POLICY: The Division of Mental Health and Developmental Services (MHDS), as well as Division agencies, will follow specific procedures to obtain Medicaid reimbursement for mental health rehabilitative treatment services as defined below.

PURPOSE: This policy is to assist MHDS' mental health agencies with 1) meeting the documentation requirements set forth by the Centers for Medicare and Medicaid Services (CMS) and Division of Health Care Financing and Policy (DHCFP, for which Medicaid is the primary program) for mental health rehabilitation services, and 2) properly submitting claims and billing for mental health rehabilitation services.

PROCEDURES:

I. Objectives of Mental Health Rehabilitation Treatment Services

A. The objectives of rehabilitation services are to provide treatment or rehabilitation in the following areas
1. Basic Skills Training;
2. Psychosocial Rehabilitation;
3. Program for Assertive Community Treatment (PACT);
4. Treatment Home Services; and
5. Clinical Case Management.

B. Definition and Standards
1. Rehabilitative Mental Health (RMH) Services must be recommended by a Qualified Mental Health Professional (QMHP) within the scope of their practice under state law. RMH services are goal orientated outpatient interventions that target the maximum reduction of mental health and/or behavioral health impairments and strive to restore consumers to their best possible mental and/or behavioral health functioning. 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 consumers' overall health. All RMH services must be directly and medically necessary.
2. Prior to providing RMH services, a QMHP must conduct a comprehensive assessment of a consumer's rehabilitation needs including the presence of a functional impairment in daily living and a mental and/or behavioral health diagnosis. The assessing QMHP must approve a written Rehabilitation Plan that includes a rehabilitation strategy sufficient in amount, duration, and scope to achieve established rehabilitation goals and objectives.

II. Recordkeeping/Documentation

A. Medical Record/Chart
For all consumers receiving mental health rehabilitation services, case records

must include the following:

1. A copy of the rehabilitation treatment plan;
2. The name of the consumer;
3. The date of the rehabilitative services provided;
4. The nature, content, and units of the specific mental health rehabilitative services; and
5. The progress made toward functional improvement and attainment of the consumer's goals as identified in the rehabilitative plan and case record.

B. Progress Notes

Progress Notes must be completed at least monthly and any time there is a substantial change in the consumer's clinical status. They must contain:

1. Documentation of progress or lack of progress toward the Treatment Plan's goals and objectives;
2. Sufficient information to support the services provided;
3. Amount, scope, and duration of the service;
4. Provider of the service; and
5. A focus on how the services furnished are a) providing for the maximum reduction of mental disability and b) providing restoration to the consumer to their best possible functional level.

C. Rehabilitative Plans

1. A comprehensive, progressive, and individualized written Rehabilitation Plan must include all the prescribed RMH services: Basic Skills Training (BST), Program for Assertive Community Treatment (PACT), Day Treatment, Psychosocial Rehabilitation, and Crisis Intervention (CI). The Rehabilitation Plan must:
   a) Include recovery goals, and provide for a process to involve the consumer, and family (if appropriate), in the overall management of care. The plan must document that the services have been determined to be rehabilitative services and will have a timeline based on the consumer's assessed needs and anticipated progress;
   b) Involve the consumer, the consumer's family or other responsible consumers (if appropriate) in the reevaluation of the plan. The reevaluation of the plan must include a review of whether the established goals and objectives are being met and whether each of the services prescribed in the plans contributed to meeting the stated established goals and objectives;
   c) Be reasonable and based on an consumer's diagnosed condition, ensuring that services are provided within the scope (therapeutic intent) of the rehabilitative services and would increase the likelihood that a consumer's disability would be reduced and functional level restored.
2. As a minimum, Rehabilitative Plans must include the following headings:
   a) Consumer's Full Name;
   b) Consumer's 11-digit Medicaid Billing Number;
   c) Intensity of Needs Determination;
   d) SMI/SED Determination;

e) Measurable Goals and Objectives;
f) Prescribed Services:
1) Specific mental health services(s) to be provided;
2) The daily service duration and therapeutic scope for each service to be provided; and
3) The provider or providers that are anticipated to provide each service.

3. For more detailed information as to the Medicaid Rehabilitative Plan requirements, please consult the Medicaid Services Manual, Chapter 400, section 402.34.

D. Eligible Consumers

By statute, Mental Health Rehabilitation Treatment services are available for consumers who are seriously mentally Ill (SMI) and who:

1. Are 18 years or older;
2. Currently, or at any time during the past continuous 12 month period,, have had a diagnosable mental, behavioral or emotional disorder that meets the coding and definitional criteria specified within the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), excluding substance abuse or addictive disorders, and irreversible dementias or mental retardation unless they co-occur with another DSM-IV diagnosed mental disorder;
3. Have a related functional impairment that substantially interferes with or limits one or more major life activities, such as social, psychological, occupational or educational, and may include limiting an adult from achieving or maintaining housing, employment, education, relationships or safety;
4. Are expected to benefit from treatment; and
5. Are recommended for services by a Qualified Mental Health Professional (QMHP) within the scope of their practice under state law.

E. Standards for Provider Participation

Facilities must be statutorily defined comprehensive mental health centers (NRS 433.144) and their affiliates.

1. Eligible providers are:
a) Licensed psychiatrists;
b) Licensed psychologists;
c) Licensed social workers;
d) Licensed RN's;
e) Psychiatric caseworkers, mental health technicians, peer supporters, and other paraprofessionals supervised by a licensed mental health professional; and
f) Approved contractors of the Division of MHDS.
2. Medicaid has classified providers into three main groups:
a) Qualified Mental Health Professionals (QMHP);
b) Qualified Mental Health Associates (QMHA); and
c) Qualified Behavioral Aides (QBAs).

III. Mental Health Rehabilitative Treatment Claims Submission and Billing

A. Services (Medicaid's definitions as a requirement for billable services)

1. **Basic Skills Training (BST):**
   Individual - Procedure Code: H2014 (no modifier)
   Group - Procedure Code: H2014 (modifier HQ)
   Basic Skills Training (BST) Services are RMH interventions designed to reduce cognitive and behavioral impairments and restore consumers to their highest level of functioning. BST services help consumers acquire constructive cognitive and behavioral skills through positive reinforcement, modeling, operant conditioning, and other training techniques. BST services teach consumers a variety of life skills, and may include basic living and self-care skills, social skills, communication skills, parental training, organizational and time management skills, and transitional living skills.
2. **Psychosocial Rehabilitation (PSR)**
   Individual - Procedure Code: H2017 (no modifier)
   Group - Procedure Code: H2017 (modifier HQ)
   Psychosocial Rehabilitative Services (PSR) are designed to reduce psychosocial dysfunction (e.g., interpersonal, cognitive, behavioral development, etc.) and restore consumers to their highest level of functioning. PSR services may include any combination of the following interventions – behavioral management, social competency, problem identification and resolution, effective communication, culturally relevant moral reasoning, emotional intimacy, self sufficiency and identifying life goals.
3. **Program for Assertive Community Treatment (PACT)**
   Individual or Group (No procedure code or modifier)
   a) A multi-disciplinary team-based approach of the delivery 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 or QMHA., For MHDS agencies this means the team may be composed of the following providers: Psychiatrist, Psychologist, Licensed Clinical Social Worker, Licensed Marriage and Family Therapist, Psychiatric Counselor, Registered nurse, and Case Manager.
   b) PACT is for consumers who have the most serious and intractable symptoms of a severe mental illness and who 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.
   c) Services are available 24 hours a day, seven days per week. Team members may interact with a consumer with acute needs several times a day. As the consumer stabilizes, contacts decrease. This team approach is facilitated by the daily team meetings in which the team is briefly updated on each consumer. 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 the consumer's changing needs. PACT is reimbursed as unbundled services.

4. **Crisis Intervention (CI) Services**
   Individual – Procedure Code: H2011 (face-to-face)
   H2011 (modifier GT) (telephone)
   NNAMHS only use 96152 (face-to-face) and H2011 (telephone)
   Group - Procedure Code: H2011 (face-to-face) and
   H2011 (modifier GT) (telephone)
   Crisis Intervention (CI) services are interventions that target situations where consumers 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 consumers to their highest level of functioning, and prevent acute hospital admissions. CI services may be provided in a variety of settings including but not limited to psychiatric emergency departments, emergency rooms, homes, foster homes, schools and homeless shelters.
5. **Day Treatment**
   Individual – Procedure Code: (currently not in use)
   Group - Procedure Code: (currently not in use
   a) Day Treatment Services are designed to reduce emotional, cognitive, and behavioral problems and restore consumers to their highest level of functioning. Day Treatment Services provide consumers with opportunities to implement and expand upon what they learned / gained from other mental and/or behavioral health therapies and interventions in safe settings. The goal of Day Treatment Services is to prepare consumers for reintegration back into their home and community based settings.
   b) Day Treatment Services includes a fluid combination of all RMH services, therefore, providers cannot bill separately for BST, Psychosocial Rehabilitation, and Crisis Intervention Services during the same time of day or day they bill for services.
6. **Medicaid Rehabilitative Mental Health Service Requirements**
   For a complete listing of all Medicaid Rehabilitative Mental Health Service requirements including prior authorization requirements, please consult the Medicaid Services Manual, Chapter 400, which can be obtained from the following website link:
   http://dhcfp.state.nv.us/MSM/CH0400/Ch%20400%20FINAL%202-9-10.pdf

B. **Billing-General**

In accordance with state law and public policy, consumers or responsible parties are financially responsible for the full cost of services rendered. No services will be denied consumers because of inability to pay. For consumers who claim inability to pay full cost of care, it is Division policy that the burden of proof to

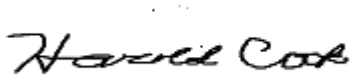
demonstrate inability to pay is the responsibility of the consumer served (or responsible parties).

C. **Medicaid Billing**
MHDS' Central Billing Office (CBO) bills for all mental health agencies' rehabilitative treatment services under their provider type 14 number. Services will be billed monthly in a professional format for daily and hourly rates utilizing the Medicaid devised procedure codes.

D. **Authorization for Services**
1. All mental health rehabilitative services require prior authorization, with the exception of CI services, which require post authorization.
2. To obtain authorizations for mental health services, MHDS agencies are required to submit First Health Services "Behavioral Health" Authorization Form (FH-11A). In return, First Health will issue the formal authorization to the MHDS agencies. (CI services require the use of the FH-11C form.)

E. **Complete Information on Billing**
Please consult MHDS Billing Policy #3.004, and the Medicaid Billing Guide, and the CMS-1500 Claim form instructions on the First Health Services Corporation website at: http://nevada.fhsc.com/providers/manuals/manuals.asp

F. **Division Agency Procedures**
Each Division agency shall develop specific written procedures to implement the provision of this policy or shall incorporate this policy into the agency policy manual.



ADMINISTRATOR

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