1. linked to their designated Supervisor.

2. Psychological Assistants registered through the Nevada Board of Psychological Examiners and has a designated licensed Psychologist through the Board of Psychological Examiners may render and their supervisor may bill for their services pursuant to NRS and NAC 461.

3. Psychological Interns registered through the Nevada Board of Psychological Examiners and has a designated licensed Psychologist through the Board of Psychological Examiners may render and their supervisor may bill for their services pursuant to NRS and NAC 461.

4. Psychological Trainees registered through the Nevada Board of Psychological Examiners and has a designated licensed Psychologist through the Board of Psychological Examiners may render and their supervisor may bill for their services pursuant to NRS and NAC 461.

403.4 OUTPATIENT MENTAL HEALTH SERVICES

These services include assessment and diagnosis, testing, basic medical and therapeutic services, crisis intervention, therapy, partial and intensive outpatient hospitalization, medication management and case management services. For case management services, refer to MSM Chapter 2500 for Non-SED and Non-SMI definitions, service requirements, service limitations, provider qualifications and documentation requirements.

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

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

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

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

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

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

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

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

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

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

B. Neuro-Cognitive, Psychological and Mental Status Testing

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

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

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

C. Mental Health Therapies

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

1. Family Therapy

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

2. Group Therapy

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

3. Individual Therapy Services

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

4. Neurotherapy

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

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

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

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

F34.1

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

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

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

6. Opposition Defiant Disorders and/or Reactive Attachment Disorders – 50 sessions
Current ICD Codes: F93.8, F91.3, F94.1, F94.2, F94.9 and F98.8

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

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

Prior authorization may be requested for additional services based upon medical necessity.

D. Mental Health Therapeutic Interventions

1. Partial Hospitalization Program (PHP) –A restorative program encompassing mental and behavioral health services and psychiatric treatment services designed for recipients who require a higher intensity of coordinated, comprehensive, and multidisciplinary treatment for mental or substance use disorders. These services are furnished under a medical model by a hospital in an outpatient setting or by a Federally Qualified Health Center (FQHC) that assumes clinical liability and meets the criteria of a Certified Mental Health Clinic (CMHC). These services are intended to be an alternative to inpatient psychiatric care and are generally provided to recipients experiencing an exacerbation of a severe and persistent mental illness and/or substance use disorder. PHP services include active therapeutic treatment and must be targeted to meet the goals of alleviating impairments and maintaining or improving functioning to prevent relapse or hospitalization. PHP is provided to individuals who are diagnosed as Severely Emotionally Disturbed (SED) or Seriously Mentally Ill (SMI), or as medically necessary under the American Society of Addiction Medicine (ASAM) criteria.

a. Scope of Services: PHP services may include:

1. Individual Therapy
2. Group Therapy (Group size must be four (4) to fifteen (15)).
3. Family Therapy
4. Medication Management
5. Medication Assisted Treatment
6. Drug Testing
7. Occupational Therapy
8. Behavioral Health Assessment
9. Basic Skills Training
10. Psychosocial Rehabilitation
11. Peer-to-Peer Support Services
12. Crisis Services

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

b. Service Limitations: PHP services are direct services provided in a mental/behavioral health setting for at least three (3) days per week and no more than five (5) days per week; each day must include at least four (4) hours of direct services as clinically indicated based on a patient-centered approach. If more/fewer hours and/or more/fewer days are indicated, the recipient should be reevaluated. PHP always requires a prior authorization and must be reauthorized every two (2) weeks.

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

d. Provider Qualifications: Direct services are face-to-face interactive services led by licensed staff and components of this service can be performed by qualified, enrolled health care workers practicing within their scope under the Direct Supervision of a QMHP-level professional,

including Interns. Interns can provide PHP services under Clinical Supervision. Direct Supervision requires that a licensed professional practicing within the scope of their Nevada licensure be onsite where services are rendered. Each component of the PHP must be provided by enrolled and qualified individuals within the scope of their practice.

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

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

1. Non-evidence-based models;
2. Transportation or services delivered in transit;
3. Club house, recreational, vocational, after-school, or mentorship program;
4. Routine supervision, monitoring, or respite;
5. Participation in community-based, social-based support groups (e.g., Alcoholics Anonymous, Narcotics Anonymous);
6. Watching films or videos;
7. Doing assigned readings; and
8. Completing inventories or questionnaires.

2. Intensive Outpatient Program (IOP) –A comprehensive interdisciplinary program of direct mental/behavioral health services which are expected to improve or maintain an individual's condition and functioning level for prevention of relapse or hospitalization. IOP is provided to individuals who are diagnosed as Severely Emotionally Disturbed (SED) or Seriously Mentally Ill (SMI), or as medically necessary under the ASAM criteria. IOP group sizes are required to be no more

than 15 recipients.

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

1. Individual Therapy
2. Group Therapy (Group size must be four (4) to fifteen (15)).
3. Family Therapy
4. Medication Management
5. Medication Assisted Treatment
6. Drug Testing
7. Occupational Therapy
8. Behavioral Health Assessment
9. Basic Skills Training
10. Psychosocial Rehabilitation
11. Peer-to-Peer Support Services
12. Crisis Services

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

b. Service Limitations: IOP services delivered in a mental/behavioral health setting are direct services provided three (3) days per week; each day must include at least three (3) hours and no more than six (6) hours of direct service delivery as clinically indicated based on a patient-centered approach. If more/fewer hours and/or more/fewer days are indicated, the recipient should be reevaluated. IOP services always require prior authorization, and must be reapproved every two (2) weeks.

c. IOP Curriculum and Utilization Management: A curriculum and a schedule for the program must be submitted with each PA request. The curriculum must outline the service array being delivered including evidence-based practice(s), best practice(s), program goals, schedule of program and times for service delivery, staff delivering services, and population served in the program.

IOP program recipients must receive on-going patient assessments, at regularly scheduled intervals and whenever clinically indicated, including intensity of needs determinations using ASAM/LOCUS/CASII to evaluate the recipient's response to treatment interventions and to monitor progress toward treatment plan goals. Recipient assessments must document the individual's response to the treatment plan, identify progress toward individual and program goals, reflect changes in identified goals and objectives, and substantiate continued stay at the current intensity/frequency of services. An updated treatment plan must be completed to justify a transfer to a higher or lower intensity/frequency of services or discharge from treatment as no longer meeting medical necessity at any level. Transfer and discharge planning must reflect best practices recognized by professional and advocacy organizations that ensure coordination of needed services, follow-up care and recovery supports.

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

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

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

1. Non-evidence-based models;

2. Transportation or services delivered in transit;

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

4. Routine supervision, monitoring or respite;

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

6. Watching films or videos;

7. Doing assigned readings; and

8. Completing inventories or questionnaires.

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

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

must be available for consult. Medication Training and Support is designed to maintain the member on the appropriate level of the least intrusive medications, encourage normalization and prevent hospitalization. Medication Training and Support may not be billed for members who reside in ICF/IID facilities.

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

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

1. If recipient was present or not;

2. Recipient's response to the medication;

3. Recipient's compliance with the medication regimen;

4. Medication benefits and side effects;

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

6. Documented within the progress notes/medication record.

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

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

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

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

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

403.2 OUTPATIENT MENTAL HEALTH (OMH) SERVICES - UTILIZATION MANAGEMENT

A. INTENSITY OF NEEDS DETERMINATION

The assessed level of needs and the amount, scope and duration of RMH services required to improve or retain a recipient's level of functioning or prevent relapse. The determination cannot be based upon the habilitative needs of the recipient. Intensity of needs determination is completed by a trained QMHP or QMHA. Intensity of needs determinations are based on several components consistent with person and family centered treatment/rehabilitation planning. Intensity of Needs redeterminations must be completed every 90 days or anytime there is a substantial change in the recipient's clinical status.

These components include:

1. A comprehensive assessment of the recipient's level of functioning;

2. The clinical judgment of the QMHP; and

3. A proposed treatment and/or rehabilitation plan.

B. INTENSITY OF NEEDS GRID

1. The intensity of needs grid is an approved Level of Care (LOC) utilization system,