Medicaid Services Manual
Transmittal Letter

July 30, 2024

To: Custodians of Medicaid Services Manual

From: Casey Angres
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Casey Angres (Sep 23, 2024 09:25 PDT)
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Subject: Medicaid Services Manual Changes
Chapter 4100-Substance Use Disorder Treatment Services and Coverage

Background And Explanation

The Division of Health Care Financing and Policy (DHCFP) is proposing a new Medicaid Services Manual (MSM) Chapter 4100- Substance Use Disorder Treatment Services and Coverage to pull substance use disorder (SUD) treatment and services coverage out of the MSM 400- Mental Health and Alcohol/Substance Use Services to create clarity and separation between the two different types of service. Include Medication Assisted Treatment (MAT), Partial Hospitalization Program (PHP), Intensive Outpatient Program (IOP), and creating a new chapter MSM Chapter 4100.

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

Entities Financially Affected The proposed changes affect all Medicaid-enrolled providers delivering SUD treatment. Those Provider Types (PT) include, but are not limited to: Physician, M.D., Osteopath, D.O., (PT 20), Advance Practice Registered Nurse, (PT 24), Nurse Midwife (PT 74), Psychologist (PT 26), (Physician's Assistant, (PT 77), Pharmacist (PT 91), Licensed Clinical Social Worker (PT 14, Specialty 305), Licensed Marriage and Family Therapist (PT 14, Specialty 306), Licensed Clinical Professional Counselor (PT 14, Specialty 307), Methadone Clinic, (PT 17, Specialty 171), Substance Use Agency Model (PT 17, Specialty 215), newly created PTs Certified Alcohol and Drug Counselor (PT 93, Specialty 701), Certified Alcohol and Drug Counselor Intern (PT 93, Specialty 703), Licensed Alcohol and Drug Counselor (PT 93, Specialty 702), Licensed Clinical Alcohol and Drug Counselor (PT 93, Specialty 709), Licensed Clinical Alcohol and Drug Counselor Intern (PT 93, Specialty 705), and Peer Recovery Support Specialist (PT 93, Specialty 706).

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

These changes are effective July 31, 2024.

Material Transmitted		Material Superseded
MTL 16/24		MTL NEW
MSM 4100-Substance Use Disorder Treatment Services and Coverage		MSM 4100-Substance Use Disorder Treatment Services and Coverage

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
4100	Introduction	Added “Introduction” section.
4101	Authority	Added “Authority” section.
4102	Definitions	Added “Definitions” section.
4103	Coverage and Limitations	Added “Coverage and Limitations” section.
4104	Office Based Opioid Treatment (OBOT)t	Added “OBOT” section.
4105	Opioid Treatment Program (OTP)	Added “OTP” section.
4106	Utilization of American Society of Addiction Medicine (ASAM)	Addes “Utilization of ASAM” section.
4107	Inpatient SUD Withdrawal Management and Treatment Services	Added “Inpatient SUD Withdrawal management and treatment services” section.
4108	Institutions of Mental Disease (IMD)	Added “IMD” section.
4109	Administrative Days Policy	Added “Administrative Days Policy” section.
4110	Outpatient Mental Health Only Treatment and Services in a SUD Treatment Clinic	Added “Outpatient Behavioral Health Treatment and Services in a SUD Treatment Clinic” section.
4111	Non-Covered Services	Added “Non-Covered Services” section.
4112	Providers	Added “Providers” Section.
4113	Providers Responsibilities	Added “Providers Responsibilities” section.
4114	Providers Requirements	Added “Provider Requirements” section.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
4115	Documentation Requirements	Added “Documentation Requirements” section.
4116	Supervision Requirements	Added “Supervision Requirements” section.
4117	Provider Qualifications	Added “Provider Qualifications” section.
4118	Recipient Responsibilities	Added “Recipient Responsibilities” section.
4119	Quality Improvement	Added “Quality Improvement” section.
4120	Hearings	Added “Hearings” section.

SUBSTANCE USE DISORDER TREATMENT SERVICES AND COVERAGE

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SUBSTANCE USE DISORDER (SUD) TREATMENT SERVICES AND COVERAGE

4100 INTRODUCTION

A. Nevada, like so many other states, has been severely impacted by the opioid epidemic declared by the U.S. Department of Health and Human Services (DHHS) in 2017. Beginning in 2014, the State adopted an integrated behavioral health clinic model to provide mental health and Substance Use Disorder (SUD) treatment using American Society of Addiction Medicine (ASAM) criteria as the framework for levels of care (LOC) and intensity of needs determination for placement. Medicaid Services Manual (MSM) Chapter 4100—Substance Use Disorder Treatment Services and Coverage, was created to align with "Nevada's Treatment of Opioid Use Disorders (OUD) and SUDs Transformation Project" with the goal to increase access to services to result in timely treatment and better outcomes. MSM Chapter 4100 specifically covers services to treat substance use and co-occurring disorders. For other Medicaid services coverage, limitations, and provider responsibilities, please see the specific MSM for reference.

B. Substance use treatment is aimed to assist recipients who struggle with alcohol and drug use to achieve mental and physical restoration of beneficiaries who struggle with alcohol and substance use. To be Medicaid reimbursable while services may be delivered in a variety of settings, they must be consistent with a medical-model service delivery system and utilize criteria of the ASAM as the framework for care and treatment.

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

4101 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:

- 42 CFR Part 2 (Confidentiality of SUD Patient Records)
- 42 CFR Part 2 (HIPAA)
- 42 CFR Part 8
- NRS 449 (Medical Facilities and Other Related Entities)
- NRS 458 (Alcohol and Other SUDs)
- NAC 458 (Abuse of Alcohol and Drugs)
- 42 CFR 440.60 (Medical or Other Remedial Care Provided by Licensed Practitioner)
- NRS 641C.250 – NRS 641C.420 (Alcohol, Drug Counselors)
- Nevada State Plan Attachment 3.1-A (13D. Rehabilitative Services)
- Section 1902(a)(20) of the SSA (State Provisions for Mental Institution Patients 65 and Older)
- 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))
- 42 CFR 435.1009 (2) (Definition of an IMD)

- 42 CFR 435.1010 (Definition of an IMD)
- 42 CFR 440.160 (Inpatient Psychiatric Services to Individuals Under Age 21)
- 42 CFR 440.2(a) (Specific Definitions of Services for Inpatient vs. Outpatient)
- 42 CFR, Part 482 (Conditions of Participation for Hospitals)
- 42 CFR, Part 435 (Eligibility in the States, District of Columbia, the Northern Mariana Islands, and American Samoa)
- 42 CFR, Part 440.130 (Definitions relating to institutional status)
- 42 CFR, Part 440 (Services: General Provisions)
- 42 CFR, Part 440.130 (Diagnostic, screening, preventive, and rehabilitative services)
- CMS 2261-P (Centers for Medicare and Medicaid Services (CMS) (Medicaid Program; Coverage for Rehabilitative Services)
- CMS State Medicaid Manual, Chapter 4, Section 4390 (Requirements and Limits applicable to Specific Services (IMD)
- NRS 629 (Healing Arts Generally)
- NRS 432.B (Protection of Children from Abuse and Neglect)
- NRS 630 (Physicians, Physician Assistants, and Practitioners of Respiratory Care)
- NRS 632 (Nursing)
- NRS 433B.010 to 433B.350 (Mental Health of Children)
- NRS 433A.010 to 433A.750 (Mental Health of Adults)
- NRS 449.01566 (Peer Support Services Defined)
- NRS 641 (Psychologists)
- NRS 641.A (Marriage and Family Therapists and Clinical Professional Counselors)

- NRS 641B (Social Workers)
- Nevada Medicaid (Substance Use Policy, Procedures, and Requirements)
- CFR 42 Subpart G 431.400-Section 1115 Demonstrations (Federal requirements for waivers)
- NAC 449 (Confidentiality)

4102 DEFINITIONS

A. SUBSTANCE USE TREATMENT CLINIC

An outpatient clinic that is appropriately certified and potentially has the ability to provide substance use treatment and at a minimum must be co-occurring capable within all covered ASAM levels of care, 1, 2, and 3

B. OPIOID TREATMENT PROGRAM

A certified site that must be licensed as a Narcotic Treatment Program if dispensing Methadone per NAC 449, where medication to treat opioid dependency, including methadone, is administered and other psychiatric services such as counseling and psychotherapy are offered or referred.

C. SUBSTANCE USE TREATMENT IN AN IMD

A residential SUD treatment program in a hospital facility of more than 16 beds or of more than 50% of admissions for psychiatric care that provides a safe and supportive setting 24 hours a day, 7 days a week for evaluation, treatment, and rehabilitation of individuals who struggle with SUD.

4103 COVERAGE AND LIMITATIONS

A. DHCFP covers medically necessary and clinically appropriate services as defined in MSM Chapter 100 for Medicaid recipients who have been diagnosed with or at risk of a SUD(s). The substance use policy is under the rehabilitative authority of the State Plan for behavioral health services.

B. 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 individualized treatment plan, to achieve maximum reduction of substance use and to restore the recipient to their optimal level of functioning.

C. DHCFP reimburses for interventions in a substance use treatment clinic medical delivery model provided by qualified Medicaid providers. Recipients are screened and assessed as meeting diagnostic criteria for SUD, substance use related disorder, substance-induced disorders, co-occurring disorders, and/or mental health disorders as defined in the current International Classification of Diseases (ICD).

D. Screening

The following screens are covered within the DHCFP program. Screens must be a nationally accepted screening instrument through Substance Abuse and Mental Health Services Administration (SAMHSA)/Center for Substance Abuse Treatment (CSAT) Treatment Improvement Protocols or other Peer Supported Literature. Below is a list of recognized tools:

1. Clinical Institute Withdrawal Assessment (CIWA)

2. Modified Mini Screen (MMS)

3. Problem Behavior Inventory (PBI)

4. Substance Abuse Subtle Screening Inventory (SASSI)

5. Substance Use Disorder Diagnostic Schedule (SUDDS)

6. Recovery Attitude and Treatment Evaluator (RAATE)

7. Treatment Intervention Inventory (TII)

8. Western Personality Interview (WPI)

9. DSM 5 Cross-Cutter 1

10. Columbia Suicide Screen

E. Assessment

A comprehensive assessment is an individualized examination which establishes the presence or absence of mental health and SUD, determines the recipient's readiness for change, and identifies the strengths and barriers that may affect the recipient's treatment.

1. The comprehensive assessment process includes an extensive recipient history which should include current medical conditions, past medical history, labs and diagnostics, medication history, substance use history, legal history, family educational and social history, employment history, trauma history, developmental history, mental health history, a differential DSM 5TR diagnosis, an ASAM initial assessment, and risk assessment.

2. The information collected from this comprehensive assessment shall be used to determine appropriate interventions and treatment planning.

F. Drug Screening and Testing

Drug screening and testing is a part of treatment for SUD. For coverage, limitations, non-covered services, and prior authorization requirements for drug testing, please reference MSM Chapter 800 - Laboratory Services. Authorization for drug screening and testing shall be requested using prior authorization Form FA-6 for Outpatient Medical/Surgical Services.

G. Pharmaceutical

For coverage, limitations, and prior authorization requirements of Narcotic Withdrawal Therapy Agents (Opioid Dependent Drugs) refer to MSM Chapter 1200 – Prescribed Drugs.

4104 OFFICE BASED OPIOID TREATMENT (OBOT)

For information on OBOT, please see Medication Assisted Treatment (MAT), and refer to MSM Chapter 3800 - Medication Assisted Treatment.

4105 OPIOID TREATMENT PROGRAM (OTP)

OTPs must provide treatment in accordance with the standards in this section and must comply with these standards as a condition of certification:

A. Administrative and Organizational Structure.

1. An OTP's organizational structure and facilities shall be adequate to ensure quality patient care and to meet the requirements of all pertinent federal, state, and local laws and regulations.

2. At a minimum, each OTP shall formally designate a program sponsor and medical director.

   a. The program sponsor shall agree on behalf of the OTP to adhere to all requirements set forth in this part.

   b. The medical director shall assume responsibility for all medical and mental health services performed by the OTP. In addition, the medical director shall be responsible for ensuring that the OTP is in compliance with all applicable federal, state, and local laws and regulations.

3. Each person engaged in the treatment of OUD must have sufficient education, training, experience, or any combination thereof, to enable that person to perform the assigned functions.

4. All practitioners and other licensed/certified health care providers, including counselors, must comply with the credentialing and maintenance of licensure and/or certification requirements of their respective professions.

5. A Licensed Physician, Advanced Practicing Registered Nurse (APRN), and Physician Assistant (PA) in good standing, maintaining a current federal waiver to prescribe drugs and biological products for the treatment of OUD, and maintaining a current state registration to dispense high risk medications for OUD; and

6. OTP Exempt MAT Provider – a midlevel practitioner, who when granted an exemption from SAMHSA, can operate independently, i.e., without the supervision of a medical director or a program physician, perform the medical director or physician functions in an OTP based on the federal opioid treatment standards under 42 CFR 8.12; and

7. OTP Mental Health treatment providers may perform Mental Health and co-occurring treatment in an OTP: Licensed Clinical Alcohol and Drug Counselor (LCADC), LCADC Intern with appropriate supervision, and Licensed Clinical Social Worker (LCSW), Licensed Marriage and Family Therapist (LMFT), and Licensed Clinical Professional Counselor (LCPC) within their scope of practice by education and training to treat mental health or co-occurring disorders.

8. Certified Alcohol and Drug Counselor (CADC), CADC Interns, Licensed Alcohol and Drug Counselor (LADC), LCADC Interns, LCSW, LMFT, LCPC within their scope of practice by education and training to treat SUD may perform substance use treatment in an OTP. CADC Interns and LCADC Interns must be supervised by a licensed clinician appropriate to their scope and in accordance with Nevada State Board of Examiners for Alcohol, Drug, and Gambling Counselors and State regulations.

9. Peer Recovery Support Specialist (PRSS) is defined as a qualified individual currently or previously diagnosed with a mental health, co-occurring disorder, or SUD, who has the skills and abilities to work collaboratively with and under the direction of a licensed clinical supervisor may provide SUD or mental health services in an OTP.

B. Admission Criteria

1. Comprehensive treatment

An OTP shall maintain current procedures designed to ensure that patients are admitted to treatment by qualified personnel who have determined, using accepted medical criteria, that: The person meets diagnostic criteria for a moderate to severe OUD; the individual has an active moderate to severe OUD, or OUD in remission, or is at high risk for recurrence or overdose. Such decisions must be appropriately documented in the patient's clinical record. In addition, a health care practitioner shall ensure that each patient voluntarily chooses treatment with Medications for opioid use disorder (MOUD) and that all relevant facts concerning the use of MOUD are clearly and adequately explained to the patient, and that each patient provides informed consent to treatment.

2. Comprehensive treatment for persons under age 18

Except in states where state law grants persons under 18 years of age the ability to consent to OTP treatment without the consent of another, no person under 18 years of age may be admitted to OTP treatment unless a parent, legal guardian, or responsible adult designated by the relevant state authority consents in writing to such treatment.

3. Withdrawal management

An OTP shall maintain current procedures that are designed to ensure that those patients who choose to taper from MOUD are provided the opportunity to do so with informed consent and at a mutually agreed-upon rate that minimizes taper-related risks. Such consent must be documented in the clinical record by the treating practitioner.

C. OTP Treatment Requirements

OTPs shall provide adequate medical, counseling, vocational, educational, and other screening, assessment, and treatment services to meet patient needs, with the combination and frequency of services tailored to each individual patient based on an individualized assessment and the patient's care plan that was created after shared decision making between the patient and the clinical team. These services must be available at the primary facility, except where the program sponsor has entered into a documented agreement with a private or public agency, organization, practitioner, or institution to provide these services to patients enrolled in the OTP. The program sponsor, in any event, must be able to document that these services are fully and reasonably available to patients.

1. Initial medical examination

a. OTPs shall require each patient to undergo an initial medical examination. The initial medical examination is comprised of two parts:

1. A screening examination to ensure that the patient meets criteria for admission and that there are no contraindications to treatment with MOUD; and

2. A full history and examination, to determine the patient's broader health status, with lab testing as determined to be required by an appropriately licensed practitioner. A patient's refusal to undergo lab testing for co-occurring physical health conditions should not preclude them from access to treatment, provided such refusal does not have potential to negatively impact treatment with medications.

b. Assuming no contraindications, a patient may commence treatment with MOUD after the screening examination has been completed. Both the screening examination and full examination must be completed by an appropriately licensed practitioner. If the licensed practitioner is not an OTP practitioner, the screening examination must be completed no more than seven days prior to OTP admission. Where the examination is performed outside of the OTP, the written results and narrative of the examination, as

well as available lab testing results, must be transmitted, consistent with applicable privacy laws, to the OTP, and verified by an OTP practitioner.

c. A full in-person physical examination, including the results of serology and other tests that are considered to be clinically appropriate, must be completed within 14 calendar days following a patient's admission to the OTP. The full exam can be completed by a non-OTP practitioner, if the exam is verified by a licensed OTP practitioner as being true and accurate and transmitted in accordance with applicable privacy laws.

d. Serology testing and other testing as deemed medically appropriate by the licensed OTP practitioner based on the screening or full history and examination, drawn not more than 30 days prior to admission to the OTP, may form part of the full history and examination.

e. The screening and full examination may be completed via telehealth for those patients being admitted for treatment at the OTP with either buprenorphine or methadone, if a practitioner or primary care provider, determines that an adequate evaluation of the patient can be accomplished via telehealth. When using telehealth, the following caveats apply:

1. In evaluating patients for treatment with schedule II medications (such as methadone), audio-visual telehealth platforms must be used, except when not available to the patient. When not available, it is acceptable to use audio-only devices, but only when the patient is in the presence of a licensed practitioner who is registered to prescribe (including dispense) controlled medications. The OTP practitioner shall review the examination results and order treatment medications as indicated.

2. In evaluating patients for treatment with schedule III medications (such as buprenorphine) or medications not classified as a controlled medication (such as naltrexone), audio-visual or audio only platforms may be used. The OTP practitioner shall review the examination results and order treatment medications as indicated.

2. Special services for pregnant patients

OTPs must maintain current policies and procedures that reflect the special needs and priority for treatment admission of patients with OUD who are pregnant. Pregnancy should be confirmed. Evidence-based treatment protocols for the pregnant patient, such as split dosing regimens, may be instituted after assessment by an OTP practitioner and documentation that confirms the clinical

appropriateness of such an evidence-based treatment protocol. Prenatal care and other sex-specific services, including reproductive health services, for pregnant and postpartum patients must be provided and documented either by the OTP or by referral to appropriate healthcare practitioners. Specific services, including reproductive health services, for pregnant and postpartum patients must be provided and documented either by the OTP or by referral to appropriate healthcare practitioners.

3. Initial and periodic physical and mental health assessment services

   a. Each patient admitted to an OTP shall be given a physical and mental health assessment, which includes but is not limited to screening for imminent risk of harm to self or others, within 14 calendar days following admission, and periodically by appropriately licensed/credentialed personnel. These assessments must address the need for and/or response to treatment, adjust treatment interventions, including MOUD, as necessary, and provide a patient-centered plan of care. The full, initial psychosocial assessment must be completed within 14 calendar days of admission and include preparation of a care plan that includes the patient's goals and mutually agreed-upon actions for the patient to meet those goals, including harm reduction interventions; the patient's needs and goals in the areas of education, vocational training, and employment; and the medical and psychiatric, psychosocial, economic, legal, housing, and other recovery support services that a patient needs and wishes to pursue. The care plan also must identify the recommended frequency with which services are to be provided. The plan must be reviewed and updated to reflect responses to treatment and recovery support services, and adjustments made that reflect changes in the context of the person's life, their current needs for and interests in medical, psychiatric, social, and psychological services, and current needs for and interests in education, vocational training, and employment services.

   b. The periodic physical examination should occur not less than one time each year and be conducted by an OTP practitioner. The periodic physical examination should include review of MOUD dosing, treatment response, other SUD treatment needs, responses and patient-identified goals, and other relevant physical and psychiatric treatment needs and goals. The periodic physical examination should be documented in the patient's clinical record.

4. Counseling and psychoeducational services

   a. OTPs must provide adequate SUD counseling and psychoeducation to each patient as clinically necessary and mutually agreed-upon, including harm

reduction education and recovery-oriented counseling. This counseling shall be provided by a program counselor, qualified by education, training, or experience to assess the psychological and sociological background of patients, and engage with patients, to contribute to the appropriate care plan for the patient, and to monitor and update patient progress. Patient refusal of counseling shall not preclude them from receiving MOUD.

b. OTPs must provide counseling on preventing exposure to, and the transmission of, human immunodeficiency virus (HIV), viral hepatitis, and sexually transmitted infections (STIs) and either directly provide services and treatments or actively link to treatment each patient admitted or readmitted to treatment who has received positive test results for these conditions from initial and/or periodic medical examinations.

c. OTPs must provide directly, or through referral to adequate and reasonably accessible community resources, vocational training, education, and employment services for patients who request such services or for whom these needs have been identified and mutually agreed-upon as beneficial by the patient and program staff.

d. MOUD are not to be contingent on a recipient's participation in counseling.

5. OTP drug testing services

When conducting random drug testing, OTPs must use drug tests that have received the Food and Drug Administration's (FDA) marketing authorization for commonly used and misused substances that may impact patient safety, recovery, or otherwise complicate SUD treatment, at a frequency that is in accordance with generally accepted clinical practice and as indicated by a patient's response to and stability in treatment, but no fewer than eight random drug tests per year patient, allowing for extenuating circumstances at the individual patient level. This requirement does not preclude distribution of legal harm reduction supplies that allow an individual to test their personal drug supply for adulteration with substances that increase the risk of overdose.

D. Recordkeeping and patient confidentiality

1. OTPs shall establish and maintain a recordkeeping system that is adequate to document and monitor patient care. This system is required to comply with all federal and state reporting requirements relevant to MOUD approved for use in treatment of OUD. All records are required to be kept confidential in accordance with all applicable federal and state requirements.

2. OTPs shall include, as an essential part of the recordkeeping system, documentation in each patient's record that the OTP made a good faith effort to determine whether the patient is enrolled in any other OTP. A patient enrolled in an OTP shall not be permitted to obtain treatment in any other OTP except in circumstances involving an inability to access care at the patient's OTP of record. Such circumstances include, but are not limited to, travel for work or family events, temporary relocation, or an OTP's temporary closure. If the medical director or program practitioner of the OTP in which the patient is enrolled determines that such circumstances exist, the patient may seek treatment at another OTP, provided the justification for the particular circumstances are noted in the patient's record both at the OTP in which the patient is enrolled and at the OTP that will provide the MOUD.

E. Medication administration, dispensing, and use

1. OTPs must ensure that MOUD are administered or dispensed only by a practitioner licensed under the appropriate state law and registered under the appropriate state and federal laws to administer or dispense MOUD, or by an agent of such a practitioner, supervised by and under the order of the licensed practitioner and if consistent with federal and state law.

2. OTPs shall use only those MOUD that are approved by the FDA under Section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) for use in the treatment of OUD. In addition, OTPs who are fully compliant with the protocol of an investigational use of a drug and other conditions set forth in the application may administer a drug that has been authorized by the FDA under an investigational new drug application under Section 505(i) of the Federal Food, Drug, and Cosmetic Act for investigational use in the treatment of OUD. Currently the following MOUD will be considered to be approved by the FDA for use in the treatment of OUD:

   a. Methadone.

   b. Buprenorphine and buprenorphine combination products that have been approved for use in the treatment of OUD; and

   c. Naltrexone.

3. OTPs shall maintain current procedures that are adequate to ensure that the following dosage form and initial dosing requirements are met:

   a. Methadone shall be administered or dispensed only in oral form and shall be formulated in such a way as to reduce its potential for parenteral misuse.

b. For each new patient enrolled in an OTP, the initial dose of methadone shall be individually determined and shall include consideration of the type(s) of opioid(s) involved in the patient's opioid use disorder, other medications or substances being taken, medical history, and severity of opioid withdrawal. The total dose for the first day should not exceed 50 milligrams unless the OTP practitioner, licensed under the appropriate state law and registered under the appropriate state and federal laws to administer or dispense MOUD, finds sufficient medical rationale, including but not limited to if the patient is transferring from another OTP on a higher dose that has been verified, and documents in the patient's record that a higher dose was clinically indicated.

4. OTPs shall maintain current procedures adequate to ensure that each MOUD used by the program is administered and dispensed in accordance with its FDA approved product labeling. The program must ensure that any significant deviations from the approved labeling, including deviations with regard to dose, frequency, or the conditions of use described in the approved labeling, are specifically documented in the patient's record.

F. Unsupervised or “take-home” medication doses

Unsupervised or “take-home” medication doses may be provided under the following circumstances:

1. Any patient in comprehensive treatment may receive their individualized take-home doses as ordered for days that the clinic is closed for business, including one weekend day (e.g., Sunday) and state and federal holidays, no matter their length of time in treatment.

2. OTP decisions on dispensing MOUD to patients for unsupervised use shall be determined by an appropriately licensed OTP medical practitioner or the medical director. In determining which patients may receive unsupervised medication doses, the medical director or program medical practitioner shall consider, among other pertinent factors that indicate that the therapeutic benefits of unsupervised doses outweigh the risks, the following criteria:

a. Absence of active SUD, other physical or mental health conditions that increase the risk of patient harm as it relates to the potential for overdose, or the ability to function safely;

b. Regularity of attendance for supervised medication administration;

c. Absence of serious mental problems that endanger the patient, the public, or others;

d. Absence of known recent diversion activity;

e. Whether take-home medication can be safely transported and stored; and

f. Any other criteria that the medical director or medical practitioner considers relevant to the patient's safety and the public's health.

3. The decision to allow unsupervised "take home" doses shall be documented in the patient's medical record. If it is determined that a patient is safely able to manage unsupervised doses of MOUD, the dispensing restrictions below apply.

The dispensing restrictions below do not apply to buprenorphine and buprenorphine products.

a. During the first 14 days of treatment, the take-home supply is limited to seven days. It remains within the OTP practitioner's discretion to determine the number of take-home doses up to seven days, but decisions must be based on the criteria listed above. The rationale underlying the decision to provide unsupervised doses of methadone must be documented in the patient's clinical record.

b. From 15 days of treatment, the take-home supply is limited to 14 days. It remains within the OTP practitioner's discretion to determine the number of take-home doses up to 14 days, but this determination must be based on the criteria listed above. The rationale underlying the decision to provide unsupervised doses of methadone must be documented in the patient's clinical record,

c. From 31 days of treatment, the take-home supply provided to a patient is not to exceed 28 days. It remains within the OTP practitioner's discretion to determine the number of take-home doses up to 28 days, but this determination must be based on the criteria listed above. The rationale underlying the decision to provide unsupervised doses of methadone must be documented in the patient's clinical record.

4. OTPs must maintain current procedures adequate to identify the theft or diversion of take-home medications, including labeling containers with the OTP's name, address, and telephone number. Programs also must ensure that each individual take-home dose is packaged in a manner that is designed to reduce the risk of accidental ingestion, including child-proof containers (see Poison Prevention

Packaging Act, Pub. L. 91-601 (15 U.S.C. 1471 *et seq.*)). Programs must provide education to each patient on: Safely transporting medication from the OTP to their place of residence; and the safe storage of take-home doses at the individual's place of residence, including child and household safety precautions. The provision of this education should be documented in the patient's clinical record.

G. Interim Treatment

Interim treatment means that on a temporary basis, a patient may receive some services from an OTP, while awaiting access to more comprehensive treatment services. The duration of interim treatment is limited to 180 days.

State approval for use of interim treatment from the State Opioid Treatment Authority (SOTA) and the Secretary is required.

1. Interim treatment

   a. The program sponsor of an OTP may admit an individual, who is eligible for admission to comprehensive treatment, into interim treatment if comprehensive services are not readily available within a reasonable geographic area and within 14 days of the individual's seeking treatment.

   b. At least two drug tests shall be obtained from patients during the maximum of 180 days permitted for interim treatment.

   c. A program shall establish and follow reasonable criteria for establishing priorities for moving patients from interim to comprehensive treatment.

   d. These transition criteria shall be in writing and shall include, at a minimum prioritization of pregnant patients in admitting patients to interim treatment and from interim to comprehensive treatment.

   e. Interim treatment shall be provided in a manner consistent with all applicable federal and state laws, including Sections 1923, 1927(a), and 1976 of the Public Health Service Act (21 U.S.C. 300x-23, 300x-27(a), and 300y-11).

2. The program shall notify the SOTA when a patient begins interim treatment, when a patient leaves interim treatment, and before the date of transfer to comprehensive services, and shall document such notifications.

3. The secretary may revoke the interim authorization for programs that fail to comply with the provisions. Likewise, the secretary will consider revoking the interim

authorization of a program if the state in which the program operates is not in compliance with the provisions of § 8.11(h).

4. All requirements for comprehensive treatment apply to interim treatment with the following exceptions:

   a. A primary counselor is not required to be assigned to the patient, but crisis services, including shelter support, should be available;

   b. Interim treatment cannot be provided for longer than 180 days in any 12-month period;

   c. By day 120, a plan for continuing treatment beyond 180 days must be created and documented in the patient's clinical record; and

   d. Formal counseling, vocational training, employment, economic, legal, educational, and other recovery support services are not required to be offered to the patient in interim treatment.

   e. Information pertaining to locally available, community-based resources for ancillary services should be made available to individual patients in interim treatment.

5. Prior authorization is required to move patients from interim into comprehensive treatment.

H. The following services are covered for OTP:

1. Medication assessment, prescribing, administering, reassessing, and regulating dose levels appropriate to the individual;

2. Supervising withdrawal management from opioids and opioid use disorder treatment;

3. Overseeing and facilitating access to appropriate treatment, including medication for other physical and mental health disorders.

4. Counseling and psychoeducational services.

I. The following services are excluded from Opioid treatment coverage:

1. Components that are not provided to or exclusively for the treatment of the eligible individual;

2. Services or components of services of which the basic nature is to supplant housekeeping or basic services for the convenience of a person receiving covered services;

3. Room and board;

4. Telephone calls or other electronic contacts, not inclusive of telehealth; and

5. Field trips or social or physical exercise activity groups.

J. Prior Authorization Process

1. The QIO-like vendor must prior authorize and approve all treatment and services.

2. Prior authorization is required for all active Medicaid recipients, pending Medicaid recipients, and Medicaid recipients covered through primary insurance. If a recipient has Medicare Part B, then authorization may need to be sent through Medicare.

3. Authorization for services to include counseling and psychoeducation is requested using form FA 11D and is valid for 90 days.

4. Authorization for prescriptions should follow requirements in MSM Chapter 1200 - Prescribed Drugs.

K. Quality Improvement

1. An OTP must maintain current quality assurance and quality control plans that include, among other things, annual reviews of program policies and procedures and ongoing assessment of patient outcomes.

2. An OTP must maintain a current "Diversion Control Plan (DCP)" as part of its quality assurance program that contains specific measures to reduce the possibility of diversion of dispensed MOUD, and that assigns specific responsibility to the OTP providers and administrative staff for carrying out the diversion control measures and functions described in the DCP.

4106 UTILIZATION OF AMERICAN SOCIETY OF ADDICTION MEDICINE (ASAM)

DHCFP utilizes the ASAM multidimensional assessment, for individuals presenting with SUD(s) to determine appropriate placement into a level of care along the continuum of care for substance use treatment. Services must meet medical necessity and clinical appropriateness as defined in MSM Chapter 100 – Medicaid Program.

The components of ASAM outpatient and residential care include harm reduction interventions, counseling, and psychotherapy to address a beneficiary's major lifestyle, attitudinal, and behavioral problems that have the potential to undermine the achievement of treatment and recovery goals.

DHCFP will reimburse for services and harm reduction techniques provided appropriate to the corresponding ASAM Level, as indicated below, of which the provider is certified by the Division and enrolled with Medicaid:

A. ASAM LEVEL 1

A clinic model that meets the certification requirement NAC 458.103 for alcohol and substance use programs. The provider will perform medical, psychiatric, and psychological services, including harm reduction, which are available onsite or through consultation or referral. Outpatient services are provided and intended for recipients with mild SUD and those in early remission. Programming consists of less than nine structured clinical hours per week. Medical and psychiatric consultations are available within 24 hours by telephone or in person, within a time frame appropriate to the severity and urgency of the consultation. Emergency services are available by telephone 24 hours a day, seven days a week. Recovery and self-help groups are a part of the overall milieu. All other services are individually billed. Long term remission monitoring is necessary within ASAM level 1.

1. 1.0 Outpatient Services

a. Level 1 Covered Services:

1. Medication management

2. 24-hour crisis intervention services face-to-face or telephonically available seven days per week

3. Mental Health/Substance Use Covered Screens

4. Comprehensive assessment

5. Individual and group counseling

6. Individual, group, and family psychotherapy

7. Peer Support Services

8. Psychoeducation services

9. Occupational Therapy

10. Recreational Therapy

11. Psychosocial Rehabilitation

12. Basic Skills Training

13. Harm Reduction interventions

b. Level 1 Prior Authorization:

1. Prior authorization is required for services after service limitations have been exceeded.

2. Post authorization is not required for intervention during a substance use crisis episode lasting 72 hours or less.

3. Individual, group, family psychotherapy, and counseling services can be utilized for up to 26 total sessions for children and adolescents and up to 18 total sessions for adults before prior authorization is required.

4. Peer Support Services can be utilized for up to 18 hours/72 units annually before prior authorization is required.

5. Provider needs to complete and submit the request for FA 11D for authorization to the QIO-like vendor.

6. Authorization is valid for 90 days.

B. ASAM LEVEL 2

Requires a comprehensive interdisciplinary program team approach of appropriately credentialed and supervised addiction treatment professionals, including physicians, acting within their scope of practice who assess and treat co-occurring substance-related disorders. Some staff are cross-trained to understand the signs and symptoms of mental

disorders and to understand and explain the uses of psychotropic medications and interactions with substance-related disorders.

1. 2.1 Intensive Outpatient Program (IOP)

   a. IOP that consists of 9 to 19 hours per week for adults and a minimum of 6 hours per week for adolescents of structured clinical services provided at least three days per week.

   b. Services should be clearly defined, scheduled, and clinically structured and provided to recipients diagnosed with SUD or co-occurring disorders when determined to be medically necessary and in accordance with an individualized treatment plan. Treatment and recovery is focused on harm reduction, major lifestyle, attitudinal, and behavior issues which impair the individual's ability to cope with major life tasks without use of substances.

   c. Services are provided in a certified, non-residential, non-hospital treatment setting typically during the day, before or after work or school, in the evening, and/or on the weekends to allow recipients to apply their skills in a "real world" environment.

   d. Frequencies and intensity are appropriate to the objectives of the treatment plan.

   e. Active affiliations with other levels of addiction care, ideally integrated, to help recipients access recovery support services.

   f. Clinical services provided by formally affiliated external addiction treatment providers and programs (ex, OTPs) may count toward the total hours of weekly clinical services if care and billing are coordinated and documented.

2. 2.5 Partial Hospitalization Program (PHP)

   a. PHP programs provide at least 20 hours per week of clinically structured high-intensity outpatient services for recipients with SUD or co-occurring disorders for adults and adolescents.

   b. Service is specifically designed for the diagnosis and active treatment and recovery of a SUD when there is a reasonable expectation for improvement or when it is necessary to maintain the person's functional level and prevent relapse or inpatient hospitalization.

c. Services within the PHP are more clinically intense than IOP and, in addition to addressing major lifestyle, attitudinal, and behavior issues which impair the individual's ability to cope with major life tasks without the addictive use of alcohol and/or other drugs, have the capacity to treat individuals, including providing harm reduction interventions, with substantial medical and co-occurring psychiatric problems.

d. 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). 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.

e. For adolescents, information for assessment and treatment planning may be obtained from a parent, guardian, or other important resources (such as a teacher or probation officer) and should include:

1. An initial withdrawal assessment, including a medical evaluation at admission (or medical review of an evaluation performed withing 48 hours preceding admission, or within 7 days preceding admission for a patient who is stepping down from a residential setting).

2. Ongoing withdrawal monitoring assessment performed several times a week.

3. Ongoing screening for medical and nursing needs, with medical and nursing evaluation available through consultation or referral.

f. For adolescents, partial hospital often occurs during school hours; such programs typically have access to educational services for their adolescent patients. Programs that do not provide educational services should coordinate with a school system in order to assess and meet their adolescent patients' educational needs. Educational services provided are designed to maintain the educational and intellectual development of the recipient and, when indicated, to provide opportunities to remedy deficits in the adolescent's education.

g. Support systems in PHPs for adolescents include:

1. Medical, psychological, psychiatric, laboratory, toxicology, educational, occupational, and other services needed by adolescents are available through consultation or referral. Medical and psychiatric consultation is available within 8 hours by telephone and within 48 hours face-to-face (depending on the urgency of the situation) through on-site services, referral to off-site services, or transfer to another level of care.

2. Emergency services, which are available by telephone 24 hours a day, 7 days a week when the program is not in session.

3. Direct affiliation with more and less intensive levels of care.

3. ASAM Level 2 Covered services:

   a. Medication management

   b. 24-hour crisis intervention

   c. Comprehensive assessment

   d. Substance use or co-occurring focused counseling and psychotherapy reflecting a variety of treatment and recovery approaches provided on individual, group, and family basis

   e. Self-help/recovery groups

   f. Psychoeducation services

   g. Drug testing

   h. Occupational Therapy

   i. Psychosocial Rehabilitation

   j. Basic Skills Training

4. ASAM Level 2 Prior Authorization:

   a. All initial IOP and PHP services require prior authorization to establish medical necessity.

b. The intensity of the services will be driven by medical necessity.

c. Prior authorization is not required for services of substance use screening and 24-hour crisis intervention.

d. Post authorization is not required for 24-hour crisis intervention.

e. Provider needs to complete and submit request for FA 11D for authorization to the QIO-like vendor.

f. Authorization for 2.1 is valid for 90 days.

g. Authorization for 2.5 is valid for three weeks.

C. ASAM LEVEL 3

Residential SUD programs provide individuals in recovery from SUD and co-occurring disorders a safe and stable 24-hour live-in setting staffed by designated addiction treatment personnel who provide a planned and structured regimen of care in order to develop harm reduction and recovery skills where skill restoration and counseling services are provided on-site to the residents as a condition of tenancy. The type and intensity of services is determined by the patient’s need and must be clinically appropriate and medically necessary.

Residential SUD is a clinic model that meets the certification requirement NAC 458.103 for alcohol and substance use programs and is made up of two distinct components: clinical services and therapeutic milieu.

Room and board are not reimbursable services through DHCFP.

1. The following ASAM residential levels are covered by Nevada Medicaid:

a. 3.1 Clinically Managed Low-Intensity Residential Services:

1. Treatment services facilitate the application of recovery, relapse prevention, and coping skills and strategies. Services also promote prosocial skills, skills of daily living, personal responsibility, and reintegration of the recipient into network systems of work, education, and family life.

2. Services are focused on improving the recipient’s functioning and coping skills to enable them to safely engage in treatment at a less intensive level of care and address readiness to change and other

challenges that impact the recipient's ability to successfully engage in recovery.

3. Appropriate for individuals who require time and structure to further develop, practice, and integrate their recovery and coping skills in a clinically managed and supportive residential environment.

4. Provides 9 to 19 hours of clinical services per week with primary focus on the skills needed for safe reintegration in the community and address intrapersonal determinants such as self-efficacy, outcome expectancies, motivation, coping, emotional states, cravings, and social and personal supports.

b. 3.5 Clinically Managed High Intensity Residential Services:

1. Treatment is delivered by a multidisciplinary treatment team under the oversight of a medical director.

2. Treatment is focused on stabilization of risky substance use and SUD related behaviors, initiation or restoration of a recovery process, and preparation for ongoing recovery with support at less intensive levels of care.

3. Designed to serve individuals who have specific limitations in the skills needed to avoid substance use in a manner that poses significant risk for serious harm or destabilizing loss in a less intensive level of care.

4. Requires clinical-led habilitative and rehabilitative services to develop and or demonstrate sufficient recovery skills to safely transition to a level of care that does not provide 24-hour supervision and a high-intensity therapeutic milieu.

5. Provides at least 25 hours per week of clinical services that address low frustration tolerance, impulsivity, emotional dysregulation, interpersonal instability, and reliance of substances to cope with stressors, at least 7 hours of structured activity per day, and a minimum of 10 hours of clinical counseling services must be provided each week for adults and adolescents.

6. Has capacity to provide social model withdrawal management.

c. 3.7WM Medically Monitored Inpatient Withdrawal Management:

1. Organized service delivered by medical professionals who provide 24-hour evaluation and management of intoxication, withdrawal, biomedical concerns, and common low complexity psychiatric concerns in a permanent residential facility.

2. Services are delivered under a defined set of physician-approved policies and physician-managed procedures and medical protocols.

3. Recipients at this level of care receive 24-hour observation, monitoring, and treatment; however, they do not require the full resources of an acute care hospital.

2. ASAM Level 3 Covered services:

a. Medical, psychiatric, psychological services, which are available onsite or through consultation or referral. Medical and psychiatric consultations are available within 24 hours by telephone or in person, within a time frame appropriate to the severity and urgency of the consultation.

b. 24-hour crisis intervention services face-to-face or telephonically available 7 days per week

c. Medication management

d. Mental Health/Substance Use Covered Screens

e. Comprehensive assessment

f. Individual and group counseling

g. Individual, group, and family psychotherapy

h. Peer Support Services

i. Psychosocial education groups

j. Drug testing and screening

3. ASAM Level 3 Prior Authorization:

a. Prior authorization is required for ASAM Level 3 services to establish medical necessity.

b. Provider needs to complete and submit request for FA 11D for authorization to the QIO-like vendor.

c. Intensity of service is dependent upon individual and presenting symptoms.

d. Prior Authorization for ASAM Level 3.7WM is valid for five days.

e. Prior Authorization for ASAM Level 3.5 is valid for 10 days.

f. Prior Authorization for ASAM Level 3.1 is valid for 10 days.

4107 INPATIENT SUD WITHDRAWAL MANAGEMENT AND TREATMENT SERVICES

Inpatient substance use services are those services delivered in freestanding substance use treatment hospitals or general hospitals with a specialized substance use treatment unit which includes a secure, structured environment, 24-hour observation and supervision by mental health substance use professionals and a structured multidisciplinary clinical approach to treatment. These hospitals provide medical withdrawal management and treatment services for individuals suffering from acute alcohol and substance use conditions.

A. COVERAGE AND LIMITATIONS

1. Hospital inpatient days may be considered a Medicaid benefit when withdrawal management and treatment for acute substance use necessitates intervention through the constant availability of physicians and/or medical services found in the acute hospital setting.

2. Medicaid reimburses for admission to with substance use units regardless of age.

3. Medicaid reimburses admission to freestanding psychiatric, and substance use hospitals for recipients age 65 and older, or those 21 and under.

4. For recipients ages 22 to 64, "Nevada's Treatment of OUDs and SUDs Transformation Project" (1115 SUD Waiver) allows for reimbursement of residential substance use and withdrawal management services within an IMD setting through December 31, 2027.

5. Medicaid reimburses only for SUD withdrawal management and treatment according to the following:

   a. Withdrawal Management

      1. Medicaid reimburses for up to five hospital inpatient withdrawal management days with unlimited lifetime admission (Medicaid covers stays beyond five days only if additional withdrawal management services are deemed medically necessary by the QIO-like vendor).

      2. Results of a urine drug screen or blood alcohol test must be provided at the time of the initial request for authorization.

   b. Treatment

1. Medicaid reimburses for up to 21 hospital inpatient treatment days with unlimited lifetime admissions as determined medically necessary by the physician (stays beyond 21 days are covered only if additional treatment services are deemed medically necessary by the QIO- like vendor).

2. Prior to inpatient admission, the referring or admitting physician must document a discussion for a plan of after care to include referrals to counseling, therapy, and peer support services within the substance use treatment continuum of care. Aftercare recommendations and the recipient's response must be documented and included as a part of the recipient's inpatient hospital record.

3. It is the hospital's responsibility to assist the recipient during hospitalization to ensure the above-mentioned post discharge resources will be utilized.

4. A psychiatric evaluation must be completed within 72 hours of any inpatient withdrawal management or treatment admission.

6. Nevada Medicaid reimburses for SUD services to recipients diagnosed with an alcohol/SUD when admitted to a general hospital without a specialized alcohol/substance use unit only under one of the following conditions:

a. The admission is an emergency and is approved by the QIO-like vendor.

1. QIO-like vendor must be contacted for authorization purposes within five business days of the emergency admission; and

2. The hospital, as determined by the QIO-like vendor, makes all efforts to stabilize the recipient's condition and discharge the recipient to a substance use/psychiatric hospital or general hospital with a substance use/psychiatric unit as expeditiously as possible; or

3. The admission is approved by the QIO-like vendor for medical withdrawal management only.

b. All transfers from withdrawal management to treatment require prior authorization. This applies to all Medicaid recipients, regardless of age.

c. The recipient is dually diagnosed as having both medical and substance use conditions which warrant inpatient general hospital services, as determined by the QIO-like vendor

d. If a recipient is initially admitted to a general hospital for acute care and is then authorized to receive SUD services:

1. The acute care is paid at the appropriate medical/surgical tier rate.

2. The alcohol/substance use services are paid at the substance use service rate.

3. Hospitals are required to bill Medicaid separately for each of the types of stays.

4. The QIO-like vendor must approve the two types of stays separately.

7. 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.

8. Non-Emergency Admissions

a. Non-emergency admissions for Medicaid eligible recipients must be prior authorized by the QIO-like vendor within one business day of the admission. Physicians may call them during normal business hours.

b. Non-emergency admissions not prior authorized by the QIO-like vendor will not be reimbursed by Nevada Medicaid.

B. PRIOR AUTHORIZATION PROCESS

1. The QIO-like vendor must prior authorize and approve all hospital admissions for both withdrawal management and treatment services to verify appropriateness of placement and justify treatment and length of stay.

2. Prior authorization is required for all active Medicaid recipients, pending Medicaid recipients, and Medicaid recipients covered through primary insurance, except Medicare Part A. If this is the case, then authorization may need to be sent through Medicare.

3. Prior to authorizing the admission, the QIO-like vendor will:

   a. Verify the physician-patient communication did occur and is documented within the recipient's record; and

   b. Verify appropriateness of admission, treatment, and length of stay according to ASAM Criteria.

C. RETROSPECTIVE REVIEWS

The QIO-like vendor authorizes only Medicaid eligible recipients, not pending eligible. Should a client become Medicaid eligible while in the facility, a retrospective review must be requested by the provider to the QIO-like vendor:

1. The medical record must be submitted to the QIO-like vendor within 30 days from the date of the eligibility determination.

2. If the information submitted is not complete, a technical denial for service will be issued.

3. The QIO-like vendor will complete the review and issue a final determination within 30 days of receipt of all requested information.

D. CONCURRENT REVIEWS

The psychiatric assessment, discharge plan and written treatment plan must be initiated, with the attending physician's involvement, during the initial authorization period.

1. For non-emergency admissions, the prior authorization request form and Certificate of Need (CON) must be submitted at least one business day prior to admission.

2. For emergency admissions, the prior authorization request form and CON must be submitted no later than five business days following admission.

3. Prior authorization requests, if medically and clinically appropriate, will be authorized up to seven days. When a recipient remains hospitalized longer than seven days the attending physician must document the medical necessity of each additional inpatient day.

4. 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.

5. The request and information submitted must identify all pertinent written medical information that supports a continued inpatient stay.

6. The request and information submitted must be in the format and within the timeframes required by the QIO-like vendor.

7. 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.

E. PRIOR RESOURCES

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

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

F. REIMBURSEMENT

1. Inpatient freestanding psychiatric and/or alcohol/substance use hospitals and general acute hospitals with a psychiatric and/or substance use unit are reimbursed a per diem, all-inclusive prospective daily rate determined and developed by the Nevada DHCFP's Rate Development and Cost Containment Unit. (Days certified as administrative are paid at the all-inclusive prospective administrative day rate.)

2. 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.)

3. 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.

4108 INSTITUION FOR MENTAL DISEASE (IMD)

A. DESCRIPTION

1. In accordance with 42 CFR 435.1010: Definition of an IMD is a hospital, nursing facility, or other institution of more than 16 beds that is more than 50% engaged in diagnosing and treating persons with mental disease while also providing medical attention, nursing care, and related services. Whether an institution is considered an IMD 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.

2. Facilities licensed as acute care hospitals and/or nursing facilities with designated psychiatric beds are reviewed based upon their aggregate bed counts.

3. Chemically dependent (CD) patients admitted for CD treatment are counted as mentally ill under the 50% guideline, according to the Centers for Medicare and Medicaid Services (CMS) Manual for IMD. The manual gives further guidance that services delivered by laypersons, such as Alcoholics Anonymous, do not constitute a medical or remedial model, and therefore, 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."

4. An institution for individuals with Intellectual and Developmental Disabilities is not considered an IMD.

5. The CMS has deferred the completion of the determination if a facility is an IMD to DHCFP. In addition to the 50% admission rate for psychiatric treatment and bed count, DHCFP utilizes additional criteria as listed in the CMS Medicaid Manual (linked below) for further determination of an IMD. The criteria include factors such as, but not limited to:

    a. Facility ownership is one single owner or governing body;

    b. The Chief Medical Officer is responsible for medical staff activities in all components;

    c. The Chief Executive Officer is responsible for administrative activities in all components;

    d. The licensure of each component;

    e. The geographic location of each facility;

f. The Condition of Participation of each component;

g. The relationship to the State Mental Health Authority;

h. The patient records that provide evidence of psychiatric/psychological care and treatment.

(State Medicaid Manual Chapter 4, http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021927.html.)

B. ABSENCES:

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 to another facility while still admitted to the IMD for the purpose of obtaining medical treatment, then it is not considered a conditional release and is not a covered service.

1. Convalescent leave – 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.

C. COVERAGE AND LIMITATIONS

1. For recipients ages 22 to 64, "Nevada's Treatment of OUDs and SUDs Transformation Project" (1115 SUD Waiver) currently allows for reimbursement of residential substance use and withdrawal management services within an IMD setting through December 31, 2027.

2. IMD Exclusion - In accordance with 42 CFR 435.1009(2), Federal Financial Participation (FFP) is not available for institutionalized individuals who are individuals under the age of 65 who are patients in an IMD unless they are under age 22 and are receiving inpatient psychiatric services under 42 CFR 440.160, which is a psychiatric hospital or a residential treatment center (RTC) for recipients under the age of 21 years. See (2e) for additional clarification.

3. All services are excluded from Medicaid payment while a recipient is admitted to an IMD, whether the services are provided in or outside of the facility.

4. Coverage of services for ages 21 up to 22 years – If a patient is receiving services immediately prior to turning age 21years, the services continue until the earlier of the date the individual no longer requires the services or the date the individual reaches 22. In this extenuating circumstance, IMD service may continue until age 22. The regulation requires that the patient must be receiving services immediately prior to age 21 and continuously up to age 22. Services cannot begin during the first year.

5. Medicaid may reimburse co pays and/or deductibles for Qualified Medicare Beneficiaries (QMB) while in an IMD.

D. PRIOR AUTHORIZATION PROCESS

1. The QIO-like vendor must certify all inpatient substance use withdrawal management and treatment admissions.

2. Transfers to and from substance use withdrawal management /treatment services require prior authorization by the QIO-like vendor.

3. For recipients under age 21 in the custody of the public agency, Nevada Medicaid reimburses for alcohol/substance use withdrawal management and treatment services only when the admission is prior authorized and certified by the QIO-like vendor.

4. Nevada Medicaid reimburses for services for recipients admitted with an alcohol/substance use condition/diagnosis to a general hospital without a specialized alcohol/substance use unit only under one of the following conditions:

   a. The admission is an emergency and is certified by the QIO-like vendor (who must be contacted, for authorization purposes, within five business days of the admission) and the hospital, as determined by the QIO-like vendor, makes all efforts to stabilize the recipient's condition and discharge the recipient to a substance use/psychiatric hospital or general hospital with a substance use/psychiatric unit as expeditiously as possible; or

   b. The admission is certified by the QIO-like vendor for medical withdrawal management only. Medicaid recipients between 21 and 64 years of age are covered for inpatient alcohol/substance use withdrawal management and treatment services only in a general hospital with a specialized alcohol/substance use unit. Those Medicaid recipients age 20 and under and age 65 and older are covered for inpatient substance use withdrawal management and treatment services in a freestanding psychiatric and/or alcohol/substance use hospital, as well as a general hospital with a

specialized alcohol/substance use unit. (For recipients ages 22 to 64, "Nevada's Treatment of 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.)

c. All transfers from withdrawal management to treatment require prior authorization. This applies to all Medicaid recipients, regardless of age.

d. Also, if a recipient is initially admitted to a hospital for acute care and is then authorized to receive alcohol/substance use services, the acute care is paid at the appropriate medical/surgical tier rate. The alcohol/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.

e. The recipient is dually diagnosed as having both medical and substance use conditions which warrant inpatient general hospital services, as determined by the QIO-like vendor; or

5. Acute inpatient admissions authorized by the QIO-like vendor do not require an additional PA for physician ordered psychological evaluations and testing. The psychologist must list the QIO-like vendors "Inpatient's authorization number" on the claim form when billing for services.

E. RETROSPECTIVE REVIEWS

The QIO-like vendor authorizes only Medicaid eligible clients, not pending eligible. Should a client become Medicaid eligible while in the facility, a retrospective review must be requested by the provider to the QIO-like vendor:

1. The medical record must be submitted to the QIO-like vendor within 30 days from the date of the eligibility determination.

2. If the information submitted is not complete, a technical denial for service will be issued.

3. The QIO-like vendor will complete the review and issue a final determination within 30 days of receipt of all requested information.

F. REIMBURSEMENT

1. Inpatient freestanding psychiatric and/or alcohol/substance use hospitals and general acute hospitals with a psychiatric and/or substance use unit are reimbursed

a per diem, all-inclusive prospective daily rate determined and developed by the Nevada DHCFP's Rate Development and Cost Containment Unit. (Days certified as administrative are paid at the all-inclusive prospective administrative day rate.)

2. 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.)

3. 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.

4109 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.

A. 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. Skilled Nursing Level (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 (NF) is not required. Issuance of this level is a reflection of the hospital services required by and provided to the recipient.

   SNL days may be authorized when one or more of the following apply, or as determined by physician review:

   a. Recipient is awaiting placement, or evaluation for placement, at a nursing facility/extended care facility, group home, or other treatment setting, for continuity of medical services, e.g.:

      1. Transfers to other facilities.

      2. Rehabilitation or independent living.

      3. Hospice, etc.

   b. Recipient is to be discharged home and is awaiting home equipment set up/availability, nursing services, and/or other caretaker requirements, e.g.:

      1. Home health nursing.

      2. Public health nursing.

      3. Durable medical equipment.

      4. Family preparation.

5. Respite care.

c. Conditions which may prevent a non-acute recipient from leaving the hospital (e.g., recipient's labs must be monitored, cultures taken for staph infection or any treatment/work up that could not be safely and effectively accomplished in another setting).

1. Therapeutic foster care.

2. Day treatment.

3. Rural mental health follow-up services.

4. Set up for wrap around services.

d. Recipient has mental disabilities that prevent NF 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 an NF placement.

b. A recipient, family, or physician refuses a psychiatric RTC) placement, group home, or psychiatric treatment center.

c. There is insufficient documentation (Monday through Friday contacts and results) in the chart reflecting adequate discharge planning.

B. AUTHORIZATION PROCESS

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

4110 OUTPATIENT MENTAL HEALTH ONLY TREATMENT AND SERVICES IN A SUD TREATMENT CLINIC

A. Providers enrolled as a Substance Use Treatment Clinic may offer Outpatient Mental Health only services to recipients diagnosed with a co-occurring SUD or mental health only disorder if the clinic is certified by the Division as ASAM Level 1.

B. The performing provider, in accordance to MSM 4100, Section 4113, must be enrolled with Medicaid in order for services to be reimbursed by Medicaid.

C. Services must be medically necessary and clinically appropriate.

D. Documentation requirements found in MSM 4100, Section 4116, apply.

E. Covered Services and PA requirements for Outpatient Mental Health only services in a Substance Use Treatment Clinic are the same as found in MSM 4100, Section 4107.A. Additionally, a CASII or LOCUS must be completed and accompany the request for prior authorization.

4111 NON-COVERED SERVICES

The following services are not covered under the substance use services program for the DHCFP:

A. Services for recipients without an assessment documenting diagnostic criteria for substance-related disorder (including SUD or substance-induced disorders) or mental health disorder as defined in the current ICD;

B. Services for marital problems without a covered, current ICD diagnosis;

C. Services for parenting skills without a covered, current ICD diagnosis;

D. Services for gambling disorders without a covered, current ICD diagnosis;

E. Custodial services, including room and board;

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

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

H. Respite;

I. Services for education;

J. Services for vocation training;

K. Habilitative services;

L. Phone consultation services; and

M. Care Coordination and treatment planning.

4112 PROVIDERS

Providers who are rendering treatment and services within each setting must obtain their own unique NPI for billing and be linked to the group specialty (Reference the billing guide for provider type 93 for additional billing information).

Providers rendering substance use treatment and services must be appropriately licensed or certified by their professional boards or have obtained the necessary certification as described in the provider enrollment checklist. In addition, providers must also have appropriate work experience with individuals who are diagnosed with SUD or mental health disorders.

The following list of providers may render substance use treatment, and supportive services in accordance to their professional license or certification, scope of work and experience:

A. Licensed Clinical Social Worker (LCSW)

B. Licensed Clinical Professional Counselor (LCPC)

C. Licensed Marriage and Family Therapist (LMFT)

D. Licensed Clinical Alcohol and Drug Counselor (LCADC)

E. Licensed Clinical Alcohol and Drug Counselor Intern (LCADC-I)

F. Licensed Alcohol and Drug Counselor (LADC)

G. Certified Alcohol and Drug Counselor (CADC)

H. Certified Alcohol and Drug Counselor Intern (CADC-I)

I. Peer Recovery Support Specialist (PRSS)

J. Pharmacists

K. Physician

L. Nurse practitioner

M. Physician assistant

N. Nurse midwife

4113 PROVIDER RESPONSIBILITIES

A. Determine placement into the appropriate level of care within the substance use treatment continuum.

B. Obtain authorization by the QIO-like vendor.

1. Must be obtained prior to admission.

2. A tentative treatment plan will be required for the QIO-like vendor's authorization:

a. The only exception is in the event of an emergency admission, in which the recipient may be admitted, and

b. The QIO-like vendor must be notified of the admission within five business days.

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

C. MEDICAL RECORDS

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

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

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

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

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

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

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

   1. The individual’s rights under state law to make decisions concerning their medical care, including the right to accept or refuse medical or surgical treatment, and the right to formulate advance directives (declarations and durable powers of attorney for health care decisions).

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

2. At a minimum, a provider’s or organization’s statement of limitation must:

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

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

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

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

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

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

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

3. Adhere to federal and state Advance Directive requirements which may be monitored or periodically reviewed by Nevada Medicaid to ensure compliance.

D. 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.

E. 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.

F. PATIENT RIGHTS

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

1. 42 CFR 482.13

2. NRS 449.730

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

G. 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).

H. HOSPITAL RESPONSIBILITIES FOR OUTSIDE SERVICES

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

I. ACUTE PSYCHIATRIC ADMISSION REQUIREMENTS

1. 42 CFR 441.152 addresses Certification of Need requirements.

2. 42 CFR 441.155 addresses Individual Plan of Care requirements.

3. 42 CFR 441.156 addresses the requirements of the composition of the team developing the individual plan of care.

J. PATIENT LIABILITY

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

4114 PROVIDER REQUIREMENTS

A. In order to be recognized and reimbursed as a Substance Use Treatment Clinic for ASAM Levels I-III by the DHCFP to provide SUD treatment, or to provide outpatient mental health treatment for individuals with mental health disorders, the provider must:

1. Be certified from the Division with approved ASAM levels of care; and

2. Be a Co-Occurring Capable Program; or

3. A Co-Occurring Enhanced Program

B. In order to be recognized and reimbursed as an inpatient for alcohol and substance use withdrawal management by DHCFP, the provider must be licensed by Nevada DPBH as:

1. An acute care general hospital with a psychiatric unit; or

2. A free-standing psychiatric hospital

3. A licensed chemical dependency specialty hospital with acute care medical and nursing staff

4. Have Medicare certification.

C. Verify Medicaid eligibility before providing services.

4115 DOCUMENTATION REQUIREMENTS

All programs require documentation in the recipient's medical record that consists of individualized treatment plans, progress notes, a discharge plan, and a discharge summary. Documentation should clearly reflect implementation of the treatment plan and the recipient's response to the therapeutic interventions for all disorders being treated, as well as subsequent amendments to the plan and treatment plan reviews conducted at specified times as documented on the treatment plan.

A. TREATMENT PLAN

A written individualized plan, referred to as treatment plan, is a person centered, comprehensive treatment guide developed jointly with the recipient, their family (in the case of legal minors) and/or their legal representative and the licensed SUD professional within the scope of their practice under state law, and adds patient-provider "shared decision making" considerations.

A Treatment Plan is rehabilitative and recovery oriented and addresses individualized goals and objectives. Goals are developed to reduce the duration and intensity of symptoms to the least intrusive service level possible while integrating care to address overall health. The Treatment Plan must consist of services designed to achieve goals to help restore the recipient to a functional level of independence. The services on a treatment plan must be medically necessary and clinically appropriate and must utilize evidence-based practices.

1. The treatment plan is based on a comprehensive assessment and includes:

a. The strengths and needs of the recipient;

b. Documentation supporting ASAM levels of care;

c. Person centered goals and objectives that are specific, measurable, attainable, realistic, and time sensitive (SMART);

d. Incorporates harm reduction principles;

e. Continue service, transfer, and discharge criteria per ASAM; and

f. Upon discharge, a continuing care plan.

2. The recipient, or their legal representative, must be involved in development of the treatment plan, be given a choice of providers, indicate an understanding of the need for services and the elements of the treatment plan. Recipient's, family's

(when appropriate), and/or representative's participation in treatment planning must be documented on the treatment plan.

a. Temporary, but clinically necessary, services do not require an alteration of the treatment plan, however, must be identified in a progress note. The note must indicate the necessity, amount scope, duration, and provider of the service.

b. Required signatures for treatment plan:

1. Recipient and their family/legal guardian (in the case of legal minors); and

2. The individual responsible for developing the plan, and;

3. The clinical supervisor of the agency must cosign assessments and treatment plans completed by an intern.

3. All SUD services requested must ensure 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

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

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

6. The requested services are to be specific, measurable, and relevant in meeting the goals and objectives identified in the Treatment Plan. The SUD licensed professional responsible for treatment plan development must identify within the Treatment Plan the scope of services to be delivered and are not duplicative or redundant of other prescribed behavioral health services.

7. The treatment plan is required to include, but not be limited to the following information:

a. Recipient's full legal name;

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

c. Intensity of Needs determination;

4. Documentation of SUD, co-occurring disorder, or mental health diagnosis;

5. Date of determination for diagnosis;

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

B. PROGRESS NOTE

A progress note is the written documentation of treatment services provided to the recipient which describes the progress, or lack thereof, towards the goals and objectives on the written treatment plan.

1. All progress notes documented with the intent of submitting a billable Medicaid SUD claim must be documented as the following:

a. In a manner that is sufficient to support the claim and billing of the services provided and;

b. Must include the amount, scope, and duration of the service(s) provided as well as identify the provider of the service(s) and;

c. Is required for each day the service was delivered, and;

d. Must be legible and must include the following information:

1. The name of the individual receiving the service(s).

2. If the services are in a group setting, it must be indicated;

3. The place of service;

4. The date the service was delivered;

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

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

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

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

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

10. A statement assessing the recipient's progress, or not, towards attaining the identified treatment goals and objectives.

C. DISCHARGE PLAN

The discharge plan must be included in the treatment plan and identifies:

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

2. Discharge Criteria, including ASAM discharge criteria as clinically appropriate;

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.

D. DISCHARGE SUMMARY

A discharge summary is 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. ASAM discharge criteria is met unless the recipient left prior to treatment being completed.

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

2. 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.

4116 SUPERVISION REQUIREMENTS

A. Clinical Supervisor – 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 to coordinate and oversee clinical services for SUD and mental health treatment. 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. For agencies providing co-occurring mental health treatment, the clinical supervisor must be either a LCADC, LCSW, LMFT, LCPC, Physician, Nurse Practitioner, PA, Nurse Midwife, or Psychologist with clinical experience in SUD and mental health treatment.

2. For agencies that are screening, referring, and coordinating care for recipients who require co-occurring mental health treatment, the clinical supervisor could be a LADC, CADC, or a LCADC, LCSW, LMFT, LCPC, Physician, Nurse Practitioner, PA, Nurse Midwife, or Psychologist with clinical experience in SUD treatment.

3. A CADC-I or LCADC-I may not act as the clinical director for an agency.

B. If the clinical supervisor of the agency will also provide supervision to CADC intern and LCADC intern, the supervisor is required to have the appropriate licensure and or training as required by the Board of Examiners in addition to their professional licensure. Supervision must be within the scope of the supervisor's practice, discipline, and field. In this case:

1. The clinical supervisor of the agency must review documentation completed by an intern.

2. The clinical supervisor of the agency must cosign assessments and treatment plans completed by an intern.

3. The clinical supervisor of the agency assumes responsibility for their licensed intern and shall maintain documentation on this.

4117 PROVIDER QUALIFICATIONS

A. GENERAL PROVIDER REQUIREMENTS:

1. Conditions of Participation

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:

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

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

2. Background Check

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 their employer. The employer must maintain both the requests and the results of the FBI criminal background check with the applicant's personnel records. Upon request, the employer must make the criminal background request and results available to Nevada Medicaid DHCFP for review.

The enrolled employer, 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.

a. If an applicant believes that the information provided as a result of the FBI criminal background check is incorrect, they must immediately inform the provider, in writing the incorrect information. The employer must inform DHCFP within five days of the discovery of the incorrect information;

b. DHCFP shall give the 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 provider pursuant to this section.

3. TB Testing

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 Behavioral Health Community Network (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.

B. SPECIFIC PROVIDER QUALIFICATIONS:

1. Interns

a. DHCFP will reimburse for SUD and co-occurring disorder treatment performed by LCADC-I and CADC-I.

b. Follow supervision in accordance with the respective boards.

c. Interns are excluded from functioning as clinical supervisors.

d. Follow supervision standards in MSM Chapter 4100 and have direct clinical oversight.

2. Peer Recovery Support Specialist

a. Follow supervision standards in MSM Chapter 4100 and have direct clinical oversight.

b. May not function as a clinical supervisor.

c. Must have current certification through Nevada Certification Board (NCB) and a copy of the certificate must be kept in the employee's file.

d. Have lived experience and a previous diagnosis of SUD.

e. Possess the skills and abilities to work collaboratively with and directly under the clinical supervisor.

f. Cannot be the legal guardian or spouse of the recipient.

4118 RECIPIENT RESPONSIBILITIES

A. Medicaid recipients are required to provide a valid Medicaid eligibility card to their service providers.

B. Medicaid recipients are expected to participate and comply with the service provider's treatment, care, and service plans, including making and keeping medical appointments.

4119 QUALITY IMPROVEMENT

Quality review is an ongoing process of certification requirements through the Division.

4120 HEARINGS

Please reference MSM Chapter 3100 – Hearings, for hearings procedures.