403.6 PROVIDER QUALIFICATIONS

403.6A REHABILITATION MENTAL HEALTH (RMH) SERVICES

RMH services may be provided by specific providers who meet the following qualifications for an authorized service:

1. QBA – Is a person who has an educational background of a high-school diploma or General Education Development (GED) equivalent and has been determined competent by the overseeing Clinical Supervisor, to provide RMH services. These services must be provided under direct contract with a BHCN or Independent RMH provider. A QBA must have the documented competencies to assist in the provision of individual and group rehabilitative services under the Clinical Supervision of a QMHP and the Direct Supervision of a QMHP or QMHA.

    a. QBAs must also have experience and/or training in service provision to people diagnosed with mental and/or behavioral health disorders and the ability to:

        1. read, write and follow written and oral instructions;

        2. perform RMH services as prescribed on the rehabilitation plan;

        3. identify emergency situations and respond accordingly;

        4. communicate effectively;

        5. document services provided; and

        6. maintain recipient confidentiality.

    b. Competency and In-services Training

        1. Before QBAs can enroll as Medicaid providers, they are required to successfully complete an initial 16-hour training program. This training must be interactive, not solely based on self-study guides or videotapes and should ensure that a QBA will be able to interact appropriately with individuals with mental health disorders. At a minimum, this training must include the following core competencies:

            a. Case file documentation;

            b. Recipient's rights;

            c. Client confidentiality pursuant to state and federal regulations;

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d. Communication skills;

e. Problem solving and conflict resolution skills;

f. Communication techniques for individuals with communication or sensory impairments;

g. Cardiopulmonary Resuscitation (CPR) certification (certification may be obtained outside the agency); and

h. Understanding the components of a Rehabilitation Plan.

2. QBAs must also receive, at a minimum, two hours of quarterly in-service training. At a minimum, this training must include any combination (or single competency) of the following competencies:

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

b. Social skills: The ability to help recipients learn how to identify and comprehend the physical, emotional and interpersonal needs of others – recipients learn how to interact with others;

c. Communication skills: The ability to help recipients learn how to communicate their physical, emotional and interpersonal needs to others – recipients learn how to listen and identify the needs of others;

d. Parental training: The ability to facilitate parents' abilities to continue the recipient's (child's) RMH care in home and community-based settings.

e. Organization and time management skills: The ability to help recipients learn how to manage and prioritize their daily activities; and/or

f. Transitional living skills: The ability to help recipients learn necessary skills to begin partial-independent and/or fully independent lives.

1. For QBAs whom will also function as peer-to-peer supporters, their quarterly in-service training must also include, at a minimum, any combination (or

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single competency) of the following competencies:

a. The ability to help stabilize the recipient;

b. The ability to help the recipient access community based mental and/or behavioral health services;

c. The ability to assist during crisis situations and interventions;

d. The ability to provide preventative care assistance; and/or

e. The ability to provide personal encouragement, self-advocacy, self- direction training and peer mentoring.

b. Applicants must have an FBI criminal background check before they can enroll with Nevada Medicaid as QBAs. Applicants must submit the results of their criminal background checks to the overseeing BHCN and/or the Individual RMH provider (who must also be a Clinical Supervisor). The BHCN and/or the individual RMH provider must maintain both the requests and the results with the applicant's personnel records. Upon request, the BHCN and/or the individual RMH provider must make the criminal background request and results available to Nevada Medicaid (DHCFP) for review.

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

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

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

The BHCN or independent RMH provider upon receiving information resulting from the FBI criminal background check, or from any other source, may not continue to employ a person who has been convicted of an offense as listed above, and as cited within MSM Chapter 100. If an applicant believes that the information provided as a result of the FBI criminal background check is incorrect, he or she must immediately inform the BHCN or independent RMH provider or the DHCFP (respectively) in writing. The BHCN or independent RMH provider or the DHCFP, that is so informed within five days, may give the employee or independent contractor a reasonable amount of time, but not more than 60 days, to provide corrected information before denying an application, or terminating the employment

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or contract of the person pursuant to this section.

e. Have had tuberculosis (TB) tests with negative results documented or medical clearance as outlined in NAC 441.A375 prior to the initiation of service delivery. Documentation of TB testing and results must be maintained in the BHCN or independent RMH provider personnel record. TB testing must be completed initially and annually thereafter. Testing and surveillance shall be followed as outlined in NAC 441A.375.3.

f. The purpose of the annual training is to facilitate the development of specialized skills or knowledge not included in the basic training and/or to review or expand skills or knowledge included in the basic training. Consideration must be given to topics suggested by recipients. Documentation of the completed training and achieved competencies meeting this requirement must be maintained by the BHCN or independent RMH provider. Training requirements may be waived if the QBA can provide written verification of comparable education and training. The BHCN or independent RMH provider must document the comparability of the written verification to the QBA training requirements.

2. QMHA, refer to Section 403.3A.

3. QMHP, refer to Section 403.3B.

403.6B REHABILITATIVE MENTAL HEALTH (RMH) SERVICES

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

Prior to providing RMH services, a QMHP must conduct a comprehensive assessment of an individual's rehabilitation needs including the presence of a functional impairment in daily living and a mental and/or behavioral health diagnosis. This assessment must be based on accepted standards of practice and include a covered, current ICD diagnosis. The assessing QMHP must approve a written Rehabilitation Plan. The rehabilitation strategy, as documented in the Rehabilitation Plan, must be sufficient in the amount, duration and scope

to achieve established rehabilitation goals and objectives. Simultaneously, RMH services cannot be duplicative (redundant) of each other. Providers must assure that the RMH services they provide are coordinated with other servicing providers. Case records must be maintained on recipients receiving RMH services. These case records must include and/or indicate:

a. the recipient's name;

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

c. the recipients and their families/legal guardians (in the case of legal minors) acknowledgement of their freedom to select a qualified Medicaid provider of their choosing;

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

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

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

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

3. Provider Qualifications:

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

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

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

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

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

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

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

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

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

e. habilitative services;

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

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

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

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

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

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

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

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

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

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

5. Administrative costs associated with room and board;

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

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

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

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

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

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q. support group services other than Peer Support services;

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

s. respite care;

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

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

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

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

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

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

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

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

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

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

2. SED or SMI determination; and
3. clinical judgment; and

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

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

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

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

2. SED or SMI determination; and

3. clinical judgment; and

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

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

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

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

2. SED or SMI determination; and

3. clinical judgment; and

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

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

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

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

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

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services; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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and objectives;

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

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

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

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

403.6C BASIC SKILLS TRAINING (BST) SERVICES

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

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

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

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

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

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

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

2. Provider Qualifications:

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

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

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

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

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

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

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

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

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BST services are based on the below daily maximums:

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

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

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

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

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

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

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

403.6D PROGRAM FOR ASSERTIVE COMMUNITY TREATMENT (PACT)

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

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

3. Services are available 24 hours a day, seven days per week. Team members may interact with a person with acute needs multiple times a day. As the individual stabilizes, contacts decrease. This team approach is facilitated by daily team meetings in which the team is briefly updated on each individual. Activities for the day are organized and team members are available to one another throughout the day to provide consultation or assistance. This close monitoring allows the team to quickly adjust the nature and intensity of services in response to individuals' changing needs. PACT is reimbursed as unbundled services.

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403.6F PEER-TO-PEER SERVICES

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

   a. Helping stabilize the recipient;

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

   c. Assisting during crisis situations and interventions;

   d. Providing preventative care assistance; and/or

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

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mentoring.

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

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

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

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

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

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

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

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

403.6G PSYCHOSOCIAL REHABILITATION (PSR) SERVICES

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

   PSR services may include any combination of the following interventions:

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

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

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

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

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

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

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

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

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

2. Provider Qualifications:

   a. QMHP: QMHPs may provide PSR services.

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

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c. QBA: QBAs may not provide PSR services.

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

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

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

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

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

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

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

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

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

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

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

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

403.6H CRISIS INTERVENTION (CI) SERVICES

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

   CI services must include the following:

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

   b. Conduct situational risk-of-harm assessment;

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

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

over the CI services rendered.

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

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

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

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

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

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

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

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403.6I CRISIS STABLIZATION CENTER

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

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

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

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

    a. De-escalate or stabilize a behavioral health crisis, whether this is occuring concurrently with a substance use disorder or not and
    b. When appropriate, avoid admission of a patient to another inpatient mental health facility or hospital and connect the patient with providers of ongoing care as appropriate for the unique needs of the patient.

3. Requirements: Crisis Stabilization Centers must operate in accordance with established administrative protocols, evidenced-based protocols for providing treatment and evidence-based standards for documenting information concerning services rendered to recipients of such services in accordance with best practices for providing crisis stabilization services. Has a policy structure in place that establishes, including but not limited to:
    a. Procedures to ensure that a mental health professional is on-site twenty-four hours a day, seven days a week;
    b. Procedures to ensure that a licensed physician, physician assistant, or psychiatric Advanced Practice Registered Nurse (APRN) is available for consultation to direct care staff twenty-four hours a day, seven days a week;
    c. Procedures to ensure[SP1] RNs, LPNs, social workers, community health workers, and peer support specialists (as defined per Chapter 449 of the Nevada Revised Statutes) are available to adequately meet the needs of recipients;
    d. Procedures to assure that restraint and seclusion are utilized only to the extent necessary to ensure the safety of patients and others
    e. Delivers crisis stabilization services:
        1. To all persons who come in the door, whether as walk-ins or drop-offs from law enforcement or a mobile crisis team.
    f. Uses a data management tool to collect and maintain data relating to admissions, discharges, diagnoses and long-term outcomes for recipients of crisis stabilization services
    g. Operating in accordance with best practices for the delivery of crisis stabilization services, CSCs must include:
        1. Recovery Orientation
            a. In a manner that promotes concepts that are integral to recovery for persons with behavioral health issues, including, without limitation, hope, personal empowerment, respect, social connections, self-responsibility and self-determination
        2. Trauma-informed care
            a. Many individuals experiencing a behavioral health crisis or substance use disorder have experienced some sort of trauma in

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the past

3. Significant use of peer staff
    a. People with lived experience who have something in common with the recipients needing help
4. Commitment to Zero Suicide/Suicide Safer Care
5. Strong commitments to safety for consumers/staff
6. Collaboration with Law Enforcement

4. Provider Responsibilities:
    a. An endorsement as a crisis stabilization center must be renewed at the same time as the license to which the endorsement applies. An application to renew an endorsement as a crisis stabilization center must include, without limitation:
        1. Proof that the applicant meets the requirements per NRS 449.0915;
        2. Proof that the hospital is a rural hospital or is accredited by the Commission on Accreditation of Rehabilitation Facilities, the Center for Improvement in Healthcare Quality, DNV GL Healthcare, the Accreditation Commission for Health Care, or the Joint Commission, or their successor organizations
    b. Medical Records: A medical record shall be maintained for each recipient and shall contain the following items in addition to requirements listed in 403.9B(2):
        1. An assessment for substance use disorder and co-occurring mental health and substance abuse disorder including a statement of the circumstances under which the person was brought to the unit and the admission date and time;
        2. An evaluation[SP2] (performed within …timeframe) by a mental health professional to include at a minimum:
            a. Mental status examination; and
            b. Assessment of risk of harm to self, others, or property
        3. Review of the person's current crisis plan;
        4. The admission diagnosis and what information the determination was based upon;
        5. Coordination with the person's current treatment provider, if applicable;
        6. A plan for discharge, including a plan for follow up that includes:
            a. The name, address, and telephone number of the provider of follow-up services; and
            b. The follow up appointment date and time, if known
        7. The clinical record must contain a crisis stabilization plan developed collaboratively with the recipient and/or guardian that includes:
            a. Strategies and interventions to resolve the crisis in the least restrictive manner possible;
            b. Language that is understandable to the recipient and members of the recipient's support system; and
            c. Measurable goals for progress toward resolving the crisis and returning to an optimal level of functioning
        8. If antipsychotic medications are administered, the clinical record must document:
            a. The physician's attempt to obtain informed consent for antipsychotic medication; and
            b. The reasons why any antipsychotic medication is administered over the recipient's objection or lack of consent.

5. Admission Criteria: Accepts all patients, without regard to:
    a. Race, ethnicity, gender, socioeconomic status, sexual orientation or place of residence of the patient;
    b. Any social conditions that affect the patient;
    c. The ability of the patient to pay; or

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

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

1. All beneficiaries receiving Crisis Stabilization shall receive an assessment of their physical and mental health. Assessment and stabilization services will be provided by the appropriate staff. If outside services are needed, a referral that corresponds with the recipient's need shall be made.
2. Has the equipment and personnel necessary to conduct a medical examination of a patient pursuant to NRS 433A.165;
    a. Medical backup services must be available either on site or by written contract or agreement with a general acute care hospital. Medical backup means immediate access within reasonable proximity to health care for medical emergencies
3. Considers whether each patient would be better served by another facility and transfer a patient to another facility when appropriate.

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

1. Case management services, including, without limitation, such services to assist patients to obtain housing, food, primary health care and other basic needs;
2. Services to intervene effectively when a behavioral health crisis occurs and address underlying issues that lead to repeated behavioral health crises;
3. Treatment specific to the diagnosis of a patient; and
4. Coordination of aftercare for patients, including, without limitation, at least one follow-up contact with a patient not later than 72 hours after the patient is discharged.

403.7 OUTPATIENT ALCOHOL AND SUBSTANCE ABUSE SERVICES POLICY

Outpatient substance abuse services may be provided by a QHMP within the scope of their practice under state law and expertise.

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