Medicaid Services Manual
Transmittal Letter

December 30, 2025

To: Custodians of Medicaid Services Manual

From: Casey Angres *Casey Angres* Casey Angres (Jan 29, 2026 10:36:09 PST)
Agency Manager

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

Background And Explanation

Revisions to Medicaid Services Manual (MSM) Chapter 400 – Mental Health Services are being proposed to align with legislative requirements for Assembly Bill (AB) 514, Rehabilitative Residential Mental Health Care (RRMHC) which was passed in the 83rd (2025) Legislative Session. This legislation requires the Nevada Health Authority (NVHA), Division of Nevada Medicaid (DNM) to ensure RRMHC services are covered and reimbursable services under Medicaid for providers with proper licensure and accreditation. The goal of this legislation is to add a place to go as a critical element of the mental health continuum of care for people with complex behavioral health needs before they can return to their community. To ensure state compliance, Nevada Medicaid is proposing revisions to the Medicaid Services Manual (MSM) Chapter 400 – Mental Health Services to create the MSM policy for coverage of RRMHC services.

RRMHC means community-based, medically monitored care being provided in a residential setting that uses established rehabilitative principles to promote the recovery of the client with a mental illness or other behavioral health condition and assist the client in achieving psychiatric stability, personal and emotional adjustment, self-sufficiency, and other skills necessary to transition to a more independent setting.

Proposed language for this new provider type (PT) name will be Community Residential Mental Health Services (CRMHS). They must be community-based, in a group home setting with no more than 16 beds, serving as a short-term rehabilitative step down from the more structured Psychiatric Residential Treatment Facility (PRTF). They can also be used as a step up from community rather than placing within a PRTF initially. Unlike PRTFs, CRMHS facilities can provide services to help the adult population too.

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. Additionally, slight changes were made throughout the Psychiatric Residential Treatment Facility (PRTF) section to align language for consistency with RRMHC language and adjust references of Division of Health Care Financing and Policy (DHCFP) or DNM to Nevada Medicaid.

Entities Financially Affected: These proposed changes affect all Medicaid-enrolled providers delivering psychiatric services. Those PTs include but are not limited to: Hospital, Inpatient (PT 11), Psychiatric Hospital, Inpatient (PT 13), PRTF (PT 63), Crisis Services (PT 87), Behavioral Health Outpatient Treatment (PT 14), Special Clinics (PT 17), and Psychologists (PT 26).

Financial Impact on Local Government for state fiscal years (SFY) 2026 and 2027:

SFY 2026: ($302,726)
SFY 2027: ($817,732)

These changes are effective January 1, 2026.

Material Transmitted	Material Superseded
MTL 35/25 Chapter 400 – Mental Health Services	MTL 14/24, 02/25, 28/25 Chapter 400 – Mental Health Services

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
401	**Authority**	Added NRS 427A.0292 (Living Arrangement Services) and NRS 439.803 (Health facility, defined) due to RRMHC being added under these definitions.
401		Added NRS 427A.125-427A.165 (State Long-Term Care Ombudsman)—RRMHC added to list of facilities for investigation and assistance.
401		Added NRS 439.800-439.890 (Health and Safety of Patients at Certain Health Facilities)—RRMHC's accountable to these regulations.
403.7	**Rehabilitative Residential Mental Health Care**	New policy section for CRMHS. This section is the general overview of CRMHS, including the definition of RRMHC which is being added to regulations per AB 514.
403.7A	**Coverage and Limitations**	New language for Coverage and Limitations. The subsections within this go over the following: Services must be medically necessary and clinically appropriate and recommended by a physician or other licensed practitioner. Covered and non-covered services, reimbursement, non-discrimination, Therapeutic Leave Days, and the Individualized Treatment Plan.
403.7B	**Eligible Provider Requirements**	New language for Eligible Provider Requirements. Outlines requirements for Eligible Providers,

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
		regarding requirements for providers to become eligible to enroll, or remain enrolled, as a CRMHS provider such as the bed limit, licensure, and accreditation.
403.7C	**Eligible Recipients**	New language for Eligible Recipients. This section covers the requirements a recipient needs to meet to be eligible to receive services in a CRMHS Level of Care (LOC), such as Seriously Emotionally Disturbed (SED) or Severely Mentally Ill (SMI) determination and CASII/LOCUS level.
403.7D	**Admission, Continued Stay and Discharge**	New language for Admission, Continued Stay and Discharge requirements. Discusses admission process, including the need for prior authorization for these services, criteria for ongoing care as well as criteria for a transition to a higher or lower LOC, and discharge planning requirements including what is needed when preparing for discharge along with a definition of an elopement for the CRMHS LOC.
403.7E	**Provider Responsibilities**	New language for Provider Responsibilities. Outlines the Provider Responsibilities requirements, with the following topics: being in compliance with this MSM chapter and other applicable MSM chapters, as well as compliance with all pertinent federal and state requirements, general CRMHS provisions, critical events/serious occurrence requirements, emergency preparedness, quality assurance/quality improvement (QA/QI), fingerprint-based criminal back-ground check, tuberculosis (TB) testing, documentation requirements, staff qualifications, and staff training.
403.8	**Psychiatric Residential Treatment Facility Services**	Changed section number from 403.7 to 403.8 due to RRMHC being placed in Section 403.7.
403.8A	**Coverage and Limitations**	Changed section number from 403.7A to 403.8A.
403.8A(7)		Changed citation from 403.7D to 403.8D.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
403.8B	**Eligible Provider Requirements**	Changed section number from 403.7B to 403.8B. Added "Eligible" to section header for consistency with header name for RRMCH for this section.
403.8B(1)(a)		Added language of National Provider Identification (NPI) for consistency with RRMCH language requirements regarding this.
403.8B(1)(f)		New subsection for reference to MSM Chapter 100 added for consistency with language with RRMHC policy.
403.8C	**Eligible Recipients**	Changed section number from 403.7C to 403.8C.
403.8D	**Admission, Continued Stay, Elopements, and Discharge**	Changed section number from 403.7D to 403.8D.
403.8D(3)(b)		Changed citation number from 403.7D(1) to 403.8D(1).
403.8E	**Provider Responsibilities**	Changed section number from 403.7E to 403.8E.
403.8E(3)(a)(1)		Changed language of DNM to Nevada Health Authority (NVHA), DNM for clarity and consistency with language used within RRMHC policy.
403.8E(5)		Changed language of DNM to Nevada Medicaid and added language at end of paragraph for consistency with language used within RRMHC policy.
403.8E(10)		Changed language of DNM to Nevada Medicaid.
403.8E(10)(c)		Added additional sentence of a reference to MSM Chapter 100 for consistency for language used within RRMCH policy.
403.8E(12)		Changed language of DNM to Nevada Medicaid.
Attachment A Policy #4-01	**Day Treatment Ages 3-6**	Fixed floating citation.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
Attachment A Policy #4-02	**Day Treatment Ages 7-18**	Fixed floating citation.
Attachment A Policy #4-03	**Day Treatment Ages 19 and Older**	Fixed floating citation.

NEVADA MEDICAID

MEDICAID SERVICES MANUAL
TABLE OF CONTENTS

MENTAL HEALTH SERVICES

MENTAL HEALTH SERVICES

400 INTRODUCTION

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

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 (IMD))
- 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 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 (PRTF) 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)
- Centers for Medicare and Medicaid Services (CMS) 2261-P, 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 427A.0292 (Living arrangement services) and NRS 439.803 (Health facility, defined)—Rehabilitative Residential Mental Health Care (RRMHC) added under these definitions
- NRS 427A.125-427A.165 (State Long-Term Care Ombudsman)—RRMHC added to list of facilities for investigation and assistance
- NRS 432.B (Protection of Children from Abuse and Neglect)
- NRS 439.800-439.890 (Health and Safety of Patients at Certain Health Facilities)
- 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 (OMH) and/or mental health rehabilitative services under the following service delivery models:

A. Behavioral Health Community Networks (BHCN)

Public or private entities that provide or contract with an entity that provides:

1. 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 Nevada Medicaid's (DNM) 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 ITP;

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 (CI) 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. ITP

a. A written ITP, 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 (NCU) 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 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 Chapter 400, Section 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 CIs; 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 DNM 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 DNM 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 DNM within five days of the discovery of the incorrect information; DNM 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 Chapter 400 Section 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 DNM for review.

   a. Refer to MSM Chapter 100, 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 DNM 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 DNM within five days of the discovery of the incorrect information; DNM 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 Section 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 (CSW) 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 DNM for review.

    a. Refer to MSM Chapter 100 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 DNM 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 DNM within five days of the discovery of the incorrect information; DNM 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 OUTPATIENT MENTAL HEALTH SERVICES

These services include assessment and diagnosis, testing, basic medical and therapeutic services, CI, 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/ Screenings: Assessments are covered for problem identification (diagnosis) and to establish measurable treatment goals and objectives. Screenings determine eligibility for admission to a treatment program.

1. Eligible Providers

   a. Assessments are provided by Licensed Professionals, Certified Professionals, or QMHPs functioning within their professional scope of practice. Screenings are provided by Licensed Professionals, Certified Professionals, QMHPs, or designated QMHAs functioning within their professional scope of practice.

2. Covered Services

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

   b. Comprehensive Assessment – A comprehensive evaluation of a recipient's history and functioning. When combined with clinical judgment, it is to include a covered and current ICD diagnosis, a summary of identified rehabilitative treatment needs and is completed when there is a substantial change in the recipient's needs.

   c. 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.

   d. Psychiatric Diagnostic Interview - 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.

   e. Psychological Assessment - 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.

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

A person-centered conference is covered as part of the functional assessment to collaboratively develop and communicate the goals and objectives of the ITP. The conference must include the recipient, a Licensed Professional, Certified Professional, or QMHP functioning within their scope related to substance use only, 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.

g. 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 a Licensed Professional, QMHP, and/or trained QMHA. This assessment was previously known as a LOC assessment. Currently, DNM recognizes LOCUS for adults and CASII for children and adolescents. There is no LOC assessment tool recognized by DNM 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.

h. SED Assessment - The SED assessment is a tool utilized to determine a recipient's eligibility for higher levels of care and Medicaid service categories for children.

i. SMI Assessment - The SMI assessment is a tool utilized to determine a recipient's eligibility for higher levels of care and Medicaid service categories for adults.

3. Authorization Requirement

Prior authorizations must be approved by Medicaid's Quality Improvement Organization (QIO)-like vendor and may not exceed 90-day intervals. Prior

authorizations must be based on the recipient's needs as documented in the treatment plan. Service provision is based on the calendar year beginning on January 1.

4. Billing

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

Code	Brief Description	Unit	Service Limitations
90791	Psychiatric diagnostic evaluation	Per evaluation	Covered up to four times per calendar year for children and two times per calendar year for adults
96127	Assessment of emotional or behavioral problems	Per evaluation	Two units per day
96156	Assessment of health behavior	Per evaluation	Covered four times per calendar year
H0002	Behavioral health screening to determine eligibility for admission to treatment program	Per evaluation	Covered one time per 90 days
H0031	Mental health assessment, by non-physician	Per evaluation	Covered up to four times per calendar year for children and two times per calendar year for adults

Prior authorization required to exceed any service limitations.

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.

Mental health therapy can be used for up to 18 units for adults and 26 units for children annually before prior authorization is required. Prior authorizations must be approved by Medicaid's QIO-like vendor and may not exceed 90-day intervals. Prior authorizations must be based on the recipient's needs as documented in the treatment plan. Service provision is based on the calendar year beginning on January 1.

1. Family Therapy

Mental health treatment service provided to a specific recipient by a Licensed Professional or 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 Licensed Professional or 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 Professional or QMHP within the scope of their practice and expertise. A certified Biofeedback Technician may assist in the provision of biofeedback treatment; however, a Licensed Professional or QMHP must provide the associated psychotherapy. Reimbursement for biofeedback treatment provided by a Biofeedback Technician is imbedded in the Licensed Professional or QMHP rate.

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 DNM 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 (PSR)
8. Peer Support Services
9. Crisis Services

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

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

prior authorization and must be reauthorized every three weeks.

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

d. Provider Qualifications: Direct services are interactive services led by licensed staff. Components of this service can be performed by qualified, enrolled health care workers, practicing within their scope under the Direct Supervision of a Licensed Professional. QMHPs and Certified Professionals 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 providers 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. PSR

8. Peer Support Services

9. Crisis Services

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

b. Service Limitations: IOP services delivered in a mental/behavioral health

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

c. IOP Curriculum and Utilization Management: A curriculum and a schedule for the program delivered through a BHCN must be submitted with each prior authorization request; 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 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 Licensed Professional. QMHPs and Certified Professionals 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. Coordinated Specialty Care – A recovery-focused, team-based early intervention model that promotes access to care and shared decision-making among specialists, the recipient, and family member(s). The comprehensive, multidisciplinary program of services is expected to improve or maintain condition and functioning level of individuals experiencing First Episode Psychosis (FEP).

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

Coordinated Specialty Care programs must ensure high-fidelity implementation of an evidence-based, nationally recognized model approved by the Division of Public and Behavioral Health (DPBH). The program must hold certification from DPBH upon approval of their certification program. The general functions of Coordinated

Specialty Care include but are not limited to: access to clinical providers with specialized training in FEP care; easy entry to the FEP specialty program through active outreach and engagement; provision of services in home, community, and clinic settings, as needed; acute care during or following a psychiatric crisis; transition to step-down services with the Coordinated Specialty Care team or discharge to regular care after 2-3 years, depending on the client's level of symptomatic and functional recovery; assurance of program quality through continuous monitoring of treatment fidelity.

a. Eligible Providers

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

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

b. Licensed Professionals: Licensed Professionals operating within their scope of practice can include but are not limited to: Board-Certified Psychiatrists, Licensed Physicians, Licensed PAs (Psychiatry), APRNs (Psychiatry), Licensed Psychologists, LCSWs, LMFTs, and LCPCs.

c. Qualified Mental Health Professionals (QMHP): QMHPs operating within their scope of practice can include CSW Interns, MFT Interns, and CPC Interns.

d. PSS: PSS have lived experience with mental illness and/or SUDs and hold peer certification. They assist individuals in achieving recovery, building self-advocacy skills, managing

symptoms, and accessing community resources. Peer support services are person centered and designed to empower individuals toward independent and productive lives.

e. Case Manager: Case management professionals assist clients with problem solving, offering solutions to address practical problems, and coordinating social services across multiple areas of need. Case management involves frequent in-person contact between the clinician and the patient/client and their family, with sessions occurring in clinics, communities, and home settings, as required.

f. SEES: The SEES strives to integrate vocational and mental health services, serves as the Coordinated Specialty Care team liaison with outside educators and employers, and frequently works with the client in the community to enhance school or job performance.

b. Eligible Members

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

c. Covered Services

1. Behavioral Health Assessment

2. Individual Therapy

3. Group Therapy

4. Family Education and Support

5. Supported Employment and Education (SEE)

6. Case Management

7. PSS

8. Crisis Services

9. Primary Care Coordination

10. Medication Management

11. Psychiatry

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

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

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

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

d. Non-Covered Services

1. Non-Evidence-Based Models

2. Documentation

3. Room and Board Expenditures

4. Transportation

5. Caregiver Services

6. Supervision

e. Authorization Requirements

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

f. Billing

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

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

g. Managed Care Members

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

4. Medication Training and Support – This service must be provided by a professional other than a physician and is covered for monitoring of compliance, side effects, recipient education and coordination of requests to a physician for changes in medication(s). To be reimbursed for this service, the provider must be enrolled as: a QMHP, an LCSW, an LMFT, or a CPC. An RN enrolled as a QMHA may also provide this service if billed with the appropriate modifier. Medication Training and Support is a 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).

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 OUTPATIENT MENTAL HEALTH SERVICES - UTILIZATION MANAGEMENT

A. Intensity of Needs Determination

The assessed level of needs and the amount, scope and duration of OMH 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 Licensed Professional, Certified Professional, 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 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. 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

A. 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 - Applied Behavior Analysis.

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:

1. the recipient's name;

2. 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;

3. 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;

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

5. 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

6. 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.

B. Inclusive Services: RMH services include BST, Program for Assertive Community Treatment (PACT), Day Treatment, PSS, PSR, and CI.

C. Provider Qualifications:

1. QMHP: QMHPs may provide BST, PACT, Day Treatment, PSS, PSR and CI services.

2. QMHA: QMHAs may provide BST, PACT, Day Treatment, PSS, PSR services under the clinical supervision of a QMHP.

3. QBA: QBAs may provide BST services under the clinical supervision of QMHP and the Direct Supervision of a QMHP/QMHA. QBAs may provide PSS under the clinical/direct supervision of a QMHP.

D. 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.

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

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

2. 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;

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

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

5. habilitative services;

6. 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;

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

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

9. 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);

10. 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;

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

    a. 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);

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

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

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

    e. Administrative costs associated with room and board;

12. 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;

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

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

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

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

17. support group services other than Peer Support services;

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

19. respite care;

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

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

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

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

1. Intensity of Need Levels I and II: Recipients may receive BST and/or PSS provided:

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

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

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

2. Intensity of Need Level III: Recipients may receive any combination of BST, PSR, Day Treatment, and/or PSS provided:

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

   b. SED or SMI determination; and

   c. clinical judgment; and

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

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

3. Intensity of Need Level IV: Recipients may receive any combination of BST, PSR,

Day Treatment, and/or PSS provided:

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

b. SED or SMI determination; and

c. clinical judgment; and

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

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

4. Intensity of Need Levels V and VI: Recipients may receive any combination of BST, PSR, Day Treatment, and/or PSS provided:

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

b. SED or SMI determination; and

c. clinical judgment; and

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

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

5. 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:

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

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

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

G. 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).

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

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

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

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

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

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

7. 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.

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

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

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

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

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

5. The recipient and/or their family/legal guardian (in the case of legal minors) do not

desire to continue the service;

6. 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

7. 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 BASIC SKILLS TRAINING 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 OMH 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 ASSERTIVE COMMUNITY TREATMENT (ACT)

ACT is a team-based, community-focused approach for individuals with serious and persistent mental illness. It provides comprehensive psychiatric treatment, rehabilitation, and support, aiming

to improve functioning and help people stay in their communities and out of inpatient treatment. ACT services are provided "assertively" meaning the team members go the extra mile to support and empower the individual to achieve their goals. ACT is a service-delivery model, not a case management program.

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

1. Eligible Providers

    a. ACT Teams:

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

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

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

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

        4. Each team must begin with at least six FTEs, irrespective of participant size, and aim for a minimum staff-to-participant ratio of 1:10 in urban areas and 1:12 in rural areas.

        5. Regardless of the size of the ACT team, it must include each of the following key personnel:

            a. Team Leader – One per ACT team.

                1. Full-time team leader/supervisor who serves as the clinical and administrative supervisor of the team, who also functions as a practicing clinician.

                2. The Team Leader must be a Licensed Professional and hold a valid Nevada clinical license in one of the following fields:

nursing, social work, marriage and family therapy, certified professional counseling, psychiatry, clinical psychology, or be a psychiatric prescriber.

3. If the Team Leader is not co-occurring disorder (COD) qualified, then at least one of the remaining team members must be a master's level SUD Treatment Specialist.

b. Psychiatric Prescriber – Average one per 100 participants.

1. A Psychiatric Prescriber on an ACT team is a healthcare professional responsible for managing the psychiatric medication needs of participants.

2. May be a psychiatrist or a psychiatric nurse practitioner.

3. May work part-time at 16 hours per week minimum per 50 participants.

c. RN – Average two per 100 participants.

1. An RN on an ACT team plays a crucial role in providing comprehensive healthcare services to clients with severe mental illnesses. They provide a range of treatment, rehabilitation, and support services, with the primary responsibility being psychiatric, not medical.

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

d. SEES - Average two per 100 participants.

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

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

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

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

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

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

a. SUD Treatment Specialist

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

2. They create ITPs that address both substance use and mental health needs, provide individual and group counseling sessions, and offer immediate support during substance use crises.

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

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

b. Case Manager

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

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

c. Certified PSS

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

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

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

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

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

b. Operational Requirements:

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

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

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

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

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

2. Team meetings:

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

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

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

3. ITPs are collaboratively developed by the entire ACT team, the participant, and any family or natural supports.

4. Service Delivery:

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

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

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

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

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

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

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

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

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

2. Eligible Members

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

1. Major depression

2. Schizophrenia

3. Bipolar disorder

4. Obsessive compulsive disorder (OCD)

5. Panic disorder

6. Post-traumatic stress disorder (PTSD)

7. Borderline personality disorder (BPD)

8. Co-occurring substance use/mental health disorders

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

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

3. Covered Services

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

1. Crisis Assessment and Intervention
2. Comprehensive Evaluation for mental health and co-occurring care
3. Psychiatric Care: psychotherapy, PSR
4. Individual supportive therapy
5. Medication Administration and Management
6. Substance Use Treatment
7. Illness Management and Recovery Skills
8. Case Management
9. Supportive Employment and Education
10. Referrals and Linkages
11. PSS

12. Family and Natural Supports Intervention, including psychoeducation

13. Assistance with Daily Living Activities (household, transportation, personal hygiene, money management, medical and dental care, community resources, and accessing other applicable benefits)

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

4. Noncovered Services

a. Non-evidence-based models

b. Caregiver Services

c. Documentation

d. Room and Board

5. Authorization Requirements

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

6. Billing

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

Code Modifier	Brief Description	Unit/ Service Limitation	Prior Authorization Requirement
H0040	ACT Daily Rate	One unit per day Must include POS code to indicate where the service was delivered	No

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

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

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

1. Medicare

2. Labor unions

3. Worker's Compensation Insurance Carriers

4. Private/group insurance

5. Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)

6. Exceptions to this rule occur in cases where Medicaid is considered primary, such as services funded by the Bureau of Family Health Services, Indian Health Services (IHS), Ryan White Act programs, and Victims of Crime.

7. Managed Care Members

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

403.6E RESERVED

403.6F PSYCHOSOCIAL REHABILITATION

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

PSR services may include any combination of the following interventions:

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

They learn the dynamic relationship between actions and consequences;

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

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

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

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

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

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

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

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

2. Provider Qualifications:

a. QMHP: QMHPs may provide PSR services.

b. QMHA: QMHAs may provide PSR services under the clinical supervision of a QMHP.

c. QBA: QBAs may not provide PSR services.

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

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

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

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

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

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

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

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

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

   g. Self-sufficiency: Recipients are experiencing severe deficits with self-confidence, self-esteem, and self-reliance; recipients express feelings of hopelessness and helplessness; dealing with anxiety: Recipients are experiencing severe deficits

managing and accepting anxiety, they are fearful of taking culturally normal and healthy rehabilitative risks;

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

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

403.7 REHABILITATIVE RESIDENTIAL MENTAL HEALTH CARE (RRMHC)

A. Medicaid reimburses for services provided in a RRMHC, otherwise known as Community Residential Mental Health Services (CRMHS) facility when rendered to eligible recipients in accordance with this section.

B. RRMHC means community-based, medically monitored care provided in a residential setting that uses established rehabilitative principles to:

1. Promote the recovery of the recipient with a mental illness or other behavioral health condition and;

2. Assist the recipient in achieving psychiatric stability, personal and emotional adjustment, self-sufficiency, and other skills necessary to transition to a more independent setting.

C. Medical, psychiatric, and psychological services are provided under the clinical supervision of a mental health professional within their scope of practice. The goal of CRMHS is to maintain the recipient's connections to their community yet receive and participate in a more intensive level of treatment in which the recipient lives safely in a 24-hour setting. Community reintegration may be progressive and with individual consideration of the recipient's safety, prior involvement in and potential for aberrant and criminal activity, mental health status, and elopement consideration. Treatment must be designed to:

1. Help the recipient manage their mental health symptoms;

2. Prevent placement in settings that are more intensive, costly, or restrictive than necessary and be appropriate to meet the recipient's needs;

3. Help the recipient improve family living and social interaction skills;

4. Help the recipient gain the necessary skills to return to the community;

5. Stabilize crisis admissions; and

6. Work with families and other support persons throughout the placement to improve their ability to care for the recipient in the home.

D. All Medicaid policies and requirements for CRMHS (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. Nevada Medicaid covers medically necessary and clinically appropriate services as defined in MSM Chapter 100 for Medicaid recipients who have been diagnosed with an SED or SMI. The CRMHS policy is under the rehabilitative authority of the State Plan for behavioral health services.

2. Services must be recommended by a physician or other licensed practitioner of the healing arts, within their scope of practice, and be prescribed on an ITP, to restore the recipient to their optimal level of functioning.

3. Covered Services

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

a. Active treatment with psychiatric and psychological services, including individual, family, and group psychotherapy designed to achieve outcomes and meet the specific requirements of the recipient's ITP;

b. Crisis assistance services designed to help the recipient and family members recognize factors that precipitate a psychiatric crisis, anticipate behaviors and symptoms, and know the resources to use when crisis is imminent or occurs;

c. Medication management and education designed to have the recipient and family understand:

1. The roll of psychotropic medication in the recipient's treatment and the effect the medication may have on their physical and mental health; and

2. The physical, emotional, or behavioral changes resulting from the recipient's use, misuse, or refusal to use psychotropic medications prescribed.

d. Psychoeducation services to address:

1. Independent living skills designed to strengthen a recipient's ability to function in a less restrictive environment than a CRMHS facility. The

services must support the recipient in carrying out the tasks of daily living, encourage the development of self-esteem, and promote self-sufficiency;

2. Recreation and leisure skills activities, including milieu therapies designed to assist the recipient in developing recreational skills and teaching the recipient and family in learning how to plan and participate in recreation and leisure activities;

3. Interpersonal skills designed to assist the recipient in developing and maintaining friendships and teaching appropriate communication and interactions with peers and others;

4. Vocational skills designed to prepare the recipient for the world of work by exploring the importance of such areas as use of time, acting responsibly, and working within the goal of an organization;

5. Assistance in parenting/guardian skills designed to achieve the outcome of parents/guardians using therapeutic techniques that address management of specific behaviors or learning issues directly related to or resulting from the recipient's emotional disturbance or mental illness.

e. Family and natural support engagement services designed to achieve the following outcomes:

1. Family members and natural supports gaining insight into family dynamics and resolving conflicts;

2. Family members and natural supports have broader family support, family goals, and improved family coping skills; and

3. Reintegration of the recipient into their family and community.

f. Any CRMHS provider receiving authorization from the QIO-like vendor to admit and provide services for a recipient is responsible for that recipient’s service and treatment needs. If a CRMHS provider does not have the staff services which requires the transfer of a recipient temporarily to another psychiatric or psychological provider (generally for only a portion of that day) for testing/evaluation/treatment, etc., it is the transferring CRMHS provider’s responsibility, not Medicaid's, to fund the particular services and, if necessary, transportation.

4. Non-covered services

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

a. Room and board;

b. General physician/nursing (non-psychiatric) services;

c. Neuropsychological services;

d. Applied Behavioral Analysis (ABA) services;

e. Medications;

f. Dental;

g. Optometry;

h. Durable Medical Equipment (DME);

i. Radiology;

j. Lab services;

k. Physical, speech, and occupational therapies; and

l. Formal educational services that may be provided to a recipient in a CRMHS facility.

Services not covered by the all-inclusive daily rate, may be billed separately by a qualified service provider and may require prior authorization.

5. Reimbursement

Reference the Nevada Medicaid State Plan, Attachment 4.19-B, describing the methods and standards of reimbursement for CRMHS for Fee-for-Service (FFS) recipients.

a. To be reimbursed for the daily bundled rate, daily activity must be provided that aligns with the recipient's treatment plan goals.

b. If the recipient is enrolled in an MCO, the MCO must determine the LOC and is responsible for reimbursement of the RRMHC/CRMHS stay. Managed care entities will be responsible for the utilization management of these recipients, including approving authorization and placement into a CRMHS facility as well as continued stays. It is the CRMHS provider'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 CRMHS provider, the provider 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.

6. Non-Discrimination

The CRMHS provider 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.

7. Therapeutic Leave Days (TLD)

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

The QIO-like vendor must be notified by the CRMHS provider 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 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 pass occurs. The recipient must also be in the final phase of treatment in the 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 pass 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 facility from a TLD pass, and such an absence has been properly documented by the facility, they 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 pass, the recipient will be considered discharged, and the QIO-like vendor must be notified of the discharge and date the recipient left the facility.

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

8. ITP

An ITP must be developed within 14 days of admission and be reviewed and updated every 30 days, or at earlier intervals if necessary.

An ITP is a written plan that documents the treatment strategy, the schedule for accomplishing the goals and objectives, and the responsible party for each treatment component. This must be based on a comprehensive assessment that includes examination of the medical, psychological, social, behavioral, and developmental aspects of the recipient's situation and reflects the need for residential care.

The ITP outlines the POC, guiding treatment interventions and strategies. It involves the recipient, family, caregivers, and authorized individuals, considering cultural and linguistic

needs. The plan emphasizes the recipient's recovery goals, priorities, and approaches to achieving them. It must be clear and understandable to the recipient and their family, clearly addressing their concerns. Development of the ITP involves the recipient and support persons to ensure the treatment aligns with their priorities and strengths.

a. Each recipient's treatment plan should identify specific skills needed and how each is addressed (e.g. individually, group). The following components must be present in the plan:

1. Concrete; measurable goals with specific objectives and timelines for achievement;

2. Treatment strategies for achieving objectives;

3. Planned duration of the overall services along with discharge criteria, with discharge and transfer planning beginning the day of admission;

4. Recommended aftercare services for goals that were both achieved and not achieved during duration of the ITP;

5. 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;

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

7. Reasons for not involving recipient or recipient's family or other natural supports, if applicable;

8. If a recipient has a history of not engaging in treatment, a treatment strategy to engage the recipient;

9. A written review describing progress (or lack thereof) in reaching goals and objectives. If no progress has been made, changes in the approach to treatment must be documented;

10. Documentation of participants/team members who were responsible in the development and updates;

11. Approval by the recipient or legal guardian. If a recipient or their guardian does not agree with the plan, document efforts to engage the person in their

treatment plan and why they were not willing to approve it;

12. Documentation indicating that a copy of the ITP was provided to the recipient and/or guardian.

403.7B ELIGIBLE PROVIDER REQUIREMENTS

1. A CRMHS provider must deliver treatment under the clinical supervision of a mental health professional and comply with the following requirements to be eligible to participate in the Nevada Medicaid program and must remain in compliance with licensing and accreditation requirements throughout their Medicaid enrollment:

   a. A CRMHS provider that has more than one physical address shall have a separate Medicaid provider number and National Provider Identification (NPI) for each facility;

   b. Be up to 16 beds and not considered an IMD;

   c. Be licensed as a RRMHC issued by the Health Care Quality and Compliance (HCQC) division of the Nevada Health Authority (NVHA) or RRMHC equivalent by the state in which it is located (limited to catchment zones);

   d. 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.

   e. 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 offence determined by Nevada Medicaid to be inconsistent with the best interest of all recipients.

403.7C ELIGIBLE RECIPIENTS

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

   a. Meet the criteria for SED for recipients under age 18 or SMI for recipients aged 18 or older.

b. Have received a CASII level of V for recipients under age 18 or a LOCUS level of V for recipients aged 18 or older.

c. Does not require 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.

403.7D ADMISSION, CONTINUED STAY AND DISCHARGE

1. Admission Process

a. Prior authorization is required before admission for CRMHS to establish medical necessity, 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 from the facility that last longer than 24 hours;

2. Acute/observation emergency room (ER) setting for longer than 24 hours; and

3. Any re-admission of a recipient back to the CRMHS facility following an inpatient hospital stay with the plan to have the CRMHS facility of record re-admit the recipient back upon stabilization. The prior authorization request must include a Discharge Summary of the acute inpatient services.

b. Provider needs to complete and submit a prior authorization request for authorization to the QIO-like vendor in 30 days or less increments.

c. The QIO-like vendor must verify for medical necessity of CRMHS:

1. The level of Intensity of Needs for CRMHS;

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

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 CRMHS treatment and placement will be made individually on a case-by-case basis. The CRMHS provider will develop its admission criteria and ensure that it has the staff and resources available to meet the needs of referred recipients who fit its admission criteria.

2. Continued Services and Transition of Care Standards

a. Continued Services is when the recipient shows progress toward treatment plan goals or treatment plan adjustments make it possible for the recipient to remain at the current LOC. For Medicaid recipients to remain in the CRMHS facility longer than 30 days, the provider 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. Continue in the current LOC when 1 or 2 and 3 and 4 are true:

1. ITP criteria have not been sufficiently addressed to recommend a lower LOC or

2. New signs/symptoms have emerged that can be addressed at the current LOC and

3. The treatment interventions at the current LOC are needed for success and

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

b. Transition of Care is when the recipient requires a change in LOC. Criteria for transition to a more intense LOC when 1, 2, or 3 are true:

1. Signs/symptoms have not improved or have worsened or

2. New signs/symptoms have emerged that meet the criteria for a higher LOC or

3. The treatment interventions are not working any longer at the current LOC.

c. Criteria for transition to a less intensive LOC apply when all of 1, 2 and 3 are true:

1. The signs/symptoms that supported admission to the current LOC have stabilized sufficiently;

2. No new signs/symptoms have emerged; and

3. Treatment interventions at a less intense LOC are effective.

d. 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.

e. 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 CRMHS provider, together with the recipient and/or 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 CRMHS stay.

3. Discharge

a. Discharge planning begins on admission and must be updated every 30 days. Permanency and stability within the community is a priority for discharge planning. The CRMHS provider must:

1. Plan for and assist recipients and their families in making the transition to less restrictive home and community-based services.

2. Arrange appropriate follow-up care in the community.

3. Provide notification to the recipient's case manager to monitor and coordinate the transition for follow-up care in the community, if applicable, before the recipient is discharged.

4. Provide, at a minimum, a 10-day written notification of the recipient's discharge to the parent/guardian, if applicable, the local education agency in which a recipient is enrolled or receiving education agency to which the recipient will be transferred to upon discharge. When a recipient has an individualized education program (IEP), the notice shall include a copy of this.

b. The QIO-like vendor will issue a denial or partial denial for CRMHS 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. CRMHS are not shown to be medically necessary and;

2. The recipient does not meet Level V of Intensity of Needs on the

CASII/LOCUS, and services for the recipient may be reasonably provided in a less restrictive setting;

3. The recipient and/or guardian 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 CRMHS 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 a CRMHS facility (the recipient is not entitled to a hearing in this case; see MSM Chapter 3100 - Hearings).

c. The CRMHS provider must ensure the following is provided to the recipient and/or 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, CASII/LOCUS level at the time of discharge, summary statement of progress, or lack of progress, made during treatment, and a list of any upcoming scheduled appointments, to ensure coordination and continuity of care for the recipient upon discharge.

d. The CRMHS provider 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 ITP including the reason for discharge, current Intensity of Needs level and recommendations for further treatment including contact information for community providers that the CRMHS provider has contacted for the recipient to ensure continuity of care post-discharge.

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

f. 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 consent from the recipient or the recipient's legal representative.

g. In the case of an elopement, where a recipient is gone from the facility for more than 24 hours, it would be considered a discharge. A new initial prior authorization request 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 facility.

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

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. In addition, providers must comply with all pertinent Federal and State requirements and must protect and promote patients' rights in accordance with applicable regulations.

2. General CRMHS Provisions

a. Treatment services promote prosocial skills, skills of daily living, personal responsibility, and reintegration of the recipient into network systems of work, education, and family life. It is appropriate for recipients who require time and structure to further develop, practice, and integrate their recovery and coping skills

in a clinically managed and supportive residential environment.

b. Services are focused on improving the recipient's functioning and coping skills to enable them to safely engage in treatment at a less intensive LOC and address readiness to change and other challenges that impact the recipient's ability to successfully engage in outpatient home and community-based services.

c. Family involvement services must be provided to help families/guardians maintain and enhance functioning, care and relationships with the recipient.

d. In addition to services provided by and in the facility, when they can be reasonably anticipated in the active ITP, the CRMHS provider must ensure that the recipient receives all treatment identified on the ITP and any other medically necessary care required for all medical, dental, psychological, social, behavioral, and developmental aspects of the recipient's situation. The CRMHS facility 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. The CRMHS provider 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 (NVHA, DNM for NV Medicaid recipients);

2. State Licensing Agency (HCQC for in-state providers; if the facility is out-of-state, reports must be made to their own licensing entity or appropriate departments); and

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

b. Information which must be reported includes, but is not limited to, deaths, injuries, assaults, suicide attempts, police or sheriff investigations, and physical, sexual, or emotional abuse allegations.

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.

c. Upon notification Nevada Medicaid may make an adverse decision against the facility. 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 facility if they are reasonably believed to be in danger.

d. If a ban is imposed, the facility must provide the Division with information regarding the facility's 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 facility should be disenrolled as a Medicaid provider and no longer eligible for reimbursement for services.

4. Emergency Preparedness

The CRMHS provider must comply with all applicable Federal, State, and local emergency preparedness requirements and 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 (QA\QI)

The CRMHS provider must have an ongoing 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 ensure that services meet the facility's expectations as to outcome. The CRMHS provider will cooperate with authorized external review systems (including the state's licensing agency, as applicable, and Nevada Medicaid) and have the QA plan be available upon request for review to Nevada Medicaid, including the state's licensing agency.

6. Fingerprint-Based Criminal Background Check

   a. To protect recipients' safety a thorough Fingerprint-Based Criminal Background Check (FCBC) and review is required and must be vetted before beginning their duties for all staff including any volunteers or accepting an employee of a temporary employment service or entering into a contract with an independent contractor.

   b. The CRMHS provider must maintain both the requests and the results of the FCBC within the personnel records. Upon request, the CRMHS provider must make the criminal background request and results available to Nevada Medicaid for review.

   c. The CRMHS provider, upon receiving information resulting from the FCBC or from any other source, may not continue to employ or utilize any persons convicted of an offense. Reference MSM Chapter 100 for further details regarding Provider Conditions of Participation.

7. Tuberculosis Testing

   The CRMHS provider shall ensure all personnel have had Tuberculosis (TB) screening or testing with negative results documented or medical clearance documented, prior to the initiation of service delivery and thereafter as outlined in NAC 441A.375 and the Centers for Disease Control and Prevention (CDC). For further information, contact the CDC or the Nevada TB Control Office at DHHS. Documentation of TB screening, testing, and results shall be maintained in the provider's personnel record.

8. Documentation

   a. The CRMHS provider 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 Nevada Medicaid 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 service, etc.;

2. Evaluations/assessments;

3. Treatment plans;

4. Doctor's orders;

5. Medications, including 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) and service location;

d. Person(s) participating in the session;

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

f. Goals and objectives targeted in the session;

g. Interventions delivered and methods used;

h. Clinical observations about the recipient/family response or reaction to treatment interventions (demeanor, mood, affect, mental alertness, thought processes, risks, etc.), including any response to significant others who may be present in the session. Significant observations, if applicable, include the following:

1. Current risk factors the recipient may be experiencing;

2. Emergency interventions;

3. Consultations with or referrals to other professionals, family, or significant others;

4. Changes in symptoms (physical or mental).

i. 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;

j. Plan for the next or future sessions including treatment changes to be implemented when interventions are ineffective;

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

8. Critical Events/SORs;

9. Discharge Summary;

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 CRMHS provider's state law, after the discharge of the recipient. Reference MSM Chapter 100 for more information on Medical Record Documentation requirements.

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

9. Staff Qualifications

a. Treatment is delivered by a multidisciplinary team under the oversight of a licensed mental health professional. The CRMHS provider must have sufficient 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. A clinical supervisor, as defined by Nevada Medicaid, is the individual with clinical oversight of the agency who must be a licensed/certified professional operating within the scope of their practice under state law. The clinical supervisor must have the specific education, experience, training, credentials, and licensure or certificate to coordinate and oversee clinical treatment for CRMHS. The clinical supervisor will have administrative and clinical oversight of the program and must ensure services provided are medically necessary, clinically appropriate, and follow an

evidence-based model recognized by the Health Division.

1. The clinical supervisor must be either an LCSW, LMFT, LCPC, Physician, Nurse Practitioner of psychiatry, or Psychologist.

c. All clinical supervision expectations shall align with existing requirements in MSM Chapter 400 Supervision Standards.

10. Staff Training

a. The CRMHS provider 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.

b. 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 Nevada Medicaid 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.

403.8 PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY 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.

403.8A 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 (DME);

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 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 TLDs 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 Section 403.8D.

403.8B ELIGIBLE 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 and NPI 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 HCQC Bureau at the Nevada 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.

f. Refer to MSM Chapter 100, 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 offence determined by Nevada Medicaid to be inconsistent with the best interest of all recipients.

403.8C 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.

403.8D 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 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 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 403.8D(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.

403.8E 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., NVHA, DNM 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. QA/QI

The PRTF must have an ongoing 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 ensure 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 Nevada Medicaid). The PRTF's QA plan must be available upon request for review to Nevada Medicaid, including the state's licensing agency.

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 Nevada Medicaid 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/SORs;

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. Reference MSM Chapter 100 for more information of Medical Record Documentation requirements.

d. All information contained in the clinical records shall be treated as confidential and shall be disclosed only to authorized persons, including Nevada Medicaid 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 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 Professional or QMHP. All rehabilitative mental health services may also be provided by a Licensed Professional, 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 Nevada Medicaid 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.

403.9 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

403.9A 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 (IMDs) 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. 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.

403.9B 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 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.

403.9C 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 for 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 DNM’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.

403.10 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.

403.10A 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. 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.

403.10B 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 1urnish 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.

403.10C 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.

403.10D AUTHORIZATION PROCESS

If appropriate, the QIO-like vendor certifies administrative days at either an SNL or ICL LOC.

403.11 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.

403.11A 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 (ECT) (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.
4. Day treatment services are:
    a. Facility based out of home services;
    b. A fluid combination of OMH and RMH services; and
    c. 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-evidence 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 DNM. 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.
4. Day treatment services are:
    a. Facility based out of home services;
    b. A fluid combination of OMH and RMH services; and
    c. 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-evidence 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 DNM.

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.

POLICY #4-03	DAY TREATMENT AGES 19 AND OLDER	

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.
4. Day treatment services are:
    a. Facility based, out of home services.
    b. A fluid combination of all the RMH services.
    c. 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-evidence 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 IMDs 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 IMDs.

    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 DNM. DNM 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.