Medicaid Services Manual
Transmittal Letter

March 25, 2025

To: Custodians of Medicaid Services Manual

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Chief of Division Compliance

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

Background And Explanation

Revisions to Medicaid Services Manual (MSM) Chapter 400 – Mental Health Services, Section 403.6I – Mobile Crisis Response Delivered by Designated Mobile Crisis Team (DMCT) are being proposed to remove the peer requirement to the Mobile Crisis Response Delivered by DMCT, as well as remove the Division of Health and Human Services (DHHS) and Division of Public and Behavioral Health (DPBH) certification requirements.

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: This proposed change affects all Medicaid-enrolled providers delivering crisis services. Those provider types (PT) include but are not limited to: Behavioral Health Outpatient Treatment (PT 14), DMCT (PT 87, Specialty 31, and Specialty 32), School Health Services (SHS) (PT 60), and Certified Community Behavioral Health Centers (CCBHC) (PT 17, Specialty 188).

Financial Impact on Local Government: No financial impact is expected.

These changes are effective March 26, 2025.

Material Transmitted	Material Superseded
MTL 05/25 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
403.6I(2)(e)	**Mobile Crisis Response Delivered by**	Removed DHHS requirements for endorsement or credentialing.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
	Designated Mobile Crisis Team (DMCT)	
403.6I(3)(b)(7)		Removed language regarding peer supporters being mandatory team providers.
403.6I(3)(c)(3)(a)		Removed language regarding DHHS oversite requirements.
403.6I(4)(a)		Removed language regarding endorsement/ certification by DHHS.
403.6I(4)(c)(8)		Corrected to Peer Support Specialist.
403.6I(4)(e)(2)	**DMCT Provider Eligibility Requirements**	Removed language of DHHS.
403.6I (4)(f)(1)		Removed language of DHHS.
403.6I (4)(f)(7)(a)		Removed language of endorsement and certification.
403.6I(6)(c)	**Authorization Process and Clinical Documentation of Service**	Removed language of DHHS.

DIVISION OF HEALTH CARE FINANCING AND POLICY

MEDICAID SERVICES MANUAL
TABLE OF CONTENTS

MENTAL HEALTH SERVICES

DIVISION OF HEALTH CARE FINANCING AND POLICY

MEDICAID SERVICES MANUAL
TABLE OF CONTENTS

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 and 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 versus. Outpatient)
- 42 CFR 441.150 to 441.156 and 441.184 (Inpatient Psychiatric Services for Individuals under age 21 in Psychiatric Facilities or Programs)
- 42 CFR, Part 456 (Utilization Control)
- 42 CFR, Part 456, Subpart G (Inpatient Psychiatric Services for Individuals Under Age 21: Admission and Plan of Care (POC) Requirements)

- 42 CFR, Part 482 (Conditions of Participation for Hospitals)
- 42 CFR, Part 483, Subpart G (Condition of Participation for the use of Restraint or Seclusion in Psychiatric Residential Treatment Facilities Providing Inpatient Psychiatric Services to Individuals Under Age 21)
- 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))
- CMS State Operations Manual (SOM), 100-07, (Chapter 2 provides guidance on CMS PRTF Certification)
- Nevada Administrative Code (NAC) 449.410-449.4495 (Psychiatric Residential Treatment Facilities—General Provisions, Licensing, Administration and Operation, and Provision of Services)
- 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 10 and 14 (Psychiatric/Substance Use Treatment Rate Development and Administrative Day Rate Development and Psychiatric Residential Treatment Facilities)
- 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 (PA), Clinical Social Workers (CSW), Marriage and Family Therapists (.MFT), 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 ensure 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 ensure 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.

i. 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 ensure 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: 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.

j. 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;

k. 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 support 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 (ITP) 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 BH service(s) (i.e., family therapy, individual therapy, medication management, basic skills training (BST), 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 POC 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 ITP 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 that the service was delivered; it 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 a Federal Bureau of Investigation (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 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 entities. 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 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 PA 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 CSW.

g. Graduate degree in Counseling and licensed as an MFT or as a CPC.

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 (LOC) 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 Chapter 400 Section 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 (MSW) 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 MFT and CPC.

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

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

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

403.4 OMH SERVICES

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

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

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

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

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

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

5. Functional Assessment – Used to comprehensively evaluate the recipient's skills, strengths and needs in relation to the skill demands and supports required in the particular environment in which the recipient wants or needs to function; as such, environment is consistent with the goals listed in the recipient's 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 LOC assessment. Currently, DHCFP recognizes LOCUS for adults and CASII for children and adolescents. There is no LOC assessment tool recognized by DHCFP for children below age six, however, providers must utilize a tool comparable to the CASII and recognized as a standard of practice in determining the Intensity of Needs for this age group.

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

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

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

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

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

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

motivation and other factors influencing treatment outcomes.

C. Mental Health Therapies

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

1. Family Therapy

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

2. Group Therapy

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

3. Individual Therapy Services

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

4. Neurotherapy

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

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

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

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

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

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

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

6. Opposition Defiant Disorders (ODD) and/or Reactive Attachment Disorders –
   50 sessions

   Current ICD Codes: F93.8, F91.3, F94.1, F94.2, F94.9 and F98.8

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

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

   Prior authorization may be requested for additional services based

upon medical necessity.

D. Mental Health Therapeutic Interventions

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

a. Scope of Services - PHP services may include:

1. Individual Therapy

2. Group Therapy

3. Family Therapy

4. Medication Management

5. Behavioral Health Assessment

6. BST

7. Psychosocial Rehabilitation

8. Peer-to-Peer Support Services

9. Crisis Services

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

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

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

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

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

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

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

1. Non-evidence-based models;

2. Transportation or services delivered in transit;

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

4. Routine supervision, monitoring or respite;

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

6. Watching films or videos;

7. Doing assigned readings; and

8. Completing inventories or questionnaires.

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

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

1. Individual Therapy

2. Group Therapy

3. Family Therapy

4. Medication Management

5. Behavioral Health Assessment

6. BST

7. Psychosocial Rehabilitation

8. Peer-to-Peer Support Services

9. Crisis Services

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

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

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

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

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

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

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

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

1. Non-evidence-based models;

2. Transportation or services delivered in transit;

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

4. Routine supervision, monitoring, or respite;

5. Participating in community based, social based support groups (i.e. AA, NA);

6. Watching films or videos;

7. Doing assigned readings; and

8. Completing inventories or questionnaires.

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

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

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

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

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

      1. If the 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 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 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 SUD, 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 SUD, 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 SUD, 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 SUD, 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 SUD, 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 SUD, 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 SUD, 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 SUD, 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 SUD, 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 SUD, 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 SUD, 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 SUD, 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 prior authorization 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 equals 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 prior authorization 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 equals 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 3700.

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 LOC possible while sustaining the recipient's overall health.

2. Inclusive Services: RMH services include 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 and 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 and 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 PAR. 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 are limited to 18 hours/72 units before prior authorization is required by Medicaid's QIO-like vendor. Prior authorizations may not exceed 90-day intervals.

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 CRISIS INTERVENTION SERVICES

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

   CI services must include the following:

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

   b. Conduct situational risk-of-harm assessment;

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

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

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

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

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

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

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

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

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

403.6I 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 CMS to assist in the development and implementation of qualifying community-based mobile crisis intervention services under its Medicaid state plan. In addition, Section 9813 of the ARPA established Section 1947 of the US SSA, which authorizes optional state plan coverage and reimbursement for qualifying mobile crisis intervention services with a temporarily enhanced 85 percent federal medical assistance percentage (FMAP) for 12 quarters during the timeframe of April 2022 to March 2027. Section 1947 also waives standard state plan requirements for state wideness, comparability, and provider choice, in addition to providing definition for qualifying community-based mobile crisis services.

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

1. Scope of Services

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

   The primary objective of this Mobile Crisis Response service is to offer "someone to come"

in the crisis continuum, established through Senate Bill (SB) 390 (during the 81st Nevada Legislative Session (2021)) and subsequent legislation that formulates a comprehensive safety net of crisis services for all Nevadans. DMCTs will respond to an individual in crisis at the individual's location, 24/7/365.

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

2. DMCT Access and Accessibility

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

j. DMCTs shall provide culturally and linguistically appropriate care.

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

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

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

3. DMCT OPERATIONAL REQUIREMENTS

a. Inclusive Services

1. Screening

a. DMCTs must establish policies and protocols to ensure:

1. Consistent screening of all individuals, and

2. Documentation of all screenings and screening findings, and

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

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

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 and 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 LOC.

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 Chapter 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 Chapter 400 Section 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 SUD support, where available

4. Harm-reduction resources, where available

5. Appropriately shared information with whomever is

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

b. Discharge from episode of care

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

a. Acute/emergent presentation of the crisis is resolved

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

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

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

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

8. Telehealth

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

1. Dictated by client preference

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

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

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

b. Best Practices

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

2. Reduce duplicative screening and assessments.

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

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

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

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

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

c. Privacy and Confidentiality Protocols

1. Policies

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

2. Training

a. DMCT Clinical Supervision is responsible for the initial and

ongoing training of staff on privacy and confidentiality practices and protocols.

3. Collaboration and Data Sharing

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

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

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

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

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

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

1. Local Law Enforcement agencies

2. Emergency Medical Services (EMS) providers

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

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

d. Excluded Services

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

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

b. Crisis services delivered solely via telehealth without the

availability of an in-person response to the individual in crisis, and/or

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

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

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

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

4. DMCT PROVIDER ELIGIBILITY REQUIREMENTS

a. DMCTs must be enrolled as a Nevada Medicaid provider

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

1. QMHP-level Independent Professional, or

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

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

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

1. Physician

2. PA

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

4. Psychologist

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

6. RN and QMHA-level

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

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

d. Provider Supervision

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

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

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

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

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

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

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

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

e. Documentation of supervisory contacts with all engaged DMCT supervisee staff, including date of supervisor review, date of observation of individual staff, log of indirect supervision contacts

(e.g., paperwork reviewed), as well as date, agenda, and action plan for all conferences with supervisee staff; and

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

e. Provider Training

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

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

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

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

a. Safety/risk screening

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

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

b. Select the appropriate screening tool; and

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

d. Interpret screening tool results.

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

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

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

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

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

d. Crisis/safety planning

e. Appropriate privacy and confidentiality policies and procedures

f. Use of Telehealth equipment

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

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

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

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

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

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

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

5. DMCT RECIPIENT ELIGIBILITY REQUIREMENTS

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

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

self, harm to others, inability to care for oneself).

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

6. AUTHORIZATION PROCESS AND CLINICAL DOCUMENTATION OF SERVICE

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

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

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

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

2. Date of crisis response episode, and

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

4. Mechanism of response (dispatch), and

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

403.6J CRISIS STABLIZATION CENTER (CSC)

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

CSCs are considered an emergency healthcare alternative, providing persons with an acute behavioral health problem (including co-occurring disorders) with prompt action, gentle response, and effective support in a respectful environment. CSCs are a no-wrong-door access. CSCs are a short-term, subacute care for recipients which support an individual's

stabilization and return to active participation in the community. Key elements include a welcoming and accepting environment, which conveys hope, empowerment, choice, and higher purpose. This model is traditionally meant to last 24 hours or less. If recipients cannot be stabilized in this period, the next step would be to refer them to an appropriate LOC at an inpatient facility. CSCs are part of a continuum of crisis services designed to stabilize and improve symptoms of distress. Recipients who can be stabilized in a CSC are anticipated to be discharged to a lower LOC.

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

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

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

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

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

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

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

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

e. Delivers crisis stabilization services:

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

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

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

1. Recovery Orientation

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

2. Trauma-informed care

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

3. Significant use of peer staff

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

4. Commitment to Zero Suicide/Suicide Safer Care.

5. Strong commitments to safety for consumers/staff.

6. Collaboration with law enforcement.

3. Provider Responsibilities:

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

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

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

Accreditation Commission for Health Care, or the Joint Commission, or their successor organizations.

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

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

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

   a. Mental status examination; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

   b. Any social conditions that affect the patient;

   c. The ability of the patient to pay; or

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

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

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

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

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

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

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

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

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

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

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

5. Authorization Process:

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

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

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

403.7 PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY (PRTF) SERVICES

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

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

direction of a physician.

C. PRTFs serve recipients under the age of 21 years with complex mental health needs and their families, based on medical necessity. PRTF treatment is intended to help recipients reach a level of functioning where less restrictive treatment will be possible in accordance with 42 CFR 441.152(a)(3).

D. All Medicaid policies and requirements for PRTFs (such as prior authorization, etc.) are the same for recipients covered by NCU, except where otherwise noted in the NCU Manual, Chapter 1000.

403.7A COVERAGE AND LIMITATIONS

1. Covered Services

Nevada Medicaid's all-inclusive PRTF daily payment rate includes the following:

a. Room and Board;

b. Active treatment including the development of the individual POC within 14 days of admission with 30-day reviews and discharge planning in accordance with 42 CFR 441.155;

c. Psychiatric and Psychological services, including consultation with other professionals, such as case managers, primary care professionals, community-based providers, school staff, and other members of the recipient's support structure;

d. Therapeutic and behavioral modification services;

e. Daily therapy as described in the POC, including, but not limited to:

1. Individual therapy services;

2. Family therapy;

3. Group therapy; and

4. Recreation and milieu therapies.

f. Nursing services;

g. PRTF-sponsored quarterly family visits; and

h. Psycho-educational services.

2. Non-Covered Services

Nevada Medicaid's all-inclusive PRTF daily payment rate does not include:

a. General physician (non-psychiatric) services;

b. Neuropsychological services;

c. ABA services;

d. Medications;

e. Dental;

f. Optometry;

g. Durable medical equipment;

h. Radiology;

i. Lab services;

j. Physical, speech and occupational therapies; and

k. Formal educational services that may be provided to a recipient in a PRTF.

3. Arranged And Concurrent Services

a. Arranged and Concurrent services that are Medicaid benefits, not covered by the all-inclusive PRTF daily rate, may be billed separately by a qualified service provider and may require prior authorization.

1. Arranged Services – Professional services, arranged by and provided at the facility, or a different location such as a dental office, by a licensed professional. This must be included in the POC.

2. Concurrent Services – Services provided by another provider can be provided at the facility that supports continuity of care and successful discharge from a PRTF.

b. Concurrent services may occur on, but are not limited to, therapeutic leave days.

c. Concurrent services may include ABA services (refer to MSM Chapter 3700 for ABA coverage requirements).

d. Transportation

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

1. Initial travel to the PRTF upon admission;

2. Travel for a PRTF Therapeutic Leave Day;

3. Travel upon discharge from the PRTF; and

4. Travel for transfer from one PRTF to another PRTF or Acute Inpatient Services.

Transportation must be coordinated in accordance with MSM Chapter 1900.

4. Reimbursement

Reference MSM Chapter 700 and the Nevada Medicaid State Plan, Attachment 4.19-A, describing the methods and standards for reimbursement of PRTFs for fee-for-service (FFS) recipients.

If the recipient is enrolled in an MCO, the MCO is responsible for reimbursement of the PRTF stay. Managed care entities will be responsible for the utilization management of these recipients, including approving authorization and placement into a PRTF, as well as continued stays at a PRTF. It is the PRTF's responsibility to contract with the MCOs to become one of their participating providers. If a recipient has a MCO plan that is not contracted with the PRTF, the PRTF must refer the recipient and the parent/guardian to the MCO and instruct them to ask for assistance in finding an in-network provider who is currently accepting new patients.

5. Non-Discrimination

The PRTF must assure that no recipient shall be excluded from participation, denied benefits, or otherwise subjected to discrimination in the performance of the services or in employment practices on the grounds of disability, age, race, color, religion, sex, national origin, or any other classification protected by federal, Nevada State Constitutional, or statutory law. Reference MSM Chapter 100 for further details.

6. PRTF Therapeutic Leave Days (TLD)

PRTF TLD are to be utilized to facilitate a recipient's discharge back to their home or a less restrictive setting. PRTF recipients are allowed to utilize TLDs based on individualized Treatment Planning needs and upon the recommendations of the PRTF clinical treatment team.

The QIO-like vendor must be notified by the PRTF of all TLDs 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.

TLDs include the day the pass begins and ends the day before the recipient returns (prior to midnight, 12:00 AM).

Duration per pass is no greater than 72 hours unless there is a documented, medically necessary reason for a longer-term pass. 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 PRTFs during the time the recipient was away on a TLD.

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

    2. The recipient must have demonstrated a series of successful incremental day passes before the TLD occurs. The recipient must also be in the final phase of treatment in the PRTF program.

    3. TLD information which verifies days used must be documented in the recipient's case file and must include: date/time of check-out for each pass, location of the pass, name(s) of the person(s) with whom the leave will be spent, the recipient's physical/emotional condition at the time of departure (including vital signs), the types/amounts of medication being provided and instructions (in lay terms) for taking them, treatment objectives to be met by use of each pass and the total number of days to be used.

    4. Documentation upon return from the TLD must include: the date/time of check in, the recipient's physical/emotional condition at the time of return (including vital signs and notation of any physical injury or complaint), whether or not any contraband was found, the types/amounts of medication being returned, if any, an explanation of any missed doses, an explanation of any early return from leave, and a brief report on the outcome of the leave (were therapeutic goals achieved?).
    5. In the event a recipient unexpectedly does not return to the PRTF from a

TLD, and such an absence has been properly documented by the PRTF, the PRTF may utilize the day the recipient was expected to return from leave as the discharge date if the period does not exceed 72 hours, or 120 hours in the case of a family emergency or an extended pass which has been approved by the QIO-like vendor.

6. If the recipient leaves without issuance of a TLD, the recipient will be considered discharged, and the QIO-like vendor must be notified of the discharge and date the recipient left the facility.

7. Any recipient who is formally discharged from a PRTF and readmitted is a new admission, regardless of the length of time away from the facility. A new initial PAR must be submitted in accordance with the admission process requirements in 403.7D.

403.7B PROVIDER REQUIREMENTS

1. A PRTF must comply with the following requirements to be eligible to participate in the Nevada Medicaid Program. The PRTF must remain in compliance with all licensing, accreditation and certification requirements throughout their Medicaid enrollment:

   a. A PRTF that has more than one physical address shall have a separate Medicaid provider number for each facility;

   b. Be licensed as a PRTF or PRTF license equivalent by the state in which it is located:

      1. In-state facilities: A facility located in the state of Nevada must have a license to operate as a PRTF from the Health Care Quality and Compliance (HCQC) Bureau at the Nevada Division of Public and Behavioral Health with the acronym being (DPBH), pursuant to NAC 449.4145.

      2. Out-of-state facilities: A facility located outside the state of Nevada must meet all licensing requirements for PRTFs in the state where the facility is located to serve Title XIX (Medicaid) recipients in that state to receive reimbursement from Nevada Medicaid.

         a. If the PRTF designation is not clearly stated on the facility's license, the facility will be required to provide documentation from their state's licensing agency, signed and dated by the director of the state licensing agency, on official states letterhead, stating that the facility meets all criteria for PRTF service provision as indicated in Part 441 Subpart D and Part 483 Subpart G of 42 CFR and has been approved to service Title XIX recipients in that state as a PRTF in accordance

with applicable state and federal laws.

b. If the facility's state does not certify PRTFs, the PRTF must be able to receive a PRTF certification from the state of Nevada.

c. Be accredited by the Joint Commission, the Commission on Accreditation of Rehabilitation Facilities (CARF), or the Council on Accreditation for Services for Families and Children Recipients as required by 42 CFR 441, Subpart D;

d. Satisfy all state and federal requirements for PRTFs, including obtaining CMS PRTF certification from a state survey agency; and

e. Provide a Letter of Attestation that the PRTF follows all requirements in 42 CFR 441, subpart D (Inpatient Psychiatric Services for Individuals Under Age 21 in Psychiatric Facilities or Programs) and 42 CFR 483, Subpart G (Condition of Participation for the Use of Restraint or Seclusion in PRTF Providing Inpatient Psychiatric Services for Individuals Under Age 21). This must be submitted when a PRTF is enrolling or revalidating.

Thereafter, annual attestations are required by July 21, or by the next business day if July 21 falls on a weekend or holiday. The attestation must be signed by an individual who has the legal authority to obligate the facility (facility director). A new attestation must be submitted whenever a new person takes over the position of facility director. The attestation form can be located on the QIO-like vendor website.

403.7C ELIGIBLE RECIPIENTS

1. To be eligible to receive care in a PRTF, Medicaid-eligible recipients must meet the following criteria:

a. Be under the age of 21 at the time of admission (a Medicaid recipient who was receiving services immediately prior to attaining age 21 may continue to receive services until they are no longer needed or until the recipient reaches age 22, whichever occurs first);

b. Have a primary covered, specific, current ICD diagnosis;

c. Have a SED determination;

d. Have received a CASII level of VI for recipients under age 18 or a LOCUS level of VI for recipients aged 18 or older;

e. Does not require an acute level or emergency care, or cannot effectively receive

services in a less restrictive setting due to symptom severity requiring supervision/intervention on a 24-hour basis;

f. Has a psychiatric condition that requires services on an inpatient basis under the direction of a physician; and

g. Has a condition that can be reasonably expected to improve, or sustained without further regression, through treatment in a PRTF setting, so that PRTF services will no longer be needed after such treatment.

403.7D ADMISSION, CONTINUED STAY, ELOPEMENTS, AND DISCHARGE

1. Admission Process

a. All PRTF admissions must be prior authorized before admission by the QIO-like vendor, including when Third Party Liability (TPL)/Other Health Care (OHC) exists.

Exceptions to this requirement include the following—in these instances only, prior authorizations may be submitted within 10 business days upon the re-admission:

1. Elopements, which are considered discharges, no matter how long the recipient was gone from the facility;

2. Acute/observation emergency room (ER) setting for longer than 24 hours, which would then be considered a discharge; and

3. Any re-admission of a youth back to the PRTF following an inpatient hospital stay with the plan to have the PRTF of record re-admit the recipient back upon stabilization. The PAR must include a Discharge Summary of the acute inpatient services.

b. PRTFs must submit the following documentation to the QIO-like vendor:

1. PRTF PAR form, located on the QIO-like vendor website, which includes but is not limited to:

a. The current functioning/current mental status of the recipient;

b. Symptoms/behaviors necessitating residential treatment;

c. The strengths of the recipient and their family and the living environment;

d. Covered/ specific, current ICD diagnosis (Note: recipients requiring PRTF LOC should not have an unspecified diagnosis);

e. Medical history;

f. Current medications;

g. CASII/LOCUS level;

h. Prior outpatient and inpatient services and the outcome of these;

i. A proposed Treatment Plan; and

j. A proposed discharge plan.

In addition, the PAR includes criteria and required documentation for providers seeking to receive a complexity add-on payment.

2. A comprehensive psychiatric assessment that has been completed within the past six months of the request for PRTF admission/readmission, which is signed by a Physician, M.D., Osteopath, D.O., or a licensed, nationally board-certified Psychiatric/Mental Health APRN; and

3. A Certificate of Need (CON) signed by a physician which certifies, per 42 CFR 441.152:

a. Ambulatory care resources available in the community do not meet the treatment needs of the recipient.

b. Proper treatment of the recipient's psychiatric condition requires inpatient or residential treatment services under the direction of a physician;

c. The services can reasonably be expected to improve the recipient's condition or prevent further regression so that services will no longer be needed.

The team certifying the need for services must be made in accordance with requirements set forth within 42 CFR 441.153.

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

1. The level of Intensity of Needs for PRTF services;

2. The ability for the recipient to benefit rehabilitatively from PRTF services;

3. The Treatment Plan includes active participation by the recipient and their family (when applicable); and

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

d. Clinical decisions regarding PRTF treatment and placement will be made individually on a case-by-case basis. The PRTF will develop its admission criteria and assure that it has the staff and resources available to meet the needs of referred recipients who fit its admission criteria.

e. All PRTFs must notify the QIO-like vendor of the transfer of a recipient to an acute psychiatric hospital or unit. Notification forms can be found on the QIO-like vendor website. 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:

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

2. The ability for the recipient to rehabilitate from acute inpatient psychiatric services;

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

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

a. Active suicidal ideation accompanied by a documented suicide attempt or documented history of a suicide attempt 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 which:

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

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

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

f. Prior authorization is required prior to transferring a recipient from one PRTF to another, which is considered a lateral transfer, for unanticipated specialized treatment services not available at the initial PRTF placement. It is the responsibility of the receiving provider to document clearly in their PAR that it is a lateral transfer from another facility with the reason for why this is needed and what their facility can offer that the current facility cannot. Lateral transfers are generally discouraged unless there is a valid reason of the need for this.

g. Prior authorizations may be fully technically denied or only partially approved if Medicaid eligibility ends during the period of the PAR request. PRTFs may request a retro-eligibility authorization review for a recipient once Medicaid eligibility has been established, or re-established. The facility must submit a PAR and all required information to the QIO-like vendor in accordance with Billing Manual requirements. The QIO-like vendor will process initial PAR s for retro- eligible recipients in accordance with MSM Chapter 100.

2. Continued Stay Authorization

a. The QIO-like vendor authorizes all PRTF stays for FFS Medicaid recipients in three-month (or less) increments. It is the PRTF's responsibility to help the recipient accomplish treatment goals within that time frame or to justify why a longer stay should be prior authorized. For Medicaid recipients to remain in PRTFs longer than three months, the PRTF must, prior to the expiration of each authorization, submit a Continuing Stay Request to the QIO-like vendor for authorization. It is recommended that this be submitted 5 to 15 days prior to the last authorized date.

b. In reviewing requests for extended treatment, the QIO-like vendor reviews the appropriateness and quality of the recipient's ongoing treatment as planned, provided, evaluated, revised and documented by the treatment team.

c. Criteria used to make a determination of medical necessity approval for a continued stay request, includes but is not limited to:

1 Psychiatric symptoms manifested by the qualifying diagnosis or conditions continue to be severe and/or complex and the severity of the symptoms contraindicate treatment occurring safely at a lower LOC. The Treatment Plan has been modified to address barriers to achieving goals; or

2. New symptoms have emerged, or previously unidentified symptoms have manifested, that require continued treatment, and the severity of symptoms contraindicate treatment occurring safely at a lower LOC;

3. Multiple symptoms and functional impairments due to psychiatric diagnosis continue to be present despite progress being documented;

4. Recipient and family/guardian continue to be actively engaged and participating per care plan goals.

d. When discharge problems arise because of the lack of an appropriate placement for the recipient, (i.e. unsuitable family environment, foster home unavailability, no group home vacancies), it is the responsibility of the PRTF, together with the legal guardian(s) to locate and/or arrange an appropriate placement. The lack of post-discharge plans alone will not be considered a valid basis for a continued PRTF stay.

3. Elopements

a. PRTFs are facilities capable of being locked, or staff-secured, to prevent elopements, which can be detrimental to the safety and well-being of the recipient and others.

b. An elopement is a situation where a recipient is off campus and out of line-of-sight of facility staff. An elopement occurrence is considered a discharge, no matter the length of time the recipient has been gone from the PRTF. A new initial PAR must be submitted, in accordance with the admission process requirements as discussed in Section 403.7D(1), upon the return of the recipient to the PRTF.

c. Once PRTF staff determine that a recipient has eloped from the facility, PRTF staff must call the local law enforcement agency and notify the parent/guardian. A complete incident report form must be initiated and include the time of discovery along with all processes implemented to assist with locating and returning the recipient to the facility and the outcome of this event. The documentation must contain the written account and statements from persons involved with full names.

d. Upon the return of a recipient from an elopement incident, the PRTF will notify the parent/guardian and law enforcement of the return so any alerts can be cancelled and documented.

e. If the recipient has a history of "repeat run-away incidents," the PRTF must develop a safety plan for the recipient and include the safety plan in their

POC/Treatment Plan. Consideration should be given to the recipient's history of running away, safety concerns (for both the recipient and the community), need for additional supervision, and/or need for a more secure placement.

4. Discharge

a. Permanency and stability within the community is a priority for discharge planning. As appropriate for the recipient's safety and well-being, the PRTF shall make efforts to engage the family/guardian in continuing contact with their recipient and implementing the plans for permanency for the recipient. Such contact shall include participation in developing case plans, updating the family/guardian on progress and inviting them to all case conferences. When in the best interests of the recipient, the PRTF designs and implements services in a manner that supports and strengthens family/guardian relationships and empowers and enables family members/guardians to assume their roles.

b. An individualized, interdisciplinary POC /Treatment Plan, in accordance with 42 CFR 441.155 must be completed, which includes problem formulation and articulation of short and long-term, measurable treatment goals, and activities designed to achieve those goals. This plan should be developed in collaboration with the recipient and parent/guardian and meet the following criteria:

1 Is reviewed and updated in collaboration with the recipient and family/guardian at least every 30 days, or at earlier intervals if necessary;

2. Includes the planned duration of the overall services along with discharge criteria, with discharge and transfer planning beginning the day of admission;

3. Identifies an available agency or agencies and independent provider(s) to provide aftercare services and the purpose of each service provider and how it addresses the recipient's identified needs with respect to supportive aftercare; and

4. Describes each referral arrangement made prior to discharge with appointment date and time, if known, for the recipient.

c. The QIO-like vendor will issue a denial or partial denial for PRTF services based on review of medical necessity and admission or continuing stay criteria. Please reference the Billing Manual for information on the appeals process for medical necessity denials. Denials may be issued for, but are not limited to:

1. PRTF services are not shown to be medically necessary and ;

2. The recipient does not meet Level VI of Intensity of Needs on the CASII/LOCUS, and services for the recipient may be reasonably provided in a less restrictive setting;

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

4. The recipient or family/guardian are non-participatory in treatment or in following the program rules and regulations to such a degree that treatment at the PRTF LOC is rendered ineffective, despite multiple, documented attempts to address non-participation;

5. The recipient is not making progress toward treatment goals despite persistent efforts to achieve this, and there is no reasonable expectation of progress at this LOC, nor is the LOC required to maintain the current level of function; and/or

6. A change in federal or state law has occurred that results in the recipient being ineligible for services in PRTF (the recipient is not entitled to a hearing in this case; see MSM Chapter 3100).

d. The PRTF must ensure the following is provided to the legal representative upon discharge of a recipient:

1 Supply or access to currently prescribed medications equal to the amount already stocked for that recipient with instructions for use;

2. Written prescriptions for all prescribed medications as needed;

3. Written information about the recipient's Medicaid-eligibility status; and

4. Copies of all pertinent medical records and post discharge plans for the recipient, including information about the recipient's personal safety plan, referrals for community providers, emergency and crisis provider contact information, and a list of any upcoming scheduled appointments, to ensure coordination and continuity of care for the recipient upon discharge.

e. The PRTF must complete a Discharge Summary which shall include but not be limited to:

1. Written documentation of the last date of service with the recipient;
2. The diagnosis at admission and discharge;

3. 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 POC/Treatment Plan including the reason for discharge, current Intensity of Needs level and recommendations for further treatment including contact information for community providers that the PRTF has contacted for the recipient to ensure continuity of care post-discharge.

f. The PRTF must notify the QIO-like vendor of all recipient discharges and provide a Discharge Summary within 30 days of the discharge.

403.7E PROVIDER RESPONSIBILITIES

1. Providers must comply with the regulations in this MSM chapter and all other applicable MSM chapters. This includes other sections within this chapter that are applicable to all providers.

2. General PRTF Service Provisions

a. A PRTF provides a less medically intensive program of treatment than a psychiatric inpatient hospital or a psychiatric unit of a general hospital could provide and must include an on-grounds educational component that provides a continuum of the recipient's current grade level.

b. PRTF services focus on the improvement of recipient's symptoms using strength and evidence-based strategies and include active family engagement services designed to improve and/or ameliorate the recipient's mental health or co-occurring mental health and substance use condition.

c. Parental involvement services must be provided to help the recipient's parents maintain and enhance parental functioning, parental care, maintenance of parent-recipient relationships, or when in the best interest of the recipient, termination of parental rights.

d. In addition to services provided by and in the facility, when they can be reasonably anticipated in the active Treatment Plan, the PRTF must ensure that the recipient receives all treatment identified on the active Treatment Plan and any other medically necessary care required for all medical, dental, psychological, social, behavioral and developmental aspects of the recipient's situation. The PRTF 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.

3. Critical Events/Serious Occurrence Reporting Requirements

a. In accordance with 42 CFR 483.374, PRTFs must report each critical event and serious occurrence involving a Nevada Medicaid recipient no later than close of business on the next business day after the event or occurrence to each of the following appropriate state entities:

1. State Medicaid Agency (i.e., DHCFP for Nevada Medicaid recipients);

2. State designated Protection and Advocacy system (i.e. Nevada Disability Advocacy and Law Center (NDALC) for in-state PRTFs; out-of-state PRTFs need to notify their appropriate state's Protection and Advocacy agency);

3. Appropriate state Child Protective Services (CPS) if the event or occurrence involved any confirmed or suspected incidents of recipient abuse and/or neglect; and

4. Appropriate state licensing entity (HCQC for in-state PRTFs; out-of-state PRTFs must notify their own licensing agency and any other appropriate state entities under that state's law);

b. 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. The notification form can be located on the QIO-like vendor website.

1. The report must include the name of the recipient involved in the serious occurrence, a description of the occurrence, and the name, street address, and telephone number of the facility.

2. In the case of a recipient under the age of 18, the facility must notify the recipient's parents/legal guardians as soon as possible, and in no case later than 24 hours after the serious occurrence.

3. Facility staff must document in the recipient's record that the serious occurrence was reported to the appropriate agencies, including names of the persons to whom the incident was reported. Documentation must also include any case numbers assigned from agencies, as applicable. A copy of the report must be maintained in the recipient's record, as well as in the incident and accident report logs kept by the facility.

4. In addition, PRTFs must report the death of any recipient to the CMS regional office by no later than close of business the next business day after

the recipient's death. Facility staff must document in the recipient's record that the death was reported to the CMS regional office.

c. Upon notification Nevada Medicaid may make an adverse decision against the PRTF. In the event of a death, suicide attempt or very serious injury, as defined within 42 CFR 483.352, of a recipient, or if there are generalized concerns as to the quality of care or other safety concerns for recipients, including allegations of abuse (e.g. sexual, physical, verbal, emotional) and/or neglect under investigation, Nevada Medicaid may make an administrative decision to impose a ban on future Medicaid-eligible admissions and remove recipients currently at the PRTF if they are reasonably believed to be in danger.

d. If a ban is imposed, the PRTF must provide the Division with information regarding the PRTFs efforts to resolve the problem(s) or issue(s) causing the ban and any requested HIPAA compliant documents regarding the event or events, including but not limited to, police reports, autopsy findings, state licensing findings, social services records and internal death, or serious injury reports. The Division will use this information to inform its decision as to whether the originally imposed ban on admissions should be removed or continued, or whether the PRTF should be disenrolled as a Medicaid provider and no longer eligible for reimbursement for services.

4. Emergency/Disaster Preparedness

In accordance with 42 CFR 441.184, the PRTF must comply with all applicable Federal, State, and local emergency preparedness requirements. PRTFs must establish written procedures for personnel to follow in an emergency/disaster. Evacuation of a facility may become necessary in the event of an emergency/disaster (e.g., fire, smoke, bomb threat, explosion, prolonged power failure, structural damage, water loss, or sewer loss, tornado, flood, earthquake, chemical leak/spill, etc.).

5. Quality Assurance/Quality Improvement

The PRTF must have an ongoing quality assurance (QA) program in which each service of the facility and service to individual recipients are reviewed and monitored to promote the highest quality service, to resolve problems that are identified, and to assure that services meet the facility's expectations as to outcome. The PRTF will cooperate with authorized external review systems (including the state's licensing agency, as applicable, and DHCFP). The PRTF's QA plan must be available upon request for review to DHCFP.

6. Fingerprint-Based Background Check
To protect recipients' safety a thorough Fingerprint-Based Background Check and review is required with results of an on-line preliminary check available for review prior to

employment, or within the timeframe required of a state's regulatory requirements, after hiring an employee, accepting an employee of a temporary employment service or entering into a contract with an independent contractor, for all licensed, regulated or registered care providers. Reference MSM Chapter 100 for further details regarding Provider Conditions of Participation.

7. Patient Rights

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

8. Federal Requirements

PRTFs must comply with all Federal and State Requirements.

9. Family Visits

a. Family Visits are based on clinical appropriateness and are utilized to support person- and family-centered Treatment Planning. It is the responsibility of PRTFs, as part of the all-inclusive daily rate, to bring up to two family members to the facility on an at least a quarterly basis when the family resides 200 miles or more from the PRTF. This includes the PRTF providing travel, lodging, and meals to the family.

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

10. Documentation

a. PRTFs must maintain comprehensive and legible medical records for each recipient as are necessary to fully disclose the kind and extent of psychiatric services provided, as well as the medical necessity for those services. In addition, it shall include, but not be limited to, the recipient's medical, nursing, social and other related treatment and care in accordance with all accepted professional standards. This information shall be available upon the request of DHCFP or its authorized agents.

b. These records must include, but are not limited to:

1. The recipient's name, date of birth, diagnosis, dates of services etc.;
2. Evaluations/assessments;

3. Treatment Plans with assigned care team members listed who were responsible for the development and updates;

4. Doctor's orders;

5. Medications, including any signed consents as applicable;

6. Medication Administration Record (MAR);

7. Progress notes, including psychotherapy notes, which must reflect:

   a. The date and time (both for start and end times) of services provided;

   b. Length/duration of sessions;

   c. Type of therapy (e.g., individual, family, group);

   d. Person(s) participating in the session;

   e. Clinical observations about the recipient/family (demeanor, mood, affect, mental alertness, thought processes, risks, etc.);

   f. Therapeutic interventions attempted and the recipient's response to the intervention(s), including any response to significant others who may be present in the session;

   g. The outcomes of sessions including the recipient's and/or family's progress toward functional improvement and the attainment of established goals and objectives, especially in relation to the discharge criteria;

   h. The nature, content and number of services provided;

   i. The name, credential(s), and signature of the person who provided the service(s).

8. Critical Events/Serious Occurrence Reports;

9. Discharge Summary;

10. Indications that the recipients and their families/legal guardians were involved in all aspects of care planning;

11. Indications that the recipients and their families/legal guardians are aware of the scope, goals, and objectives of PRTF services; and

12. The recipients and their families/legal guardians acknowledgement that PRTF services are designed to reduce the duration and intensity of care to the least intrusive LOC possible while sustaining the recipient's overall health.

c. All clinical records of discharged recipients shall be completed promptly and shall be filed and retained for a minimum of six years from date of payment, or longer as required by a PRTF's state law, after the discharge of the recipient.

d. All information contained in the clinical records shall be treated as confidential and shall be disclosed only to authorized persons, including DHCFP and its agents.

11. Staff Qualifications

a. A PRTF must employ sufficient full-time professional staff to provide clinical assessments, therapeutic interventions, ongoing program evaluations, and adequate residential supervision 24 hours a day, seven days a week. The team of professional staff must be appropriately licensed, trained, and experienced in providing mental health and residential treatment.

b. The PRTF must have a Medical Director who has overall medical responsibility for the PRTF program. The Medical Director must be a board-certified/board eligible psychiatrist with specific experience in child and adolescent psychiatry and must be available on a regularly scheduled basis to support the program and conduct regular onsite, in-person visits at the PRTF to assess the overall quality of care being provided at the PRTF.

c. The PRTF must have an Interdisciplinary team of physicians and other personnel who are employed by, or provide services to recipients in, the PRTF in accordance with 42 CFR 441.156. Based on education and experience, preferably including competence in child psychiatry, the team must be capable of:

1. Assessing the recipient's immediate and long-range therapeutic needs, developmental priorities, and personal strengths and liabilities;

2. Assessing the potential resources of the recipient's family;

3. Setting treatment objectives; and

4. Prescribing therapeutic modalities to achieve the plan's objectives.

d. Recipients must receive at a minimum, two monthly face-to-face/one-on-one sessions with a child and adolescent psychiatrist or nationally board-certified

Psychiatric/Mental Health APRN. A psychiatrist or nationally board-certified Psychiatric/Mental Health APRN must also be available 24 hours a day.

e. Clinical psychotherapy must be provided by a licensed behavioral health professional or QMHP. All rehabilitative mental health 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.

f. PRTF 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 section of this Chapter. Out-of-state PRTF providers must comply with the Interns/Psychological Assistants requirements in their own state.

12. Staff Training

a. A PRTF must ensure that qualified personnel meet or exceed the requirements for pre-service and in-service trainings with respect to facility objectives, policies, services, community resources, state and federal policies, and best practice standards. The facility is required to document evidence of the participation/completion of all employee training and retain in each personnel record the required new worker orientation and annual in-service training, as well as any in-service training provided by the facility during the year. Facilities will provide proof by individual employee records that training requirements are fulfilled. Review of those records will occur during monitoring both by the state survey agency and DHCFP via inspections and/or facility record reviews. Personnel records must reflect the date of training, number of training hours, and the signature of the participant.

b. All full and part-time clinical and direct care staff shall be trained in the following de-escalation and CPR training guidance in accordance with 42 CFR 483.376 including but not limited to:

1. The use of non-physical and non-restraining intervention skills, such as de-escalation, mediation, conflict resolution, active listening, and verbal and observational methods to prevent emergency safety situations; and

2. Safe and appropriate restraint and seclusion techniques, including the ability to respond to signs of physical distress in beneficiaries who are being restrained or in seclusion, including adult and child CPR. Competency of certification in CPR shall be demonstrated and documented annually.

c. Other topics for training include but are not limited to:

1. Patient rights;
2. Managing behavior;
3. Psychiatric emergencies;
4. First aid;
5. Incident reporting (completion/follow-up);
6. Abuse prevention/reporting;
7. Suicide prevention;
8. HIPAA/Confidentiality;
9. Emergency preparedness;
10. Infection Control; and
11. Cultural Awareness.

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 VI 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 VI 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 must be maintained for each recipient and must contain the following:

   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 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 must 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. Progress notes must be signed by the provider that delivered the service.

   d. 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.

   e. Patient records must indicate whether or not the patient has an advance directive.

3. For inpatient and outpatient services, the provider must comply with Healthy Kids (EPSDT) and QIO-like vendor authorization guidelines, as discussed previously in this chapter.

4. Pursuant to the Omnibus Budget Reconciliation Act of 1990 (OBRA 90) and federal

regulation 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. Providers must also ensure compliance with state law respecting advanced directives and inform patients that any complaints concerning advance directives may be filed with the Nevada State Health Division, HCQC.

5. 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.

6. 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.

7. 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.

8. 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 the QIO-like vendor during normal business hours. (Non-emergency admissions not prior

authorized by the QIO-like vendor will not be reimbursed by Nevada Medicaid.)

9. 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).

10. 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 which requires the transfer of 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.

11. Acute Psychiatric Admission Requirements

a. 42 CFR 441.152 addresses Certification of Need requirements.

b. 42 CFR 441.155 addresses Individual POC requirements.

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

12. 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 PAR form and Certificate Of Need (CON) must be submitted at least one business day prior to admission. For emergency admissions, the PAR form and CON must be submitted no later than five business days following admission. PARs, 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 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 (DME).

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 Pre-admission Screening and Resident Review (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 PRTF placement, group home or other placement option..

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 must be maintained for each recipient and must contain the following:

   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 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 must 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. Progress notes must be signed by the individual rendering provider.

   d. 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.

   e. Patient records must indicate whether or not the patient has an advance directive.

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

4. Pursuant to the OBRA 90 and federal regulation 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. Providers must also ensure compliance with state law respecting advanced directives and inform patients that any complaints concerning advance directives may be filed with the Nevada State Health Division, HCQC.

5. 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.

6. 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.

7. 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.

8. 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 the QIO-like vendor during normal business hours. (Non-emergency admissions not prior

authorized by the QIO-like vendor will not be reimbursed by Nevada Medicaid.)

9. 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).

10. 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 which requires the transfer of 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.

11. Acute Psychiatric Admission Requirements

a. 42 CFR 441.152 addresses CON requirements.

b. 42 CFR 441.155 addresses Individual POC requirements.

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

12. Patient Liability

IMDs/freestanding psychiatric hospitals are exempt from 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 LOC.

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 Current Procedural Terminology (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 and II	No Services Authorized
Level III	Maximum of three hours per day
Level IV	Maximum of three hours per day
Levels V and 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 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 OMH 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 and II	No Services Authorized
Level III	Maximum of four hours per day
Level IV	Maximum of five hours per day
Levels V and 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 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 and II	No Services Authorized
Level III	No Services Authorized
Level IV	Maximum of five hours per day
Levels V and 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 FFS shall not reimburse for any services for individuals who are ages 22-64 years that are in an 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 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 PRTF 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 AA, 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.

e. Coverage of services for ages 21 up to 22 years – If a patient is receiving services immediately prior to turning age 21, 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: CMS has deferred the completion of the determination if a facility is an IMD to DHCFP. 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 (CEO) 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.