provided in combination may not exceed the maximum individual daily limits established for each RMH service.

e. Additional RMH Service Authorizations: Recipients may receive any combination of additional medically necessary RMH services beyond established daily maximums. Additional RMH services must be prescribed on the recipient's rehabilitation plan and must be prior authorized by Medicaid's QIO-like vendor. Additional RMH services authorizations may only be authorized for 30-day periods. These requests must include:

1. a lifetime history of the recipient's inpatient psychiatric admissions; and

2. a 90-day history of the recipient's most recent outpatient psychiatric services; and

3. progress notes for RMH services provided over the most current two-week period.

7. Each authorization is for an independent period of time as indicated by the start and end date of the service period. If a provider believes it is medically necessary for services to be rendered beyond the scope (units, time period or both), of the current authorization, the provider is responsible for the submittal of a new prior authorization request. It is recommended that the new request be submitted 15 days prior to the end date of the existing service period, so an interruption in services may be avoided for the recipient. In order to receive authorization for RMH services all of the following must be demonstrated in the rehabilitation plan and progress notes (if applicable).

a. The recipient will reasonably benefit from the RMH service or services requested;

b. The recipient meets the specific RMH service admission criteria;

c. The recipient possesses the ability to achieve established treatment goals and objectives;

d. The recipient and/or their family/legal guardian (in the case of legal minors) desire to continue the service;

e. The recipient's condition and/or level of impairment does not require a more or less intensive level of service;

f. The recipient does not require a level of structure, intensity and/or supervision beyond the scope of the RMH service or services requested; and

g. The retention of the RMH service or services will reasonably help prevent the discomposure of the recipient's mental and/or behavioral health and overall well-being.

8. Exclusion and Discharge Criteria: Prior authorization will not be given for RMH services if any of the following apply:

a. The recipient will not reasonably benefit from the RMH service or services requested;

b. The recipient does not continue to meet the specific RMH service admission criteria;

c. The recipient does not possess the ability to achieve established rehabilitation goals and objectives;

d. The recipient demonstrates changes in condition, which warrants a more or less intensive level of services;

e. The recipient and/or their family/legal guardian (in the case of legal minors) do not desire to continue the service;

f. The recipient presents a clear and imminent threat of serious harm to self and/or others (recipient presents the intent, capability and opportunity to harm themselves and others); The recipient's condition and/or level of impairment requires a more intensive level of service; and

g. The retention of the RMH service or services will not reasonably help prevent the discomposure of the recipient's mental and/or behavioral health and overall wellbeing.

403.6A RESERVED

403.6B RESERVED

403.6C BST SERVICES

1. Scope of Service: BST services are RMH interventions designed to reduce cognitive and behavioral impairments and restore recipients to their highest level of functioning. BST services are provided to recipients with age and developmentally inappropriate cognitive and behavioral skills. BST services help recipients acquire (relearn) constructive cognitive and behavioral skills through positive reinforcement, modeling, operant conditioning, and other training techniques. BST services reteach recipients a variety of life skills. BST services may include the following interventions:

   a. Basic living and self-care skills: Recipients learn how to manage their daily lives; recipients learn safe and appropriate behaviors;

   b. Social skills: Recipients learn how to identify and comprehend the physical, emotional and interpersonal needs of others-recipients learn how to interact with others;

   c. Communication skills: Recipients learn how to communicate their physical, emotional, and interpersonal needs to others. Recipients learn how to listen and identify the needs of others;

   d. Parental training: Parental training teaches the recipient's parent(s) and/or legal guardian(s) BST techniques. The objective is to help parents continue the recipient's RMH care in home and community-based settings. Parental training must target the restoration of recipient's cognitive and behavioral mental health impairment needs. Parental training must be recipient centered;

   e. Organization and time management skills: Recipients learn how to manage and prioritize their daily activities; and/or

   f. Transitional living skills: Recipients learn necessary skills to begin partial-independent and/or fully independent lives.

2. Provider Qualifications:

   a. QMHP: QMHPs may provide BST services. QMHA: QMHAs may provide BST services under the clinical supervision of a QMHP.

   b. QBA: QBAs may provide BST services under the clinical supervision of QMHP and the direct supervision of a QMHP or QMHA.

3. Service Limitations: All BST services must be prior authorized. Up to two hours of BST services per day for the first 90 consecutive days, one hour per day for the next 90 consecutive days and anything exceeding current service limitations above 180 consecutive days would require a prior authorization meeting medical necessity. Any service limitations may be exceeded with a prior authorization demonstrating medical necessity. Services are based on a calendar year. Prior authorizations may not exceed 90-day intervals.

   If a recipient has been receiving BST services for six consecutive months, the provider must validate that continued services are reasonable and necessary. To be considered reasonable and necessary, the following conditions must be met:

   a. Expectation that the patient's condition will improve significantly in a reasonable and predictable period of time, or the services must be necessary for the establishment of a safe and effective rehabilitative therapeutic design required in connection with a specific disease state.

   b. The amount, frequency and duration of BST must be reasonable under accepted standards of practice.

   c. If the rehabilitation plan goals have not been met, the re-evaluation of the rehabilitation/treatment plan must reflect a change in the goal, objectives, services, and methods and reflect the incorporation of other medically appropriate services such as outpatient mental health services.

   d. Documentation demonstrates a therapeutic benefit to the recipient by reflecting the downward titration in units of service. The reduction in services should demonstrate the reduction in symptoms/behavioral impairment.

   BST services are based on the below daily maximums:

Service Limitations	Children: CASII	Adults: LOCUS
Levels I, II, III, IV, V	Maximum of two hours per day for the first 90 days. This service limitation may be exceeded with a prior authorization demonstrating medical necessity.	Maximum of two hours per day for the first 90 days. This service limitation may be exceeded with a prior authorization demonstrating medical necessity.
Levels I, II, III, IV, V	Maximum of one hour per day for the next 90 days. This service limitation may be exceeded with a prior authorization demonstrating medical necessity.	Maximum of one hour per day for the next 90 days. This service limitation may be exceeded with a prior authorization demonstrating medical necessity.

Levels I, II, III, IV, V	Service limits exceeding two 90-day intervals may be overridden with a prior authorization meeting medical necessity.	Service limits exceeding two 90-day intervals may be overridden with a prior authorization meeting medical necessity.

4. Admission Criteria: The recipient and at least one parent and/or legal guardian (in the case of legal minors) with whom the recipient is living must be willing to participate in home and community-based services; and assessment documentation must indicate that the recipient has substantial impairments in any combination of the following areas:

   a. Basic living and self-care skills: Recipients are experiencing age-inappropriate deficits in managing their daily lives and are engaging in unsafe and inappropriate behaviors;

   b. Social skills: Recipients are experiencing inappropriate deficits in identifying and comprehending the physical, emotional and interpersonal needs of others;

   c. Communication skills: Recipients are experiencing inappropriate deficits in communicating their physical, emotional and interpersonal needs to others;

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

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

403.6D PACT

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

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

3. Services are available 24 hours a day, seven days per week. Team members may interact with a person with acute needs multiple times a day. As the individual stabilizes, contacts decrease. This team approach is facilitated by daily team meetings in which the team is briefly updated on each individual. Activities for the day are organized and team members are available to one another throughout the day to provide consultation or assistance. This

close monitoring allows the team to quickly adjust the nature and intensity of services in response to individuals' changing needs. PACT is reimbursed as unbundled services.

403.6E RESERVED

403.6F PEER-TO-PEER SERVICES

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

   a. Helping stabilize the recipient;

   b. Helping the recipient access community based mental and/or behavioral health services;

   c. Assisting during crisis situations and interventions;

   d. Providing preventative care assistance; and/or

2. Providing personal encouragement, self-advocacy, self-direction training, and peer mentoring.

   Provider Qualifications: A peer supporter is a qualified individual who is currently or was previously diagnosed with a mental and/or behavioral health disorder and who possess the skills and abilities to work collaboratively with and under the clinical and direct supervision of a QMHP. The selection of the supporter is based on the best rehabilitation interest of the recipient. A peer supporter cannot be the legal guardian or spouse of the recipient. At a minimum, a peer supporter must meet the qualifications for a QBA. Peer supporters are contractually affiliated with a BHCN, independent professional (Psychologists and Psychiatrists), or individual RMH providers may provide services to any eligible Medicaid-recipient, if determined appropriate in the treatment planning process.

3. Service Limitation: All Peer-to-Peer services require prior authorization by Medicaid's QIO-like vendor. Prior authorizations may not exceed 90-day intervals. Peer-to-Peer service limits are based on the below 30-day maximums.

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

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

   a. The recipient would benefit from the peer supporter's understanding of the skills needed to manage their mental and/or behavioral health symptoms and for utilization of community resources;

   b. The recipient requires assistance to develop self-advocacy skills;

   c. The recipient requires peer modeling in order to take increased responsibilities for his/her own recovery; and

   d. Peer-to-Peer support services would be in the best interest of the recipient and would most likely improve recipient's mental, behavioral and overall health.

403.6G PSR SERVICES

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

   PSR services may include any combination of the following interventions:

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

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

c. Problem identification and resolution: Recipients learn problem resolution techniques and gain confidence in their problems solving skills;

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

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

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

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

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

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

2. Provider Qualifications:

a. QMHP: QMHPs may provide PSR services.

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

c. QBA: QBAs may not provide PSR services.

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

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

Levels IV & V	Maximum of three hours per day	Maximum of three hours per day
Level VI	Maximum of four hours per day	Maximum of four hours per day

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

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

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

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

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

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

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

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

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

   i. Sense of humor: Recipients are experiencing severe deficits seeing or

understanding the various humorous perspectives regarding life's challenges.

403.6H CI SERVICES

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

   CI services must include the following:

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

   b. Conduct situational risk-of-harm assessment;

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

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

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

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

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

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

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

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

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

403.6I MOBILE CRISIS RESPONSE DELIVERED BY DESIGNATED MOBILE CRISIS TEAM (DMCT)

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

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

1. Scope of Services

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

The primary objective of this Mobile Crisis Response service is to offer "someone to come" in the crisis continuum, established through Senate Bill (SB) 390 (during the 81st Nevada Legislative Session) and subsequent legislation that formulates a comprehensive safety net of crisis services for all Nevadans. DMCTs will respond to an individual in crisis at the individual's location, 24/7/365.

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

2. DMCT Access and Accessibility

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

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

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

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

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

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

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

   c. DMCTs shall attempt to meet the needs of all Nevadans, with consideration given to the providers' identified catchment area and including specific populations (i.e., Tribal communities and multicultural communities, LGBTQ+, children and

adolescents, aging populations, individuals with disabilities, individuals experiencing substance use, etc.).

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

e. Continuity of operations and disaster plans shall comply with state standards, DHHS requirements for endorsement or credentialing, and DHCFP requirements for enrollment.

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

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

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

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

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

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

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

j. DMCTs shall provide culturally and linguistically appropriate care.

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

l. Services to children and youth up to 18 years old shall adhere to DHHS DCFS System of Care core values and guiding principles.

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

3. DMCT OPERATIONAL REQUIREMENTS

a. Inclusive Services

1. Screening

a. DMCTs must establish policies and protocols to ensure:

1. Consistent screening of all individuals, and

2. Documentation of all screenings and screening findings, and

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

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

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

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

2. Assessment

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

b. Selected assessments tools must be:

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 & Management of Suicidality (CAMS) and other tools that meet state requirements.

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

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

b. Documentation of assessment results.

e. Crisis and Safety Plans

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

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

3. Medical Records

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

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

4. Advance Directives

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

b. DMCTs must follow Nevada Medicaid guidance on advance directives, as set forth in MSM 100.

5. Harm Reduction

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

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

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

6. Family Engagement

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

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

7. Coordination of Care

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

1. Assigned case managers

2. Primary Care Providers (PCP)

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

4. Harm-reduction resources, where available

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

b. Discharge from episode of care

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

a. Acute/emergent presentation of the crisis is resolved

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

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

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

e. DMCTs may continue to provide bridge services and supports 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

8. Telehealth

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

1. Dictated by client preference

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

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

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

b. Best Practices

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

2. Reduce duplicative screening and assessments.

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

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

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

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

7. Regarding Peer-to-Peer Support Services, it is the intent of policy that the DMCT include one team member who is a certified peer and recovery support services provider (per Nevada Certification Board), to the greatest extent possible, as Peer Supporters will become mandatory team service providers, certified by DHHS and enrolled with Nevada Medicaid (per SB 390), by July 1, 2026.

c. Privacy and Confidentiality Protocols

1. Policies

a. Providers shall have established/written policies in compliance with State and Federal privacy and confidentiality laws (e.g., Health Insurance Portability and Accountability Act (HIPAA)), as well as

established protocols set forth in accordance with MSM Chapter 100, Chapter 400, and Chapter 3300.

2. Training

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

3. Collaboration and Data Sharing

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

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

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

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

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

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

      1 Local Law Enforcement agencies

      2 Emergency Medical Services (EMS) providers

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

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

d. Excluded Services

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

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

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

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

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

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

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

4. DMCT PROVIDER ELIGIBILITY REQUIREMENTS

a. DMCTs must be endorsed or certified by DHHS

b. DMCTs must be enrolled as a Nevada Medicaid provider

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

1. QMHP-level Independent Professional, or

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

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

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

1. Physician

2. Physician Assistant

3. Advance Practice Registered Nurse (APRN) and Independent Nurse Practitioner (NP) with a focus in psychiatric mental health

4. Psychologist

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

6. RN and QMHA-level

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

8. Certified Peer Supporter (per Nevada Certification Board) and QBA-level

e. Provider Supervision

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

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

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

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

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

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

c. Supervisors review in-person or via telehealth the response to crisis episode with all involved QMHP-level Intern and QMHA-level

staff, and shall appropriately document the time and content of that supervisory discussion; and

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

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

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

f. Provider Training

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

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

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

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

a. Safety/risk screening

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

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

b. Select the appropriate screening tool; and

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

d. Interpret screening tool results.

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

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

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

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

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

d. Crisis/safety planning

e. Appropriate privacy and confidentiality policies and procedures

f. Use of Telehealth equipment

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

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

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

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

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

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

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

5. DMCT RECIPIENT ELIGIBILITY REQUIREMENTS

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

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

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

6. AUTHORIZATION PROCESS AND CLINICAL DOCUMENTATION OF SERVICE

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

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

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

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

2. Date of crisis response episode, and

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

4. Mechanism of response (dispatch), and

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

403.6J CRISIS STABLIZATION CENTER

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

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

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

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

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

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

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

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

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

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

e. Delivers crisis stabilization services:

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

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

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

1. Recovery Orientation

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

2. Trauma-informed care

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

3. Significant use of peer staff

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

4. Commitment to Zero Suicide/Suicide Safer Care.

5. Strong commitments to safety for consumers/staff.

6. Collaboration with law enforcement.

3. Provider Responsibilities:

a. An endorsement as a CSC must be renewed at the same time as the license to which the endorsement applies. An application to renew an endorsement as a CSC must include, without limitation:

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

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

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

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

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

a. Mental status examination; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

b. Any social conditions that affect the patient;

c. The ability of the patient to pay; or

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

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

1. All beneficiaries receiving Crisis Stabilization shall receive an assessment of their physical and mental health. Assessment and stabilization services

will be provided by the appropriate staff. If outside services are needed, a referral that corresponds with the recipient's needs shall be made.

2. Has the equipment and personnel necessary to conduct a medical examination of a patient pursuant to NRS 433A.165.

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

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

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

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

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

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

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

5. Authorization Process:

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

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

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

403.7 RESIDENTIAL TREATMENT CENTER (RTC) SERVICES

A. RTC services are delivered in psychiatric, medical-model facilities, in- or out-of-state, that are accredited by the Joint Commission, the Commission on Accreditation of Rehabilitation Facilities (CARF) or the Council on Accreditation of Services for Families and Children (COA) and licensed as an RTC within their state. RTC services are for recipients under age 21 and must be provided before the individual reaches age 21. If the individual was receiving services in an RTC immediately before reaching age 21, these must be provided before:

1. the date the individual no longer requires the services; or

2. the date the individual reaches 22; and

3. is certified in writing to be necessary in the setting in which it will be provided.

B. The objective of RTC services is to assist recipients who have behavioral, emotional, psychiatric and/or psychological disorders, or conditions, who are no longer at or appropriate for an acute level of care, or who cannot effectively receive services in a less restrictive setting and who meet medical necessity and admission criteria for RTC services. RTCs are part of the mental health continuum of care and are an integral part of Nevada Medicaid's behavioral health system of care. Recipients who respond well to treatment in an RTC are anticipated to be discharged to a lower level of care, such as intensive home and community-based services, or to the care of a psychiatrist, psychologist or other QMHP.

All Medicaid policies and requirements for RTC's (such as prior authorization, etc.) are the same for NCU, except where noted in the NCU Manual, Chapter 1000.

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

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

403.7A COVERAGE AND LIMITATIONS

1. Nevada Medicaid's all-inclusive RTC daily rate includes room and board, active treatment, psychiatric services, psychological services, therapeutic and behavioral modification services, individual, group, family, recreation and milieu therapies, nursing services, all medications, quarterly RTC-sponsored family visits, psycho-educational services, and supervised work projects.

2. The all-inclusive daily rate does not include general physician (non-psychiatrist) services, neuropsychological, dental, optometry, durable medical equipment, radiology, lab, and therapies (physical, speech and occupational) or formal educational services. Services that are Medicaid benefits must be billed separately by the particular service provider and may require prior authorization.

3. The QIO-like vendor may authorize all RTC stays, both Fee-for-Service and Health Maintenance Organization (HMO) (see MSM Chapter 3600) Medicaid in three-month (or less) increments. For Medicaid recipients to remain in RTCs longer than three months, the RTC must, prior to the expiration of each authorization, submit a Continuing Stay Request to the QIO-like vendor for authorization.

4. For recipients under the age of 21 in the custody of a public child welfare agency, Nevada Medicaid will reimburse for prior authorized RTC services only when the public child welfare agency has also approved the admission.

5. Criteria for Exclusion from RTC Admission

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

   a. Psychiatric symptoms requiring acute hospitalization;

b. The following conditions which limit the recipient's ability to fully participate in RTC services and cannot be reasonably accommodated by the RTC;

1. Physical Disability;

2. Learning Capacity;

3. Traumatic Brain Injury (TBI);

4. Organic brain syndrome;

c. Pregnancy, unless the RTC can appropriately meet the needs of the adolescent, including obtaining prenatal care while in the facility. In the case of the birth of the infant while the recipient is in the RTC, planning for the infant's care is included in the discharge plan. (In such an instance the infant would be covered individually by Medicaid for medically necessary costs associated with medical care);

d. Chronic unmanageable violent behavior incompatible with RTC services which poses unacceptable and unsafe risks to other clients or staff for any reason (i.e., a danger to self, others or property);

e. Medical illness which limits the recipient's ability to fully participate in RTC services and is beyond the RTC's capacity for medical care;

f. Drug and/or alcohol withdrawal management is required as a primary treatment modality before a recipient can benefit rehabilitatively from RTC services; or

g. A diagnosis of Oppositional Defiant Disorder (ODD) and/or Conduct Disorder, alone and apart from any other covered, current ICD diagnosis.

6. RTC Therapeutic Home Passes

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

a. The following guidelines must be adhered to for reimbursement. Failure to follow these guidelines will result in non-payment to RTCs during the time the recipient was away on a Therapeutic Home Pass:

1. A physician's order is required for all Therapeutic Home Passes. If it is clinically appropriate for the recipient to travel alone, this must be specified in the physician's order.

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

3. Therapeutic Home Pass information which verifies days used must be documented in the recipient's case file and must include: dates for each pass, location of the pass, treatment objectives to be met by use of each pass and the total number of days used per calendar year. A copy of the physician order for each pass must also be maintained in the recipient's clinical case file.

4. The RTC must track the number of Therapeutic Home Passes used as the QIO-like vendor will not reimburse RTCs for pass days for any recipient exceeding a total of three passes per calendar year.

5. If the recipient leaves without issuance of a Therapeutic Home Pass the recipient will be considered discharged and the QIO-like vendor must be notified of the discharge and date the recipient left the facility.

6. In the event a recipient unexpectedly does not return to the RTC from a Therapeutic Home Pass or family emergency, and such an absence has been properly documented by the RTC, the RTC may utilize the day the recipient was expected to return from leave as the discharge date as long as the period does not exceed 72 hours. In the case of a family emergency or an extended pass which has been approved by the QIO-like vendor, this period cannot exceed 120 hours.

7. Any recipient who is formally discharged from an RTC and is readmitted is considered to be a new admission, regardless of the length of time away from the facility. Prior authorization and a Certificate of Need (CON) signed by a physician, is required for payment.

8. The three passes per calendar year Therapeutic Home Pass policy applies to

all RTC recipients, regardless of the recipient's custody status.

9. Therapeutic Home Passes include the day the pass begins and ends the day before the recipient returns (prior to midnight).

7. Transportation

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

a. initial travel to the RTC upon admission;

b. travel for an RTC Therapeutic Home Pass;

c. travel upon discharge from the RTC; and

d. travel for transfer from one RTC to another RTC or Acute Inpatient Services.

Transportation must be coordinated in accordance with Chapter 1900 of the MSM.

403.7B PROVIDER RESPONSIBILITIES

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

2. Critical Events Reporting Requirements RTCs are required to notify within 48 hours:

a. The QIO-like vendor of any critical event or interaction involving any Nevada Medicaid RTC recipient. Information which must be reported includes, but is not limited to, deaths, injuries, assaults, suicide attempts, police or sheriff's investigations and physical, sexual or emotional abuse allegations.

b. The State Medicaid agency, State-designated client protection and advocacy agency and the Nevada State Bureau of Health Care Quality and Compliance (HCQC) of a resident's death, serious injury or suicide attempt for an in-state facility. If the facility is out-of-state, their own state licensing entity or appropriate departments as well as the QIO-like vendor and Nevada State Medicaid;

c. Their local CMS office of the death of any recipient, no later than the close of business the next business day after the resident's death per 42 CFR 483.374(c).

1. Upon notification of a critical event, Nevada Medicaid may make an adverse decision against the RTC. In the event of a death, suicide attempt,

or very serious injury (injury requiring hospitalization) of a recipient, Nevada Medicaid may make an administrative decision to impose a ban on future Medicaid-eligible admissions and/or remove recipients currently at the RTC, if they are believed to be in danger.

2. If a ban is imposed, Medicaid must receive and review HIPAA compliant documents requested from the RTC, including but not limited to, police, autopsy, state licensing, social services and internal death or serious injury reports before a decision is made to remove or continue the imposed ban or terminate the contractual relationship with the RTC.

3. RTC Regulatory and Compliance Requirements

The RTC must ensure on-going Joint Commission, COA or CARF accreditation and comply with all accreditation requirements.

4. Letter of Attestation

The RTC must comply with 42 CFR Subpart G 483.374(a) and submit a Letter of Attestation to Nevada State, by the individual having legal authority to do so (i.e., facility director, CEO, or administrator), which confirms the facility is in compliance with CMS standards governing the use of restraint and seclusion. The Letter of Attestation must be submitted at the time of enrollment as a Medicaid provider and at any time there is a change in the legal authority of the RTC. A copy of an example Letter of Attestation is available upon request from Nevada Medicaid.

5. QA/Quality Improvement

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

6. Quarterly Family Visits

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

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

7. Discharge Accompaniments

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

a. Supply or access to current prescribed medications;

b. The recipient's Medicaid-eligibility status;

c. All pertinent medical records and post discharge plans to ensure coordination of and continuity of care.

8. Clinical Requirements

a. The RTC must have a Medical Director who has overall medical responsibility for the RTC program. The Medical Director must be a board-certified/board eligible psychiatrist with specific experience in child and adolescent psychiatry.

b. Psychiatric/Medical Services

1. Medicaid-eligible children and adolescents must receive, at a minimum, two monthly face-to-face/one-on-one sessions with a child and adolescent psychiatrist and a psychiatrist must be available 24 hours a day.

2. The RTC must provide routine medical oversight to effectively coordinate all treatment, manage medication trials and/or adjustments to minimize serious side effects and provide medical management of all psychiatric and medical issues.

c. Clinical psychotherapy (individual, group or family therapy) must be provided by a licensed QMHP. All RMH services may also be provided by a QMHP, a QMHA or a QBA within the scope of their practice under state law and expertise. Consultation by a licensed clinical psychologist must be available when determined medically necessary.

d. RTC Interns/Psychological Assistant

1. RTC providers may be reimbursed for services provided by Interns/ Psychological Assistants within the all-inclusive daily rate if they meet the requirements as prescribed in the Provider Qualifications – Outpatient Mental Health Services section of this Chapter.

2. Approved out-of-state RTC providers must comply with the

Interns/Psychological Assistants requirements in their own state.

9. Patient Rights

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

10. Federal Requirements

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

403.7C AUTHORIZATION PROCESS

1. Admission Criteria

All RTC admissions must be prior authorized by the QIO-like vendor. RTCs must submit the following documentation to the QIO-like vendor:

a. RTC Prior Authorization Request Form which includes a comprehensive psychiatric assessment current within six months of the request for RTC admission; and

b. A CON signed by a physician which includes:

1. The current functioning of the recipient;

2. The strengths of the recipient and their family;

3. Covered, current ICD diagnosis;

4. Psychiatric hospitalization history;

5. Medical history; and

6. Current medications.

c. An initial individualized treatment plan; and

d. A proposed discharge plan.

2. The QIO-like vendor must verify the medical necessity for all RTC services and verify:

a. The level of intensity of needs for RTC services;

b. The ability for the recipient to benefit rehabilitatively from RTC services;

c. The treatment plan includes active participation by the recipient and their family (when applicable); and

d. The discharge plan is viable and includes coordinated case management services.

3. All RTCs must notify the QIO-like vendor of the transfer of a recipient to an acute psychiatric hospital or unit. If the transfer is not emergent, the hospital must receive prior authorization for the transfer. For transfers to an acute psychiatric hospital or unit, the QIO-like vendor must verify the medical necessity for acute inpatient psychiatric services and verify:

a. The Level of Intensity of Needs for acute inpatient psychiatric services;

b. The ability for the recipient to benefit rehabilitatively from acute inpatient psychiatric services;

c. Effective care coordination is in place for pre- and post-transfer service; and

d. One of the following admission criteria has been met by the recipient:

1. Active suicidal ideation accompanied by a documented suicide attempt or documented history of a suicide attempt within the past 30 days; or

2. Active suicidal ideation within the past 30 days accompanied by physical evidence (e.g. note) or means to carry out the suicide threat (e.g. gun, knife or other deadly weapon); or

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

a. Resulted in harm to self, others or property;

b. Demonstrates that control cannot be maintained outside of inpatient hospitalization; and

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

4. The RTC must request prior authorization from the QIO-like vendor to return a recipient to the RTC from acute psychiatric services. The prior authorization request must include a Discharge Summary of the acute psychiatric inpatient services.

5. Prior authorization is required prior to transferring a recipient from one RTC to another for unanticipated specialized treatment services not available at the initial RTC placement.

6. RTCs may request a retro-eligibility authorization review from the QIO-like vendor for reimbursement for an RTC patient who was not Medicaid-eligible at the time of admission and later becomes eligible for Medicaid for the period RTC services were provided.

   a. If a client becomes Medicaid eligible after admission to an RTC, the facility must submit an initial Prior Authorization request and all required information to the QIO-like vendor in accordance with MSM Chapter 100.

   b. The QIO-like vendor will process initial prior authorization requests for retro-eligible recipients in accordance with MSM Chapter 100.

7. Continuing Stay Criteria

   a. The RTC must submit a Continuing Stay Request to the QIO-like vendor prior to the expiration of the current authorization period.

   b. The QIO-like vendor will process Continuing Stay Requests for RTC services within 14 days of receipt of all required information.

   c. The RTC must notify the QIO-like vendor of all Medicaid recipient discharges within 24 hours of the discharge and provide a Discharge Summary within 30 days for a planned discharge and within 45 days of an unplanned discharge. In the case of a recipient's transfer to another program, a verbal summary must be given at the time of transition and followed with a written summary within seven calendar days of the transfer.

   d. Continued Stays Requests not authorized by the QIO-like vendor will not be reimbursed by Medicaid. The RTC must submit a request for reconsideration to the QIO-like vendor within the timelines as outlined in the QIO-like vendor's billing manual for RTC's if the continuing stay request has been denied.

8. Discharge Criteria

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

   a. RTC services are not shown to be medically necessary;

   b. The service exceeds Medicaid program limitations;

c. Level 6 of Intensity of Needs is not met, and services may be provided in a less restrictive setting;

d. Specialized RTC services are not required;

e. The legal guardian for the Medicaid recipient has requested the services be withdrawn or terminated;

f. The services are not a Medicaid benefit; and/or

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

9. Reimbursement

RTC's all-inclusive daily rates are negotiated by the provider through the DHCFP's Rates and Cost Containment Unit. Please see MSM Chapter 700 and the Nevada Medicaid State Plan, Attachment 4.19-A, describing the methods and standards for reimbursement of Residential Treatment Centers.

403.8 INPATIENT MENTAL HEALTH SERVICES POLICY

A. Inpatient mental health services are those services delivered in freestanding psychiatric hospitals or general hospitals with a specialized psychiatric unit which include a secure, structured environment, 24-hour observation and supervision by mental health professionals and provide a multidisciplinary clinical approach to treatment.
Inpatient mental health services include treatments or interventions provided to an individual who has an acute, clinically identifiable covered, current ICD psychiatric diagnosis to ameliorate or reduce symptoms for improved functioning and return to a less restrictive setting.

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

CASII	Children: CASII	Adults: LOCUS
Levels I to V	Not Authorized	Not Authorized
Level VI Secure, 24-Hour, Services with Psychiatric Management	Inpatient Hospitalization Authorized	Inpatient Hospitalization Authorized

403.8A COVERAGE AND LIMITATIONS

1. Admissions

a. Certification Requirement:

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

The order must be issued:

a. During the hospital stay;

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

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

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

a. The recipient meeting Level 6 criteria on the Intensity of Needs grid and must include: The date and time of the order and the status of the recipient's admission (i.e., inpatient, observation, same day surgery, transfer from observation, etc.).

b. Admission Date and Time:

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

c. Transfers and Planned Admissions:

For those instances in which a physician's admission order was issued for a planned admission and before the recipient arrives at the hospital, the order must be signed by the physician and indicate the anticipated date of admission. A physician's order must also be issued for transfers from another acute care hospital.

Responsibilities:

1. The admission must be certified by the QIO-like vendor based on:

   a. Medical necessity;

   b. Clear evidence of a physician's admission order; and the

   c. Recipient meeting Level 6 on the intensity of needs grid.

2. The hospital must submit all required documentation including:

   a. The physician's order which is signed by a physician and reflects the admission date and time; and

   b. All other pertinent information requested by the QIO-like vendor.

d. Observation:

   1. Observation status cannot exceed a maximum of 48 hours.

   2. Observation begins when the physician issues an observation status order and ends when the recipient is discharged from the hospital.

3. A new admissions order must be issued and signed by a physician when a recipient is admitted to inpatient status post discharge from an observation stay. Nevada Medicaid reimburses for admissions certified by the QIO-like vendor to a:

   a. Psychiatric unit of a general hospital, regardless of age; or

   b. Psychiatric hospital (Institution for Mental Diseases) for recipients under age 21 or 65 or older.

   For recipients under age 21 in the custody of the public child welfare agency, Nevada Medicaid reimburses for inpatient mental health services only when:

   c. The child welfare agency also approves the admission/placement (this does not apply to placements at State-owned and operated facilities); and the admission is certified by the QIO-like vendor.

4. Reimbursement

   a. Nevada Medicaid reimburses for services for recipients admitted with a mental health or psychiatric condition to a general hospital without a psychiatric unit only under one of the following conditions:

1. The admission is an emergency and is certified by the QIO-like vendor. The hospital must submit clinical documentation to the QIO-like vendor within five business days of the admission and make all efforts to stabilize the recipient's condition and discharge the recipient to a psychiatric hospital or general hospital with a psychiatric unit in as expeditiously as possible; or

2. The recipient has been dually diagnosed as having both medical and mental diagnoses which warrant inpatient general hospital services, as determined by the QIO-like vendor.

b. Nevada Medicaid does not reimburse for services not authorized by the QIO-like vendor.

c. If a recipient is initially admitted to a hospital for acute care and is then authorized by the QIO-like vendor to receive mental health services, the acute care is paid at the medical/surgical rate.

5. Authorized substance use services are paid at the substance use service rate (reference MSM Chapter 4100).

6. Absences

a. In special circumstances, Nevada Medicaid may allow up to an eight-hour pass from the acute hospital without denial of payment. Absences may include, but are not limited to, a trial home visit, a respite visit with parents (in the case of a child), a death in the immediate family, etc. The hospital must request prior authorization from the QIO-like vendor for an absence if the absence is expected to last longer than eight hours.

b. There must be a physician's order that a recipient is medically appropriate to leave on pass and the therapeutic reason for the pass must be clearly documented in the chart prior to the issuance of the pass. Upon the recipient's return, the pass must be evaluated for therapeutic effect and the results clearly documented in the recipient's chart.

7. Non-Covered Services Reference Section 403.9A.

403.8B PROVIDER RESPONSIBILITIES

1. Authorization by the QIO-like vendor must be obtained prior to admission. A tentative treatment plan will be required for the QIO-like vendor's authorization. The only exception is in the event of an emergency admission, in which the recipient may be admitted, and the QIO-like vendor must be notified of the admission within five business days.

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

2. Medical Records

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

a. An initial assessment of the recipient's clinically identifiable psychiatric disorder, which should include a chief complaint or equivalent, a history of the disorder, a statement of the circumstances which led to the request for services, a mental status examination and observations, a diagnosis or differential diagnosis and a statement of treatment goals and objectives and method of treatment.

b. A written, individualized treatment plan (ITP) to address the problems documented during the intake evaluation. The plan shall include the frequency, modality and the goals of treatment interventions planned. It also shall include the type of personnel that will furnish the service.

c. Dated progress notes are required for each treatment encounter to include the amount of time services were rendered, the type of service rendered, the progress of the recipient with respect to resolution of the presenting symptoms or problems, any side effects or necessary changes in treatment and the interval to the next treatment encounter.

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

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

d. Patient Self-Determination Act (Advance Directives) Compliance Pursuant to the Omnibus Budget Reconciliation Act of 1990 (OBRA 90), and federal regulations at 42 CFR 489.100, hospitals which participate in and receive funding from Medicare and/or Medicaid must comply with The Patient Self-Determination Act (PSDA) of 1990, including Advance Directives. Specifically, the PSDA requires all Medicare and Medicaid hospital providers to do the following: Provide written information to all adult (age 18 and older) patients upon admission concerning:

1. The individual’s rights under state law to make decisions concerning their

medical care, including the right to accept or refuse medical or surgical treatment, and the right to formulate advance directives (declarations and durable powers of attorney for health care decisions).

2. The written policies of the provider or organization respecting implementation of such rights, including a clear and precise statement of limitation if the provider cannot implement an advance directive on the basis of conscience.

At a minimum, a provider's or organization's statement of limitation must:

a. Clarify any differences between institution-wide conscience objections and those that may be raised by individual physicians;

b. identify the state legal authority permitting such objections (which in Nevada is NRS 449.628); and

c. describe the range of medical conditions or procedures affected by the conscience objection.

e. Document in the individual's medical record whether the individual has an advance directive.

f. Not to condition the provision of care or otherwise discriminate against an individual based on whether the individual has executed an advance directive.

g. Ensure compliance with the requirements of state law respecting advance directives. The hospital must inform individuals any complaints concerning the advance directives requirements may be filed with the state survey and certification agency (which in Nevada is the Nevada State Health Division, HCQC). Provide education of staff concerning its policies and procedures on advance directives (at least annually).

h. Provide for community education regarding issues concerning advance directives (at least annually). At a minimum, education presented should define what constitutes an advance directive, emphasizing that an advance directive is designed to enhance an incapacitated individual's control over medical treatment, and describe applicable state law concerning advance directives. A provider must be able to document and verify its community education efforts.

Nevada Medicaid is responsible for monitoring/reviewing hospitals periodically to determine whether they are complying with federal and state Advance Directive

requirements.

4. QA Medical Care Evaluation Studies

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

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

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

6. Patient Rights

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

a. 42 CFR 482.13.

b. NRS 449.730.

c. Joint Commission "Restraint and Seclusion Standards for Behavioral Health." Available at the following website: www.jointcommission.org.

7. Non-Emergency Admissions

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

8. Claims for Denied Admissions

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

9. Hospital Responsibilities for Outside Services

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

10. Acute Psychiatric Admission Requirements

a. 42 CFR 441.152 addresses Certification of Need requirements.

b. 42 CFR 441.155 addresses Individual Plan of Care requirements.

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

11. Patient Liability

IMDs/freestanding psychiatric hospitals are exempt from Patient Liability (PL) requirements.

403.8C AUTHORIZATION PROCESS

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

1. For purposes of Medicaid mental health services, an emergency inpatient psychiatric admission to either a general hospital with a psychiatric unit or freestanding psychiatric hospital, is defined as meeting at least one of the following three criteria:

a. Active suicidal ideation accompanied by a documented suicide attempt or documented history of a suicide attempt(s) within the past 30 days; or

b. Active suicidal ideation within the past 30 days accompanied by physical evidence (e.g. note) or means to carry out the suicide threat (e.g., gun, knife or other deadly weapon); or

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

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

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

3. Which is expected to continue without treatment.

2. Concurrent Reviews

For non-emergency admissions, the prior authorization request form and CON must be submitted at least one business day prior to admission. For emergency admissions, the prior authorization request form and CON must be submitted no later than five business days following admission. Prior authorization requests, if medically and clinically appropriate, will be authorized up to seven days. If additional inpatient days are required, a provider must submit a concurrent (continuing stay) authorization request within five business days of the last day of the current/existing authorization period. The request and information submitted must identify all pertinent written medical information that supports a continued inpatient stay. The request and information submitted must be in the format and within the timeframes required by the QIO-like vendor. Failure to provide all pertinent medical information as required by the QIO-like vendor will result in authorization denial. Inpatient days not authorized by the QIO-like vendor are not covered.

The psychiatric assessment, discharge plan and written treatment plan must be initiated, with the attending physician's involvement, during the initial authorization period. In addition, when a recipient remains hospitalized longer than seven days the attending physician must document the medical necessity of each additional inpatient day.

3. Nevada Medicaid will reimburse for services for recipients admitted with a mental health or psychiatric condition to a general hospital without a psychiatric unit only under one of the following conditions:

a. The admission is an emergency admission and is certified by the QIO-like vendor (who must be contacted within five business days after the admission). The hospital must make all efforts to stabilize the recipient's condition and discharge the

recipient to a psychiatric hospital or general hospital with a psychiatric unit as expeditiously as possible; or

b. The recipient has been dually diagnosed as having both medical and mental conditions/diagnoses which warrant inpatient general hospital services, as determined by the QIO-like vendor.

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

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

5. Prior Resources

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

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

6. Reimbursement

Inpatient freestanding psychiatric and hospitals and general acute hospitals with a psychiatric unit are reimbursed a per diem, all-inclusive prospective daily rate determined and developed by the Nevada DHCFP’s Rate Development and Cost Containment Unit. (Days certified as administrative are paid at the all-inclusive prospective administrative day rate.)

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

403.9 ADMINISTRATIVE DAYS POLICY

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

403.9A COVERAGE AND LIMITATIONS

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

1. SNL is a unique payment benefit of the Nevada Medicaid program. These reimbursement levels provide for ongoing hospital services for those recipients who do not require acute care. Discharge to a nursing facility is not required. Issuance of this level is a reflection of the hospital services required by and provided to the recipient.

   SNL days may be authorized when one or more of the following apply, or as determined by physician review:

   a. Recipient is awaiting placement, or evaluation for placement, at a nursing facility/extended care facility, group home, or other treatment setting, for continuity of medical services, e.g.:

      1. Transfers to other facilities.

      2. Rehabilitation or independent living.

      3. Hospice, etc.

   b. Recipient is to be discharged home and is awaiting home equipment set up/availability, nursing services and/or other caretaker requirements, e.g.:

      1. Home health nursing.

      2. Public health nursing.

      3. Durable medical equipment.

      4. Family preparation.

5. Respite care.

c. Conditions which may prevent a non-acute recipient from leaving the hospital (e.g., recipient's labs must be monitored, cultures taken for staph infection or any treatment/work up that could not be safely and effectively accomplished in another setting).

1. Therapeutic foster care.

2. Day treatment.

3. Rural mental health follow-up services.

4. Set up for wrap around services.

d. Recipient has mental disabilities that prevent nursing facility placement (e.g., failed PASRR screening), and the recipient will eventually go to an institution of mental diseases.

2. ICL is a unique payment benefit of the Nevada Medicaid program, which provides reimbursement for ongoing hospital services, for those recipients who cannot be discharged due to social reasons.

ICL days are authorized when one or more of the following apply, or as determined by physician review:

a. Stable child awaiting adoption or discharge home when the mother is discharged.

b. Ready for discharge and is awaiting transportation.

c. ICL at a nursing home or alternate setting.

d. Victim of crime in need of assessment and evaluation.

3. Administrative days are denied when:

a. A recipient, recipient's family or physician refuses a Nursing Facility (NF) placement.

b. A recipient, family or physician refuses a psychiatric RTC placement, group home or psychiatric treatment center.

c. There is insufficient documentation (Monday through Friday contacts and results)

in the chart reflecting adequate discharge planning.

403.9B PROVIDER RESPONSIBILITIES

1. Authorization by the QIO-like vendor must be obtained prior to admission. A tentative treatment plan will be required for the QIO-like vendor's authorization. The only exception is in the event of an emergency admission, in which the recipient may be admitted, and the QIO-like vendor must be notified of the admission within five business days.

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

2. Medical Records

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

   a. An initial assessment of the recipient's clinically identifiable psychiatric disorder, which should include a chief complaint or equivalent, a history of the disorder, a statement of the circumstances which led to the request for services, a mental status examination and observation, a diagnosis or differential diagnosis, and a statement of treatment goals and objectives and method of treatment.

   b. A written, individualized treatment plan (ITP) to address the problems documented during the intake evaluation. The plan shall include the frequency, modality, and the goals of treatment interventions planned. It also shall include the type of personnel that will furnish the service.

   c. Dated progress notes are required for each treatment encounter to include the amount of time services were rendered, the type of service rendered, the progress of the recipient with respect to resolution of the presenting symptoms or problems, any side effects or necessary changes in treatment, and the interval to the next treatment encounter.

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

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

d. PSDA Advance Directives Compliance Pursuant to the OBRA 90, and federal regulations at 42 CFR 489.100, hospitals which participate in and receive funding from Medicare and/or Medicaid must comply with the PSDA of 1990, including advance directives. Specifically, the PSDA requires all Medicare and Medicaid hospital providers to do the following: Provide written information to all adult (age 18 and older) patients upon admission concerning:

1. The individual's rights under state law to make decisions concerning their medical care, including the right to accept or refuse medical or surgical treatment, and the right to formulate advance directives (declarations and durable powers of attorney for health care decisions).

2. The written policies of the provider or organization respecting implementation of such rights, including a clear and precise statement of limitation if the provider cannot implement an advance directive on the basis of conscience.

   At a minimum, a provider's or organization's statement of limitation must:

   a. Clarify any differences between institution-wide conscience objections and those that may be raised by individual physicians;

   b. Identify the state legal authority permitting such objections (which in Nevada is NRS 449.628); and

   c. Describe the range of medical conditions or procedures affected by the conscience objection.

e. Document in the individual's medical record whether the individual has an advance directive.

f. Not to condition the provision of care or otherwise discriminate against an individual based on whether the individual has executed an advance directive.

g. Ensure compliance with the requirements of state law respecting advance directives. The hospital must inform individuals that any complaints concerning the advance directive requirements may be filed with the state survey and certification agency (which in Nevada is the Nevada State Health Division, HCQC). Provide education of staff concerning its policies and procedures on advance directives (at least annually).

h. Provide for community education regarding issues concerning advance directives (at least annually). At a minimum, education presented should define what

constitutes an advance directive, emphasizing that an advance directive is designed to enhance an incapacitated individual's control over medical treatment, and describe applicable state law concerning advance directives. A provider must be able to document and verify its community education efforts.

Nevada Medicaid is responsible for monitoring/reviewing hospitals periodically to determine whether they are complying with federal and state advance directive requirements.

3. QA Medical Care Evaluation Studies

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

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

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

5. Patient Rights

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

a. 42 CFR 482.13.

b. NRS 449.730.

c. Joint Commission "Restraint and Seclusion Standards for Behavioral Health." Available at the following website: www.jointcommission.org.

6. Non-Emergency Admissions

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

7. Claims for Denied Admissions

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

8. Hospital Responsibilities for Outside Services

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

9. Acute Psychiatric Admission Requirements

a. 42 CFR 441.152 addresses Certification of Need requirements.

b. 42 CFR 441.155 addresses Individual Plan of Care requirements.

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

10. Patient Liability

IMDs/freestanding psychiatric hospitals are exempt from Patient Liability (PL) requirements.

403.9C RECIPIENT RESPONSIBILITIES

1. Medicaid recipients are required to provide their Medicaid card to their service providers.

2. Medicaid recipients are expected to comply with the service provider’s treatment, care and service plans, including making and keeping medical appointments.

403.9D AUTHORIZATION PROCESS

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

403.10 ELECTROCONVULSIVE THERAPY (ECT)

Effective date March 1, 2004, ECT is a treatment for mental disorders, primarily depression, but also acute psychotic episodes in Schizophrenia and Bipolar Disorder. A low voltage alternating current is used to induce a generalized seizure that is monitored electrographically while under general anesthesia and muscle relaxation.

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

Prior Authorization is required.

403.10A COVERAGE AND LIMITATIONS

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

1. Prior authorization requires documentation of the following medically necessary indicators:

    a. Severe psychotic forms of affective disorders.

    b. Failure to respond to other therapies.

    c. Medical preclusion to use of drugs.

    d. Need for rapid response.

    e. Uncontrolled agitation or violence to self or others.

    f. Medically deemed for probable preferential response to ECT.

2. Recipients under 16 years of age must have all of the above indicators and:

    a. Two prior medication trials predetermined by a physician.

b. Two concurring opinions by a Board-Certified Psychiatrist.

c. Informed written consent by custodial parent(s)/legal guardian.

3. Covered, current ICD Codes:

F20-F29 Schizophrenic disorders.

F30-F33.9 Affective psychoses and depressive type psychoses and other nonorganic psychoses.

4. Covered CPT Codes:

90870 – Electroconvulsive therapy (includes necessary monitoring); single seizure.

5. Reasons for Denial

a. Continuing use of ECT without evidence of recipient improvement.

b. Diagnostic codes not encompassed in the foregoing list.

6. Coding Guidelines

a. Anesthesia administration for ECT is a payable service only if provided by a physician other than the one administering ECT.

b. If billing is received for ECT and a visit on the same day, the latter will be denied if rendered by the physician administering ECT.

7. Documentation Requirements

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

404 HEARINGS

Please reference MSM Chapter 3100 – Hearings, for hearings procedures.

POLICY #4-01	DAY TREATMENT AGES 3-6	

A. DESCRIPTION

Day treatment services are interventions performed in a therapeutic milieu designed to provide evidence-based strategies to reduce emotional, cognitive, and behavioral problems. Day treatment services target emotional, cognitive and behavioral functioning within a variety of actual and/or simulated social settings. Day treatment services provide recipients the opportunity to implement and expand upon (trial and error) what they previously learned/gained from other mental and/or behavioral health therapies and interventions in a safe setting. The goal of day treatment services is to restore recipients to their highest level of functioning while preparing them for reintegration back into home and community-based settings.

B. POLICY

Day treatment coverage is limited to medically necessary services and is reimbursed at an hourly rate. Day treatment services must:

1. Have goals and objectives that are:
    a. time specific;
    b. measurable (observable);
    c. achievable;
    d. realistic;
    e. time limited;
    f. outcome driven;
    g. individualized;
    h. progressive; and
    i. age/developmentally appropriate.
2. Provide for a process to involve the recipient, and family or other responsible individuals; and
3. Not be contingent on the living arrangements of the recipient.

Day treatment services are:

1. Facility based out of home services;
2. A fluid combination of Outpatient Mental Health and RMH services; and
3. Provided under a BHCN medical model.

C. PRIOR AUTHORIZATION IS REQUIRED

D. COVERAGE AND LIMITATIONS

1. COVERED SERVICES

Clinical documentation must demonstrate the recipient meets all of the following criteria to be considered a covered benefit:

a. Early Childhood Service Intensity Instrument (ECSII) level II or CASII score of III or higher;

b. A primary covered, current ICD diagnosis;

c. SED;

d. Requires and will benefit from opportunities to test their acquired emotional, cognitive and behavioral skills in settings that emulate their normal home and community-based environments;

e. Clinical evidence that the recipient's condition requires a structured program with treatment that cannot be provided in a less intensive outpatient setting;

f. Adequate social support system available to provide the stability necessary for maintenance in the program; and

g. Emotional, cognitive and behavioral health issues which:

1. are incapacitating, interfering with daily activities or places others in danger to the point that it causes anguish or suffering;

2. require intensive, coordinated, multifaceted interventions within a therapeutic milieu; and

3. cannot be appropriately addressed in a day care or school setting, as the issues are impacting their ability to function in those settings and/or are contributing to expulsion or near expulsion from day care, head start, school and/ or home placements.

Service Limitations	Ages 3-6: CASII
Levels I & II	No Services Authorized
Level III	Maximum of three hours per day
Level IV	Maximum of three hours per day
Levels V & VI	Maximum of three hours per day

2. NON-COVERED SERVICES

   a. Transportation or services delivered in transit.

   b. Facilities licensed as a daycare.

   c. Club house, recreational, vocational, afterschool, or mentorship programs.

   d. Services provided in the home or homelike setting including campus/institution establishment that furnishes (in single or multiple facilities) food, shelter and some treatment or services to four or more persons unrelated to the proprietor.

   e. Routine supervision, monitoring or respite.

   f. Non-evidenced based models.

   g. Non milieu models.

   h. Programs restricted or only provided to those recipients who reside at the same location.

E. PROVIDER REQUIREMENTS

To receive reimbursement day treatment programs must be separately enrolled with the DHCFP. Program Criteria:

1. Services not to exceed three hours per day, five days per week;

2. Parental/caregiver involvement and participation in the day treatment program;

3. Ongoing participation in family counseling/therapy;

4. Minimum staff to recipient ratio is 1:3;

5. Maximum group size is six;

6. Therapeutic milieu design;

7. Services must be provided by a QMHP or by a QMHA under the Direct Supervision of an onsite QMHP;

8. Evidence based programmatic model with established curriculum and schedule;

9. Program admission, service continuation and discharge criteria; and

10. Policies and procedures specific to the day treatment program which at a minimum address the following:

    a. Clinical and Direct Supervision;

b. HIPAA and client's rights;

c. Service provision and documentation; and

d. Admission and discharge criteria and process.

For individual provider requirements see MSM Chapter 400.

For enrollment, prior authorization and billing instructions please refer to the QIO-like vendor website.

A. DESCRIPTION

Day treatment services are interventions performed in a therapeutic milieu designed to provide evidence-based strategies to reduce emotional, cognitive, and behavioral problems. Day treatment services target emotional, cognitive, and behavioral functioning within a variety of actual and/or simulated social settings. Day treatment services provide recipients the opportunity to implement and expand upon (trial and error) what they previously learned/gained from other mental and/or behavioral health therapies and interventions in a safe setting. The goal of day treatment services is to restore recipients to their highest level of functioning while preparing them for reintegration back into home and community-based settings.

B. POLICY

Day treatment coverage is limited to medically necessary services and is reimbursed at an hourly rate. Day treatment services must:

1. Have goals and objectives that are:
    a. time specific;
    b. measurable (observable);
    c. achievable;
    d. realistic;
    e. time limited;
    f. outcome driven;
    g. individualized;
    h. progressive; and
    i. age/developmentally appropriate.
2. Provide for a process to involve the recipient and family or other responsible individuals; and
3. Not be contingent on the living arrangements of the recipient.

Day treatment services are:

1. Facility based out of home services;
2. A fluid combination of Outpatient Mental Health and RMH services; and
3. Provided under a BHCN medical model.

C. PRIOR AUTHORIZATION IS REQUIRED

D. COVERAGE AND LIMITATIONS

1. COVERED SERVICES

Clinical documentation must demonstrate the recipient meets all of the following criteria to be considered a covered benefit:

a. CASII score of III or higher;

b. A primary covered, current ICD diagnosis;

c. Determined SED;

d. Requires and will benefit from opportunities to test their acquired emotional, cognitive and behavioral skills in settings that emulate their normal home and community-based environments;

e. Clinical evidence that the recipient's condition requires a structured program with treatment that cannot be provided in a less intensive outpatient setting;

f. Adequate social support system available to provide the stability necessary for maintenance in the program; and

g. Emotional, cognitive and behavioral health issues which:

1. are incapacitating, interfering with daily activities or places others in danger to the point that it causes anguish or suffering;

2. require intensive, coordinated, multifaceted interventions within a therapeutic milieu; and

3. cannot be appropriately addressed in a day care or school setting, as the issues are impacting their ability to function in those settings and/or are contributing to expulsion or near expulsion from day care, school and/ or home placements.

Service Limitations	Ages 7-18: CASII
Levels I & II	No Services Authorized
Level III	Maximum of four hours per day
Level IV	Maximum of five hours per day
Levels V & VI	Maximum of six hours per day

2. NON-COVERED SERVICES

a. Transportation or services delivered in transit.

b. Facilities licensed as a daycare.

c. Club house, recreational, vocational, afterschool or mentorship programs.

d. Services provided in the home or homelike setting including campus/institution establishment that furnishes (in single or multiple facilities) food, shelter and some treatment or services to four or more persons unrelated to the proprietor.

e. Routine supervision, monitoring or respite.

f. Non-evidenced based models.

g. Non milieu models.

h. Programs restricted or only provided to those recipients who reside at the same location.

E. PROVIDER REQUIREMENTS

To receive reimbursement day treatment programs must be separately enrolled with the DHCFP.

1. Program Criteria:

a. Services not to exceed six hours per day, five days per week;

b. Parental/caregiver involvement and participation in the day treatment program;

c. Ongoing participation in individual therapy (not reimbursed under day treatment model);

d. Minimum staff to recipient ratio is 1:5;

e. Maximum group size is 10;

f. Therapeutic milieu design;

g. Services must be provided by a QMHP or by a QMHA under the Direct Supervision of an onsite QMHP;

h. Evidence based programmatic model with established curriculum and schedule;

i. Program admission, service continuation and discharge criteria; and

j. Policies and procedures specific to the day treatment program which at a minimum address the following:

1. Clinical and Direct Supervision;

2. HIPAA and client's rights;

3. Service provision and documentation; and

4 Admission and discharge criteria and process.

For individual provider requirements see MSM Chapter 400.

For enrollment, prior authorization and billing instructions please refer to the QIO-like vendor website.

A. DESCRIPTION

Day treatment services are RMH interventions performed in a therapeutic milieu to provide evidence- based strategies to restore and/or retain psychiatric stability, social integration skills and/or independent living competencies to function as independently as possible. Services provide recipients the opportunity to implement and expand upon what was previously learned from other mental or behavioral health therapies and interventions in a safe setting. The goal of day treatment services is to prepare recipients for reintegration back into home and community-based settings, prevent hospitalizations and ensure stability.

B. POLICY

Day treatment coverage and reimbursement is limited to medically necessary services and are covered at an hourly rate.

Day treatment services must:

1. Have goals and objective that are:
    a. time specific;
    b. measurable (observable);
    c. achievable;
    d. realistic;
    e. time limited;
    f. outcome driven;
    g. individualized;
    h. progressive; and
    i. age/developmentally appropriate.
2. Must involve the recipient and family or other individuals, as appropriate, and
3. Not be contingent on the living arrangements of the recipient.

Day treatment services are:

1. Facility based, out of home services.
2. A fluid combination of all the RMH services.
3. Provided under a BHCN medical model.

C. PRIOR AUTHORIZATION IS REQUIRED

D. COVERAGE AND LIMITATIONS

1. COVERED SERVICES

Clinical documentation must demonstrate that the recipient meets all of the following criteria:

a. Must have LOCUS score of IV, V, or VI;

b. A primary covered, current ICD diagnosis;

c. Determined as SMI;

d. Requires and benefits from opportunities to test their acquired emotional, cognitive and behavioral skills in settings that emulate their normal home and community-based environments;

e. The recipient's condition requires a structured program with treatment that cannot be provided in a less intensive outpatient setting;

f. An adequate social support system is available to provide the stability necessary for maintenance in the program; and

g. Recipient's emotional, cognitive and behavioral issues which:

1. require intensive, coordinated, multifaceted interventions within a therapeutic milieu; and

2. are incapacitating, interfere with daily activities or place others in danger to the point that it causes anguish or suffering.

Service Limitations	Ages 19 and older: LOCUS
Levels I & II	No Services Authorized
Level III	No Services Authorized
Level IV	Maximum of five hours per day
Levels V & VI	Maximum of six hours per day

2. NON-COVERED SERVICES

a. Transportation or services in transit.

b. Facilities licensed as adult daycare may not provide day treatment services.

c. Recreational, mentorship or club house programs.

d. Services in a home based or home-like settings, including campus/institutions that furnish in single or multiple areas, food, shelter and some treatment/services to four or more persons unrelated to the proprietor.

e. Non-evidenced based models.

f. Non milieu models.

g. Programs restricted to only those recipients residing at the same location.

E. PROVIDER REQUIREMENTS

1. Program Criteria:

a. Day Treatment services must be provided by a QMHP or by a QMHA under the Direct Supervision of an onsite QMHP;

b. Services not to exceed a maximum of six hours a day, five days a week;

c. Must involve the recipient and family or other individuals, as appropriate in the day treatment program and family counseling/therapy;

d. Minimum staff to recipient ratio is 1:5;

e. Maximum group size is 10;

f. Therapeutic milieu design;

g. Evidence based programmatic model with established curriculum and schedule;

h. Program admission, service continuation and discharge criteria in place; and

i. Policies and procedures specific to the day treatment program which as a minimum address the following:

1. Clinical and Direct Supervision;

2. HIPAA and client's rights;

3. Service provision and documentation; and

4. Admission and discharge criteria and process

Day Treatment services will only be reimbursable to those programs which have been approved and enrolled to serve as Day Treatment Program service providers

For individual provider requirements see MSM Chapter 400.

For enrollment, prior authorization and billing instructions please refer to the QIO-like vendor's

Billing Manual and Guidelines.

POLICY #4-04	INSTITUTION FOR MENTAL DISEASE (IMD)	

A. DESCRIPTION

Nevada Medicaid Fee-for-Service (FFS) shall not reimburse for any services for individuals who are ages 22-64 years that are in an Institution for Mental Disease (IMD). An IMD is defined as a hospital, nursing facility or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, and also provides for medical attention, nursing care and related services.

For recipients ages 22 to 64, "Nevada's Treatment of Opioid Use Disorders (OUDs) and Substance Use Disorders (SUDs)Transformation Project" (1115 SUD Waiver) allows for reimbursement of substance use and withdrawal management services within an IMD setting through December 31, 2027.

B. COVERAGE AND LIMITATIONS

1. IMD Exclusion - In accordance with 42 CFR 435.1009(2), Federal Financial Participation (FFP) is not available for institutionalized individuals who are individuals under the age of 65 who are patients in an IMD, unless they are under age 22 and are receiving inpatient psychiatric services under 42 CFR 440.160, which is a psychiatric hospital or a residential treatment center for recipients under the age of 21 years. See (2e) for additional clarification.

    a. All services are excluded from Medicaid payment while a recipient is admitted to an IMD, whether the services are provided in or outside the facility.

2. In accordance with 42 CFR 435.1010: Definition of IMD means a hospital, nursing facility or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental disease, and also provides for medical attention, nursing care and related services. Whether an institution is an institution for mental diseases is determined by its overall character being that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such.

    a. Facilities licensed as acute care hospitals and/or nursing facilities with designated psychiatric beds are reviewed based upon their aggregate bed counts.

    b. The CMS Manual for IMD states, alcohol and other chemical dependency syndromes are classified as mental disorders, which subject them to the IMD regulations. The manual gives further guidance that services delivered by laypersons that do not constitute a medical or remedial model such as Alcoholics Anonymous do not qualify for federal matching funds. The "major factor differentiating these facilities from other chemical dependency treatment facilities are the primary reliance on lay staff." Chemically dependent patients admitted for CD treatment are counted as mentally ill under the 50% guideline.

    c. An institution for individuals with Intellectual and Developmental Disabilities is not considered an institution for mental diseases.

    d. Periods of Absence: Regulation allows for an individual to have a conditional release or convalescent leave from the IMD. During this time period the patient is not considered to be in the IMD. Services may be covered by Medicaid during this time period for emergency or other medical treatment. The periods of absence relate to the course of treatment of the recipient's mental disorder. If the patient needs emergency or other medical treatment during this time period, these services may be covered because the patient is not considered to

be in an IMD. If a patient is transferred while in the IMD for the purpose of obtaining medical treatment, it is not considered a conditional release and is not a covered service.

1. Convalescent – when a patient is sent home for a trial visit.

2. Conditional release – when a patient is released from the institution on the condition that the patient receives outpatient treatment or other comparable services.

d. Coverage of services for ages 21 up to 22 years – If a patient is receiving services immediately prior to turning age 21years, the services continue until the earlier of the date the individual no longer requires the services or the date the individual reaches 22. In this extenuating circumstance, IMD service may continue until age 22. The regulation requires that the patient must be receiving services immediately prior to age 21 and continuously up to age 22. Services cannot begin during the 21st year.

3. Guidelines for Determining if a facility is an IMD: The CMS has deferred the completion of the determination if a facility is an IMD to the DHCFP. The DHCFP utilizes the criteria as listed in the CMS Medicaid Manual for this determination. The criteria include factors such as, but not limited to:

a. Facility ownership is one single owner or governing body;

b. The Chief Medical Officer is responsible for medical staff activities in all components;

c. The Chief Executive Officer is responsible for administrative activities in all components;

d. The licensure of each component;

e. The geographic location of each facility;

f. The Condition of Participation of each component;

g. The relationship to the State Mental Health Authority;

h. The patient records; that provide evidence of psychiatric/psychological care and treatment; and

i. The current need for institutionalization for more than 50% of all the patients in the facility is resulting from mental disease, including but not limited to the bed count.

4. Medicaid may reimburse co pays and/or deductibles for Qualified Medicare Beneficiaries (QMB) while in an IMD.

(State Medicaid Manual Chapter 4, http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021927.html.