

**32-000 MENTAL HEALTH AND SUBSTANCE ABUSE TREATMENT SERVICES FOR CHILDREN AND ADOLESCENTS**

**32-001 Definitions:** The following definitions apply to regulations in this chapter:

**Active Treatment:** Implementation of an individual plan of care that is developed and supervised by a practitioner able to diagnose major mental illness based on a diagnostic evaluation. The plan of care identifies specific treatment interventions, describes therapies, and specifies discharge plans.

**American Society of Addiction Medicine (ASAM):** References the most current edition of the placement criteria published by the American Society of Addiction Medicine. It is used to match clients with substance-related disorders to appropriate levels of care for substance abuse treatment.

**Biopsychosocial Assessment:** A comprehensive assessment of the client's biological, social, psychological, psychiatric components. Part I of a Pretreatment Assessment (PTA).

**Child and Adolescent Needs and Strengths (CANS):** An assessment tool used to identify children's risk factors to a degree sufficient to tailor targeted treatment to their presented clinical problems.

**Client:** A child or adolescent under the age of 21.

**Client Assistance Program (CAP):** Client Assistance Programs are a short-term, solution-focused set of interventions to assist a client who is eligible for the Medicaid managed care benefit of mental health and/or substance abuse services. The client is eligible for up to five services per calendar year to assist a client in reducing or eliminating the current stressors that are interfering with the client's daily living and wellbeing.

**Community-Based Treatment:** Treatment services provided in a facility or clinic that is not an institution, preferably located in the client's home community and environment. Examples include outpatient mental health/substance abuse services, Intensive Outpatient Programs, Day Treatment, Professional Resource Family Care, and Therapeutic Group Home (ThGH) services.

**Community Treatment Aide (CTA):** An educated, trained, skilled, non-licensed direct care staff person competent to teach and instruct mental health and/or substance abuse skill building services and interventions in the client's home or other appropriate location conducive for treatment intervention to the client and the client's caregivers. These services are delivered in an outpatient community-based setting (client's home, school, or child care setting) and are not billable in an inpatient, office, or clinic service.

**Conferences with Family or Other Responsible Persons:** A treatment service provided to advise family or other responsible persons regarding methods/interventions to assist the client in managing mental health/substance abuse symptoms and problems. The treatment intervention is provided by a licensed practitioner of mental health and/or substance abuse services acting within his/her scope of practice. Family and other responsible persons are those individuals who have direct care giving responsibilities to the client. These may include parents, foster parents, relatives who are appointed guardians who have day to day care giving responsibilities. The service shall be related to current treatment issues based on the client's primary diagnosis. The service shall have a direct effect on the treatment of the client and require the expertise of the licensed practitioner providing the service.

**Co-Occurring Disorders:** Clients with substance abuse disorders and mental health disorders who require treatment for both disorders simultaneously.

**Department:** The Department of Health and Human Services of the State of Nebraska.

**Diagnostic & Statistical Manual (DSM):** The most current edition of the Diagnostic & Statistical Manual of mental disorders as published by the American Psychiatric Association.

**Direct Care Staff:** A trained, skilled, non-licensed individual who has a bachelor's degree or greater in psychology, sociology, or a related human services field and two years of experience in human service related employment or two years of human service experience and two years of training in psychology, sociology or a related human services field. Each staff shall complete training and shall have demonstrated skills and competency in the treatment of clients with mental health and substance abuse disorders prior to delivery of services. Direct Care Staff provide rehabilitation services.

**Division:** The Department of Health and Human Services, Division of Medicaid and Long-Term Care.

**Early Periodic Screening, Diagnosis and Treatment (EPSDT):** A health check designed to screen for and treat illnesses in clients under the age of 21 and freely available to any Medicaid-eligible member of that population.

**Family:** May include biological parents, stepparents, or adoptive parents; siblings or half siblings; and extended family members as appropriate and necessary to achieve the client's treatment goals.

**Family Psychotherapy:** A treatment encounter between the client, the nuclear and/or extended family, and a licensed practitioner of mental health and/or substance abuse services acting within his/her scope of practice. These services shall focus on the family as a system and include a comprehensive family assessment. The specific objective of treatment shall be to alter the family system to increase the functional level of the identified client and all family members.

**Family Substance Abuse Counseling:** A face-to-face treatment session which occurs between an identified client and the client's nuclear or extended family and a licensed practitioner skilled in substance abuse related disorders and family issues. The specific objective of family substance abuse counseling is to focus on the family and the family system to increase the functional level of the identified client and the client's family related to substance abuse.

**Functional Impairment:** Serious limitations of a client that substantially interfere with or limit role functioning in major life activities.

**Group Psychotherapy:** A treatment encounter between the client and a licensed practitioner of mental health and/or substance abuse services acting within his/her scope of practice in the context of a group setting of 3-12 clients. Group psychotherapy shall provide active treatment for a primary diagnosis. Medicaid does not cover groups that are only supportive or educational in nature, or the services of a co-therapist.

**Group Substance Abuse Counseling:** An encounter between a client and a licensed practitioner whose scope of practice allows the practitioner to provide alcohol/drug treatment and has special skills and knowledge in a group setting of 3-12 clients for the purposes of assisting clients in achieving treatment objectives. Group substance abuse counseling shall provide active treatment for a primary diagnosis. Medicaid does not cover groups that are only supportive or educational in nature, or the services of a co-therapist.

**HCPCS/CPT:** Healthcare Common Procedure Coding System/Current Procedural Technology codes used for Medicaid billing and reimbursement.

**HIPAA:** Health Insurance Portability and Accountability Act rules that pertain to privacy and security of a client's health records and information. Pub. L. No. 104-191 (August 21, 1996), as amended.

**Individual Psychotherapy:** A therapeutic one-to-one encounter between the client and a licensed practitioner whose scope of practice includes mental health services acting within his/her scope of practice to provide active treatment for an acceptable primary mental health diagnosis. Note that no additional reimbursement is made for medication checks performed by a physician in the course of client psychotherapy.

**Individual Substance Abuse Counseling:** A therapeutic one-to-one encounter between the client and a licensed practitioner whose scope of practice includes substance abuse services. The service is provided to a Medicaid-eligible client with a diagnosis of substance abuse or substance dependence.

**Initial Diagnostic Interview:** Includes a review of the biopsychosocial components, a mental status examination, and formulation of diagnosis and treatment recommendations. It is Part II of a Pretreatment Assessment.

**Inpatient Mental Health/Substance Abuse Services:** Services delivered to Medicaid-eligible clients and reimbursed by Medicaid that are administered in a hospital or freestanding psychiatric facility through programs providing 24 hours per day of treatment.

**Institution:** In this document Institution refers to a hospital or freestanding psychiatric facility setting that does not create a home-like environment for clients.

**Institution of Mental Disease (IMD):** A hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental disease, including medical attention, nursing care and related services. An institution is an IMD if its overall character is that of a facility established and maintained primarily for the care and treatment of individuals with mental disease.

**Licensed:** Unless otherwise specified, the term licensed refers to a license or credential issued by the State of Nebraska.

**Licensed Alcohol/Drug Abuse Counselor (LADC):** A person licensed by the Department's Division of Public Health to perform alcohol and drug counseling, or by the appropriate agency in the state where the service is performed

**Licensed Independent Mental Health Practitioner (LIMHP):** A person licensed to provide mental health assessment and treatment to clients who can diagnose major mental illness and supervise Licensed Mental Health Practitioners.

**Licensed Mental Health Practitioner (LMHP):** A practitioner who holds himself/herself out as a person qualified to engage in mental health practice or a person who offers or renders mental health services. This practitioner is fully licensed and shall adhere to his/her scope of practice.

**Provisionally Licensed Mental Health Practitioner (PLMHP):** An individual who has achieved provisional licensure to provide mental health/substance abuse services with supervision to achieve clinical hours necessary to become fully licensed.

**Nebraska Medicaid Managed Care Program (NMMCP):** For this chapter, NMMCP refers to the Medicaid managed care program responsible for managing the mental health and substance abuse services for clients receiving the managed care benefit for behavioral health services.

**Nebraska Medical Assistance Program:** The Nebraska's Medicaid Program.

**National Accreditation:** Meeting the standards set by The Joint Commission (TJC), the Commission on Accreditation of Rehabilitation Facilities (CARF), and the Council On Accreditation (COA).

**Outpatient Mental Health Substance Abuse Services:** Mental health and/or substance abuse services for which a client receives less than 24 hours of treatment in an outpatient facility, clinic, or client's home.

**Physician Direction:** Physician direction means services furnished by or under the direction of a physician without regard to the program itself is administered by a physician without regard to whether the program itself is administered by the physician. Physician direction does not mean that the physician shall necessarily be an employee of the program or be utilized on a full-time basis or be present in the facility during all the hours the services are provided. However, each client's care shall be under the supervision of a physician directly affiliated with the program. The physician shall see the client, prescribe the type of care provided and if services are not limited, periodically review the need for continued care. The physician shall assume professional responsibility for the services provided and assure that the services are medically appropriate.

**Practitioner:** A professional eligible to provide services to a client.

**Pretreatment Assessment (PTA):** A comprehensive mental health and substance abuse assessment. Consists of a Biopsychosocial Assessment administered by a licensed practitioner whose scope of practice includes mental health and/or substance abuse services and an Initial Diagnostic Interview completed by a physician with a specialty in psychiatry, licensed psychologist, or a Licensed Independent Mental Health Practitioner (LIMHP).

**Provider:** A person, business, organization, or other entity that furnishes Medicaid goods or services under an approved provider agreement with the Department.

**Psychiatric Assessment:** A client comprehensive diagnostic assessment provided by a licensed physician with a specialty in psychiatry.

**Psychiatric Residential Treatment Facilities (PRTF):** A residential inpatient level of care that provides mental health and substance abuse treatment services for clients under the age of 21.

**Psychiatrist:** A licensed physician with a specialty in psychiatry.

**Psychological Assessment:** A client assessment provided by a licensed psychologist.

**Recovery:** A process of healing the mind, body, and spirit inclusive of transformation of clients with mental health and/or substance abuse conditions.

**Rehabilitation Services:** Promote recovery, full community integration, and improved quality of life for clients diagnosed with mental health and/or substance abuse disorders.

**Research-Based Practice (RBP):** A thoughtful integration of the best available evidence and clinical expertise which enables mental health and substance abuse practitioners to address health care questions with an evaluative and qualitative approach.

**Strength-Based:** An ongoing approach that identifies a client's positive resources and abilities. These strengths are built upon by developing strategies to address the identified need in order to achieve a defined outcome.

**Supervising Practitioner:** A licensed physician with a specialty in psychiatry, licensed psychologist, or LIMHP who supervises therapists and/or programs delivering mental health and substance abuse services.

**Trauma-Informed Care:** Services informed about and sensitive to trauma-related issues present in survivors, but the services need not be specifically designed to treat symptoms related to sexual or physical abuse, or other trauma.

**Treatment Plan:** A written document developed prior to the delivery or continuation of mental health/substance abuse services. It contains specific treatment recommendations determined during the Initial Diagnostic Interview by the licensed physician with a specialty in psychiatry, licensed psychologist, or LIMHP.

**32-001.01 Requirements, Standards, and Conditions for Provider Participation in Child/Adolescent Mental Health and Substance Abuse Treatment Services:** The requirements of this section apply to all mental health and substance abuse services for clients under the age of 21 provided under the Medicaid.

**General Requirements:** Programs shall meet the following requirements to qualify for reimbursement from Medicaid:

**Family Component:** Family treatment and interventions shall address family of origin concerns. Unless prohibited by the client/legal guardian or state/federal confidentiality laws, providers shall involve the family in assessment, treatment planning, updating of the treatment plan, therapy, and transition/discharge planning.

Providers shall schedule meetings and sessions in a flexible manner to accommodate a family's schedule. This includes the ability to schedule sessions at a variety of times including weekends and/or evenings.

Family involvement, or lack thereof, shall be documented in the clinical record. The provider shall also document their attempts to involve the family in treatment plan development, reviews, and services.

**Community-Based Care:** Mental health and substance abuse treatment services shall be delivered in the client's home community when possible in an office, clinic, or client's home.

**Developmentally Appropriate Care:** Treatment and care shall address the client's biological, psychological, and social development. Treatment interventions shall be congruent with the developmental level of the client based on the findings of comprehensive psychiatric and psychological assessments.

**Coordinated Services:** If a client receives services from more than one mental health and substance abuse provider, documented coordination of all services shall be identified in the client's treatment plan. Coordination of services is required as part of the overall treatment plan and is not billable as a separate service. The services provided shall be identified in one overall treatment plan developed for the client and the client's family.

**Specialized Services:** Facilities and programs may specialize and provide treatment for sexually offending behaviors, substance abuse, or dual diagnosed individuals. If a program provides for this treatment to any of these categories, the program shall provide documentation regarding the appropriateness of any research-based, trauma-informed, programming and training as well as compliance with the ASAM level of care being provided when appropriate.

**Out-of-State Services:** Out-of-state providers of services covered in this chapter shall have a specific plan detailing how they shall comply with the Family Component and how they shall transition the client under the age of 21 back to their home community. The provider shall be approved by the Division as a provider of Nebraska Medicaid services through the enrollment process and shall be appropriately credentialed in the managed care network.

**Quality Assurance and Utilization Review:** All providers participating in Medicaid shall agree to provide services under the requirements of 471 NAC 2-001.03, Provider Agreements. If there is any question or concern about the quality of service being provided by an enrolled provider, the Department or the Department's designee may perform quality assurance and utilization review activities, such as clinical record reviews and on-site visits, to verify the quality of service.

If the provider or the services do not meet the standards of this chapter, the provider may be subject to administrative sanctions under 471 NAC 2-002 or denial of provider agreement for good cause identified in 471 NAC 2-001.02A. The Department may request a refund for all services not meeting Chapter 32 requirements. If the clients are in immediate jeopardy the sanctions may be imposed under 471 NAC 2-002.05 without a hearing.

**Cultural Competence:** Providers of mental health and substance abuse services to clients shall be culturally competent. This includes awareness, acceptance, and respect of differences and continuing self-assessment regarding culture.

Cultural competence includes careful attention to the dynamics of differences and how they affect interactions, assumptions, and the delivery of services. Providers also demonstrate cultural competence through continuous expansion of cultural knowledge and resources through training, readings, etc., and by providing a variety of adaptations to service models in order to meet the needs of different cultural populations.

Culturally competent providers:

1. Hire unbiased employees.
2. Seek advice and consultation from the minority community.
3. Actively decide whether or not they are capable of providing services to clients from other cultures.
4. Provide support for staff to become comfortable working in cross-cultural.
5. Understand the interplay between policy and practice.
6. Are committed to policies that enhance services to diverse clientele.

**32-001.01A Determining Medical Necessity:** Medical necessity indicates a need for treatment services to diagnose, treat, cure, prevent an illness, or that may reasonably be expected to relieve the mental health or substance abuse pain symptoms and improve the overall mental health and substance abuse condition of the patient.

Medically necessary services shall be provided at the appropriate level of intensity based upon the documented clinical evaluation included in the Pretreatment Assessment. Clients receiving these services shall have a diagnosable mental health or substance abuse condition and be experiencing functional impairments as a result of this condition.

Note that prior authorization through the Department or its designee may be required for treatment.

Medically necessary treatment interventions and supplies are:

1. Necessary to meet the basic health needs of the client.
2. Rendered in most cost efficient manner and type of setting appropriate for the delivery of covered service.
3. Consistent in type, frequency, and duration of treatment with scientifically based guidelines of national medical, research, or health care coverage organizations or governmental agencies.
4. Consistent with the diagnosis of the condition.
5. Required for means other than convenience of the client or his/her provider.
6. Not more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency.
7. Of demonstrated value.
8. Not rendered at a more intense level of service than can be safely provided.

Covered mental health and substance abuse services are those in which the mental health and/or substance abuse diagnosis is identified in the Diagnostic and Statistical Manual of Mental Disorders as published by the American Psychiatric Association (current version).

Medicaid reimburses for mental health and/or substance abuse psychotherapy services for clients whose primary diagnosis is a mental health or substance abuse disorder. Developmental disabilities, mental retardation, or V code diagnosis are considered for psychotherapy services when these conditions are not the primary diagnosis causing the symptoms and when the client's dysfunctions and problems can be relieved by providing psychotherapy services identified in this chapter. Medicaid covers Pretreatment Assessments to diagnose mental health and/or substance abuse conditions and medication management when medications are necessary to stabilize the mental health and/or substance abuse symptoms.

A client shall meet medical necessity criteria to be eligible for any of the Mental Health or Substance Abuse Services. A licensed physician with a specialty in psychiatry, licensed psychologist, or licensed Independent Mental Health Practitioner (Supervising Practitioner) shall establish that the client meets medical necessity criteria for a particular service through a face-to-face assessment before the client is admitted for treatment. An Initial Diagnostic Interview meets that assessment requirement.



**32-001.01B Statement of Medical Necessity:** A Statement of Medical Necessity shall be included in the client's clinical record. The statement shall be completed by a licensed physician with a specialty in psychiatry, licensed psychologist, or licensed Independent Mental Health Practitioner and this documentation shall be provided to the treating provider each time the client is admitted.

When a client is accepted into a level of care for treatment a Statement of Medical Necessity shall be completed and signed prior to treatment delivery by the program's Supervising Practitioner. The statement confirms the need for treatment at the specific level of care a client requires and identifies current problem areas that shall be addressed in treatment. The signature provides documentation that the care has been recommended by the Supervising Practitioner of the service.

The Statement of Medical Necessity shall certify that:

1. Less restrictive treatment interventions do not meet the needs of the client.
2. Proper treatment of the client's mental health or substance abuse condition requires services at this level of care.
3. The treatment intervention can reasonably be expected to improve the client's condition or prevent further regression so that treatment services shall no longer be needed.

**32-001.02 Pretreatment Assessment (PTA):** For services in this chapter to be covered by Medicaid, medical necessity shall be established through a Pretreatment Assessment. This comprehensive assessment shall occur prior to the development of a treatment plan and prior to the initiation of treatment interventions. (EXCEPTION: Clients receiving treatment crisis intervention or inpatient hospital services are not required to receive a Pretreatment Assessment before crisis services are initiated. Providers of outpatient crisis services or inpatient psychiatric hospital services shall facilitate or perform the Pretreatment Assessment following alleviation of the crisis situation.)

The PTA identifies a client's problems and needs, develops goals and objectives, and determines appropriate strategies and methods of intervention. Clinical information from the PTA shall be outlined in the individualized treatment plan and should reflect an understanding of how the service shall address the client's particular issues.

Providers shall encourage families to actively participate in the PTA.

Medicaid coverage eligibility requires that a client has a diagnosable mental health or substance abuse disorder of sufficient duration to meet diagnostic criteria specified within the Diagnostic and Statistics Manual of the American Psychiatric Association (current version) resulting in functional impairment that substantially interferes with or limits the client's role or functioning within his/her family, school, or community. This does not include V-codes or developmental disorders as the primary condition of focus and treatment, except for assessments and medication management.

Psychotherapy services are available when a primary mental health or a substance abuse condition requiring treatment exists and there is reasonable expectation that the functional level of the client and the treatment outcome can improve through receiving mental health and/or substance abuse treatment services identified in this chapter. Eligible improvements include:

1. Increased adaptive ability.
2. Relapse prevention.
3. Active symptomatology stabilization in an emergency situation.
4. Resolved symptoms of a primary mental health and/or substance abuse condition.

Pretreatment Assessments that are incomplete or do not include both the Biopsychosocial Assessment and Initial Diagnostic Interview shall not be reimbursed. (EXCEPTION: Payment for a Biopsychosocial Assessment may be considered when the client fails to keep a scheduled appointment with the Supervising Practitioner for the completion of an Initial Diagnostic Interview, despite the licensed practitioner's efforts to assist the client to meet this requirement. The licensed practitioner whose scope of practice includes mental health and/or substance abuse services who is receiving supervision shall review the Biopsychosocial Assessment with his/her Supervising Practitioner to establish probable diagnosis. Documentation of the consultation shall be placed in the client's clinical record.

In these situations, Medicaid shall consider payment when the licensed practitioner whose practice allows for providing mental health treatment has met all Medicaid requirements and was unable, in spite of efforts to obtain a complete comprehensive assessment due to the abrupt termination of the client from treatment.)

**32-001.02A Components of a PTA:** A Pretreatment Assessment is composed of Biopsychosocial Assessment (Part I) and an Initial Diagnostic Interview (Part II).

The Biopsychosocial Assessment (Part I of the PTA) shall be completed by a licensed practitioner whose scope of practice includes mental health services and acting within his/her scope of practice who is enrolled as a Medicaid provider of mental health services. Mental health and/or substance abuse practitioners shall gather the information included on the assessment through a direct face-to-face client interview, an interview with the family and/or the primary caregiver, and a comprehensive review of the client's past records.

The Initial Diagnostic Interview (Part II of the PTA) shall be completed within timeframes specified and identified in each subchapter by a licensed physician whose specialty is psychiatry, licensed psychologist, or licensed independent mental health practitioner acting within his/her scope of practice who is enrolled as a provider of Medicaid mental health services.

The recommendations shall be developed by the licensed practitioners and the practitioners shall sign the Pretreatment Assessment. When practicing individually without other licensed practitioners, a physician whose specialty is psychiatry, licensed psychologist or LIMHP shall provide the Biopsychosocial Assessment and the Initial Diagnostic Interview, develop diagnosis, and document the recommendations for treatment and/or community-based services in the treatment plan prior to the delivery of services. Only physicians can recommend inpatient treatment.

The Pretreatment Assessment shall include, but is not limited to the following information:

**32-001.02A(1) Biopsychosocial Assessment (Part I of the PTA)**

Presenting Problem and Goals as Described by:

1. Client;
2. Family;
3. Others;

Social History:

4. Environmental influences (moves and reasons, housing conditions);

Family Dynamics:

5. Demographic and historical information;
6. Divorces, separations, deaths, and incarcerations of parents and significant others (include reasons);
7. Parent and family vocational history;
8. Parent and family treatment history;
9. Client's Mental Health History;
10. Symptoms include age of onset;
11. Diagnoses past and current;
12. History of Mental Health Treatment, including psychotropic medications and their effectiveness;
13. Current treatment interventions including psychotropic medications and their effectiveness;

Academic, Intellectual History and Vocational History:

14. Academic history
15. Most recent IQ and Intellectual Functioning, learning disabilities, behavioral disorders, and other functional impairments
16. Vocational History or training
17. Interventions and outcomes

Medical History of the Client:

18. Physical development
19. Prenatal, birth, development milestones
20. Past/current chronic medical conditions and past/current medications prescribed and their effectiveness
21. Chronic medical conditions and medications taken
22. Sexual development, reproductive history

Legal Issues:

23. Legal history
24. Current legal status

Offender Issues

25. Status Offenses;
26. Violence to property;
27. Violence and assault to others;
28. Other;

Victim Issue:

29. Physical Abuse;
30. Sexual Abuse;
31. Emotional Abuse;
32. Neglect (emotional, environmental, etc.);
33. Other;

The Client's Substance Abuse History:

34. Client use (age of onset and patterns of use);
35. History and consequences of use;
36. Past/current substance abuse diagnosis;
37. History of substance abuse treatment, including outcomes;
38. Current treatment/supportive interventions (alcoholics anonymous, narcotics anonymous, etc.);
39. Personal Assets and Liabilities.

**32-001.02A(2) Initial Diagnostic Interview (Part II of the PTA)**

Review of the Biopsychosocial Assessment

Initial Diagnostic Interview, including supplemental information to the Biopsychosocial Assessment, a mental status examination, and diagnosis when a mental health and/or substance abuse diagnosis exists

Recommendations:

1. Other assessments, medically necessary to answer additional questions identified in the PTA.
2. Treatment needs and recommended interventions for client and family.
3. Identification of who needs to be involved in the client's treatment.
4. Overall plan to meet the needs of the client including transitioning to other treatment and/or support services and discharge planning.
5. A means to evaluate the client's progress throughout their treatment and outcome measures at discharge.
6. Identification of needed community supports and resources and a plan for facilitating connections with those community services.

**32-001.02B The Biopsychosocial Assessment Addendum:** A Biopsychosocial Assessment Addendum is an abbreviated form of the Biopsychosocial Assessment identified in 471 NAC 32-001.02A(1). It is intended to update a previously completed assessment when new information regarding the client becomes available and the information is relevant to the client's treatment episode and development of a treatment plan.

The addendum shall be completed by a Medicaid enrolled licensed practitioner whose scope of practice includes mental health services. The licensed practitioner whose scope of practice includes mental health services shall complete a Biopsychosocial Assessment Addendum in a typed narrative document. At a minimum, the Biopsychosocial Assessment addendum shall include:

1. The client's name;
2. Date of service;
3. Date of original Biopsychosocial Assessment completed;
4. Reason for conducting the addendum;
5. Components requiring updating; and
6. A summary of the new information.

Licensed practitioners whose practice allows for providing mental health services and completing the Biopsychosocial Assessment and/or the Biopsychosocial Assessment Addendum shall make the addendum available to the additional/future treatment providers in compliance with HIPAA and other state and federal regulations.

A Biopsychosocial Assessment addendum shall be followed by the Initial Diagnostic Interview to develop a complete and comprehensive Pretreatment Assessment.

**32-001.02C Distribution of the Pretreatment Assessment:** Providers shall distribute complete copies of the Pretreatment Assessment to other treatment providers in a timely manner when the clinical information is necessary for providing additional/future treatment services and the appropriate releases of information are secured.

If a client requires/requests a change of his/her provider of services in the course of a treatment episode, or the client begins a new treatment episode, the new provider of services shall obtain a copy of the original Biopsychosocial Assessment and/or request an addendum to the Biopsychosocial Assessment if it is determined to be medically necessary. This licensed practitioner shall obtain a current (new) Initial Diagnostic Interview by the licensed physician whose specialty is psychiatry, licensed psychologist, or a licensed Independent Mental Health Practitioner (Supervising Practitioner) providing supervision.

**32-001.02D Payment for Assessments:** The Pretreatment Assessment shall address each area listed in this section to be eligible for reimbursement.

Payment for a Biopsychosocial Assessment (Part I) and the Initial Diagnostic Interview (Part II) of the Pretreatment Assessment is made according to the procedure codes and modifiers identified in 471-000-532.

Licensed practitioners whose scope of practice includes mental health services shall use the Biopsychosocial Assessment procedure code and the Initial Diagnostic Interview procedure code completed by the licensed physician whose specialty is psychiatry, licensed psychologist, or licensed Independent Mental Health Practitioner to bill for these functions. The reimbursement for these codes includes:

1. Interview time;
2. Documentation review;
3. Writing the report and recommendations.

Providers of the Pretreatment Assessment (Part I and II) bill these assessments on claim Form CMS-1500 or the standard electronic Health Care Claim: Professional Transaction (ASC X12N 837). The completed Pretreatment Assessment shall be included in the client's clinical record and available for review upon request and with proper releases.

Failure to produce a completed Pretreatment Assessment to Medicaid or its designee upon request, or lack of inclusion in the client's clinical record determined during review, shall cause claim denial and/or claim refund request.

Medicaid shall provide reimbursement for one Biopsychosocial Assessment per treatment episode. Addendums may be provided if medically necessary and additional clinical information becomes available that is essential for treatment planning. If the client leaves treatment prior to a successful discharge and returns for further treatment, the provider shall assess the need for a new Biopsychosocial Assessment or an addendum to an original Biopsychosocial Assessment.

A new Initial Diagnostic Interview is required before reinitiating treatment. Practitioners shall use national standard code sets to bill for this activity. Prior authorization is obtained through Medicaid or its designee.

**32-001.02E Procedure Codes and Description for Pretreatment Assessments:** HCPCS/CPT procedure codes used by Medicaid for the Biopsychosocial Assessment and for the Initial Diagnostic Interview are listed in the Nebraska Medicaid Practitioner Fee Schedule (471-000-532).

**32-001.02F Provider Expectations when completing the Pretreatment Assessment:** Providers conducting a Pretreatment Assessment shall do the following:

1. Providers shall complete the Pretreatment Assessment prior to the initiation of treatment. (EXCEPTION): CAP sessions, crisis services, and acute inpatient hospitalization may be initiated without a comprehensive assessment.
2. Practitioners shall provide a comprehensive assessment that completely addresses all the areas described in the outline for Pretreatment Assessments.
3. Practitioners shall make the Pretreatment Assessment available to additional/future treatment providers in compliance with HIPAA and other State and Federal regulations.

4. Practitioners shall complete a comprehensive narrative report integrating all aspects of the assessment (Checklists are worksheets from which a comprehensive narrative report may be drafted, but are not themselves recognized as a comprehensive narrative report).
5. Practitioners may use multiple sessions as necessary to complete a comprehensive Biopsychosocial Assessment. However, the assessment is billed and reimbursed only one time per treatment episode. The date of the practitioner's first session is the date that identifies the Biopsychosocial Assessment.
6. Practitioners shall include the completed Pretreatment Assessment in the client's clinical record.
7. Practitioners shall assess the acuity/urgency of the client's condition during the completion of the Biopsychosocial Assessment and facilitate and schedule the Initial Diagnostic Interview with the Supervising Practitioner relative to the acuity/urgency of the client's condition.
8. Practitioners shall present a copy of the Biopsychosocial Assessment to the Supervising Practitioner for further review and prior to the Supervising Practitioner conducting the Initial Diagnostic Interview.

**32-001.02G Timeframes for Completion of Initial Diagnostic Interview and Statement of Medical Necessity:** An Initial Diagnostic Interview and a Statement of Medical Necessity shall be completed by the Supervising Practitioner within the following timeframes or sooner if medically necessary:

1. Outpatient Services: Prior to the initiation of treatment services.
2. Intensive Outpatient Services (IOP): At admission to the intensive outpatient program.
3. Day Treatment: At admission or within 24 hours of admission.
4. Partial Hospitalization: At admission or within 24 hours of admission.
5. Treatment Foster Care: At admission or within 24 hours of admission.
6. Therapeutic Group Home: At admission or within 24 hours of admission.
7. Psychiatric Residential Treatment Centers: At admission or within 24 hours of admission.
8. Inpatient Acute Hospitalization: At admission or within 24 hours of admission.

**32-001.03 Supervising Practitioner:** Medicaid has designated clinical supervisory responsibilities to practitioners considered by the Department's Division of Public Health to be a licensed physician with a specialty in psychiatry, licensed psychologist or licensed independent mental health practitioner who can diagnose and treat major mental illness within his/her scope of practice.

**32-001.03A Involvement of the Supervising Practitioner:** When a Licensed Mental Health Practitioner who is not eligible to practice independently provides mental health and/or substance abuse treatment services, he/she shall develop a professional working relationship with a physician whose specialty is psychiatry, licensed psychologist, or supervising practitioner who is able to diagnose major mental illness. This licensed physician whose specialty is psychiatry, licensed psychologist, licensed independent mental health practitioner then becomes the Supervising Practitioner.

A Supervising Practitioner shall review the Biopsychosocial assessment and meet face to face with the client seeking treatment. He/she shall complete the Initial Diagnostic Interview and provide specific treatment recommendations to the Licensed Mental Health Practitioner. The Initial Diagnostic Interview shall be completed and signed prior to the development of a treatment plan, referral to a particular level of care, and delivery of services.

A licensed physician whose specialty is psychiatry, licensed psychologist or licensed Independent Mental Health Practitioner may agree to function as Supervising Practitioners of licensed practitioners and programs who require clinical supervision. These include:

1. Licensed Physician (M.D.) (psychiatry specialty preferred);
2. Licensed Osteopathic Physician (D.O.) (psychiatrically trained preferred) D.O.;
3. Licensed Psychologist (Ph.D. or Psy.D.);
4. Licensed Independent Mental Health Practitioners (LIMHP) (outpatient services only).

**32-001.03B Supervising Practitioners for Levels of Mental Health and/or Substance Abuse Services:** A licensed physician whose specialty is psychiatry, licensed psychologist or LIMHP may provide supervision for certain designated practitioners and programs. They are:

Outpatient Mental Health and/or Substance Abuse Services:

1. Physician (whose specialty is psychiatry)
2. Psychologist
3. Licensed Independent Mental Health Practitioner

Intensive Mental Health and/or Substance Abuse Outpatient Programs (IOP):

4. Physician (whose specialty is psychiatry)
5. Psychologist
6. Licensed Independent Mental Health Practitioner (LIMHP)

Mental Health and/or Substance Abuse Day Treatment:

7. Physician (whose specialty is psychiatry)

Mental Health and/or Substance Abuse Partial Hospitalization:

8. Physician (whose specialty is psychiatry)

Mental Health and/or Substance Abuse Professional Resource Family Care (PRFC):

9. Physician (whose specialty is psychiatry)
10. Psychologist

Therapeutic Group Home (ThGH):

11. Physician (whose specialty is psychiatry)
12. Psychologist



Acute Psychiatric Inpatient Hospitalization and Psychiatric Residential Treatment Facility (PRTF):

13. Physician (whose specialty is psychiatry)

**32-001.03C Practice of Supervision:** Supervision by the Supervising Practitioner is the clinical oversight of a treatment activity or course of treatment. In addition to providing the Initial Diagnostic Interview clinical supervision includes, but is not limited to:

1. Development and supervision of the client's treatment plan
2. Review of treatment plan and progress notes
3. Client-specific case discussion
4. Ongoing and periodic assessments of the client (as defined in each section)
5. Diagnosis, treatment intervention or issue-specific discussion

The Supervising Practitioner is a source of information and guidance for the therapist in outpatient treatment or for all members of the program's treatment team. The clinical involvement of the Supervising Practitioner shall be reflected in the Pretreatment Assessment, the treatment plan, and the mental health and/or substance abuse treatment interventions provided.

The Supervising Practitioner shall be available; in person, by telephone, or by fax; to provide assistance and direction to the licensed practitioner whose scope of practice includes mental health services during the time mental health and/or substance abuse services are provided.

Supervision may occur individually or in a group setting. In a group setting the confidentiality of the client and the client's specific clinical review of the treatment plan shall be maintained.

Supervision is not billable by either the supervised practitioner/treatment team or the designated Supervising Practitioner as it is considered a mandatory component of the care.

Psychiatric resident physicians, Physician Assistants (PA's) and Advanced Practice Registered Nurses (APRN's) may not supervise other licensed practitioners for Medicaid purposes.

Regardless of the level of care, the Supervising Practitioner shall periodically evaluate the treatment program and determine if treatment goals are being met and if changes in direction or emphasis in goals are needed. These changes shall be identified by amending the treatment plan.

**32-001.03D Supervision Coverage Issues:** The Supervising Practitioner and staff under is/her supervision shall have a plan to provide alternative supervision and emergency coverage by another eligible Supervising Practitioner during the Supervising Practitioner's absence due to vacation or illness.

In the event of an action against the Supervising Practitioner's license that results in the limitation of services or practice, the licensed practitioner shall document and implement a plan to establish a relationship with another Supervising Practitioner.

To initiate a change of Supervising Practitioners for a particular practice a licensed practitioner of the practice shall document a transition plan to assure maintenance of quality care and clinical supervision. This documentation shall include:

1. A plan to notify Medicaid of the change;
2. A plan to notify the client of the supervisory change;
3. Appointments for assessments by the incoming Supervising Practitioner;
4. Signed releases of information;
5. A plan to coordinate routine and crisis care during the transition for clients in the midst of a treatment episode.

**32-001.04 Standards For Participation For Providers of Mental Health and Substance Abuse Services For Children and Adolescents:** All providers of mental health and substance abuse services shall complete Form MC-19 (Medical Assistance Provider Agreement) and submit the completed form to Medicaid for approval.

Nebraska Medicaid approves providers who are willing to complete the provider enrollment application and meet Medicaid's standards for services/programs for which the provider is intending to enroll. The provider shall be advised in writing when his/her participation is approved and enrollment is complete.

A separate application shall be submitted for each particular mental health and substance abuse treatment service. Each level of care/service shall be considered for approval separately.

The provider shall meet all of the following standards in order to be enrolled with Medicaid:

**32-001.04A Enrollment of Community-Based Services and Physician Services:** The enrollment application Form (MC-19) is for community-based mental health and/or substance abuse services/programs and for physicians of all specialties including psychiatric practice.

In addition to the completed application, community-based services/programs (except for traditional outpatient services) shall provide a program description that fully describes the service the provider intends to deliver to Medicaid clients. This description shall identify how the provider intends to meet the Medicaid requirements identified in each subchapter for the desired enrolled services/programs.

The provider shall submit program information as required, including but not limited to:

1. Licensure copy
2. Accreditation copy
3. Statement of philosophy, purpose and mission
4. Target population
5. Staffing roster and organizational chart
6. A full description of services including:
7. The assessment process
8. Treatment planning
9. Service delivery
10. Discharge planning and community interface
11. Family involvement policy
12. The role and responsibilities of the Supervising Practitioner

Providers enrolling for community-based mental health and/or substance abuse services/programs shall agree to provide cost information to Medicaid upon request.

In order to provide services to clients who are eligible to receive Medicaid managed care mental health benefits, providers shall apply to Medicaid's managed care entity for membership in the managed care network.

Medicaid-enrolled providers who have not completed the credentialing process and do not have membership in the managed care network are:

Not eligible to receive prior authorization for services for a managed care eligible client  
Not eligible to receive payment for any mental health and/or substance abuse service delivered to a client receiving the Medicaid managed care benefit for mental health and/or substance abuse services.

**32-001.04B Enrollment of Hospitals Providing Mental Health and/or Substance Abuse Services:** A hospital that provides inpatient hospital, partial hospitalization, and outpatient hospital services shall complete Form MC-19 (Medical Assistance Provider Agreement), see 471-000-91, and submit a completed form to Medicaid for approval as a Medicaid provider of psychiatric hospital services.

The hospital shall submit information with the provider agreement including, but not limited to:

1. A complete description of the psychiatric program and the elements of the program (e.g., policies and procedures, staffing, services, etc.).
2. A statement of the total number of psychiatric beds that are identified by the Department's Division of Public Health or the agency in the State in which the facility is located (EXCEPTION: For partial hospital programs, provide the total capacity of clients that the program can serve on a daily basis).
3. Documentation that the psychiatric program meets the family-centered community-based requirements of this chapter.

4. A description of how the initial assessment is provided following admission procedures.
5. A description of how the psychiatric services shall interface with community services for discharge planning and service provision within 7 days following discharge.
6. A copy of The Joint Commission (TJC) or the American Osteopathic Organization (AOA) accreditation survey.
7. A description of how individual, group, and family psychotherapy services, psychoeducational services, and rehabilitation services shall be provided.
8. Any other information requested.

At enrollment, providers shall sign an agreement to provide cost information to Medicaid on an annual basis or as requested.

Providers are responsible for verifying that their employees providing treatment services are appropriately licensed through the Department's Division of Public Health, Licensing Unit or the licensing agency in which the facility is located and act only within their scope of practice.

**32-001.04C Provider Enrollment Updates:** A provider shall send to Medicaid an update of any changes in its services or its hospital/clinic/facility.

Providers shall also send to Medicaid a current list of staff, staff titles, license numbers and Social Security numbers once per year on the anniversary of the provider's enrollment with Medicaid for mental health and substance abuse services.

Information shall be sent to Medicaid if the provider changes the way they provide mental health and/or substance abuse services. These changes shall be accompanied by Form MC-19 (Medical Assistance Provider Agreement). Providers shall submit cost information to Medicaid upon request of Medicaid.

**32-001.05 Conditions for Participation for Mental Health and/or Substance Abuse Community-Based Services:** The community-based provider that provides mental health and/or substance abuse services to Medicaid-eligible clients shall meet the following standards to ensure compliance with Medicaid regulations, licensing and any other state or local regulatory requirements:

1. The service and/or program is developed for the care and treatment of clients with a primary mental health and/or substance abuse disorder.
2. The practitioner providing the service and/or facility associated with the program, when required, is licensed by the Department's Division of Public Health, Licensing Unit (EXCEPTION): If the service is located in another State, it shall be licensed by the designated authority for that State.
3. With the exception of traditional outpatient and intensive outpatient services, the service/program is accredited by The Joint Commission (TJC), Counsel on Rehabilitation Facilities (CARF) or by the Counsel on Accreditation (COA).

4. Includes a utilization review plan applicable for all Medicaid clients.
5. Maintains medical records that are sufficient to permit Medicaid or its designee to determine the comprehensiveness and intensity of treatment to the client.
6. Meets all the staffing requirements Medicaid requires to deliver an active treatment program.
7. The service and/or program meets all requirements of the Family Component detailed in 471 NAC 32-001.01 Requirement Standards and Conditions for Provider Participation.

**32-001.05A Conditions for Participation for Psychiatric Hospital Service**

**Providers:** A hospital that provides psychiatric and/or substance abuse services and programs shall meet the following conditions for participation to ensure that payment is made only for psychiatric treatment in a hospital:

1. Be maintained for the care and treatment of patients with primary mental health disorders.
2. Be a facility licensed as a hospital by the Department's Division of Public Health (EXCEPTION: If the hospital is located in another state, it shall be licensed by an officially designated authority for standard-setting in that state).
3. Be accredited by The Joint Commission (TJC) or by the American Osteopathic Association (AOA)
4. Be a hospital which is consistent with the requirements for participation in Medicaid for psychiatric hospitals
5. Be a hospital that has in effect a utilization review plan applicable to all Medicaid clients
6. Be a hospital with medical records that are sufficient to permit the Department or its designee to determine the comprehensiveness and intensity of treatment furnished to the client
7. Be a hospital with staffing requirements that the Medicaid Program finds necessary to carry out an active treatment program (see 471 NAC 32-001.08)
8. Be a hospital whose policies meet all requirements of the Family Component detailed in 471 NAC 32-001.01 Requirement Standards and Conditions for Provider Participation in Children/Adolescent Mental Health and Substance Abuse Treatment Services: General Requirements.

**32-001.05B Locations for Community-Based Services:** Community-based mental health and substance abuse services shall be provided in a professional environment conducive to client confidentiality. Those locations may include:

1. A community-based mental health and/or substance abuse facility which is appropriately licensed.
2. A private office.
3. A clinic.
4. The client's home.
5. The client's school.
6. A nursing facility.

**32-001.06 Staffing Standards for Community-Based Mental Health and/or Substance Abuse Treatment Services:** Assessment and treatment services shall be provided by licensed practitioners whose scope of practice includes mental health and/or substance abuse services.

The following providers may provide mental health and substance abuse services:

**32-001.06A Independent Practitioners:** Providers of Nebraska Medicaid who are considered to be able to diagnose major mental illness and practice without supervision, and who are independently licensed to provide mental health and substance abuse services include:

1. A licensed physician (with a specialty in child and adolescent psychiatry preferred).
2. A licensed Osteopathic Physician (preferably a physician with a specialty in child and adolescent psychiatry).
3. A Licensed Psychologist.
4. A Licensed Independent Mental Health Practitioner (LIMHP).

An Advanced Practice Registered Nurse (APRN) and Physician Assistants (PA) may provide direct care as allowed within their scope of practice and the practice agreement with their supervising physician. A copy of the practice agreement shall be submitted at the time of enrollment and updated with any changes.

For Medicaid purposes, psychiatrically trained Advanced Practice Registered Nurses and Physician Assistants may not supervise services in place of a psychiatrist or physician.

**32-001.06B Providers Requiring Supervision:** Services of the following licensed practitioners shall be rendered under the supervision of a Supervising Practitioner as defined in 471 NAC 32-001.03A. Services shall be provided within the practitioner's scope of practice and licensure regulations.

For Medicaid purposes, the following practitioners qualify as licensed practitioners for mental health or substance abuse services for clients when supervised by a Supervising Practitioner:

1. Licensed Mental Health Practitioner (LMHP);
2. Provisionally Licensed Mental Health Practitioner (PLMHP);
3. Provisionally Licensed Psychologist;
4. Registered Nurse;
5. Licensed Alcohol/Drug Abuse Counselor (LADC);
6. Community Treatment Aide (CTA);
7. Direct Care Staff.

**32-001.07 Staffing Standards for Hospitals that Provide Psychiatric Services:** A hospital providing psychiatric and substance abuse services shall meet the standards for participation identified in 471 NAC 32-001.04C.

The hospital shall have staff adequate in number and qualified to carry out an active program of evaluation and treatment for clients who need psychiatric stabilization and treatment services, and shall meet the following standards:

**32-001.07A Hospital Personnel:** Hospitals which provide inpatient psychiatric or substance abuse services shall be staffed with the number of qualified professional, technical, and supporting personnel, and consultants required to carry out an intensive and comprehensive active treatment program. The program shall include evaluation of client and family needs, establishment of client and family treatment goals, and implementation (directly or by arrangement) of a broad-range therapeutic program.

The therapeutic program shall include, at minimum, the professional medical, nursing, social work, psychological, and activity-based therapies required to carry out an individual treatment plan for each client and his/her family.

The following standards shall be met:

Qualified professional and technical personnel shall be available to evaluate each client at the time of admission, including diagnosis of mental health and/or substance abuse disorder. Services necessary for the evaluation include:

1. Psychiatric diagnostic evaluation by a licensed psychiatrist enrolled with the Department.
2. Biopsychosocial Assessment, including a family assessment by the multidisciplinary team of practitioners.
3. A nursing assessment by a licensed registered nurse.
4. A substance abuse assessment when appropriate.
5. A physical examination including a complete neurological exam.
6. Laboratory, radiological, and other diagnostic tests as necessary.
7. Psychological evaluation and testing as necessary.

The number of qualified professional personnel, including consultants and technical and supporting personnel, shall be adequate to ensure representation of the disciplines necessary to establish short-range and long-term goals. They shall also be adequate to plan, carry out, and periodically revise a treatment plan for each client based on scientific interpretation of the following:

1. The degree of physical disability and indicated remedial or restorative measures including nutrition, nursing, physical medicine, and pharmacological therapeutic interventions.
2. The degree of psychological impairment and appropriate measures to be taken to relieve treatable distress and to compensate for nonreversible impairments where found.

3. Appropriate nursing measures and nursing interventions.
4. The capacity for social interaction, and appropriate nursing measures and milieu therapy to be undertaken, including group living experiences, occupational and recreational therapy, and other prescribed activities to maintain or increase the client's capacity to manage activities of daily living.
5. The environmental and physical limitations required to protect the client's health and safety with a plan to compensate for these deficiencies and to develop the client's potential for return to his/her own home, a foster home, a skilled nursing facility, a community mental health center, or other alternatives to full-time hospitalization.

**32-001.07A(1) Director of Inpatient Services and Medical Staff:** Inpatient mental health services shall be delivered under the supervision of a clinical director, service chief, or the equivalent qualified to provide the leadership required for an intensive treatment program. The number and qualifications of physicians shall be adequate to provide essential mental health services.

The following standards shall be met:

The clinical director shall be a licensed physician with a specialty in psychiatry, preferably child/adolescent trained. The clinical director, service chief, or equivalent shall meet the training and experience requirements for examination by the American Board of Psychiatry and Neurology or the American Osteopathic Board of Neurology and Psychiatry.

The medical staff shall be qualified legally, professionally, and ethically for the positions to which they are appointed

The number of physicians shall be commensurate with the size and scope of the treatment program

The physician's personal involvement in all aspects of the client's care shall be documented in the client's medical record (e.g., physician's orders, progress notes, nurse's notes)

The physician shall be available; in person, by telephone, or by fax; to provide assistance and direction as needed.

**32-001.07A(2) Advanced Practice Registered Nurse (APRN) Services:** An Advanced Practice Registered Nurse (APRN) may provide psychiatric treatment in an inpatient psychiatric hospital when:

1. The APRN practices within his/her scope of practice.
2. The APRN has an integrated practice agreement with the attending physician who has a specialty in psychiatry.
3. The APRN and the physician who has a specialty in psychiatry have identified roles and responsibilities in their professional relationship (this relationship shall be defined at the time of enrollment with the Medicaid Program).



4. The APRN provides medically necessary services that are not a duplication of those required by and provided by the attending physician who has a specialty in psychiatry.
5. The APRN is an enrolled Medicaid provider and credentialed in the managed care network.

**32-001.07A(3) Availability of Physicians and Other Personnel:** Physicians and other appropriate professional personnel shall be available at all times to provide necessary medical, surgical, diagnostic, and treatment services, including specialized services. If medical, surgical, diagnostic, and treatment services are not available within the hospital, qualified consultants or attending physicians shall be immediately available or a satisfactory arrangement shall be established for transferring clients to a general hospital enrolled as Medicaid providers.

**32-001.07A(4) Nursing Services:** Nursing services shall be delivered under the direct supervision of a licensed registered nurse who is qualified by education and experience for the position. The number of registered nurses, licensed practical nurses, and other nursing personnel shall be adequate to formulate and carry out the nursing components of a treatment plan for each client.

The following standards shall be met:

The registered nurse supervising the nursing program shall have a master's degree in psychiatric or mental health nursing or its equivalent from a school of nursing accredited by the National League for Nursing, or shall be qualified by education or experience in the care of the mentally ill or substance abusers. They also shall have demonstrated competence to:

1. Complete a comprehensive nursing assessment;
2. Participate in interdisciplinary formulation of treatment plans;
3. Provide skilled nursing care and therapy; and
4. Direct, supervise, and train others who assist in implementing and carrying out the nursing components of each client's treatment plan.

The staffing pattern shall ensure the availability of a registered nurse 24 hours each day for:

1. Direct care as identified on the client's active treatment plan;
2. Supervising care performed by other nursing personnel; and
3. Assigning nursing care activities not requiring the services of a professional nurse to other nursing service personnel according to the client's needs and competence in appropriation of the nursing staff available.

The number of registered nurses, including nurse consultants, shall be adequate to formulate a nursing care plan in writing for each client and to ensure that the plan is carried out.

Registered nurses and other nursing personnel shall be prepared by continuing in-service and staff development programs for active participation in interdisciplinary meetings affecting the planning or implementation of nursing care plans for patients. The meetings include diagnostic conferences, treatment planning sessions, and meetings held to consider alternative facilities and community resources.

**32-001.07A(5) Psychological Services:** Psychotherapy shall be ordered and directed by a physician with a specialty in psychiatry. The psychological services shall be delivered under the supervision of a licensed psychologist. The psychology staff, including consultants, shall be adequate in numbers and be qualified to plan and carry out assigned responsibilities.

The following standards shall be met:

The psychology department or service shall be provided by and under the supervision of a licensed psychologist who is contracted by or employed by the hospital

Psychologists, consultants, and supporting personnel shall be adequate in number and be qualified to assist in essential diagnostic formulations, and to participate in:

1. Program development and evaluation of program effectiveness;
2. Training and program evaluation activities;
3. Therapeutic interventions (e.g., milieu, client, family, and group psychotherapy);
4. Interdisciplinary conferences and meetings held to establish diagnoses, goals, and treatment programs; and
5. Psychological testing.

**32-001.07A(6) Social Work Services and Staff:** Social work services shall be under the supervision of a certified master social worker. The social work staff shall be adequate in numbers and be qualified to fulfill responsibilities related to the specific needs of client clients and their families, the development of community resources, and consultation with other staff and community agencies.

The following standards shall be met:

The director of the social work department or service shall have a master's degree from an accredited school of social work, shall meet the experience requirements for certification by the Academy of Certified Social Workers and shall be appropriately certified by the Department's Division of Public Health, Licensing Unit.

Social work staff, including other social workers, consultants, and other assistants or case aides shall be qualified and numerically adequate to:

1. Conduct preadmission evaluations;
2. Provide biopsychosocial data for diagnosis, treatment planning for direct therapeutic services to clients, client groups, or families;
3. Develop community resources;
4. Conduct appropriate social work program evaluation and training activities;
5. Participate in interdisciplinary conferences and meetings concerning diagnostic formulation and treatment planning, including identification and utilization of other facilities and alternative forms of care and treatment.

Social work staff shall participate in discharge planning and in implementing the discharge plan. Social work staff shall connect with community support providers to arrange follow-up care and assist the client with the specific goals of the discharge plan.

**32-001.07A(7) Licensed Mental Health Practitioners, Licensed Drug/Alcohol Counselors, Consultants, Volunteers, Assistants, Aides:** Licensed mental health and/or substance abuse practitioners, consultants, volunteers, assistants, or aides shall be sufficient in number to provide comprehensive therapeutic activities. These activities include, but are not limited to, occupational, recreational, and physical therapy, as needed, to ensure that appropriate treatment is provided to each client, and to establish and maintain a therapeutic milieu.

The following standards shall be met:

Mental Health Counseling Services shall be provided by licensed practitioners whose scope of practice includes mental health services.

Substance Abuse Counseling Services shall be provided by licensed drug/alcohol abuse counselors or by other licensed practitioners whose scope of practice includes substance abuse services.

Occupational therapy services shall be provided under the supervision of a licensed occupational therapist who is a graduate from an occupational therapy program approved by the Council on Education of the American Medical Association. In the absence of a full-time occupational therapist, a licensed occupational therapy assistant may function as the director of the activities program with consultation from a fully-qualified and licensed occupational therapist.

When physical therapy services are offered, the services shall be given by or under the supervision of a licensed physical therapist who is a graduate of a physical therapy program approved by the Council on Medical Education of the American Medical Association in collaboration with the American Physical Therapy Association or its equivalent. In the absence of a full-time physical therapist, physical therapy services shall be available by arrangement with a certified local hospital, or by consultation or part-time services furnished by a fully-qualified and licensed physical therapist.

Educational Program Services, when required by law, shall be available. Educational Services shall only be one aspect of the treatment plan, not the primary reason for admission or treatment. Educational services are not covered for payment by Medicaid.

Recreational or activity therapy services shall be available under the direct supervision of a member of the staff who has demonstrated competence in therapeutic recreation programs

Other occupational therapy, recreational therapy, activity therapy, and physical therapy assistants or aides shall be directly responsible to qualified supervisors and shall be provided special on-the-job training to fulfill assigned functions.

The total number of rehabilitation personnel, including consultants, shall be sufficient to:

1. Permit adequate representation and participation in interdisciplinary conferences and meetings affecting the planning and implementation of activity and rehabilitation programs, including diagnostic conferences
2. Maintain all daily scheduled and prescribed activities, including maintenance of appropriate progress records for clients

Volunteer service workers shall be:

1. Under the direction of a supervisor of volunteers
2. Provided appropriate orientation and training
3. Available daily in sufficient numbers to assist clients and their families in support of treatment services and therapeutic activities

**32-001.08 Active Treatment:** Active treatment is provided under an individualized treatment plan developed by the Supervising Practitioner and licensed practitioner whose scope of practice includes mental health services or by a psychiatrist with a specialty in psychiatry, licensed psychologist or a LIMHP who is in solo outpatient practice. The plan shall be based on a thorough evaluation of the client's current symptoms, problems, and restorative needs and potentialities for a primary mental health or substance abuse diagnosis.

For outpatient services and mental health and/or substance abuse programs, treatment provided to the client shall be documented in the clinical record in a manner and with a frequency to provide a full picture of the therapies provided, as well as an assessment of the client's reaction to the treatment interventions.

An isolated service, such as a single session with a licensed practitioner or a routine laboratory test not furnished under a planned program of therapy or diagnosis is not active treatment even though the service was therapeutic or diagnostic in nature.

The services shall reasonably be expected to improve the client's biopsychosocial condition or to determine a mental health and substance abuse diagnosis in a timely manner. The treatment shall, at a minimum, be designed to reduce or control the client's mental health and substance abuse symptoms and to facilitate the client's movement to a less restrictive environment within a reasonable period of time. This Active Treatment is determined by the licensed physician with a specialty in psychiatry, licensed psychologist, or LIMHP who developed the mental health and/or substance abuse diagnosis and provided recommendations identified in the Pretreatment Assessment. Methods of measuring the client's progress and timeframes to meet the treatment goals shall be part of the treatment plan.

All services shall be provided face-to-face to meet the active treatment criteria.

Mental health and substance abuse programs that meet this requirement include individual psychotherapy, group psychotherapy, family psychotherapy, drug psychotherapy, and substance abuse counseling.

If the only activities prescribed for the client are primarily diversional in nature, or provide a social, educational, or recreational outlet for the patient, Medicaid does not consider the services to meet active treatment requirements and shall not reimburse for them.

For active treatment, the services of a licensed practitioner of outpatient mental health and/or substance abuse services providing services within their scope of practice which allows for provision of mental health treatment shall be directed and supervised by a Supervising Practitioner.

A licensed physician with a specialty in psychiatry, licensed psychologist, or LIMHP in solo practice may also provide services that meet active treatment requirements when the services meet the mental health and/or substance abuse treatment needs of the client. Active Treatment in mental health and/or substance abuse programs shall be prescribed by the Supervising Practitioner to meet the specific mental health and/or substance abuse needs of the client.

Active treatment services shall be reimbursed and evaluated by the level of care needed, not solely by the practitioner level of the staff providing the care.

**32-001.08A Treatment Plans:** The treatment plan is a comprehensive plan of care formulated by the licensed practitioners under the direction of a licensed physician with a specialty in psychiatry, licensed psychologist, or licensed independent mental health practitioner and is based on the individual needs of the client. The treatment plan validates the necessity and appropriateness of services and outlines the service delivery needed to meet the client's needs, reduce symptoms, and improve overall functioning.

The treatment plan shall be based upon a Pretreatment Assessment that identifies the client's presenting problems and needs in areas of emotional, behavioral, and skills development. The treatment plan shall:

1. Be individualized to the client;
2. Include the specific symptoms or skills to be addressed;
3. Provide clear and realistic goals;
4. Provide objectives services, strategies, and methods of intervention to be implemented;
5. Provide criteria for achievement target dates; and
6. Provide methods for evaluating both the client's progress and the performance of the practitioner facilitating the intervention.

The goals and objectives documented on the treatment plan shall reflect the recommendations included in the Pretreatment Assessment and the integration of input from the Supervising Practitioner and the licensed practitioners who will provide services. The treatment interventions provided shall reflect these recommendations, goals, and objectives.

Evaluation of the treatment plan by a licensed practitioner who will provide services and/or the Supervising Practitioner shall reflect the client's response to the treatment interventions based on the recommendations, goals, and objectives.

The provider shall document their attempts to comply with the Family Component detailed in 471 NAC 32-001.01 Requirements, Standards, and Conditions for Provider Participation in Child/Adolescent Mental Health and Substance Abuse Treatment Services: General Requirements.

A treatment plan shall be developed for every client within the time frames specified for each type of service and shall be placed in the client's clinical record. If a treatment plan is not developed within the specified time frames, services rendered may not be reimbursable through Medicaid.

The Treatment Plan shall be reviewed and updated by the treatment team and licensed practitioners according to the client's level of care. Minimum time frames for treatment plan reviews are identified in the sections for each type of service or level of care within this chapter. The purpose of this review is to ensure that services and treatment goals continue to be appropriate to the client's current needs, and to assess the client's progress and continued need for mental health services.

The Supervising Practitioners and licensed practitioners who provide services shall sign and date the treatment plan at each treatment plan review. The Supervising Practitioner shall document that medical necessity and active treatment remains necessary to improve the client's level of functioning.

If the client receives services from more than one mental health and substance abuse provider these providers shall coordinate their services and develop one overall treatment plan for the client or family. This treatment plan shall be familiar to all providers and shall be implemented by the licensed practitioners working with the client and/or family.

**32-001.08B Transition and Discharge Planning:** Beginning at the time of admission, whenever a client is transferred from one level of care to another, transition and discharge planning shall occur and be documented. The focus of transition and discharge planning is to facilitate a timely transition out of the treatment system or to a less restrictive level of care. Treatment providers are responsible for transition and discharge planning.

Providers shall meet the following standards regarding transition and discharge planning:

1. Transition and discharge planning shall begin on admission;
2. Discharge planning shall be based on the treatment plan to achieve the client's discharge from the current treatment status and transition into a different level of care;
3. Transition and discharge planning shall address the client's need for ongoing treatment to maintain treatment gains and to continue normal physical and mental development following discharge. Inpatient and residential facilities must arrange a follow up outpatient appointment within 7 days;
4. Discharge planning shall include identification of and clear transition into developmentally appropriate services needed following discharge;
5. Treatment providers shall make or facilitate referrals and applications to the next level of care or treatment provider;
6. The current provider shall arrange for prompt transfer of appropriate records and information to ensure continuity of care during transition into the next level of care;
7. A written transition and discharge summary shall be provided as part of the clinical record; and
8. The parents/guardians and case manager or their contracted designee (if the client is a state ward) shall be included in all phases of transition and discharge planning. This participation shall be clearly documented in the client's clinical record.

**32-001.08C Clinical Records:** Each provider of mental health and substance abuse services for clients under the age of 21 shall maintain a clinical record for each Medicaid-eligible client that fully discloses the extent of the treatment services rendered. The clinical record shall contain documentation sufficient to justify Medicaid participation, and shall allow an individual not familiar with the client to evaluate the course of treatment.

Clinical records shall be arranged in a logical order such that the clinical information can be easily reviewed, audited, and copied. Each provider shall maintain accurate, complete, and timely records and shall always adhere to procedures that ensure the confidentiality of clinical data.

Progress notes shall identify the name and title of the practitioner and the date of service. The progress note shall also identify the type of therapy, beginning and end date and time of the service delivered.

The absence of appropriate, legible, and complete records may result in recoupment of previous payments for services.

**32-001.08C(1) Documentation of Treatment Services for Community-Based Mental Health and/or Substance Abuse Services:** The records of clients receiving community-based services shall include, at minimum, the following:

1. Copy of the Pretreatment Assessment;
2. Client's diagnosis (all five Axes) and a Statement of medical necessity;
3. Treatment plans (initial treatment plan, comprehensive treatment plan, and revisions);
4. Progress notes (for MH/SA practitioner, Supervising Practitioner, and other staff providing direct care responsibilities);
5. Discharge planning;
6. The client's Medicaid I.D. number;
7. Completed consent forms; and
8. Any other relevant communication related to the client's treatment.

Clinical records shall be maintained for a minimum of six years in a secure location to ensure client confidentiality. Providers of all levels of care shall have written policies explaining their methods of assuring confidentiality. The policies shall be explained to the client at the initiation of the treatment relationship.

Clinical records shall be written legibly or typed. If three separate individuals cannot understand the information written in a record because of handwriting or an automated document system that is difficult to read, the program shall provide a readable format.

Providers of mental health and/or substance abuse services for clients shall comply with Medicaid's or Medicaid's designee's requests to review clinical records. This review may include photocopies or on-site reviews at the discretion of Department staff.

**32-001.08C(2) Documentation for Treatment Services Provided in Hospital-Based Programs:** Providers of acute inpatient psychiatric and substance abuse services are referred to 471 NAC 32-001.08B for requirements regarding medical records.

The mental health records maintained by a hospital shall document the intensity of the treatment provided to clients in the hospital. For inpatient services, medical records shall stress the psychiatric and substance abuse components of the record, including a history of findings and treatment provided for the psychiatric or substance abuse condition for which the client is hospitalized.

In addition to the information required in 471 NAC 32-001, the medical record shall include:



1. The identification data, including the client's legal status (e.g., voluntary admission, Board of Mental Health commitment, court mandated, state ward);
2. A provisional or admitting diagnosis which is made on every client at the time of admission and includes the diagnoses of co-occurring diseases as well as the psychiatric or substance abuse diagnoses;
3. The complaint of others regarding the client, as well as the client's comments;
4. The psychiatric evaluation (including a medical history, which contains a record of mental status and notes the onset of illness, the circumstances leading to admission, attitudes, behavior, intellectual functioning, memory functioning, orientation, and an inventory of the client's strengths in a descriptive, not interpretative, fashion);
5. A complete neurological examination, when indicated;
6. A social history sufficient to provide data on the client's relevant past history, present situation, social support system, community resource contacts, and other information relevant to good treatment and discharge planning;
7. A complete family assessment as described in 471 NAC 32-001;
8. Reports of consultations, psychological evaluations, electroencephalograms, dental records, and special studies;
9. The client's Pretreatment Assessment (see 471 NAC 32-001.012);
10. The client's treatment plan reviews
11. The treatment received by the client, which is documented in a manner and with a frequency to ensure that all active therapeutic efforts (e.g., individual, group, and family psychotherapy, drug therapy, milieu therapy, occupational therapy, recreational therapy, nursing care, and other therapeutic interventions) are included;
12. Progress notes which are recorded by the physician who has a specialty in psychiatry, nurse, social worker, and (when appropriate) others significantly involved in active treatment modalities. The frequency is determined by the condition of the client, but progress notes shall be recorded daily by nursing staff, at each contact by a physician who has a specialty in psychiatry or by other therapeutic staff (e.g. O.T., R.T.). Progress notes shall contain a concise assessment of the client's progress and recommendations for revising the treatment plan as indicated by the client's condition;
13. The psychiatric or substance abuse diagnosis contained in the final diagnosis written in the terminology of the American Psychiatric Association's Diagnostic and Statistical Manual (DSM current version);
14. Therapeutic leave days prescribed by the physician under the treatment plan. The client's response to time spent outside the hospital shall be entered in the client's hospital medical record;
15. Transition and discharge planning documentation;
16. Proof of family and community involvement; and
17. The discharge summary (including a recapitulation of the client's hospitalization, recommendations for appropriate services concerning follow-up within 7 days, and a brief summary of the client's condition on discharge).

**32-001.08C(3) Record Retention:** The provider shall retain financial records, supporting documents, statistical records, and all other pertinent records related to the cost information for a minimum of six years after the end of the report period. The Department shall retain all cost information for at least six years after receipt from the provider.

**32-001.09 Services Provided to State Wards:** If the client is a state ward receiving medically necessary mental health and/or substance abuse services, the Department case manager or contracted designee shall be directly involved in all phases of assessment, treatment planning, active treatment, and transition/discharge planning and shall receive monthly progress reports regarding the client's therapy.

The case manager or contracted designee shall be contacted for consent to treat and consent for medication initiation and changes. This does not preclude the provider's responsibility to work with the client's family. The monthly report shall address, at a minimum, current treatment goals, progress toward those treatment goals and any adjustment to the plan, and therapy goals for anticipated treatment services the following month. Payment for services may be denied if appropriate reports are not provided to the Department case manager or a contracted designee in a timely manner.

**32-001.10 Inspection of Care (IOC):** Medicaid or Medicaid's designee may conduct inspection of care reviews for mental health and substance abuse services for clients under the age of 21. It does so by dispatching an Inspection of Care Team that completes a comprehensive Inspection of Care report.

Copies of the IOC report may be made available to the licensing agency for the facility. The IOC team shall make referrals to any current accreditation agency or other licensing agencies, such as the Department's Division of Public Health.

Medicaid may initiate an Inspection of Care using the following identified standards:

**32-001.10A Inspection of Care Team:** Medicaid's or Medicaid's designee's inspection of care team consists of a licensed physician who has a specialty in psychiatry and practices within his/her scope of practice and who is knowledgeable about mental health and substance abuse services along with other appropriate personnel as necessary.

The inspection of care team shall meet the following requirements:

1. The inspection of care team shall have a licensed physician who has a specialty in psychiatry who is knowledgeable about mental health and substance abuse services and other appropriate personnel.
2. The team shall be supervised by a licensed physician who has a specialty in psychiatry, but coordination of the team's activities remains the responsibility of Medicaid.
3. A member of the inspection of care team may not have a financial interest in any institution of the same type in which s/he is reviewing care but may have a financial interest in other facilities or institutions. A member of the inspection of care team may not review care in an institution where s/he is employed or contracted, but may review care in any other facility or institution.
4. The psychiatrist member of the team may not inspect the care of a client for whom s/he is the attending physician.
5. A primary consumer, secondary consumer, or family member may be included in the inspection of care team at the discretion of Medicaid or its designee.

**32-001.10A(1) Components of the Inspection of Care:** The team's inspection shall include:

1. Personal contact with and observation of each Medicaid-eligible client reviewed;
2. Review of each Medicaid-eligible client's medical record; and
3. Review of the facility/provider's policies as they pertain to direct patient care for each client being reviewed in the inspection of care.

**32-001.10A(2) Determinations by the Team:** The inspection of care team shall determine in its inspection whether the services available in the facility are adequate to:

1. Meet the mental health and/or substance abuse needs of each client;
2. Promote the client's maximum physical, mental, and psychosocial functioning;
3. Provide for effective transition/discharge;

The inspection of care team shall also determine if:

4. It is necessary and desirable for the client to remain in the facility;
5. It is feasible to meet the client's health needs through alternative institutional or non-institutional services; and
6. Each client under the age of 21 in a psychiatric facility is receiving active treatment.

**32-001.10A(3) Basis for Determinations:** In making the determinations by the team on the adequacy and appropriateness of services and other related matters, the team shall determine what items shall be considered in the review. These include, but are not limited to:

1. The psychiatric and medical evaluations, family assessments, social and psychological evaluations, and the plan of care are complete and current the plan of care, and when required, a plan for treatment services are followed and all physician ordered services, are provided and properly recorded.
2. The attending program physician reviews prescribed medications at least every 30 days.
3. Tests or observations of each client indicated by his/her medication regimen are made at appropriate times and properly recorded.
4. The physician, nurse, and other practitioners' progress notes are completed as required and appear to be consistent with the observed condition of the client.
5. The client receives adequate services, based on such observations as:
  - a. Cleanliness;
  - b. General physical condition and grooming;
  - c. Mental status;
  - d. Apparent maintenance of maximum physical, mental, and psychosocial function;
6. The client receives adequate treatment services, as evidenced by:
  - a. A planned program of activities to prevent regression;
  - b. Progress toward meeting objectives of the plan of care;
  - c. The client needs any service that is not furnished through the facility or through arrangements with others;
  - d. The client needs a continued placement in the facility or there is an appropriate plan to transfer the client to an alternate method of care in the least restrictive, most appropriate environment that meets the client's needs;
7. Direct involvement of families and/or legal guardians, in all phases of treatment (this includes wards of the Department's Division of Children And Family Services).
8. The facility's and/or provider's standards of care and policy and procedure meets the requirements for adequacy, appropriateness, and quality of services as they relate to client Medicaid clients.
9. The facility's transition/discharge plans are adequate and up to date.

**32-001.10A(4) Frequency of Inspections:** The inspection of care team and Medicaid or its designee shall determine, based on the quality of care and services being provided in a facility and the condition of clients in the facility, at what intervals inspections shall be made.

The inspection of care team may inspect the care and the services provided to each client annually or more frequently if necessary as determined by the inspection of care team and Medicaid or its designee.

**32-001.10A(5) Follow-up Visits:** If, after an inspection of care is complete, the inspection of care team determines that a follow-up visit is required to ensure adequate care, a follow-up visit may be initiated by the team. This shall be determined by the inspection of care team and shall be noted in the inspection of care report.

**32-001.10A(6) Notification Before Inspection:** The inspection of care team may inspect a facility with no prior notice at their discretion.

If notification is given, no facility or provider may be notified of the time of inspection more than 48 working hours before the scheduled arrival of the inspection of care team.

**32-001.10A(7) Reports on Inspections:** The inspection of care team shall submit a report to the Director of the Division of Medicaid and Long-Term Care after completing each inspection. The report shall not contain the names of clients. Codes shall instead be used. The facility shall receive a copy of the codes.

The report shall include the dates of the inspection and the names and qualifications of the team members. The report shall also contain the observations, conclusions, and recommendations of the team concerning:

1. The adequacy, appropriateness, and quality of all services provided in the facility or through other arrangements, including physician services to clients.
2. Specific findings about clients in the facility.

**32-001.10A(8) Copies of Reports:** Medicaid or its designee shall send a copy of the inspection of care report to:

1. The facility or provider inspected;
2. The facility's utilization review committee;
3. The Department's Division of Public Health, Licensing Unit;
4. The Department's Division of Children and Family Services; and
5. Other licensing agencies or accrediting bodies at the discretion of the review team.

If abuse or neglect is suspected, Medicaid or its designee's staff shall make a referral to the appropriate investigative body.

**32-001.10A(9) Facility Response:** Within 15 days following the receipt of the inspection of care team's report, the facility shall respond to the Inspection of Care Team in writing, and shall include the following information in the response:

1. A reply to any inaccuracies in the report (written documentation to substantiate the inaccuracies shall be sent with the reply and Medicaid shall take action based upon confirmed documentation).
2. A complete plan of correction for all identified Findings and Recommendations.
3. Changes in level of care or discharge.
4. Action to individual client recommendations.
5. Projected dates of completion on each of the above.

If additional time is needed, the facility may request an extension.

At the facility's request, copies of the facility's response shall be sent to all parties who received a copy of the inspection report.

A return site visit may occur after the written response is received to determine if changes have completely addressed the review team's concerns from the IOC report.

Medicaid or its designee shall take appropriate action based on confirmed documentation of inaccuracies.

**32-001.10A(10) Department Action on Reports:** Medicaid shall take corrective action as needed based on the report and recommendations of the team.

**32-001.10A(11) Failure to Respond:** If the facility or provider fails to submit a timely and/or appropriate response, Medicaid or its designee may take administrative sanctions (see 471 NAC 2-002 ff), or may suspend Medicaid payment for an individual client or the entire payment to the facility.

**32-001.10A(12) Appeals:** A Medicaid client, their legal guardian, or their provider may appeal when:

1. His/her mental health and/or substance abuse services are reduced;
2. His/her mental health and/or substance abuse services are terminated;
3. His/her form of mental health and/or substance abuse services is changed to be more or less restrictive; and
4. He/she thinks that the Department's actions are erroneous.

### **32-001.11 Rehabilitation Services**

The following services are Rehabilitation Services:

1. Day Treatment provided by a Direct Care Worker;
2. Intensive Outpatient Service provided by a Direct Care Worker;
3. Community Treatment Aide;
4. Professional Resource Family Care; and
5. Therapeutic Group Home.

These Rehabilitation Services are provided as part of a comprehensive specialized psychiatric program available to all Medicaid-eligible children with significant functional impairments resulting from an identified mental health or substance abuse diagnosis.

The medical necessity for these Rehabilitation Services shall be determined by a licensed psychologist, licensed independent mental health practitioner (LIMHP) or physician acting within the scope of his/her practice. The Rehabilitation Services are furnished by or under the direction of a psychologist, LIMHP or physician to promote the maximum reduction of symptoms and/or restoration of a client to his/her best age-appropriate functional level.

**32-001.11A Limitations:** Rehabilitation Services are subject to prior approval, shall be medically necessary, and shall be recommended by a psychologist, LIMHP, or physician according to an individualized treatment plan that addresses the client's assessed needs.

If the client is recommended for a Rehabilitation Service the Pretreatment Assessment document shall accompany the referral information to the rehabilitation program provider.

The activities included in the Rehabilitation Service shall be intended to achieve identified treatment plan goals or objectives.

A treatment plan is required to identify the medical or remedial services intended to reduce the identified condition as well as the outcomes for the individual client. The treatment plan shall specify the frequency, amount, and duration of Rehabilitation Services. An amended treatment plan should be developed if there is no measureable reduction of disability or restoration of functional level.

The new plan should identify a different rehabilitation strategy with revised goals and Rehabilitation Services. Only one Rehabilitation Service may be authorized or provided on any given day (e.g., a client cannot receive both CTA and Professional Resource Family Care on the same day).

Anyone providing substance abuse or mental health Rehabilitation Services shall be certified by Medicaid or its designee, in addition to any license required for the facility or agency to practice in the State of Nebraska.

Providers shall maintain clinical records that include a copy of the treatment plan; the name of the client; dates of Rehabilitation Services provided; the nature, content, and units of Rehabilitation Services provided; and progress made toward functional improvements and/or goals identified in the treatment plan.

Any Rehabilitation Services or components of Rehabilitation Services of which the basic nature is to supplant job training, housekeeping, homemaking, or basic services for the convenience of a person receiving covered Rehabilitation Services (e.g.; housekeeping, shopping, child care, and laundry services) are not covered.

Rehabilitation Services cannot be provided in an institute for mental disease (IMD).

Room and board is excluded from any rates provided in a residential setting.

Therapeutic group homes providing Rehabilitation Services shall identify and obtain prior approval from Medicaid or its designee for a minimum of two evidence-based practices and submit to fidelity reviews on these evidence-based practices on an annual basis by an independent body approved by Medicaid or its designee.

Rehabilitation Services provided to clients shall include communication and coordination with the family and/or legal guardian.

Coordination with other services should occur as needed to achieve the treatment goals. All coordination shall be documented in the youth's clinical record.

Rehabilitation Services may be provided at an office-based facility, in the community, or in the client's place of residence as outlined in the treatment plan.

Transportation of clients is not included in rehabilitation rates. Components that are not provided to, or directed exclusively towards the treatment of, the Medicaid-eligible client are not eligible for Medicaid reimbursement.

Rehabilitation Services shall be offered to all clients who need them regardless of their living arrangements including foster care. Clients covered by Medicaid, including their parents and guardians, shall be able to choose any willing and qualified provider of Rehabilitation Services. Medically necessary Rehabilitation Services for an eligible client shall be provided by qualified Medicaid providers distinct from the placement of a client and excluding room and board.

Rehabilitation Services may not include reimbursement for other services to which an eligible client has been referred, including foster care programs and services including, but not limited to:

- (1) Research gathering and completion of documentation required by the foster care program;
- (2) Assessing adoption placements;
- (3) Recruiting or interviewing potential foster care parents;
- (4) Serving legal papers;
- (5) Home investigations;
- (6) Providing transportation;
- (7) Administering foster care subsidies; and
- (8) Making placement arrangements.



**32-001.12 Payment for Mental Health and Substance Abuse Treatment Services:**

Payment for mental health and substance abuse treatment services is based upon rate established by Medicaid. Rates are set annually, for the period July 1 through June 30. Rates are set prospectively for this period.

Payment rates for treatment services for clients under the age of 21 are provided on a unit basis. A unit of service is defined according to the CPT and HCPCS approved code set unless otherwise specified.

All services have an initial authorization level of benefit (EXCEPTION: Outpatient services provided to Medicaid clients who are not eligible for the mental health managed care benefits package). Prior authorization is required prior to service delivery for medically necessary outpatient psychotherapy services which exceed the limitation of the initial authorization.

All services provided while a person is a resident of an IMD are considered content of the institutional service and not otherwise reimbursable by Medicaid.

Providers may be required to report their costs for each mental health and substance abuse treatment service on an annual basis. Providers desiring to enroll in the Medicaid Program who have not previously reported their costs shall agree to provide cost information as needed upon the request of Medicaid or its designee as a condition of enrollment for Medicaid.

Providers shall submit cost and financial information for each mental health and substance abuse treatment service within 30 days of the request. Financial and statistical records for the period covered by the cost information document shall be accurate and sufficiently detailed to substantiate the data reported. All records shall be readily available upon request by Medicaid for verification.

If the provider fails to provide cost information, Medicaid may suspend payment until cost information is received. At the time of the suspension is imposed, Medicaid shall notify the provider that no further payment shall be made until proper cost information is received by Medicaid.

In setting payment rates, Medicaid shall consider those costs which are reasonable and necessary for the active treatment of the clients being served. Such costs shall include those necessary for licensure and accreditation, meeting all staffing standards for participation, meeting all service standards for participation, meeting all requirements for active treatment, maintaining medical records, conducting utilization review, meeting inspection of care and discharge planning.

Telehealth: Services provided by licensed mental health and substance abuse practitioners via telehealth technologies are covered subject to the limitations as set forth in state regulations.

**32-001.12A Unallowable Costs:** The following costs are not reimbursed by Medicaid's Mental Health and Substance Abuse program:

1. Provisions for income tax;
2. Fees for boards of directors;
3. Non-working officers' salaries;
4. Promotion expense, except for promotion and advertising as allowed in HIM-15 (NOTE: Yellow Page display advertising is not allowable, but one Yellow Page informational listing is allowable);
5. Travel and entertainment, other than for professional meetings and direct operations of the treatment program (e.g., costs of motor homes, boats, and other recreational vehicles as well as operation and maintenance expenses for real property used as vacation facilities, etc.);
6. Donations;
7. Expenses of non-related facilities and operations included in expense;
8. Insurance and/or annuity premiums on the life of officer or owner;
9. Bad debts, charity, and courtesy allowances;
10. Cost and portions of costs which are determined by Medicaid not to be reasonably related to the efficient production of service because of either the nature or amount of the particular expenditure;
11. Education costs;
12. Services provided by the client's physicians or other medical providers that are not enrolled in the Mental Health and Substance Abuse program (e.g., drugs, laboratory services, radiology services, or services provided);
13. Return on equity;
14. Costs for services which occurred in a prior or shall occur in a subsequent fiscal year;
15. Expenses for equipment, facilities, and programs (e.g., recreation, trips) provided to clients that Medicaid determines are not reasonably related to the efficient production of service;
16. Costs of amusements, social activities, and related expenses for employees and governing body members (EXCEPTION: They are allowable when part of an authorized client treatment program);
17. Costs of alcoholic beverages;
18. Costs resulting from violations of, or failure to comply with federal, state, and local laws and regulations;
19. Costs relating to lobbying or attempts to influence/promote legislative action by local, state, or federal government;
20. Costs of lawsuits or other legal or court proceedings against the Department and/or any of its Divisions, its employees, or the State of Nebraska; and
21. Mileage and conference fees for home-based family therapy providers of outpatient psychiatric services. Those costs are assumed to be covered in the rates.

**32-001.12B Billing Requirements:** For Mental Health and Substance Abuse Services, providers shall follow these requirements:

1. Providers of mental health and substance abuse treatment services in a non-hospital setting shall submit claims for services on an appropriately completed Form CMS-1500 (see 471-000-64) or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837)
2. Payment for approved mental health treatment and substance abuse services is made to the facility or provider named on the provider agreement.
3. Providers of mental health and substance abuse treatment services from a hospital shall submit claims for services on an appropriately completed Form CMS-1450 or the standard electronic Health Care Claim: Institutional transaction (ASC X12N 837).
4. Payment for approved mental health treatment substance abuse services is made to the provider named on the provider agreement.

**32-001.12B(1) Procedure Codes:** Providers shall use HCPCS/CPT codes when submitting claims to Medicaid for Medicaid services. HCPCS/CPT procedure codes used by Medicaid are listed in the Nebraska Medicaid Practitioner Fee Schedule (see 471-000-532).

**32-002 Outpatient Mental Health and Substance Abuse Treatment Services:** Outpatient mental health and substance abuse services are available to clients under the age of 21 when the treatment is medically necessary, and the need for care at this level has been identified on a Pretreatment Assessment.

Outpatient mental health and substance abuse services shall be family centered, community based, culturally competent, and developmentally appropriate.

**32-002.01 Covered Outpatient Mental Health and Substance Abuse Treatment Services:** Outpatient mental health and substance abuse services reimbursable by Medicaid include:

1. Psychiatric outpatient crisis intervention services;
2. Client Assistance Program (managed care benefit only);
3. Biopsychosocial Assessment;
4. Biopsychosocial Addendum;
5. The Initial Diagnostic Interview;
6. Psychological testing;
7. Comprehensive Child and Adolescent Assessment (CCAA);
8. Comprehensive Child and Adolescent Assessment Addendum;
9. Youth Sexual Offending Risk Assessment;
10. Youth Sexual Offending Risk Assessment Addendum;
11. Substance Abuse Assessment;
12. Substance Abuse Assessment Addendum;
13. Individual Psychotherapy;
14. Individual Substance Abuse Counseling;
15. Group Psychotherapy;
16. Group Substance Abuse Counseling;
17. Family Psychotherapy;
18. Family Substance Abuse Counseling;
19. Conferences with family or other responsible persons advising them on how to assist the client;
20. Mental Health and Substance Abuse Community Treatment Aide Treatment Interventions;
21. Medication Management Services; and
22. Hospital Observation Room Services (23:59).

Outpatient mental health and substance abuse services shall be provided by licensed practitioners whose scope of practice includes mental health and/or substance abuse services.

**32-002.02 Non-Covered Treatment Services:** Services not covered and not reimbursed by Medicaid in this chapter include, but are not limited to:

1. Applied Behavioral Analysis (ABA)
2. Biofeedback Services
3. Educational Services
4. Behavior Modification Management and Planning

**32-002.03 Mental Health and Substance Abuse Treatment Services:** Mental health and substance abuse treatment services shall be the most appropriate and effective treatment intervention provided to the client to improve the client's recovery and reduce his/her mental health and/or substance abuse symptoms.

**32-002.04 Covered Outpatient Mental Health and Substance Abuse Services:** The following services are covered when treatment services are identified in an active treatment plan developed and based upon recommendations in a Pretreatment Assessment:

**32-002.04A Crisis Outpatient Services:** Crisis outpatient services are outpatient individual or family mental health and/or substance abuse interventions involving a Medicaid-eligible client or an eligible client and the client's family. The service is provided by a licensed practitioner operating within his/her scope of practice with the goal of stabilizing or relieving symptoms of mental health or substance abuse.

This is an immediate service to the client assessed with emergent/urgent conditions and therefore does not require a comprehensive Pretreatment Assessment as identified in 471 NAC 32-001.02 before treatment interventions/services are delivered. A short-term plan shall be developed and shall identify a means to facilitate a complete and comprehensive Pretreatment Assessment if ongoing treatment services appear to be medically necessary following stabilization.

A client is eligible to receive short-term crisis management services of no more than five sessions per episode of crisis.

**32-002.04B Client Assistance Program (CAP):** Client Assistance Programs are a short-term, solution-focused set of interventions to assist a client who is eligible for the Medicaid managed care benefit of mental health and/or substance abuse services. The client is eligible for up to five services per calendar year to assist a client in reducing or eliminating the current stressors that are interfering with the client's daily living and wellbeing.

Therapeutic interventions shall be provided by a licensed practitioner whose scope of practice includes mental health and/or substance abuse treatment services who assists the client by empowering the client and client's family to attain a more manageable level of functioning. If in the course of providing the sessions it is determined that the client shall need additional interventions, the provider may request authorization for a Pretreatment Assessment as described in 471 NAC 32-001.02.

**32-002.04C Biopsychosocial Assessment:** The Biopsychosocial Assessment is an in-depth assessment of the client's medical, social, academic, legal, psychiatric and substance abuse issues, etc., completed prior to an Initial Diagnostic Assessment. It is Part I of the two-part Pretreatment Assessment. A complete description of this assessment is found in 471 NAC 32-001.02A1.

**32-002.04D Biopsychosocial Assessment Addendum:** An abbreviated form of the Biopsychosocial Assessment as identified in 471 NAC 32-001.02A.

**32-002.04E The Initial Diagnostic Interview:** An Initial Diagnostic Interview and includes a review of the biopsychosocial components, a mental status examination, and formulization of diagnosis and treatment recommendations. It is Part II of a Pretreatment Assessment. Licensed physicians with a specialty in psychiatry, licensed psychologists and licensed independent mental health practitioners may complete the Initial Diagnostic Interview. A complete description of this assessment is found in 471 NAC 32-001.02A2.

**32-002.04F Psychological Testing and Evaluation:** Testing and evaluation services may be accessed when they are medically necessary, can reasonably be expected to contribute to a diagnosis, and can reasonably be expected to contribute to a client's plan of care.

Medical necessity shall be documented. Testing and evaluation services may be performed by a licensed psychologist. A specially licensed psychologist, or provisionally licensed psychologist may administer psychological tests under the direct supervision of a licensed psychologist in order to be eligible for Medicaid payment.

Psychological testing may be used to guide differential diagnosis of psychiatric disorders and disabilities by using one or more standardized measurements, instruments, or procedures to observe and record human behavior. It requires the application of appropriate normative data for interpretation or classification. Testing may also be used to provide an assessment of cognitive and intellectual abilities, personality and emotional characteristics, and neuropsychological function.

A copy of the testing narrative report shall be kept in the client's clinical record. When the evaluation is medically necessary and court-ordered, the provider shall note this information on the client's treatment plan and include documentation of the clinical need in the testing report.

Routine testing that is not medically necessary is not reimbursable by Medicaid.

**32-002.04G Comprehensive Child and Adolescent Assessment (CCAA):** A CCAA is a comprehensive assessment of a juvenile's social, physical, psychological, and educational development and needs, including the recommendation for a client-specific individualized treatment plan when treatment is necessary and recommended. The final report shall contain a set of treatment recommendations and diagnostic impressions that is the consensus of the entire multidisciplinary assessment team. A CCAA may be used in lieu of the Pretreatment Assessment for referral and treatment planning.

A CCAA is available to all Medicaid-eligible clients under the age of 19, who are wards of the State that exhibit behaviors so severe to call them to the attention of juvenile or county court, to determine their mental health and/or substance abuse treatment needs.

A CCAA shall receive prior authorization by Medicaid or its designee and shall be court-ordered. If the client has received a CCAA in the previous 12 months and a subsequent evaluation is ordered, the provider may complete an addendum to the current CCAA to obtain updated clinical information.

**32-002.04G(1) CCAA Uses:** A CCAA is:

1. An enhanced assessment is necessary for a client with behavioral problems and delinquent behaviors severe enough to call them to the attention of the Juvenile or County Court
2. Used by treating practitioners to determine a diagnosis and to develop a comprehensive plan of care with specific treatment goals and objectives along with appropriate strategies and methods for intervention for the client
3. Completed prior to the initiation of treatment and shall document the client's current functioning and treatment needs
4. Not for educational purposes
5. Used when the client has behavioral health symptoms or a history of behaviors which are so severe that the client cannot function safely in society because he or she presents a risk to self or others or are so severe they interfere with the age appropriate and developmentally relevant activities of daily living
6. Expected to provide an accurate diagnosis, treatment recommendations and appropriate strategies and methods of intervention
7. Utilized by the Judge to make a final recommendation for treatment and/or placement of clients

**32-002.04G(2) CCAA Team:** A CCAA shall be completed by licensed practitioners operating within their scope of practice. The team of practitioners shall be enrolled in the Medicaid mental health and/or substance abuse program and complete and maintain a provider contract with Medicaid and with Medicaid's Managed Care entity. The provider agreement shall identify the panel of practitioners who comprise the team.

The team shall have demonstrated proficiency in conducting and documenting assessments in a standard manner that shall assist in treatment planning for clients and shall maintain timely and quality assessments.

The CCAA provider shall have completed the Comprehensive Adolescent Severity Inventory (CASI) training.

The provider team shall be a group of practitioners, including at a minimum:

1. A licensed physician who has a specialty in psychiatry;
2. A licensed psychologist;
3. A Licensed Mental Health Practitioner (LMHP);
4. A Licensed Alcohol and Drug Counselor (LADC);
5. A Licensed Practitioner with expertise to conduct sex offender risk assessments; and
6. A licensed physician to complete a wellness check.

**32-002.04G(3) CCAA Standardized Report:** The CCAA document shall be a coordinated, complete document which provides one standardized/comprehensive report.

The CCAA results shall be developed in a standardized report signed by the Supervising Practitioner. The Supervising Practitioner shall coordinate all of the assessment information, make a final recommendation for treatment and sequence the order of treatment if more than one recommendation is made.

The standardized report may be used by treating practitioners, probation officers, children and family service workers, courts and judges to assist in accessing and providing treatment to the Medicaid client.

The CCAA shall be forwarded to the court by the Office of Juvenile Services worker.

**32-002.04G(4) Components of a CCAA Document:** All components of the CCAA, including the standardized report with supporting documentation, shall be completed within ten working days. Those components are:

**32-002.04G(4)(a) Records Search:** A review and summary of the client's records to include but not be limited to past evaluations, past psychiatric treatment records, information from current providers, school records, child welfare records, juvenile probation and juvenile diversion records and other relevant historical information.

**32-002.04G(4)(b) Collateral Contacts:** A review and summary of any collateral contacts that are relevant to the comprehensive assessment. At a minimum, it shall include the client's school, CFS caseworker, care coordinator, probation/parole officer, and past/present treatment providers.

**32-002.04G(4)(c) Family Assessment:** A current assessment completed by an appropriately licensed practitioner whose scope of practice includes mental health and/or substance abuse services which addresses the family functioning, family dynamics and their impact on the client's treatment needs. The family assessment shall include all parents identified by the client's caseworker and the assessment is based on a direct face-to-face interview conducted in the clinician's office or in the client's home pursuant to the requirement that at least 20% of interviews shall be provided in the client's home.

**32-002.04G(4)(d) Comprehensive Adolescent Severity Inventory (CASI):** Completion of all ten elements of the Comprehensive Adolescent Severity Inventory including:

1. Health information;
2. Stressful life events;
3. Education;
4. Alcohol and drug use;
5. Use of free time;
6. Peer relationships;
7. Sexual behavior;
8. Family/household members
9. Legal issues; and
10. Mental health.



**32-002.04G(4)(e) Initial Diagnostic Interview:** A review of the first four components of the CCAA and the client's wellness check, interview with the client, evaluation of current medications or recommendation for medication and its management, completion of a mental status exam and a DSM (most current) diagnosis, if appropriate.

**32-002.04G(4)(f) Wellness Check:** A wellness check includes but is not limited to the following:

1. Client's height, weight, blood pressure, pulse, temperature, vision test results, hearing test results and medical history (the client who receives a wellness check shall receive subsequent follow-up as deemed medically necessary by the practitioner).
2. Any pertinent laboratory test completed by medical professionals (a full written explanation shall be documented when tests are not completed).
3. Sexually transmitted disease testing (excluding HIV testing) when ordered by medical staff (if HIV testing is indicated, it should be noted in the recommendation).

If a Wellness Check/Health Check was conducted in the past twelve months it shall be identified in the record search component and included with the supporting documentation.

A new Wellness Check/Health Check is not required if the current one completed within the past 12 months is representative of the client's medical condition.

If there has not been a Wellness Check/Health Check conducted in the past 12 months, one should be done during the residential or community-based evaluation.

It is preferable to have the Wellness Check/Health Check completed by the client's primary care physician and the result of the examination included with this assessment. If that is not possible a Wellness Check/Health Check should be conducted by a member of the Preferred Provider Team.

**32-002.04G(4)(g) Psychological Testing:** Psychological testing and other mental health assessments if clinically applicable and appropriate shall be arranged and completed as a part of the CCAA. Any additional testing/assessment shall be authorized separately from the CCAA but shall be considered a part of the CCAA and completed under the direction of the Supervising Practitioner. This may include but is not limited to psychological testing, sexual risk offender assessment, eating disorder assessment and substance abuse assessments.

The results of any additional testing/assessment shall be incorporated into the CCAA.

Any additional testing/assessment shall be completed within this specified ten day evaluation.

**32-002.04G(4)(h) Standardized Report and Recommendations:** The standardized report shall adhere to the following format:

1. Demographics;
2. Presenting problem/primary complaint;
3. Medical history;
4. School/work/military history;
5. Alcohol/drug history summary;
6. Legal history;
7. Family/social/peer history in-home/in-office;
8. Psychiatric/behavioral history – psychotropic medication;
9. Collateral information (family/friends/criminal justice/victim issues);
10. Case formalization (e.g., how these conclusions were arrived at, what causes the client to behave as he/she does, etc.);
11. Clinical impression;
12. Substance abuse treatment recommendations, if applicable (include primary/ideal level of care recommendation, available level of care, barriers to ideal recommendations and client/family response to recommendations); and
13. Mental health recommendations, if applicable (include treatment needs and level of care, recommendations for clients and their families according to Medicaid clinical guidelines identity of individuals needed to be involved in treatment areas needing further evaluation and client/family response to recommendations).

If more than one recommendation is made (e.g. substance abuse and mental health treatment or substance abuse and behavioral intervention for conduct disorder), the Supervising Practitioner shall determine how the two recommendations shall be sequenced and coordinated.

**32-002.04G(4)(i) Recommendations:** The recommendations shall be developed by all the practitioners participating in the CCAA and signed by the Supervising Practitioner.

The Supervising Practitioner shall complete all necessary requests for authorizations, treatment referrals and written applications as required for services such as but not limited to inpatient treatment services.

The Supervising Practitioner shall participate in all peer and reconsideration reviews associated with the requests as appropriate.

**32-002.04G(4)(j) Supporting documentation:** The provider shall include a list of records reviewed and identify the source of each, an organized summary of record research, and a list of collateral contacts by facility, contact persons and dates contacted.

**32-002.04G(4)(k) Timelines for Completion:** All components of the CCAA as clinically indicated (including the standardized report for supporting documentation and any related psychological and other mental health assessment) shall be completed and delivered to Medicaid or its designee within 10 working days.

Day one begins with the day following receipt of the request to complete the CCAA. The completed CCAA shall be received no later than 5 p.m. on the 10<sup>th</sup> day.

**32-002.04G(4)(l) CCAA Evaluation Locations:** Community-based or residential evaluation is recommended. In most cases, the Office of Juvenile Services/Children and Family Service worker shall determine the most appropriate evaluation location.

**32-002.04G(4)(m) Community-Based Evaluation:** A CCAA is completed in the client's home, the clinician's office, or another setting in the community whether the client normally resides. Access to the client is arranged by appointment through the client's parents or legal guardian.

**32-002.04G(4)(n) Residential Evaluation:** The CCAA is completed in highly structured staff secure and duly licensed residential facility provided or arranged by the preferred provider. A residential facility allows mental health professionals to observe a client in a setting on a 24-hour basis for a maximum of three days.

Residential evaluations may include a maximum of three days room and board payment.

**32-002.04H Comprehensive Child and Adolescent Assessment (CCAA) Addendum:** At times a client's existing symptoms, problems, or behaviors need clarification and/or the information was not identified in the original CCAA. The provider may need to complete a portion of the CCAA again within 12 months of the original CCAA to clarify or update the treatment needs. This is referred to as a CCAA addendum.

**32-002.04I Sexual Offending Risk Assessment for Clients Under the Age of 21:** A sexual offending risk assessment is an assessment developed to identify how mental health and/or substance abuse diagnosis may relate to sexual offending behavior. A sexual offending risk assessment is accessed to assist in developing client treatment recommendations, if treatment is indicated. The Sex Offender Risk Assessment may be used in lieu of the Biopsychosocial Assessment as Part I of the Pretreatment Assessment.

The complete sexual offending risk assessment shall be available to other practitioners in compliance with HIPAA and other state and federal regulations for the purpose of developing appropriate treatment intervention strategies.

This sexual offending risk assessment is not a forensic evaluation but intended to guide treatment and recovery from a mental health or substance abuse diagnosis.

The sexual offending risk assessment is available:

1. To clients who are Medicaid-eligible and receive Medicaid managed care mental health and substance abuse service benefits
2. To clients under the age of 21
3. When clients' symptoms and behaviors indicate this assessment is medically necessary

**32-002.04I(1) Components of a Sexual Offending Risk Assessment:**

Practitioners providing this assessment shall provide a typewritten report which includes the components listed below that resulted in the treatment recommendation. The report shall be signed by the Independent Licensed Mental Health Practitioners or licensed mental health practitioners along with their supervising practitioner who compiled the information in the report.

All components of the Sexual Offending Risk Assessment shall be individualized, family-centered, community-focused, strength-based, culturally competent and trauma informed.

The necessary components and outline for a sexual offending risk assessment include demographic, biopsychosocial, and assessment results information as follows:

**32-002.04I(1)(a) Demographic information:**

1. Reasons for referral;
2. A list of evaluation procedures including:
  - a) Clinical interview of the client, family members;
  - b) Initial Diagnostic Interview;
  - c) Collateral contact;
  - d) Reviewed documents;
  - e) Review of previous psychological testing; and
3. Risk Assessment Instruments measuring both dynamic and static factors (e.g., ERASOR – 2 ASO Questionnaire Juvenile Risk Assessment Scale).

**32-002.04I(1)(b) Biopsychosocial Information:**

1. Background information;
2. Family relationships and dynamics, family response to the current symptoms and problems;
3. Social functioning;
4. School/academic history;
5. Substance abuse history;
6. Legal history;

7. Mental health treatment history;
8. Sexual offense history;
9. Trauma/victimization history; and
10. Personal strengths.

**32-002.04I(1)(c) Assessment Results:**

1. Level of Cognitive/Adaptive functioning;
2. Personality and Behavior Factors;
3. Sexual Offending Risk Assessment using both static and dynamic factors;
4. Sexual Misconduct Patterns;
5. Perception/Understanding, Motivation/Empathy for the Victim;
6. Current Supervision and access to victim; and
7. Risk to reoffend.

**32-002.04I(1)(d) Staffing Requirements:** Each part of the Sexual Offending Risk Assessment shall be completed by a licensed practitioner acting within his/her scope of practice who is enrolled in Medicaid in the mental health and substance abuse program. The practitioners shall be contracted to provide mental health services by the Nebraska managed care entity.

**32-002.04J Sexual Offending Risk Assessment Addendum:** A sexual offending risk assessment addendum is intended and available to update a previously completed sexual risk offending assessment when new information becomes available to a practitioner and the service has been determined to be medically necessary.

An addendum is available to update a previous sexual offending risk assessment for clients who are Medicaid managed care eligible and are under the age of 21.

**32-002.04J(1) Necessary Assessment Addendum Instruments:** The Sexual Offending Risk Assessment Addendum shall update, as medically necessary, the following components:

1. Clinical interview of client and family members;
2. Clinical interview with collateral resources;
3. A review of documentation;
4. An Initial Diagnostic Interview;
5. Risk assessment instruments measuring both dynamic and static factors;
6. Psychological testing for cognitive/adaptive functioning if medically necessary;

The Sexual Offending Risk Assessment Addendum is expected to update the following components as medically necessary:

1. Demographic information;
2. Reason for referral;
3. List of evaluation procedures including:
  - a) Clinical interview of the client and family members;
  - b) Initial Diagnostic Interview;
  - c) Collateral resources;
  - d) Reviewed documents (protection and safety worker notes, legal documents, school records, treatment records, medical records, etc.);
  - e) Review of previous psychological testing if any (may include cognitive/adaptive functioning, behavior, personality measures);
4. Risk assessment instruments using both dynamic and static factors and ERASOR-2, ASO Questionnaire Juvenile Risk Assessment Scale
5. Biopsychosocial Information including;
6. Background information;
7. Family relationships and dynamics;
8. Current situation;
9. Social functioning;
10. School/academic history;
11. Substance abuse history;
12. Legal history;
13. Mental health treatment history;
14. Sexual offense history;
15. Trauma/victimization history;
16. Personal strengths;
17. The Results of Assessment including;
18. Level of Cognitive Adaptive Functioning;
19. Personality Behavior Factors;
20. Sexual Offending Risk Assessment using both static and dynamic factors;
21. Sexual Misconduct Patterns;
22. Perception/Understand of Motivation/Empathy for Victim;
23. Current Supervision and Access to Victim;
24. Diagnostic Impression;
25. Least Restrictive Treatment, Safety and Supervision Recommendations;
26. Risk to reoffend;

**32-002.04K Adolescent Substance Abuse Assessment:** For Nebraska Medicaid Enrolled Providers of Mental Health/Substance Abuse Treatment Services, this assessment may be completed in lieu of the Biopsychosocial Assessment (Part I of the Pretreatment Assessment (PTA) identified in Chapter 32 of the Nebraska Medical Assistance Program. This assessment in addition to the Initial Diagnostic Interview provided by a psychologist, psychiatrist or a LIMHP shall serve as a comprehensive Pretreatment Assessment (includes Part I and II of the PTA) for mental health and substance abuse problems.

The following is based on the Adolescent Criteria of the Client Placement Criteria for the Treatment of Substance-Related Disorders. Providers shall use the American Society of Addiction Medicine, Second Edition Revised (ASAM PPC-2R or current version). Providers are responsible to refer to the ASAM PPC-2R ADOLESCENT PLACEMENT MANUAL for the complete criteria.

The Adolescent Substance Abuse Assessment shall be completed in an appropriately licensed Nebraska Substance Abuse Treatment Center and by a licensed practitioner who is supervised when necessary who is working within his/her scope of practice and licensed as follows:

1. Substance Abuse Assessment: LADC, LIMHP, LMHP, LMHP/LADC, LMHP/PLADC, Psychologist, Psychiatrist;
2. Co-Occurring Assessment (SA/MH): LMHP, LIMHP, LMHP/LADC, LMHP/PLADC, Psychologist, Psychiatrist.

Components of The Adolescent Substance Abuse Assessment Report: The Adolescent Substance Abuse Assessment Report is comprised of three components:

- I. Screening Instruments and Scores
- II. The CASI and Initial Diagnostic Interview
- III. Multidimensional Risk Profile To Determine Type and Intensity of Services

These three components are subdivided as follows:

**32-002.04K(1) Screening Instruments and Scores:** All Adolescent Substance Abuse Assessment Reports shall include the use and results of at least one of the following nationally accepted screening instruments (the instruments may be electronically scored if indicated acceptable by author):

1. Substance Abuse Subtle Screening Inventory (SASSI);
2. Treatment Intervention Inventory (TII);
3. Substance Use Disorder Diagnostic Schedule (SUDDS);
4. Michigan Alcohol Drug Inventory Screen (MADIS);
5. Michigan Alcoholism Screening Test (MAST);
6. Mini International Neuropsychiatric Interview (MINI);
7. Western Personality Interview (WPI);
8. Problem Behavior Inventory (PBI);
9. Recovery Attitude and Treatment Evaluator (RAATE);
10. Clinical Institute Withdrawal Assessment (CIWA).

**32-002.04K(2) CASI:** The Comprehensive Adolescent Severity Inventory (CASI) is required to be used in a face-to-face structured interview. The CASI is to be scored and utilized to provide information to the Supervising Practitioner who completes the Initial Diagnostic Interview and the multi-risk profile. (NOTE: The completed Comprehensive Adolescent Severity Inventory (CASI) document shall be equivalent to a comprehensive biopsychosocial assessment. Providers shall use the "Comments" area in each section to further complete and specifically describe clinical information when checklists and inventories are not adequate.)

The CASI (biopsychosocial assessment in the substance abuse evaluation) shall include all of the following:

- A. Demographics
  - 1. Face Sheet  
Complete 1-18 as well as "reason for intake," "insurance information," "disability," "known to foster care," "known to juvenile/criminal justice, and other agencies."
  - 2. General Information  
Complete 1-18 as well as "Comments."
  - 3. Legal Guardians
  - 4. Other Involved Adults
- B. Health Information
  - 1. Medical symptoms, problems and diagnoses
  - 2. Prescribed medications and medication information (daily as well as "as necessary" medications)
  - 3. Last physical or last appointment by medical physician
  - 4. Comments (specific information is necessary)
- C. Stressful Life Events  
Complete 1-14 and "Comments"
- D. Education
  - Section I  
Complete 1-24 and "Comments"
  - Section II  
Complete 1-26 and "Comments"
- E. Drug/alcohol Use
  - Complete 1-11 and "Comments"
  - Complete 12-18 and "Comments"
  - Complete 19-30
  - Complete 31-35 and "Comments"
  - Complete 36-45 and "Comments"



- F. Use of Free Time
  - 1. Section I – Employment  
Complete 1-13 and "Comments"
  - 2. Section II  
Completed only if the client is not currently enrolled or attending school  
Complete 14-17 and "Comments"
  - 3. Section III - Leisure Activity  
Complete 18-37 and "Comments"
- G. Peer Relationships  
Complete 1-13 and "Comments"  
Complete 14-26 and "Comments"
- H. Sexual Behavior  
Complete 1-12 and "Comments"  
Complete 13-21 and "Comments"
- I. Family/Household Member Relationships  
Complete 1-62 and "Comments"
- J. Legal Issues  
Complete 1-16 and "Comments"
- K. Mental Health  
Complete 1-33 and "Comments"
- L. Interviewer Perceptions  
Complete 1-12 and "Comments"
- M. Other Diagnostic/Screening Tools - Score and Results
- N. Initial Diagnostic Interview- Item N-O shall be completed by an appropriate independent licensed clinician (e.g. psychiatrist or psychologist)  
The Initial Diagnostic Interview shall include, at a minimum:
  - A review of the CASI (biopsychosocial assessment) and supplemental clinical information edit as necessary
  - A mental status examination
  - A diagnostic formulization.
- O. Recommendations  
Complete III. Multidimensional Risk Profile  
Complete the ASAM Clinical Assessment and Placement Summary

The CASI shall include collateral contacts (with appropriate signed releases) with the client's family/guardian to gather relevant information about individual and family functioning and through collateral contacts with former and current healthcare providers, friends, and court contacts to verify medical history, substance usage, and legal history.

When dually-credentialed practitioners complete the evaluation their recommendations shall include co-occurring issues by providing the axis- 5 diagnosis using the current version of the DSM. This Biopsychosocial Assessment includes both Mental Health and Substance Abuse components and another comprehensive mental health assessment would not be necessary.

When LADCs complete the evaluation they shall include a screening for possible co-occurrence of mental health problems and include referral for mental health assessment as appropriate in their recommendations.

With appropriate releases of information, it is expected that this assessment shall be shared with other professionals involved in the client's assessment and treatment.

**32-002.04K(3) Multidimensional Risk Profile:** Recommendations for individualized treatment, potential services, modalities, resources, and interventions shall be based on the ASAM national criteria multidimensional risk profile. Below is a brief overview on how to use the matrix to match the risk profile with type and intensity of service needs. The provider is responsible for referring to ASAM PPC-2R for the full matrix when applying the risk profile for recommendations:

**Step 1:** Assess all six dimensions to determine whether the client has immediate needs related to imminent danger, as indicated by a Risk Rating of "4" in any of the six dimensions. The Dimensions with the highest risk rating determines the immediate service needs and placement decision.

**Step 2:** If the client is not in imminent danger, determine the client's Risk Rating in each of the six dimensions. (For clients who have co-occurring problems, assess Dimensions 4, 5 and 6 separately for the mental and substance-related disorders. This assists in identifying differential mental health and addiction treatment service needs and helps determine the kind of co-occurring services most likely to meet the client's needs.)

**Step 3:** Identify the appropriate types of services and modalities needed for all dimensions with any clinically significant risk ratings. Not all dimensions may have sufficient severity to warrant service needs at the time of the assessment.

**Step 4:** Use the Multidimensional Risk Profile produced by this assessment in Steps 2 and 3 to develop an initial treatment plan and placement recommendation. This is achieved by identifying which level of care appropriate for service needs in all relevant dimensions can effectively and efficiently be provided. The appropriate Intensity of Service, Level of Care, and Setting may be the highest Risk Rating across all the dimensions, but the interaction of needs across all dimensions may require more intensive services than the highest Risk Rating alone.

**Step 5:** Make ongoing decisions about the client's continued service needs and placement by repeating Steps 1 through 4. Keep in mind that movement into and through the continuum of care should be a fluid and flexible processes that is driven by continuous monitoring of the client's changing Multidimensional Risk Profile.

**32-002.04L Substance Abuse Assessment Addendum:** The Substance Abuse Assessment Addendum is intended to update a previously completed Substance Abuse Assessment or other comprehensive assessment when new information becomes available.

The Substance Abuse Assessment Addendum is available to clients under the age of 21 who are Medicaid-eligible and need an assessment to update and guide mental health and/or substance abuse treatment services.

Each part of the substance abuse assessment addendum shall be completed by a fully licensed practitioner whose scope of practice includes substance abuse services and who are enrolled with Medicaid as providers, and who is enrolled with Medicaid as a provider and who is contracted and credentialed to provide substance abuse services by the Mental Health Managed Care Entity.

**32-002.04L(1) Substance Abuse Assessment Addendum Development:** All components of the comprehensive assessment addendum shall be individualized, family centered, community focused, strength based, culturally competent and trauma informed.

The following components are necessary at a minimum for a complete assessment addendum:

1. Client Name
2. Date of Service
3. Date Original Substance Abuse Assessment or comprehensive assessment completed
4. Reason for Conducting Addendum
5. Components Needing Update
6. Summary of Information

**32-002.04L(2) Provider Expectations:** Expectation of providers completing a substance abuse assessment addendum are as follows:

Provide a Substance Abuse Assessment Addendum accessible to additional/future treatment providers with appropriately signed consent forms (the SA assessment and SA Addendums should be "portable" documents that accompany the Medicaid client throughout his/her mental health and/or substance abuse treatment)

Provide an organized Substance Abuse Assessment Addendum which is a comprehensive, integrated, typed document in narrative form (Checklists are not acceptable as a completed Substance Abuse Assessment or Addendum document but may be an internal worksheet from which the assessment is drafted)

**32-002.05 Psychotherapy:** Medicaid recognizes three types of psychotherapy:

**32-002.05A Individual Psychotherapy:** A face-to-face active treatment session between a client and an appropriately licensed practitioner whose scope of practice includes providing mental health services for a primary mental health disorder. These psychotherapy services are scheduled sessions to focus on improving the mental health symptoms that significantly impair the client's functioning in at least one life domain such as family, social, occupational, educational, etc.

The goals, frequency and duration of the service shall vary according to the client's individual needs and the identified symptoms experienced by the client. The treatment shall be identified in an active treatment plan and the licensed practitioner whose scope of practice allows for provision of mental health services shall continue ongoing treatment toward achievement of the targeted treatment goals for this treatment episode. Targeted treatment goals shall be obtainable based upon the history of previous functioning ability. Treatment shall be restorative and rehabilitative but not habilitative in nature.

No additional reimbursement is made for medication checks performed by a physician in the course of individual psychotherapy.

**32-002.05B Group Psychotherapy:** A face-to-face treatment session between a client and a licensed practitioner whose scope of practice includes mental health services in the context of a group setting of 3-12 clients.

Group psychotherapy shall be provided in a confidential, professional setting such as a therapist's office, a clinic or hospital facility. Group psychotherapy shall be provided as an active treatment service for a primary psychiatric disorder in which identified treatment goals are a part of the client's active treatment plan and there is reasonable expectation that group psychotherapy can improve the client's psychiatric symptoms.

Medicaid does not cover groups that are primarily supportive, social or educational in nature. Medicaid does not cover group therapy services that are ongoing without established targeted treatment goals. Group sessions for maintenance, socialization, skill building or symptom management are not included as covered interventions in this chapter.

**32-002.05C Family Psychotherapy:** A face-to-face treatment session between an identified client and the client's nuclear or extended family, and a licensed practitioner whose scope of practice includes mental health services. These services shall focus on the family as a system and include a comprehensive family assessment. The specific objective of treatment shall be to alter the family system to increase the functional level of the identified client and the client's family system.

The session shall include the involvement of the client and the client's family members and licensed practitioner whose scope of practice includes mental health services. The intent is to focus on the client's mental health and substance abuse needs and this does not create eligibility for treatment of other family members. Family participation in treatment does not create Medicaid eligibility for family members.

A service provided to an identified client with family as observers in the session is not considered family psychotherapy.

**32-002.06 Substance Abuse Counseling:** Medicaid recognizes three types of substance abuse counseling:

**32-002.06A Individual Substance Abuse Counseling:** A face-to-face counseling session between a client and a licensed practitioner whose scope of practice includes substance abuse services for a primary substance abuse disorder. This service shall meet Level I of the Youth Criteria of a Patient Placement Criteria for Treatment of Substance-Related Disorders of the American Society of Addiction Medicine (ASAM) (current version).

Providers shall refer to the ASAM manual for complete criteria for placement. Outpatient substance abuse individual therapy shall reasonably be expected to improve the active symptoms of a primary substance abuse disorder which are identified in a client's individualized active treatment plan. The service shall be designed to assist the client to achieve favorable change to his/her alcohol or other drug using behaviors. Goals, frequency and duration of treatment shall vary according to the client's needs and response to treatment.

Providers treating clients with co-occurring mental health and substance abuse disorders shall preferably be dually-licensed and coordinate with other service providers to achieve a well-organized coordinated plan of care.

Medicaid does not cover services that are ongoing without identified achievable treatment goals and that are only supportive, social, or educational services.

**32-002.06B Group Substance Abuse Counseling:** Outpatient substance abuse group services considered an active treatment session between a licensed practitioner and a group of 3-12 clients who have a primary substance abuse diagnosis. Treatment is provided in a face-to-face group setting for each client who has an individualized active treatment plan for which this group service can assist the client with meeting their individualized treatment goals.

Substance abuse group counseling shall meet the Level I of the youth criteria of Patient Placement Criteria for Treatment of Substance-Related Disorders of the American Society of Addiction Medicine (ASAM) (current version).

Groups that are primarily for education, socialization and support do not meet the criteria for treatment identified in an active treatment plan and are not included in this chapter.

**32-002.06C Family Substance Abuse Counseling:** A face-to-face treatment session which occurs between an identified client and the client's nuclear or extended family and a licensed practitioner skilled in substance abuse related disorders and family issues. The intent is to focus on the client's substance abuse needs and does not create eligibility for other family members to receive treatment for their issues. The service shall be for a client with a primary substance related disorder and meet the criteria of Level I of youth criteria of Patient Placement Criteria for Treatment of Substance-Related Disorders of the American Society of Addiction Medicine (ASAM).

Providers shall refer to the ASAM manual for complete criteria. The specific objective of family substance abuse counseling is to focus on the family and the family system to increase the functional level of the identified client and the client's family related to substance abuse. Family substance abuse counseling shall be provided with all of the family members essential to the client's active treatment plan. Family participation in treatment does not create Medicaid eligibility for family members.

A service provided to the client with family as observers in a session is not considered family substance abuse counseling.

**32-002.07 Conferences with Family and Other Responsible Persons Advising Them on How to Assist the Client:** Medicaid shall consider payment for conferences with family and other persons caring for the individual advising them on how to assist the client when this assistance can reasonably be expected to improve the client's mental health or substance abuse condition. The need for a conference shall be documented in the client's active treatment plan and shall include the primary caregiver but may also include school staff members, child care providers, etc., with the appropriate releases of information signed.

The service requires the expertise of the treating mental health practitioner.

**32-002.08 Mental Health and Substance Abuse Community Treatment Aide Services:** Community Treatment Aide (CTA) services are supportive, and psychoeducational interventions provided primarily in the client's natural environment. Natural environment primarily is the client's home but may also include a foster home, school, or other appropriate community locations conducive for the delivery of CTA services per the service.

Community Treatment Aide (CTA) services are designed to assist the client with compensating for or eliminating functional deficits and interpersonal and/or environmental barriers associated with their mental illness. CTA services shall enhance the client's and caregiver's ability to manage the client's mental health and substance abuse symptoms. Activities included shall have the intention of achieving the identified goals or objectives as set forth in the individual's individualized treatment plan.

The service is delivered by a highly skilled, educated and trained non-licensed staff person under the direction and supervision of a licensed practitioner who simultaneously provides family and/or individual therapy on a regular basis to the client and the client's caregiver/family.

A CTA provider performs the following functions:

1. Provides training and rehabilitation of basic personal care and activities of daily living through training the youth and the usual caregiver
2. Promotes improvement in the youth's social skills and relationship skills through training and education of the youth and the usual caregiver
3. Teaches and instructs the caregiver in crisis and de-escalation techniques
4. Teaches and models appropriate behavioral treatment interventions and techniques for the youth and the youth's caregiver
5. Teaches and models appropriate coping skills to manage dysfunctional behavior for the youth and the youth's caregiver
6. Provides information about medication compliance and relapse prevention and reports to his/her Supervising Practitioner and prescribing physician
7. Teaches and models proper and effective parenting practice

**32-002.8A Provider Qualifications:** Agencies shall be certified by Medicaid or Medicaid's designee.

The CTA agency shall assure that the program includes criminal abuse, neglect registry, and criminal background checks of the CTA workers and completion of the agency's approved basic training program for all CTA staff.

The CTA staff shall be employed/contracted within the same agency as the therapist/licensed practitioner providing psychotherapy services to the client and the client's family.

**32-002.08B Community Treatment Aide Programs:** Community Treatment Aide services are available to all clients under the age of 21. Services provided to clients receiving the managed care benefits shall receive prior authorization from Medicaid or its designee.

**32-002.08C Types of Community Treatment Aide Programs:** Providers interested in providing Community Treatment Aides may apply for enrollment by developing a program description of the type of program they wish to implement, either Large Agency Based Community Treatment Aide or Small Agency Based Community Treatment Aide. The differences are as follows:

**32-002.08C1 Large Agency Based Community Treatment Aide programs:**

These are large agencies that have:

1. Multiple programs and/or levels of care;
2. Achieved and maintained national accreditation for the agency;
3. More than one location that provides a variety of services which may include a Community Treatment Aide program;
4. A designated program/clinical director for a CTA program;
5. A multidisciplinary team of practitioners which may include a licensed physician whose specialty is psychiatry, licensed psychologists, licensed APRN's, LIMHP's, LMHP's and LADC's (these agencies may employ provisional practitioners such as PLP and PLMHP's);
6. Written policies and procedures that meet Medicaid's community treatment Aide program requirements;
7. Supervising Practitioner for the program;
8. Policies that all CTA services are provided within the agency staff and do not share CTA staff with other agencies;
9. An approved CTA training program; and
10. Approved policies and procedures that guide the operation of the CTA program.

**32-002.08C2 Small Agency Community Treatment Aide Programs:** Groups of practitioners or a single practitioner that have:

1. An outpatient clinic generally at just one location;
2. Not achieved nor are pursuing national accreditation;
3. Developed a CTA program, usually implemented from only one location and generally operates out of the practitioner's office; and
4. Designated one fully-licensed practitioner that fulfills the role of the Program/Clinical Director of the community treatment Aide program for the group.

5. Limited practitioner specialties, education, and experience within the practitioner group. (NOTE: practitioners involved in the program are fully licensed)
6. A team of mental health and/or substance abuse practitioners that have a written program description and policies and procedures for the CTA program that all licensed and unlicensed staff within the group shall adhere to
7. A Supervising Practitioner that meets Medicaid's responsibilities for supervision
8. Team CTA services provided by the enrolled group of CTA staff and the group does not share CTA services with any other practitioner outside of the group

**32-002.08C3 Community Treatment Aide Staffing Requirements:** The following personnel staff Community Treatment Aide programs:

**32-002.08C3(a) CTA Program/Clinical Director:** This practitioner may be a licensed physician with a specialty in psychiatry, Licensed Mental Health Practitioner (LMHP), licensed registered nurse (RN), licensed APRN, LIMHP, or a licensed psychologist. The program/clinical director shall be a fully licensed practitioner who is providing services within his/her scope of practice and licensure and has two years of professional experience in mental health and/or substance abuse treatment of individuals under the age of 21. The practitioner has professional experience in a treatment setting similar to that which the practitioner is providing the services of a program director.

The responsibilities of the program/clinical director include, but are not limited to:

1. Oversees, implements, and coordinates all treatment services and activities provided within the program.
2. Continually incorporates new clinical information and best practices into the program to assure program effectiveness and viability.
3. Oversees the process to identify, respond to and report crisis situations on a 24-hour per day/7-day per week basis.
4. Clinical management of the program in conjunction with the Supervising Practitioner.
5. Assures quality organization and management of clinical records, other program documentation and confidentiality.

**32-002.08C3(b) CTA Therapist:** This individual shall be a licensed practitioner, including a physician with a specialty in psychiatry, psychologist, LIMHP, LMHP and APRN (agency CTA programs may also include provisionally licensed psychologists and provisionally Licensed Mental Health Practitioners as therapists). Large agency CTA programs may also include provisional. The practitioner providing psychotherapy services for the client and oversight of the supervision to the Community Treatment Aide service shall be practicing within their scope of practice.

The responsibilities of the CTA therapist include, but are not limited to:

1. Reports to the Program/clinical director and Supervising Practitioner for clinical and non-clinical guidance and direction.



2. Communicates treatment issues to the Supervising Practitioner as needed.
3. Provides individual and family psychotherapy according to the active treatment plan.
4. Provides supervision to the community treatment Aide staff person, guiding the active treatment plan implementation in the home/living environment and co-signing all CTA progress notes.
5. Assists in developing active treatment plans for clients in his/her care.
6. Provides input to the multi-disciplinary team and attends treatment team meetings.
7. Provides continuous and ongoing assessment of the active treatment plan to assure that the clinical needs of the client/parent/caregiver are met. This includes transitioning the client to other treatment and care settings as necessary.

**32-002.08C3(c) Community Treatment Aide Staff Person:** This staff person shall have a bachelor's degree in psychology, social work, child development or a related field and the equivalent of one year of full-time experience in direct child/adolescent services or mental health and/or substance abuse services. (Equivalent time in graduate studies may substitute for work experience.)

The community treatment aide staff person may have a two years post-high-school education in the human services or related fields and a minimum of two years (or full-time equivalent) experience in direct child/adolescent services or mental health and/or substance abuse services.

The community treatment Aide shall be employed/contracted within the same agency as the therapist/licensed practitioner providing psychotherapy services to the client and the client's family.

The responsibilities of a CTA staff person include, but are not limited to:

1. Understands the active treatment plan and discharge plan
2. Provides supervision and rehabilitation of basic personal care and activities of daily living through training the client and the usual caregiver
3. Promotes improvement in the client's social skills and relationship skills through training and education of the client and the usual caregiver
4. Teaches and instructs the caregiver in crisis and de-escalation techniques
5. Teaches and models for the client's caregiver appropriate behavioral treatment interventions and techniques
6. Teaches and models for the client and client's caregiver appropriate coping skills to manage dysfunctional behavior
7. Provides information about medication compliance and relapse prevention and report to his/her Supervising Practitioner and prescribing physician
8. Teaches and models proper and effective parenting practice
9. Understands boundaries and professionalism

Unit of Service: A 15 minute unit is used for unlicensed direct care staff.

**32-002.09 Medication Management Services:** Medication management may only be done when medically necessary. When the physician, physician assistant or advanced practice registered nurse provides psychotherapy services, medication management is considered a

part of the psychotherapy service. A physician may provide medication management when a licensed psychologist or other licensed practitioners whose scope of practice includes mental health and/or substance abuse services.

**32-002.10 Medical Necessity:** Outpatient mental health and/or substance abuse services shall meet the medical necessity requirements as identified in 471 NAC 32-001.03.

**32-002.11 Supervising Practitioner:** The outpatient treatment interventions provided by a Licensed Mental Health Practitioner (LMHP), Provisionally Licensed Mental Health Practitioner (PLMHP) or a Licensed Drug and Alcohol Counselor (LADC) shall be directly supervised according to the following standards:

1. The Supervising Practitioner shall prescribe and order all treatment interventions based on the Biopsychosocial Assessment completed by a licensed practitioner and the Supervising Practitioner's Initial Diagnostic Interview.
2. The Supervising Practitioner and the licensed practitioner who requires clinical supervision shall have a supervisory contact (either in person or by phone) every 30 days, or more often if necessary, to review the treatment of the client and the Treatment Plan. This supervisory contact and related changes in the treatment program should be reflected on the Treatment Plan. There is no additional payment available to the Supervising Practitioner or a licensed practitioner whose scope of practice allows for the provision of mental health and substance abuse treatment services for this supervisory contact.
3. Providers shall meet the requirements and comply with the requirements of 471 NAC 32-001.03A, B, and C.

**32-002.12 Coverage for Outpatient Mental Health and Substance Abuse Services:** Medicaid covers outpatient mental health and substance abuse services when psychotherapy services are medically and clinically necessary. Providers shall meet all of the standards identified in 471 NAC 32-001.01(A and B).

**32-002.13 Standards for Participation for Outpatient Services:** Providers interested in becoming a provider of mental health and/or substance abuse outpatient community-based services shall review and comply with 471 NAC 32-001.04A licensed hospitals shall review and comply with 471 NAC 32-001.04B for requirements of hospitals wishing to provide outpatient mental health and/or substance abuse services.

**32-002.14 Conditions for Participation as a Provider of Outpatient Services:** Providers shall review and comply with the Conditions for Participation for outpatient community-based services identified in 471 NAC 32-001.05 and hospitals shall review and comply with 471 NAC 32-001.05A for conditions of participation.

**32-002.15 Location of Mental Health and/or Substance Abuse Services:** Providers of outpatient services may provide outpatient services at various professional locations. Providers of community-based services shall review and agree to comply with the standards of 471 NAC 32-001.04D.

**32-002.16 Staffing Standards for Outpatient Services:** Community-based service providers shall review and comply with 471 NAC 32-001.05A for information regarding staffing standards. Hospitals shall review and comply with 471 NAC 32-001.05B.

**32-002.17 Active Treatment:** Active treatment for outpatient services is documented through the use of a treatment plan. An active Treatment Plan shall be developed by licensed practitioner whose scope of practice includes mental health and/or substance abuse services providing therapy with the Supervising Practitioner (licensed psychologist, licensed physician whose specialty is psychiatry, or a Licensed Independent Mental Health Practitioner (LIMHP)).

The plan shall be based on a thorough evaluation of the client's restorative needs, for a primary diagnosis of mental health or substance abuse from the current Diagnostic and Statistics Manual published by the American Psychiatric Association. Providers are also referred to and expected to comply with the active treatment requirements in 471 NAC 32-001.08.

**32-002.18 Treatment Planning:** Providers are expected to review and comply with the requirements of 471 NAC 32-001.08A for standards regarding treatment planning. In addition, for outpatient treatment services, at a minimum the treatment plan shall be updated every 90 days or sooner if medically necessary. The client's clinical record shall reflect all communication between the Supervising Practitioner and the licensed practitioner who is providing services regarding treatment plan adjustments as necessary between written treatment plan reviews.

**32-002.19 Clinical Records:** Providers shall comply with the requirements identified in 471 NAC 32-001.08C(1 through 3) for regulations regarding clinical records and documentation for community-based services and for hospitals.

**32-002.20 Payment for Outpatient Mental Health and Substance Abuse Services:** Payment for outpatient mental health and substance abuse services is made according to the Nebraska Medicaid Practitioner Fee Schedule at 471-000-532. Nebraska Medicaid pays for covered outpatient mental health and substance abuse services at the lower of:

1. The provider's submitted charge
2. The allowable amount for that procedure code in the Nebraska Medicaid Practitioner Fee Schedule for that date of service. The allowable amount is indicated in the fee schedule as:
  - a) The unit value multiplied by the conversion factor
  - b) The maximum allowable dollar amount
  - c) The reasonable charge for the procedure as determined by Medicaid (indicated as "BR" - by report or "RNE" - rate not established - in the fee schedule)
  - d) The National Correct Coding Initiative Rates
  - e) A percent of Medicare charge

Billable Hour Limitation: CTA is limited to 750 hours per calendar year. This limit can be exceeded when medically necessary with prior authorization.

**32-002.21 Revisions of the Fee Schedule:** HCPCS/CPT codes used by Medicaid are listed in the Medicaid Practitioner Fee Schedule at 471-000-532. Medicaid reserves the right to adjust the fee schedule to:

1. Comply with changes in state or federal requirements
2. Comply with changes in national standard code sets, such as HCPCS and CPT
3. Comply with the National Correct Coding Initiative
4. Establish an initial allowable amount for a new procedure based on information that was not available when the fee schedule was established for the current year
5. Adjust the allowable amount when Medicaid determines that the current allowable amount is:
  - a. Correct for payments not appropriate for the service provided
  - b. Correct errors in data or calculation

**32-002.22 Billing Requirements:** For outpatient mental health and substance abuse service providers the following requirements shall be met:

1. Community mental health and substance abuse programs providing outpatient services shall submit all claims for services on an appropriately completed Form CMS-1500 (see 471-000-64) or the standard electronic Health Care Claim: Practitioner transaction (ASC X12N 837).
2. Hospitals providing outpatient mental health services shall submit all claims for non-physician services on an appropriately completed Form CMS-1450 or the standard electronic Health Care Claim: Institutional transaction (ASC X12N 837).
3. All physician services shall be submitted on an appropriately completed Form CMS-1500 or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837).
4. Payment for approved outpatient services provided by employees of a hospital is made to the provider as named on the provider agreement.
5. Independent providers of outpatient mental health and substance abuse services shall submit all claims for outpatient services provided on an appropriately completed Form CMS-1500 (see 471-000-64) or the standard Health Care Claim: Professional transaction (ASC X12N 837).
6. Payment for approved outpatient services provided by a community based provider are made to the provider as identified on the provider agreement payment information. (See Appendices for completing the enrollment form).

**32-002.23 Inspections of Care:** Medicaid's inspection of care team may conduct Inspection of Care reviews for Outpatient Mental Health and Substance Abuse Services. Please refer to 471 NAC 32-001.11.

**Procedure Codes:** HCPCS/CPT procedure codes used by Medicaid are listed in the Nebraska Medicaid Practitioner Fee Schedule at 471-000-532. Medicaid shall reimburse HCPCS and CPT codes according to the National Correct Coding Initiative.

**32-003 Intensive Outpatient Mental Health and Substance Abuse Services (IOP) for**

**Children/Adolescents:** Intensive Outpatient Psychiatric services provide group-based, non-residential, intensive outpatient mental health and/or substance abuse treatment services consisting primarily of psychotherapy services and substance abuse counseling services. Child/Adolescent Intensive Outpatient services are available to Medicaid-eligible clients who meet the admission guidelines for this level of care and are under the age of 21.

Services shall be provided to improve the mental health and/or substance abuse condition/s that may significantly interfere with the individual's ability to function in the community. Psychotherapy and substance abuse counseling services shall be goal oriented treatment sessions conducted as individual, group, and/or family psychotherapy or substance abuse counseling services.

IOP services achieve specific goals through a group of individualized treatment interventions and services. Individualized treatment shall provide the basis for transitioning a client to a less intense level of care if additional services are clinically necessary. Individualized treatment is based upon an active treatment plan and a specific plan for discharge from IOP when the treatment goals have been met.

IOP services shall be community-based, family-centered, culturally competent and developmentally appropriate and meet the General Requirements identified in 471 NAC 32-001.01. Please specifically note the Family Component in 471 NAC 32-001.01. Providers shall understand and incorporate the principals of Recovery and Trauma-Informed Care. Providers shall also review Definitions identified in 471 NAC 32-001 and apply the definitions to the policy requirements.

Treatment shall be offered during the day and may be scheduled before and after a work schedule and/or school schedule and also may occur on the weekend. Treatment services may be appropriately used to transition a client from higher levels of care and may be provided for clients at risk of needing more intensive care than traditional weekly outpatient treatment services.

The goals, frequency and duration of the intensive outpatient program shall vary according to the individual needs of the client and the client's response to the day-to-day treatment intervention. Treatment services may be appropriately used to transition a client from higher levels of care and may be provided for clients at risk of needing more intensive care than traditional weekly outpatient treatment services.

Clients whose symptoms include uncontrolled disruptive behavior shall have de-escalation and anger management identified in the initial treatment plan, and measures shall be taken to aggressively enforce and manage those behaviors at the earliest time possible. IOP Direct Care Staff shall be aware of safety issues unique to each child and provide safety intervention.

Procedures such as seclusion and restraint to manage client behavior are not permitted.

**32-003.01 Medical Necessity:** Covered IOP services shall be medically necessary services and provided following a comprehensive assessment which determines the medical necessity for treatment. Providers are referred to 471 NAC 32-001.03 and shall comply with these medical necessity requirements.

**32-003.02 Evaluation and Diagnostic Services:** A Pretreatment Assessment (PTA) is the comprehensive assessment referred to in 471 NAC 32-003.01 and defined in 471 NAC 32-001.02. The PTA shall be completed prior to determining a need for admission into the intensive outpatient program. The PTA identifies the clinical need for treatment and the most effective treatment intervention/level of care to meet the medical necessity needs of the client.

If the client is recommended for an intensive outpatient program the Pretreatment Assessment document shall accompany the referral information to the intended intensive outpatient program provider.

The Pretreatment Assessment is used as follows:

1. The clinical information in the Pretreatment Assessment of the referral source shall justify the need for referral to the intensive outpatient program. It shall state that an intensive outpatient program is the most appropriate level of care based on the level of acuity and the client's ability to participate and benefit from the service if this is the practitioner's recommendation.
2. After referral information is received by the program and when a client is accepted into the program, the Supervising Practitioner of the IOP program shall provide a diagnostic assessment within 24 hours of admission. This initial diagnostic assessment shall support and confirm the diagnosis and treatment needed at this level of care. The Supervising Practitioner provides recommendations specific to the intensive outpatient program as well as treatment goals to be met in the individualized plan of care.
3. The intensive outpatient program shall include the Pretreatment Assessment information when obtaining prior authorization for the service by Medicaid or Medicaid's designee.
4. The Supervising Practitioner may identify additional assessments in his/her recommendations or for other medical consultations if these are medically necessary. The IOP provider shall assist the client in completing any other assessments to determine clarification of diagnoses or to identify other conditions which may impact the client's mental health and/or substance abuse condition.

**32-003.03 Prior Authorization:** All IOP services for clients receiving the managed care benefit require prior authorization by Medicaid or Medicaid's designee. Providers shall include the recommendations of the Pretreatment Assessment (PTA).

**32-003.04 Standards of Participation for IOP Services:** Providers of IOP community-based services shall comply with the enrollment requirements of 471 NAC 32-001.04A and review the setting (location) for delivering community-based services to the client. See 471 NAC 32-001.05B. Providers of hospital-based services shall meet the enrollment requirements for hospitals identified in 471 NAC 32-001.04B.

**32-003.05 Conditions of Participation for IOP Services:** Providers of IOP community-based services shall review the conditions of participation identified in 471 NAC 32-001.04B and comply with those conditions. Providers of hospital-based IOP services shall also know the conditions of participation for hospitals identified in 471 NAC 32-001.04C.

**32-003.06 Covered Intensive Outpatient Programs:** Intensive outpatient services provide assessment, treatment planning, and treatment to the client. Treatment planning includes the initial treatment plan and treatment plan reviews.

IOP providers deliver active treatment services such as individual, group, and family psychotherapy and substance abuse counseling by a licensed practitioner as medically necessary. The group of treatment services shall be individualized, goal-specific, and time-limited and shall be based upon the specific problems, behaviors and dysfunctions of the identified Medicaid client.

Medication management is available to all clients participating in an IOP service when medication is prescribed by an appropriately licensed practitioner. This service shall be medically and clinically necessary for the mental health and/or substance abuse disorder requiring treatment. The practitioner providing medication management shall consult with the program periodically and may bill for all directly delivered medication management services separate from the payment to the program for IOP services.

Intensive outpatient programs that implement or provide services such as Applied Behavioral Analysis (ABA) techniques and programs that primarily provide interventions to develop and manage individualized behavioral modification plans are not covered in this chapter.

**32-003.07 Staffing Standards for IOP Programs:** Providers of community-based IOP services shall review and comply with staffing requirements for licensed practitioners identified in 471 NAC 32-001.06.

Staffing for hospitals providing IOP hospital-based services shall comply with staffing requirements for hospitals identified in 471 NAC 32-001.07.

Practitioners eligible to provide the Supervising Practitioner responsibilities are identified in 471 NAC 32-001.03B. Programs shall identify a Supervising Practitioner at the time of enrollment. The Supervising Practitioner shall understand and review and comply with the standards regarding the role and responsibilities of supervision identified in 471 NAC 32-001.03(C and D).

One Supervising Practitioner shall be responsible for the clinical direction of the program and for the individualized treatment of each client participating in the program. Providers of programs shall identify a coverage Supervising Practitioner to serve the program in the unforeseen absence of the designated Supervising Practitioner due to illness or vacations.

The program shall identify an on-call system of licensed practitioners available for crisis management when the client is not in the program's scheduled hours and/or the program is not in session.

IOP Agencies shall be licensed by the State of Nebraska and certified by Medicaid or its designee. Dual-licensure is required for licensed practitioners providing IOP Services when co-occurring conditions (e.g., mental health/substance abuse diagnoses) occur.

**Program/Clinical Directors:** Each agency shall employ Program/Clinical Directors to supervise the program and direct the care. A program/clinical director shall be a LMHP, diploma RN, APRN, LIMHP, licensed Psychologist. Dual-licensure (e.g., LMHP/LADC or LMHP/PLADC) is required for Intensive Outpatient Services when co-occurring conditions (mental health and/or substance abuse programs occur).

Practitioners who meet the criteria of the program/clinical director may not also serve in the role of the program's therapist.

The responsibilities of a program/clinical director for intensive outpatient services include, but are not limited to:

1. Oversees, implements, and coordinates all treatment services.
2. Consistently incorporates new clinical information and best practices into the program to assure program effectiveness and viability.
3. Oversees the process to identify, respond to, and report crisis situations on a 24-hour per day, 7 day per week basis.
4. Clinical management of the program in conjunction and consultation with the Supervising Practitioner.
5. Assures confidentiality, quality, organization, and management of clinical records and other program documentation.
6. Applies and supervises the gathering of outcome data and determines the effectiveness of the program for the clients served.

**IOP Therapist/s:** A IOP therapist/s shall include any of the following practitioners who may be a physician with a specialty in psychiatry, an LMHP, an LIMHP, PLMHP, LADC, licensed Psychologist, Provisionally Licensed Psychologist or licensed APRN. The licensed practitioner provider mental health and/or substance abuse services for clients in the IOP program shall be operating within his/her scope of practice.

The responsibility of the IOP therapist/s include but are not limited to:

1. Report to the program/clinical director and supervising practitioner for clinical and non-clinical guidance and direction.
2. Communicate treatment issues to the Program/Clinical Director and to the Supervising Practitioner as needed.
3. Provides individual, group, and/or family psychotherapy and/or substance abuse counseling.
4. Assist in developing and updating treatment plans for clients in the IOP service in conjunction with the other multidisciplinary team members.
5. Provide assistance to direct care staff implementing the treatment plan when directed by the Program/Clinical Director.
6. Provide clinical information to the multidisciplinary team and attend treatment team meetings.
7. Provide continuous and ongoing assessment to assure that the clinical needs of the client and the client's parent/caregiver are met.



**Direct Care Staff:** The direct care staff shall meet one of the following requirements:

1. A bachelor's degree or higher in psychology, sociology, or related human service field, plus a minimum of one year work experience or graduate studies in direct child/adolescent services or mental health and/or substance abuse services
2. Two years of post-high-school education in the human services field, plus a minimum of two years of experience or training in the human services field with demonstrated skills and competencies in treatment of youth with mental illness

The requirements for Direct Care Staff listed in this section become effective for staff hired on or after the effective date of this policy. Basic requirements of Direct Care Staff include:

1. Complete the initial program training and successfully complete the agency's competency check
2. Demonstrate skill and competency in the treatment of clients with mental health and substance abuse disorders prior to delivery of services
3. Shall pass the child abuse check, adult abuse registry, and motor vehicle screens.
4. Complete specific training for behavioral management and update the training as required by the program
5. Understand de-escalation techniques and demonstrate the ability to implement those techniques effectively

Direct Care Staff perform the following functions in IOP services:

1. Provide psychoeducational activities and interventions to help clients develop social, recreational and other independent living skills as appropriate. Psychoeducational therapy services include, but are not limited to:
  - a. Crisis Intervention Plan and Aftercare Planning
  - b. Social Skills Building
  - c. Life Survival Skills
  - d. Substance Abuse Prevention Intervention
  - e. Self-care services
  - f. Therapeutic recreational activity
  - g. Medication education and medication compliance groups
  - h. Health care issues group (e.g., nutrition, hygiene, personal wellness)
2. Implements their role in providing services identified in the treatment plan and discharge plan for each client
3. Provide continual care to clients in the program
4. Report all crisis or emergency situations to the program/clinical director or to the program's designee in the absence of the program/clinical director
5. Understand the program's philosophy regarding behavior management and apply its philosophy in daily interactions with the clients in care

Unit of Service: A 15-minute unit is used for unlicensed direct care staff.

**32-003.08 Active Treatment Services for IOP Programs:** Active treatment begins with the referral Pretreatment Assessment, Initial Diagnostic Assessment completed by the IOP Supervising Practitioner and the recommendations of these assessments identified in the treatment plan.

Whether the assessment determines a mental health disorder, substance abuse disorder or co-occurring disorders, active treatment shall be identified by treatment interventions that are goal-directed and targeted toward regaining/restoring skills and abilities that a client once achieved but has lost through mental illness and/or substance abuse conditions.

Providers of community-based IOP's and hospital-based IOP's shall comply with the regulations of 471 NAC 32-001.08 for active treatment. In addition, the Supervising Practitioner shall:

1. Complete a face-to-face initial diagnostic assessment prior to delivering treatment services and within 24 hours of admission (if the Supervising Practitioner of the referral PTA is the same Supervising Practitioner of the IOP program, then the referral Initial Diagnostic Interview can serve as the admission diagnostic interview if the assessment provides clear direction to the IOP program regarding recommendations to develop the treatment plan)
2. Provide a face-to-face treatment service every 30 days at minimum
3. Directly participate in and supervise the development of the initial treatment plan within 14 days of admission (the recommendations of the IOP Supervising Practitioner serves as the plan of care until the treatment plan is developed by the 14<sup>th</sup> day following admission)

4. Update the goal-directed treatment plan with the multidisciplinary team each 30 days
5. Monitor and supervise the treatment services delivered
6. Review the progress and benefit of the services to the client and adjust the treatment plan as necessary
7. Review and supervise discharge planning with each treatment plan review and provide direction for adjustment as necessary

**32-003.09 Program Availability:** The program shall be available at a minimum of 9 scheduled hours per week for at least 3 hours of availability per day. The program shall be offered at a minimum of 3 times per week but may also be available up to 7 days per week.

The program shall be flexible in offering a menu of treatment services to meet the client's individual needs and offer a schedule of participation for the client in the program. The program shall identify an on-call system of licensed practitioners available for crisis management when the client is not in the program's scheduled hours and/or the program is not in session.

The provider of IOP services shall bill each treatment service separately and the program shall be offered a minimum of 3 hours per day. The client may attend the number of hours/services as medically necessary per day. The provider shall bill per procedure code definition for the licensed practitioners and the psychoeducational per diem.

**32-003.10 Treatment Planning:** An individualized treatment and recovery plan including an aggressive discharge plan shall be developed with the participation of the client and the client's family/guardian by the multidisciplinary treatment team consisting of the Supervising Practitioner and the program's licensed practitioners whose scope of practice includes mental health and/or substance abuse services. The program shall meet the active treatment guidelines as identified in 471 NAC 32-001.08A.

The treatment plan shall be goal-directed with means of measuring the achievement of each treatment goal and estimating the targeted date for each goal completion. The treatment plan shall include a crisis management plan for the client.

If the client remains in the program after 14 days, the treatment plan shall be reviewed by the team each 14 days.

**32-003.11 Transition and Discharge Planning:** Providers are expected to be knowledgeable of active treatment standards with targeted dates for treatment goal completion which leads to a timely discharge and apply the requirements of 471 NAC 32-001.08B to the program.

**32-003.12 Clinical Records:** Providers shall review the requirements for clinical records identified in 471 NAC 32-001.08C(1 through 3), apply these regulations to their practice, and comply with the requirements.

**32-003.13 Services to Wards of the State:** Providers are referred to 471 NAC 32-001.09 for procedures regarding services provided to state wards.

**32-003.14 Inspections of Care:** Medicaid or Medicaid's designee may review the care of individuals receiving Medicaid IOP services as per 471 NAC 32-001.10. Providers shall understand the Medicaid quality and compliance procedures and requirements and be responsive with these procedures upon the request of Medicaid or its designee.

**32-003.15 Payment for IOP Services:** Providers are referred to 471 NAC 32-001.12 for information regarding the billing of community-based and hospital IOP services.

Licensed practitioners shall bill for psychotherapy separately from psychoeducational services using the procedure code in the fee schedule. Licensed practitioners and direct care staff may not bill the same hour at the same time.

Clinical supervision costs for unlicensed practitioners are built into the rate for psychoeducational treatment services.

Medicaid or the Medicaid's designee shall provide prior authorization for the number of hours of treatment per client need and periodically review the medical need for continued treatment services.

IOP Direct Care Staff time may only be billed in an office-based facility with a well-organized group of services that include both active treatment and rehabilitative services supervised by an independent licensed practitioner.

**32-003.16 Payment Limitations:** Agency providers cannot receive Medicaid reimbursement for treatment services provided to clients who live in any institution and are transported to the program.

Agency providers may not be located in an Institution or on the grounds of an Institution where the clients who are participating in day treatment or intensive outpatient services are receiving room and board services.

Payment is not available for services for clients:

1. Living in institutions.
2. Whose needs are social or educational and may be met through a less structured program.
3. Whose primary diagnosis and functional impairment is acutely psychiatric in nature and whose condition is not stable enough to allow them to participate in and benefit from the program
4. Whose behavior may be very disruptive and/or harmful to other program participants or staff members
5. Whose program is designed to provide applied behavioral analysis (ABA)
6. Whose primary symptoms and dysfunctions are due to a developmental disorder and the client's referral information supports that the client cannot participate and benefit from the IOP.

Educational services are not eligible for payment by the Medicaid Program, and do not apply towards the hours of treatment services. Providers shall be familiar with each client's IEP and coordinate with the client and the client's school to achieve the IEP. Educational services may not be the primary reason for admission or treatment. Academic educational services, when required by law, shall be available to the client.

**32-003.17 Billable Hour Limitation:** IOP direct care staff billing is limited to 750 hours per calendar year (EXCEPTION: this limit can be exceeded when medically necessary with prior authorization). The number of hours per day shall be determined by the specific clinical needs of the client and by the level of acuity of the client. The overall program may generally only bill for 3 hours per day for intensive outpatient services.

**32-003.18 Billing Requirements and Procedure Codes:** Providers shall review and know 471 NAC 32-001.12B(1) for billing requirements and procedure codes.

**32-004 Mental Health and/or Substance Abuse Day Treatment Services for Children/Adolescents:** Day treatment services are available to clients under the age of 21 when the client has participated in an EPSDT screen, the treatment is medically necessary, and the need for this level of care is identified as part of a Pretreatment Assessment (see 471 NAC 32-001.02).

A Pretreatment Assessment shall be completed prior to admission into a day treatment program. Day treatment services shall meet all requirements in 471 NAC 32-001 through 471 NAC 32-001.15.

Clients whose symptoms include uncontrolled disruptive behavior shall have de-escalation and anger management identified in the initial treatment plan, and measures shall be taken to aggressively enforce and manage those behaviors at the earliest time possible. Day Treatment Direct Care Staff shall be aware of safety issues unique to each child and provide safety intervention within the milieu.

Day treatment services may prevent inpatient services. They may also be implemented to facilitate the movement of the client from an inpatient setting (e.g. a hospital or Psychiatric Residential Treatment Facilities) to a setting in which the client is capable of functioning within the community and with less frequent contact with the mental health or substance abuse provider.

Day treatment services shall be community based, family centered, culturally competent, and developmentally appropriate and shall meet the general requirements as identified in 471 NAC 32-001.01 for all Medicaid client treatment services. Providers shall also review and apply the definitions identified in 471 NAC 32-001 in their day treatment program development and in their daily practice.

Day Treatment Services achieve specific goals through a group of individualized treatment interventions and services. Individualized treatment shall provide the basis for transitioning a client to a less intense level of care if additional services are clinically necessary. Individualized treatment is based upon an active treatment plan and a specific plan for discharge from Day Treatment when the treatment goals have been met.

Day Treatment Services may be appropriately used to transition a client from higher levels of care and may be provided for clients at risk of needing more intensive care than traditional weekly outpatient treatment services.

Day Treatment Services agencies shall be accredited by a national accrediting body as identified in 32-001.05 Conditions for Participation for Mental Health and/or Substance Abuse Community-Based Services. With the exception of traditional outpatient and intensive outpatient services, the service/program is accredited by The Joint Commission (TJC), Counsel on Rehabilitation Facilities (CARF) or by the Counsel on Accreditation (COA)

**32-004.01 Medical Necessity:** Day treatment services are covered when the services are determined to be medically necessary (as defined in 471 NAC 32-001.01A and B), and when provided due to the recommendations of a Pretreatment Assessment completed as per 471 NAC 32-001.02. This PTA is the referral document provided to the day treatment provider for review when the day treatment provider is considering the client for the program.

**32-004.02 Standards of Participation for Day Treatment Services:** Providers interested in developing a mental health and/or substance abuse day treatment service shall review and comply with 471 NAC 32-001.04B Provider Enrollment for Community-Based Services.

**32-004.03 Conditions for Participation as a Provider of Day Treatment Services:** A provider shall review and comply with conditions of participation for day treatment community-based services as identified in 471 NAC 32-001.05.

**32-004.04 Location of Day Treatment Services for Mental Health and/or Substance Abuse Services:** Providers of Day Treatment Services can offer the program at a variety of professional locations in the community if the location is not in an institution where the client is receiving room and board services or any other facility which provides treatment, services, and room and board that is considered an institution.

Providers shall review and comply with the standards of 471 NAC 32-001.05B which identifies the location of services.

**32-004.05 Staffing Standards for Day Treatment Services:** Community-based day treatment providers shall review and comply with the staffing requirements of practitioners eligible to practice in day treatment programs. These practitioners are identified in 471 NAC 32-001.06 Staffing Standards for Community-Based Services.

In addition to licensed practitioners whose scope of practice includes mental health and/or substance abuse services identified in 471 NAC 32-004.05, the day treatment program shall contract/employ a Supervising Practitioner who is a licensed physician with a specialty in psychiatry as identified in 471 NAC 32-001.03C(3) and he/she shall understand and meet the responsibilities of a Supervising Practitioner as identified in 471 NAC 32-001.03(A, B and D).

Agencies shall be licensed by the State of Nebraska if licensing is required for the service. Dual-licensure is required for licensed practitioners providing Day Treatment Services when co-occurring conditions (e.g., mental health/substance abuse diagnoses) occur.

**32-004.05A Supervising Practitioner:** Specific to the day treatment program services, the Supervising Practitioner shall:

1. Review the referral PTA and complete an initial diagnostic assessment at admission or within 24 hours of admission and prior to service delivery (EXCEPTION: When the Supervising Practitioner day treatment psychiatrist is the same psychiatrist as the psychiatrist who completed the referral PTA, the Initial Diagnostic Interview shall serve as the admission Initial Diagnostic Interview provided that:
2. The Initial Diagnostic Interview was completed within 30 days prior to day treatment admission.
3. The information in the Initial Diagnostic Interview is current and provides sufficient recommendations for the day treatment team to develop an initial plan of care.
4. Assume accountability to direct the care of the client at the time of admission and during the entire day treatment stay.
5. Assist in developing and supervising a comprehensive active treatment plan of care within 10 days of admission.

6. Provide a review and continued supervision of the treatment plan by updating the plan at a minimum of each 30 days thereafter.
7. Provide clinical direction in the development of the treatment and recovery plan.
8. Provide a face-to-face assessment/service to the client at least every 14 days (or more often as medically necessary).
9. Provide crisis management including supervision and direction to the staff to resolve any crisis of the client's condition.
10. Monitor and supervise an aggressive plan to transition the client from the program into less intensive treatment services (as medically necessary).

**32-004.05B Program/Clinical Director:** A program/clinical director shall be a LMHP, licensed RN, licensed APRN, LIMHP, licensed psychologist, or licensed physician whose scope of practice is psychiatry. Dual-licensure (e.g., LMHP/LADC or LMHP/PLADC) is required for Day Treatment Services when co-occurring conditions (mental health and/or substance abuse programs occur).

Practitioners who meet the criteria of the program/clinical director may not also serve in the role of the program's therapist.

The responsibilities of a program/clinical director include, but are not limited to:

1. Oversees, implements, and coordinates treatment services
2. Continually incorporates new clinical information and best practices into the program to assure program effectiveness and viability
3. Oversees the process to identify, respond to, and report crisis situations on a 24-hour per day, 7 day per week basis
4. Clinical management of the program in conjunction and consultation with the Supervising Practitioner
5. Assures confidentiality, quality organization, and management of clinical records and other program documentation
6. Applies and supervises the gathering of outcome data and determines the effectiveness of the program for the clients served

**32-004.05C Day Treatment Therapist:** A day treatment therapist shall be a licensed practitioner who is a physician with a specialty in psychiatry, LMHP, LIMHP, PLMHP, LADC, licensed psychologist, Provisionally Licensed Psychologist, or licensed APRN. The licensed practitioner providing mental health and/or substance abuse services for clients in the treatment program shall be operating within his/her scope of practice.

The responsibilities of the day treatment therapist include, but are not limited to:

1. Reports to the program/clinical director and Supervising Practitioner for clinical and non-clinical guidance and direction.
2. Communicates treatment issues to the Program/Clinical Director and to the Supervising Practitioner as needed.
3. Provides individual, group, and/or family psychotherapy and/or substance abuse counseling.



4. Assists in developing and updating treatment plans for clients in day treatment care in conjunction with the other multidisciplinary team members.
5. Provides assistance to direct care staffing implementing the treatment plan when directed by the Program/Clinical Director.
6. Provides clinical information to the multidisciplinary team and attends treatment team meetings.
7. Provides continuous and ongoing assessment to assure the clinical needs of the client and the parent(s)/caregiver(s) are met.

**32-004.05D Registered Nurse or Advanced Practice Registered Nurse (RN or APRN)**: Nursing services shall be provided by a licensed Registered Nurse or Advanced Practice Registered Nurse (APRN). The nurse shall operate within his/her scope of practice and shall be available in the program when programming occurs. The nurse shall have documented experience and training in the treatment of clients. The nurse shall be present onsite during the operation of the day treatment program.

The responsibilities of a Registered Nurse or APRN in the program include, but are not limited to:

1. Reports to the program/clinical director for programmatic guidance;
2. Coordinates care with the physician with the specialty in psychiatry and medical physician as necessary regarding medical, psychiatric, and physical treatment issues;
3. Provides nursing assessments on the first day of admission for each client;
4. Reviews all medical treatment orders and implements orders as directed;
5. Serves as a member of the multidisciplinary treatment team and participates in treatment team meetings;
6. Provides medical intervention within his/her scope of practice as necessary;
7. Manages the storage, delivery, and dispensing of medication to clients as necessary;
8. Oversees medication, education, and health education issues;
9. Abides by all state and federal regulations; and
10. Coordinates psychiatric and medical care as directed by physicians.

**32-004.05E Direct Care Staff**: Direct Care Staff shall have:

1. A high school diploma or equivalent
2. One year of work experience in the human services field
3. Completed program training
4. Demonstrated skills and competencies in treatment of youth with mental illness

Requirements for Direct Care Staff listed in this section become effective for staff hired on or after the effective date of this policy.

**32-004.05E1** Basic requirements of Direct Care Staff in Day Treatment Services include:

1. Complete the initial program training and successfully complete the agency's competency check.
2. Demonstrate skill and competency in the treatment of clients with mental health and substance abuse disorders prior to delivery of services.

3. Shall pass the child abuse check, adult abuse registry, and motor vehicle screens.
4. Complete specific training for behavioral management and update the training as required by the program.
5. Understand de-escalation techniques and demonstrate the ability to implement those techniques effectively.

**32-004.05E2** Direct Care Staff perform the following functions in Day Treatment Services:

1. Provide psychoeducational activities and interventions to help clients develop social, recreational and other independent living skills as appropriate. Psychoeducational therapy services include, but are not limited to:
  - a. Crisis Intervention Plan and Aftercare Planning;
  - b. Social Skills Building;
  - c. Life Survival Skills;
  - d. Substance Abuse Prevention Intervention;
  - e. Self-care services;
  - f. Therapeutic recreational activity;
  - g. Medication education and medication compliance groups;
  - h. Health care issues group (e.g., nutrition, hygiene, personal wellness).
2. Implement the treatment plan and discharge plan for each client.
3. Provide continued care and safety to clients in the program milieu.
4. Report all crisis or emergency situations to the program/clinical director or to the program's designee in the absence of the program/clinical director.
5. Understand the program's philosophy regarding behavior management and apply its philosophy in daily interactions with the clients in care.

**32-004.05E3** Unit of Service: A 15-minute unit is used for unlicensed Direct Care Staff.

**32-004.06 Covered Day Treatment Services:** Day treatment services shall lead to an attainment of specific goals through a group of individualized treatment interventions and services. Individualized treatment shall provide the basis for transitioning the client to a less intense level of care if additional services are clinically necessary. Individualized treatment is based upon an active treatment plan and a specific plan for discharge from day treatment when the treatment goals have been met.

Covered Day Treatment Services include, but are not limited to:

1. The Initial Diagnostic Interview by the Supervising Practitioner
2. Other assessments including nursing assessment
3. Medication management
4. Psychotherapy services
5. Substance abuse counseling
6. Psychosocial modalities provided in a structured setting

**32-004.07 Prior Authorization of Day Treatment Services:** All Day Treatment Services shall be authorized prior to delivery of treatment and based upon the medical necessity information in the Pretreatment Assessment. Medicaid or its designee provides prior authorization following a clinical review for medical necessity.

The number of hours per day of day treatment shall be determined by the specific clinical needs of the client and by the level of acuity of the client. Medicaid or its designees shall provide prior authorization for the treatment services per client's medical need and shall periodically review the medical need for continued treatment services.

**32-004.08 Day Treatment Services and Program Requirements:** The following services shall be included and identified for the day treatment program and described for the day treatment program in order to be approved for participation in the Medicaid Program. The program shall be available for any client participating in the program:

**32-004.08A Medically Necessary Psychotherapy and Substance Abuse Counseling Services:** These services shall demonstrate active treatment for a client with a mental health and/or substance abuse diagnosis. All clients need not partake in all treatment services, if the service/s is not appropriately beneficial or in any way counterproductive to the client's treatment needs, progress and active treatment goals. The treatment plan shall identify the reason for omission of individual, group, and family psychotherapy if any of psychotherapy modalities are excluded from the active treatment plan.

The following services and frequency of services are minimum requirements:

1. Weekly Individual Psychotherapy and/or Substance Abuse Counseling
2. Daily Group Psychotherapy and/or Substance Abuse Counseling
3. Weekly Family Psychotherapy and/or Family Substance Abuse Counseling

Other services may include, but are not limited to:

4. Crisis Intervention Plan and Aftercare Planning
5. Social Skills Building
6. Life Survival Skills
7. Substance Abuse Prevention Intervention
8. Self-care services
9. Recreational Therapy
10. Medication education and medication compliance groups and
11. Health care issues group (may include nutrition, hygiene, personal wellness)

**32-004.08B Medically Necessary Nursing Services:** A licensed Registered Nurse shall evaluate the particular nursing needs of each client by completing a nursing assessment within 24 hours of admission. Registered Nurses shall practice within their scope. In addition to the nursing assessments, responsibilities of the nurse include but are not limited to those responsibilities identified in 471 NAC 32-004.05D.

**32-004.08C Medically Necessary Psychological Diagnostic Services:** Testing and evaluation services shall be available and when provided reasonably be expected to contribute to the diagnosis and plan of care established for the individual client.

Testing and evaluation services may be performed by a Licensed Psychologist, Specially Licensed Psychologist, Provisionally Licensed Psychologist acting within his/her scope of practice who is supervised by a licensed psychologist to administer tests as necessary. Medical necessity shall be documented by the program's supervising physician who has a specialty in psychiatry.

**32-004.08D Medically Necessary Pharmaceutical Services:** Medications shall be dispensed by the program and pharmacy services shall be provided under the supervision of a registered pharmacy consultant (alternatively the program may contract for these services through an outside facility or provider).

All medications shall be stored in a special locked storage space and administered only by a physician, registered nurse, licensed practical nurse or registered medication aide or other licensed practitioner who is authorized within his/her scope of practice to administer medications.

If medications are not dispensed in the day treatment program, the program at a minimum shall have knowledge of all medications currently prescribed to the day treatment client participating in the program. The program shall have an established contract/relationship with a pharmacy to gain access to consultation and to respond to the program's urgency to access medication through the orders of the physician in the program.

**32-004.08E Medically Necessary Dietary Services:** If meals are provided by a day treatment program, services shall be supervised by a registered dietitian based on the client's individualized dietary needs. Day treatment programs may contract for these services through an outside facility or provider.

If the program does not provide meals onsite, at a minimum the program shall establish a relationship with a dietician for consultation when dietary problems are identified on the client's active treatment plan and nutritional assistance is needed. The specific treatment need should be identified and the objective of the service documented as a part of the active treatment plan of the client.

**32-004.08F Educational Program Services:** Academic educational services shall be available when required by law, though are not necessarily provided by the day treatment program. Educational services shall be one aspect of the treatment plan, not the primary reason for admission or treatment. Whether provided onsite or in the community, coordination of educational services shall be identified in the active treatment plan. Providers are encouraged to support the client's educational plan provided in a non-institutional environment.

Providers shall be familiar with each client's Individualized Educational Program (IEP) and work with the client and the client's school to achieve the plan. A program staff member shall be identified to coordinate with the educational program and all coordination responsibilities shall be identified in the treatment plan and documented in the treatment notes.

Educational services are not eligible for payment by the Medicaid Program, and do not apply towards the hours of treatment services.

**32-004.09 Management of the Day Treatment Milieu:** A day treatment setting shall provide a well-organized, supportive therapeutic environment where clients can achieve progress in accomplishing the goals of their individualized, active treatment plan. The expectation is that all the clients have the ability to partake in treatment programming with a least number of disruptions and distractions.

The program philosophy shall be to provide an aggression-free environment. Providers shall identify and teach de-escalation strategies to their staff prior to allowing staff to provide direct care services.

Procedures such as seclusion and restraint to manage the treatment milieu are not permitted in day treatment programs. Staff aggression, both verbal and physical, shall not be tolerated in the program environment and the program shall aggressively manage staff behavior through education and training measures.

Clients whose symptomatology includes uncontrolled disruptive behavior shall have de-escalation and anger management identified in the initial treatment plan and measures shall be taken to aggressively enforce and manage those behaviors at the earliest time possible.

**32-004.10 Program Availability:** The program shall be available a minimum of three hours per day and a minimum of five days per week. Providers are encouraged to develop programs of greater flexibility offering up to 12-hours per day and 7-days per week.

**32-004.11 Active Treatment:** Providers shall review 471 NAC 32-001.08 and meet all active treatment requirements for community-based services.

Active treatment in day treatment begins with the Supervising Practitioner completing the Initial Diagnostic Interview, then supervising and participating in treatment plan development according to the recommendations made in the Pretreatment Assessment.

The licensed physician whose specialty is psychiatry shall complete a direct service to the client at a minimum of each 14 days. The licensed physician whose specialty is psychiatry shall identify physician directed care through the clinical record documentation of treatment direction and client progress.

**32-004.12 Comprehensive Treatment Plan:** Within ten days of admission the comprehensive treatment plan shall be developed by the established multidisciplinary treatment team for each particular client. The treatment team members shall sign and date the treatment plan which indicates their attendance and involvement in the active treatment team meeting which is supervised and directed by the licensed physician whose specialty is psychiatry.

At a minimum of every 30 days the treatment team, client, and parent(s)/guardian(s) of the client shall meet, identify barriers in treatment, update treatment goals, and modify the treatment plan to help achieve those goals.

NOTE: The program shall establish a relationship with other programs which offer emergency services and have a written plan for immediate admission or readmission for appropriate more intensive services as necessary.

**32-004.13 Discharge Planning in Day Treatment Services:** Discharge planning shall begin at the date of admission.

Providers shall know and apply the discharge planning requirements for community-based services identified in 471 NAC 32-001.08B.

**32-004.14 Staffing Ratios:** Providers shall use the following rules and ratios when staffing Day Treatment Service programs (ratios listed here may need to be increased if some treatment interventions are delivered in the community and offsite of the program or due to level of acuity):

1. All staffing shall be adequate to meet the individualized treatment needs of the client and meet the responsibilities of each staff position as outlined in the staffing requirements.
2. The Supervising Practitioner's hours shall be adequate to provide the necessary direct services and the administrative responsibilities as the supervisor of the day treatment program and the individualized care for each of the clients.
3. The program director shall have adequate hours to fulfill the expectations and responsibilities of the program/clinical director's description in this chapter.
4. Registered Nurse hours shall be adequate to provide the necessary nursing services to all clients admitted to the program and to meet all health care needs of the client during the client's day treatment service episode.
5. The ratio of therapists/licensed practitioners to clients served shall be 1:12.
6. The ratio of direct care staff to clients served shall be 1:6.

**32-004.15 Clinical Records:** Providers shall review and comply with the clinical records requirements identified in 471 NAC 32-001.08(C) for requirements regarding clinical records and documentation for community-based services.

**32-004.16 Documentation in Day Treatment Services:** Providers shall review and apply the requirements of 471 NAC 32-001.08C(1) Documentation Requirements for Community Based Services to their policies and procedures for Day Treatment Services.

**32-004.17 Services to State Wards:** Providers shall know the special procedures that apply when providing treatment to clients who are wards of the State. Providers should review 471 NAC 32-001.09 Services to State Wards and apply those procedures to their practice.

**32-004.18 Inspections of Care:** The providers shall know Medicaid's ability to review services reimbursed by Medicaid either through a site visit or required copies of records. For more information refer to 471 NAC 32-001.10.

**32-004.19 Payment for Day Treatment Services:** Providers shall review and meet the requirements of 471 NAC 32-001.11 and 471 NAC 32-001.12.

Reimbursement for services is based upon a Medicaid fee schedule established by the State of Nebraska. Except as otherwise noted in the Plan, the State-developed fee schedule is the same for both governmental and private individual practitioners. It is applicable to all services reimbursed via a fee schedule.

The fee schedule and any annual/periodic adjustments to the fee schedule are published at <http://www.dhhs.ne.gov/med/provhome.htm> (The Department's Division of Medicaid and Long-Term Care website). The agency's rates are set as of July 1 annually and are effective for services provided on or after that date.

Provider enrollment and retention will be reviewed periodically to ensure that access to care and adequacy of payments are maintained.

The Medicaid fee schedule will be equal to or less than the maximum allowable under the same Medicare rate, where there is a comparable Medicare rate.

Room and board costs are not included in the Medicaid fee schedule.

Licensed practitioners shall bill for psychotherapy separately from psychoeducational services billed by unlicensed practitioners using the procedure codes in the fee schedule. Licensed and unlicensed practitioners may not bill for the same client at the same time.

Clinical supervision costs for unlicensed practitioners are built into the unlicensed direct care practitioner rate.

Medicaid or the Medicaid's designee shall provide prior authorization for the number of hours of treatment per client need and periodically review the medical need for continued treatment services.

Day Treatment Direct Care Staff time may only be billed in an office-based facility with a well-organized, supportive therapeutic environment for youth so clients can apply the goals of their individualized, active treatment plan and achieve progress in accomplishing those goals.

**32-004.19A Billable Hour Limitation:** Day Treatment Direct Care Staff billing is limited to 750 hours per calendar year (EXCEPTION: this limit can be exceeded when medically necessary with prior authorization). The number of hours per day shall be determined by the specific clinical needs of the client and by the level of acuity of the client.

The overall program shall generally only bill for 6 hours a day for day treatment, unless additional hours are medically necessary and approved by Medicaid or its designee.

**32-004.20 Billing Requirements and Procedure Codes:** Providers shall refer to 471 NAC 32-001.15 regarding billing requirements and procedure codes.

**32-004.21 Day Treatment Services Not Covered By Medicaid:** Payment is not available for Day Treatment Services for clients:

1. In long term care facilities
2. Whose needs are social or educational and may be met through a less structured program
3. Whose primary diagnosis and functional impairment is acutely psychiatric in nature, and whose condition is not stable enough to allow them to participate in and benefit from the program
4. Whose behavior may be very disruptive and/or harmful to other program participants or staff members
5. Whose program is designed to provide applied behavioral analysis (ABA)
6. Whose primary symptomatology and dysfunctions are due to a developmental disability disorder
7. Whose referral information supports that the client cannot benefit from the services identified in this chapter when provided in a day treatment setting
8. Who live in any institution and are transported to the program

**32-004.22 Claims Processing:** Claims for Day Treatment Services are submitted to Medicaid using Form HFCA-1500 for community-based programs. Services granted prior authorization by Medicaid or by Medicaid's designee and all claims are subject to utilization review by the Department prior to payment.

**32-004.23 Costs Not Included in the Day Treatment Fee:** Day treatment psychoeducational services provided by direct care staff or by licensed practitioners and the administrative supervision of the service are considered to be part of the fee for day treatment. These services are billed in 15 minute increments. Licensed practitioner services for psychotherapy/counseling are billed per procedure code assigned to the psychotherapy service.

If a client is enrolled with another managed care vendor for medical-surgical services, it may be necessary to pursue prior authorization or referral with that entity.

**32-004.24 Charges Reimbursed Separately From the Day Treatment Fee:** The following charges can be reimbursed separately from the day treatment fee when the services are medically necessary, part of the client's overall treatment plan, and compliant with Medicaid policy:

1. Direct client services performed by the Supervising Practitioner;
2. Prescription medications (including injectable medications);
3. Direct client services performed by a physician other than the Supervising Practitioner;
4. Treatment services for a physical injury or illness provided by other non-mental health practitioners;
5. Therapy services provided by licensed practitioners whose scope of practice includes the provision of mental health and substance abuse treatment services identified on the day treatment provider agreement application and/or approved agreement of the provider.



**32-004.25 Procedure Codes and Descriptions for Mental Health and/or Substance Abuse Day Treatment:** HCPCS/CPT procedure codes used by Medicaid are listed in the Nebraska Medicaid Practitioner Fee Schedule at 471-000-532.

**32-005 Professional Resource Family Care (PRFC) Services:** Professional Resource Family Care occurs in a surrogate home when specially trained surrogate parents are available at all times to provide consistent behavior management services, therapeutic interventions, treatment and render services and Supervising Practitioner services under the direction of a Supervising Practitioner.

Professional Resource Family Care services are available to clients under the age of 21 when the client has participated in an EPSDT screen, treatment is medically necessary, and the Pretreatment Assessment documents the need for admission into PRFC services.

Professional Resource Family Care provides short-term and intensive supportive resources for the client and his/her family. It is intended to serve a crisis stabilization option for the family in order to avoid psychiatric inpatient and institutional treatment of the client by responding to potential crisis situations through the utilization of a co-parenting approach provided in a surrogate family setting.

The goal is supporting the client and family in ways that address current acute and/or chronic mental health needs and coordinate a successful return to the family setting at the earliest possible time. During the time the professional resource family is supporting the client, there is regular contact with the family to prepare for the client's return and his/her ongoing needs as part of the family. It is expected that the client, family and professional resource family are integral members of the client's individual treatment team.

Providers shall abide by the Family Component of the General Requirements as detailed in 471 NAC 32-001.01 Requirements, Standards, and Conditions for Provider Participation in Children/Adolescent Mental Health and Substance Abuse Treatment Services: General Requirements.

Licensed outpatient mental health and/or substance abuse services can be provided by an appropriately licensed practitioner operating within his/her scope of practice.

Functions of a Professional Resource Family: A Professional Resource Family performs the following functions:

1. Promotes improvement in the client's social skills and family/peer relationships skills through training and education of the client and the usual caregiver.
2. Teaches the caregiver crisis and de-escalation techniques.
3. Teaches and models appropriate behavioral treatment interventions and techniques to the client and the client's caregiver.
4. Teaches and models appropriate coping skills to manage dysfunctional behavior to the client and the client's caregiver.
5. Teaches and models proper and effective parenting practice to biological parents or the client's primary caregiver.
6. Provides information about medication compliance and relapse prevention to the prescribing and/or Supervising Practitioner.

7. Reports to his/her agency Program Manager.
8. Provides training and rehabilitation of basic personal care and activities of daily living by training the client and the usual caregiver.
9. Helps the client develop positive peer relationships.
10. Works with the family to explore community resources in the client's and families' natural setting.

**32-005.01 General Requirements:** Providers shall review and apply the general requirements and philosophy of Chapter 32 identified in 471 NAC 32-001.01A and apply those requirements to the daily practices.

In addition to these requirements agencies shall be licensed by the State of Nebraska as a Child Placing Agency. Each agency shall employ a PRFC Supervisor to supervise the PRFC program.

PRFC services require prior authorization by Medicaid or its designee. The duration of services is pre-approved for up to 30 days per episode and up to 90 days per calendar year. Additional days can be authorized with prior approval from a Medicaid or its designee.

Services provided to clients shall include communication and coordination with the family and/or legal guardian. Coordination with other services should occur as needed to achieve the treatment goals. All coordination services shall be documented in the client's clinical record.

PRFC services may not be provided simultaneously with ThGH care and shall not duplicate any other Medicaid State Plan Rehabilitation Service or service otherwise available to a recipient at no cost as charity care.

Surrogate Parent Training and Qualifications: Each agency shall employ a PRFC Specialist who shall provide training and support to the surrogate parents. Surrogate parents shall meet the following qualifications:

1. Have a high school diploma or equivalent.
2. Be 21 years of age or older.
3. Have a minimum of 2 years experience working with children, be equivalently qualified by education in the human services field, or have a combination of work experience and education with one year of education substituting for one year of experience.
4. Complete training according to a curriculum approved by State prior to providing the service.
5. Pass the child abuse check, adult abuse registry and motor vehicle screens.
6. Each surrogate family setting shall have a Foster Family license issued by the State.
7. Each surrogate parent shall be supported by a PRFC Agency with appropriate clinical supervision, training, and staffing.
8. Understand de-escalation techniques and demonstrate the ability to implement those techniques effectively.

**32-005.02 Definitions:** Providers shall review the definitions identified in 471 NAC 32-001.01B and apply those definitions to the services for which the provider is enrolled. PRFC agencies shall particularly be familiar with the definitions related to PRFC services.

**32-005.03 Pretreatment Assessment:** Prior to a referral to PRFC services, the client shall have a Pretreatment Assessment as identified in 471 NAC 32-001.02 by qualified practitioners. The conclusions and recommendations of this comprehensive assessment shall be included with the referral to PRFC services if the licensed physician with a specialty in psychiatry, licensed psychologist or licensed independent mental health practitioner has determined that this level of care is the most appropriate level of care to meet the client's needs.

**32-005.04 Medical Necessity:** A provider shall review the requirements for the coverage of medically necessary services and shall review 471 NAC 32-001.01A and B to become familiar with the definition of medical necessity.

**32-005.05 Supervising Practitioner of Professional Resource Family Care (PRFC) Services:** Providers shall meet the requirements of 471 NAC 32-001.03 regarding the Supervising Practitioner for PRFC. The Supervising Practitioner for PRFC services shall be a licensed physician with a specialty in psychiatry or a licensed psychologist. See 471 NAC 32-001.04.

**32-005.06 Standards for Participation:** Providers are referred to 471 NAC 32-001.04 and 471 NAC 32-001.04A(1) for provider standards for PRFC.

**32-005.07 Conditions for Participation for Professional Resource Family Care (PRFC) Services:** Providers shall know and comply with the conditions of participation for community-based services identified in 471 NAC 32-001.04B. In addition, PRFC providers shall:

1. Meet the minimum regulations for surrogate homes caring for children.
2. Employ licensed and approved surrogate parents for PRFC.
3. Be licensed as a Child Placing Agency (providers shall maintain that license to remain eligible to provide PRFC services).
4. Provide both planned and unplanned respite care services.
5. Provide treatment in the PRFC home.
6. Be licensed, certified, or accredited through a national accreditation body such as The Joint Commission (TJC), Commission on Accreditation of Rehabilitation Facilities (CARF), and also by the Council on Accreditation (COA).

**32-005.08 Staffing Standards for Participation for Professional Resource Family Care (PRFC) Services:** PRFC service staff shall receive ongoing and regular clinical supervision through a Child Placing Agency by a licensed physician with a specialty in psychiatry or licensed psychologist with experience regarding this specialized mental health service, and such supervision shall be available at all times to provide support, and/or consultation.

The following standards shall be met by providers staffing PRFC services:

**32-005.08A Staff Members:** The following staff positions shall be included in a PRFC program description. All staff shall be operating within the scope of practice.

**32-005.08A1 PRFC Supervisor:** The role of the PRFC supervisor is to provide support, direction and consultation to the treatment team and the PRTF specialist. The PRFC supervisor activities shall be performed by a fully licensed practitioner whose scope of practice includes mental health services as defined in 471 NAC 32-001.04 who is acting within his/her scope of practice.

PRFC responsibilities include, but are not limited to:

PRFC Specialist supervision: The PRFC supervisor shall provide regular support and guidance to the PRFC staff through regular supervisory meetings and informal contact as needed. This PRFC supervisor to specialist ratio shall be flexible to accommodate for the variables such as severity of clients served or by the experience/qualifications of the caseworker staff, however, shall be adequate to meet the supervision needs of a specialist and support needs of the PTFC surrogate parents.

Treatment planning: The PRFC supervisor is a member of the treatment team and shares the responsibilities of developing the plan. S/he also evaluates progress reports and updates.

Crisis on-call: The PRFC supervisor provides coordination and back-up to ensure that 24-hour on-call crisis intervention services are available and delivered to surrogate parents and biological families or caregivers.

Other responsibilities: May include, but are not limited to:

1. Case management;
2. Case assessment;
3. Parent support and consultation;
4. Clinical and administrative supervision of staff;
5. Surrogate parent recruitment;
6. Orientation;
7. Training and selection;
8. Youth intake and placement;
9. Record keeping; and
10. Program evaluation.

**32-005.08A2 PRFC Specialist:** The PRFC specialist is the practical leader of the treatment team and assists in the development of the treatment plan. He/she supports and consults with the surrogate family, youth and their family or caregiver, and other members of the treatment team. He/she also advocates for, coordinates, and links surrogate parents and youth and their families to other services available in the community.

PRFC specialist activities shall be performed by a licensed practitioner as defined in 471 NAC 32-001.04 who is acting within his/her scope of practice.

PRFC Specialist responsibilities include, but are not limited to:

**32-005.08A2(a) Treatment Team Leadership:**

1. Under the direction of the Supervising Practitioner and the PRFC supervisor, the PRFC specialist takes primary day-to-day responsibility for leadership of the treatment team. The PRFC specialist organizes and manages all team meetings and team decision making. The PRFC specialist takes an active role in identifying goals and coordinating treatment services provided to clients.
2. The PRFC specialist provides information and training to treatment team members who may not be familiar with the PRFC model. The PRFC specialist prepares these individuals to work with surrogate parents and client families in a manner which is supportive of their roles. The PRFC specialist also prepares them to work with the team in a manner consistent with PRFC practices and values.

Treatment planning: The PRFC specialist takes primary responsibility for the preparation of each client/family's written comprehensive treatment plan and the written updates of the plan. The PRFC specialist seeks to inform and involve other team members, surrogate parents, and the client family in this process.

Support/consultation to surrogate parents: The PRFC specialist shall provide regular support and technical assistance to the surrogate parents in their implementation of the treatment plan and with regard to their other responsibilities. The fundamental components of technical assistance shall be the design or revision of in-home treatment strategies, including proactive goal setting and planning, the provision of ongoing child-specific skills training, and problem solving during home visits.

**32-005.08A2(b) Other types of support/supervision include but are not limited to:**

1. Emotional support and relationship building
2. The sharing of information and general training to enhance professional development
3. Assessment of the client's progress
4. Observation/assessment of family interactions and stress
5. Assessment of safety issues
6. A minimum of weekly contact by phone or in person with the surrogate parent of each client family on his/her caseload
7. Visiting the treatment home to meet with at least one PRFC parent no less than twice per month (more often as is necessary)

**32-005.08A2(c) Caseload:** The preferred maximum number of clients that may be assigned to a single PRFC specialist is ten (individuals or siblings strips). (Flexibility within this standard is possible and shall be considered on an individual program basis.)

The number of client/families assigned to a PRFC specialist is a function of:

1. The size/density of the geographic area
2. The array of job responsibilities assigned
3. The difficulty of the population served

**32-005.08A2(d) Contact with client/family:** The PRFC specialist or other program staff shall regularly have face-to-face contact with clients/families to allow them opportunity to communicate special concerns, to make direct assessment of their progress, and to monitor for potential abuse. The face-to-face contact shall occur monthly at minimum (more often based on the current needs of the client/family and the surrogate parents), and applies on an individual client/family basis.

**32-005.08A2(e) Support/consultation of the client/families:** The PRFC specialist shall support and enhance the client's relationships with his/her family during his/her time in PRFC. The PRFC specialist shall arrange and encourage regular contact and visitation as specified in the treatment plan. The PRFC specialist shall seek to include the client/family in treatment team meetings, treatment planning, and decision making, and shall keep them informed of the client's progress.

**32-005.08A2(f) Community liaison and advocacy:** The PRFC specialist shall work with the treatment team to identify community resources that shall help meet the needs of clients/families and the objectives of the treatment plan. The PRFC specialist shall advocate for and coordinate these services while providing technical assistance to the community agency.

**32-005.08A2(g) Crisis on-call:** The PRFC specialist shall work with other professionals on the team to coordinate 24-hour crisis coverage.

**32-005.09 Surrogate Parent Selection:** Surrogate parents are selected in part on the basis of their acceptance of the program's treatment philosophy and their ability to practice or carry out this philosophy on a daily basis. They shall be willing to accept the intense level of involvement and supervision provided by the treatment team in their surrogate parenting functions and the impact of that involvement on their family life. Surrogate parents shall be willing to carry out all tasks specified in their PRFC program's job description including working directly and in a supportive fashion with the families of clients placed in their care.

The program shall have a written policy explaining the procedures and criteria for surrogate parent selection.

Surrogate parents shall meet the requirements listed in 471 NAC 32-001.01 Requirements, Standards and Conditions for Provider Participation in Child/Adolescent Mental Health and Substance Abuse Treatment Services: General Requirements.

**32-005.09A PRFC Surrogate Parent:** Surrogate treatment parents are members of the treatment team whose primary responsibility is to implement the specific strategies and interventions of the treatment plan. The surrogate parent responsibilities also include providing parenting duties as outlined in State and agency regulations. A surrogate parent must be available 24 hours a day to respond to crisis or emergency situations. This may preclude one of the surrogate parents from working outside the home. Surrogate parents may not provide day care for children in the home.

**32-005.09A(1) Surrogate Parent Responsibilities:**

1. Surrogate role: Treatment duties encompass the basic parenting duties typically required of parents/primary caregivers. These include but are not limited to:
  - a) Nutrition
  - b) Clothing
  - c) Shelter and physical care
  - d) Nurturance and acceptance
  - e) Supervision
2. Treatment Planning: The PRFC surrogate parent shall assist the team in the development of treatment plans for the client/family in their care. Surrogate parents contribute vital input based upon their observations of the client/family in the natural environment of the treatment home.
3. Treatment Implementation: The surrogate parents have the primary responsibility for implementing the interventions identified on the daily interventions identified on the treatment plan.
4. PRFC Team Meetings: The surrogate parent shall work cooperatively with other team members and will attend team meetings, training sessions or other meetings required by the program as identified in the client's treatment plan.
5. Record Keeping: The surrogate parent shall systematically record information and document activities as required by the agency and by standards under which it operates. The surrogate parent shall keep a systematic record of the client/family's behavior progress and targeted areas on a daily basis.
6. Contact with the Child's Family/Next Caregiver: The surrogate parent shall assist the client in maintaining contact with his/her family/next caregiver and work actively to enhance and support these relationships as identified in the treatment plan.



7. Permanency Planning Assistance: The surrogate parent shall assist with efforts by the PRFC treatment team to meet the client's permanency planning goals. These must include but are not limited to:
  - a) Emotional support
  - b) Advice
  - c) Demonstration of effective child behavior management and other therapeutic interventions to the child's family/next caregiver; and
  - d) Support to the child and child's family/next caregiver during the initial period of post-treatment foster care placement.
8. Community Relations: The surrogate parent shall develop and maintain positive working relationships with service providers in the community such as schools, Departments of Recreation, Social Services Agencies and mental health programs and professionals.
9. The surrogate parent shall work with other members of the treatment team to advocate on behalf of the child/family to achieve the goals identified in the treatment plan. This includes obtaining educational, vocational, medical, and other services needed to implement the treatment plan and to assure full access to and provision of public services to which the child is legally entitled; and
10. Notice of request for child move. Unless a move is required to protect the health and safety of the child and other PRFC family members, the treatment parent shall provide at least 14 days notice to the program staff if requesting a child's removal from the home so as to allow for a plan full and minimally disruptive transition.

**32-005.10 Surrogate Parent Training:** Surrogate parent training shall be a systematic, planned, and documented process which includes competency-based skill training that is not limited education through didactic instruction. Training shall be consistent with the program's treatment philosophy and methods and prepare surrogate parents to carry out their responsibilities as agents to the treatment process.

Respite care staff shall be trained appropriately, as defined by the treatment program.

The Surrogate Parent and Respite Care staff training curriculum shall be approved by Medicaid. The training shall include the following components:

1. Pre-service training: Prior to the placement of clients in their homes, all surrogate parents shall complete the following training requirements:
  - a) Basic: Surrogate parents shall satisfactorily complete the pre-service training required of all surrogate parents
  - b) Agency specific: 20 hours of agency-specific primarily skill-based training consistent with the agency's treatment methodology and the service needs of the client.
2. In-service training: Each surrogate parent shall have a written educational plan on record that is developed by the PRFC parent and their supervisors. This plan describes the content and objectives of in-service training.
3. All surrogate parents shall complete a minimum of 12 hours of in-service training annually based on the specific training needs identified in the development plan and specific services surrogate parents are required to provide. In-service training shall emphasize skill development as well as knowledge acquisition and may include a variety of formats and procedures including in-home training provided by the PTFC specialist.

**32-005.11 Surrogate Parent Support:** PRFC programs are obligated to provide intensive support, technical assistance, and supervision to all surrogate parents. This shall include specific management and supervision services in addition to the following:

**32-005.11A Information Disclosure:** All information the PRFC program receives concerning a client/family to be placed with a treatment family shall be shared with and explained to the prospective PRFC family prior to placement.

Surrogate parents have access to full disclosure of information concerning the client as well as the responsibility to maintain agency standards of confidentiality regarding such information. The information shall include, but is not limited to:

1. The client's strengths and assets
2. Mental health and/or substance abuse diagnosis, symptoms and medication
3. Initial intervention strategies for addressing identified problems and needs

**32-005.11B Respite:** Respite care shall be available at both planned and crisis times. The respite care provider shall be trained according to the standards set by the PRFC program and approved by Medicaid or its designee. The respite care providers shall be informed of the client/family treatment plan and supervised in their implementation of the specific in-home strategies. There is no additional payment for respite care as this is a cost that shall be included in the rate posted on the fee schedule.

**32-005.11C Counseling:** During their tenure as surrogate parents, families shall have access to counseling and therapeutic services arranged by the PRFC program for personal issues or problems caused or exacerbated by their work as treatment families. These issues may include marital stress or abuse of their own children by a PRFC client/family in their care.

**32-005.11D Peer support:** The PRFC program shall facilitate the creation of support networks for treatment families (these may include formal groups, informal meetings, of "buddy" systems).

**32-005.11E Financial Support:** PRFC program financial support to surrogate parents shall cover the cost of care associated with their treatment responsibilities and special needs of the client/family. Financial support given to surrogate parents is directly related to the special skills, functions, and responsibilities required of them in fulfilling their roles as surrogate parents. This is above and beyond the payment covering room, board, and care costs. Medicaid does not cover room and board costs.

**32-005.12 Staff Training and Support:** All professional staff require pre-service and ongoing professional development relevant to the PRFC model and to their individual job responsibilities.

The staff training plan shall be approved by Medicaid or its designee.

**32-005.13 Crisis On-Call:** The program shall provide on-call crisis intervention support to the PRFC surrogate parents, youth and their biological family or caregiver for 24 hours per day.

**32-005.14 Liability Insurance:** Professional staff shall be covered by liability insurance.

**32-005.15 Legal Advocacy and Representation:** The agency shall assist staff in obtaining legal advocacy and representation should the need arise in connection with the proper performance of their professional duties.

**32-005.16 Active Treatment:** A provider shall know 471 NAC 32-001.06 and adhere to the requirements of active treatment in PRFC programs.

**32-005.17 Treatment Planning In Professional Resource Family Care (PRFC) Programs:** Providers shall understand and comply with the regulations for community-based treatment planning as identified in 471 NAC 32-001.07.

**Treatment Plan:** Within 7 days of admission, the comprehensive treatment plan shall be developed by the established multidisciplinary team of staff providing services for each client. Each treatment team member shall sign and indicate their attendance and involvement in the treatment team meeting.

The treatment team review shall be directed and supervised by the supervising practitioner at a minimum of every 14 days. The Supervising Practitioner shall provide a direct service to the client every 14 days thereafter at a minimum to review the need for continued care. The Supervising Practitioner shall review the treatment plan with the treatment team every 14 days at minimum to track progress, revise the treatment plan to address any lack of progress and to monitor for current medical problems and concomitant substance use issues.

The surrogate parents, client and client's biological family or caregiver, and legal guardian shall be included as treatment planning members in the initial plan and in the update plan to update treatment goals. The treatment team meeting shall identify any barriers to treatment and modify the plan in order to continue to facilitate active movement towards the time-limited treatment goals initiated by the plan.

**32-005.18 Clinical Records:** Providers shall maintain records as identified for community-based providers in 471 NAC 32-001.08.

**32-005.19 Documentation Requirements for Community-Based Services:** Providers shall comply with requirements of documentation for community-based services identified in 471 NAC 32-001.08C(1) and provide training to PRFC parents who provide recordkeeping in their home.

**32-005.20 Services to State Ward:** Providers shall comply with the special requirements of services offered to clients who are wards of the State of Nebraska and adhere to all communication requirements regarding the legal guardian and assist in the client's successful transition back to the client's home or to the particular permanency plan.

**32-005.21 Inspections of Care:** Medicaid or Medicaid's designee may review the care of individuals receiving PRFC services as per 471 NAC 32-001.10. Providers shall understand the requirements of Medicaid regarding quality and compliance procedures and be responsive to the request for clinical records and onsite reviews by Medicaid or its designee. Providers are expected to provide access ability to clinical records, clients and program staff as necessary and to respond to the request for clinical records for offsite review.

**32-005.22 Payment for Professional Resource Family Care (PRFC) Services:** Providers shall review the requirements for payment of community-based services and the particular requirements for PRFC providers. Medicaid enrolls PRFC agencies and the agency shall provide support, training and compensation to the PRFC parent licensed to provide care.

The Supervising Practitioner providing direct care services may bill separately from the PRFC per diem.

Unit of Service: A day unit is used for unlicensed direct care staff.

**32-005.23 Billing Requirements and Procedure Codes:** Providers are referred to 471 NAC 32-001.15 regarding the requirements for billing PRFC services.

**32-005.24 Documentation in the Client's Clinical Record:** Each client/family's clinical record shall contain the following information:

1. The treatment plan;
2. The team progress notes, recorded chronologically. The frequency is determined by the client's condition, but the progress notes shall be recorded at least daily. The progress notes shall contain a concise assessment of the client/family's progress and recommendations for revising the treatment plan, as indicated by the client/family's condition, and discharge planning;

3. The program's treatment plan reviews an updated treatment plan;
4. The discharge summary; and
5. Other documentation as required in 471 NAC 32-001.05.

**32-005.25 Procedure Codes and Descriptions for Professional Resource Family Care (PRFC):** HCPCS/CPT procedure codes used by Medicaid are listed in the Nebraska Medicaid Practitioner Fee Schedule at 471-000-532.

**32-005.26 Costs Not Included in the Professional Resource Family Care (PRFC) Per Diem:** The PRFC per diem does not include room and board costs.

If the client is enrolled with another managed care vendor for medical-surgical services, it may be necessary to pursue prior authorization or referral with that entity.

The following charges can be reimbursed separately from the PRFC per diem when the services are necessary, part of the client's overall treatment plan, and compliant with Medicaid policy:

1. Direct client services performed by the Supervising Practitioner
2. Prescription medications (including injectable medications)
3. Direct client services performed by a licensed physician or psychologist other than the Supervising Practitioner
4. Treatment services for a physical injury or illness provided by other professionals
5. Other necessary treatment interventions including individual/group/family therapy

**32-005.27 Services Not Covered:** Reimbursement is not available for PRFC for clients:

1. Receiving services in an out-of-state facility, except as outlined in 471 NAC 1-004.04, Services Provided Outside Nebraska
2. Whose needs are social or educational and may be met through a less structural program
3. Whose primary diagnosis and functional impairment is so severe in nature and whose condition is not stable enough to allow them to participate in and benefit from the program

REV. (8-18-2011)  
MANUAL LETTER #

NEBRASKA DEPARTMENT OF  
HEALTH AND HUMAN SERVICES

MEDICAID  
471 NAC 32-006

32-006 Reserved

**32-007 Therapeutic Group Home (ThGH):** ThGHs deliver an array of clinical, treatment, and related services, including psychiatric supports, integration with community resources, and skill-building taught within the context of a home-like setting. ThGH treatment shall focus on reducing the severity of the behavioral health issue that was identified as the reason for admission. Most often, targeted behaviors relate directly to the client's ability to function successfully in the home and school environment (e.g., compliance with reasonable behavioral expectations, safe behavior, and appropriate responses to social cues and conflicts).

The goal of a therapeutic group home is to maintain the client's connections to their community, yet receive and participate in a more intensive level of treatment in which the client lives safely in a 24-hour setting. The emphasis of a therapeutic group home is to restore the client to a improved level of functioning in order that the client may live and function in a less restrictive level of care. Therapeutic group homes are facilities specifically designed not to resemble institutions that let 4-8 clients live in a home-like environment with an organized, professional staff who deliver safety, supervision, rehabilitation services, and treatment services.

Treatment shall:

1. Focus on reducing the behavior and symptoms of the mental health and/or substance abuse disorder that necessitated the removal of the client from his/her usual living situation
2. Decrease problem behavior and increase developmentally-appropriate, normative and pro-social behavior in clients who are in need of out-of-home placement
3. Transition clients from therapeutic group homes to home- or community-based living with outpatient treatment (e.g., individual and/or family therapy).

Therapeutic group homes are community-based services that are family-centered, culturally competent and developmentally appropriate. Therapeutic Group Home Services (ThGH) are available to clients under the age of 21 when the client has participated in an EPSDT screen, the treatment is clinically necessary, and the need for this level of care has been identified as a part of a Pretreatment Assessment.

ThGH services are utilized when it is determined that less intensive levels of treatment are unsafe, unsuccessful, or unavailable. The client requires active treatment and rehabilitation services that would not be able to be provided at a less restrictive level of care. ThGH services are provided on a 24-hour basis with vision/oversight by the Program Director and Supervising Practitioner.

An Initial Diagnostic Interview is required upon admission. The Supervising Practitioner shall provide a direct service to the client every 14 days thereafter at minimum to review the need for continued care. The Supervising Practitioner shall review the treatment plan with the treatment team every 14 days at minimum to track progress, revise the treatment plan to address any lack of progress, and to monitor for current medical problems and concomitant substance use issues.

The individualized, strengths-based services and supports:

1. Are identified in partnership with the client and his or her family and support system to the fullest possible extent
2. Are developmentally appropriate
3. Are based on both clinical and functional assessments
4. Are clinically monitored and coordinated
5. Have 24-hour availability
6. Are implemented with oversight from a licensed mental health professional
7. Assist with the development of skills for daily living and support success in community settings, including home and school

The ThGH shall coordinate with the client's community resources, with the goal of transitioning the client out of the program as soon as possible. Discharge planning begins upon admission with concrete plans for the client to transition back into the community. Clear action steps and target dates shall be outlined in the treatment plan. The treatment plan shall also include behaviorally-measurable discharge goals.

For treatment planning, the program shall also use a standardized assessment and treatment planning tool such as the Child and Adolescent Needs and Strengths. The assessment protocol shall differentiate across life domains, as well as risk and protective factors, sufficiently so that a treatment plan can be tailored to the areas related to the presenting problems of each youth and their family in order to ensure targeted treatment. The tool should also allow tracking of progress over time. The specific tools and approaches used by each program shall be specified in the program description and are subject to approval by Medicaid or its designee.

The program shall ensure that requirements for Pretreatment Assessment are met prior to treatment commencing. Annually, facilities shall submit documentation demonstrating compliance with fidelity monitoring for at least two research-based and/or one level of ASAM (American Society of Addiction Medicine) criteria. Medicaid or its designee shall approve the auditing body providing the fidelity monitoring.

For service delivery, the program shall incorporate at least two research-based approaches pertinent to the sub-populations of ThGH clients to be served by the specific program. The specific research-based models to be used should be incorporated into the program description and submitted to the Medicaid or its designee for approval. For milieu management, all programs should also incorporate some form of research-based, trauma-informed programming and training if the primary research-based treatment model used by the program does not.

Psychotropic medications should be used with specific target symptoms identification, with medical monitoring and 24-hour medical availability, when appropriate and relevant.



**32-007.01 General Requirements:** Therapeutic group homes shall meet the general requirements identified in 471 NAC 32-001.01. Providers of therapeutic group homes shall review and apply the definitions in 471 NAC 32-001 to their daily practice and meet the definitions as described in the policy. Therapeutic group homes shall meet all of the requirements of 471 NAC 32-000 through 471 NAC 32-001.12 for community-based services.

A Therapeutic Group Home shall be licensed as a mental health center or substance abuse treatment center and may not exceed eight beds unless grandfathered (see 471 NAC 32-007.07B).

At least 21 hours of active and rehabilitation treatment per week for each client is required to be provided by qualified staff (e.g., having a certification in the research-based practices selected by the facility and/or licensed practitioners operating within their scope of practice in Nebraska and meeting ThGH licensure requirements), consistent with each client's treatment plan and meeting assessed needs.

Staffing schedules shall have overlap of shift hours to accommodate information exchange for continuity of client treatment, adequate numbers of staff, (see 471 NAC 32-007.14), appropriate staff gender mix and the consistent presence and availability of licensed practitioners during wake hours and on-call availability during sleep hours. In addition, staffing schedules should ensure the presence and availability of licensed practitioners on nights and weekends, when parents are available to participate in family therapy with the family/next caregiver and to provide input on the treatment of their child.

**32-007.02 Unit of Service:** Day unit for unlicensed direct care staff.

**32-007.03 Limitations:** ThGH programs are subject to the following restrictions:

Staff Limitations: Licensed physicians with a specialty in psychiatry, licensed psychologists, LIMHPs, LMHPs, licensed APRNs, and dually-credentialed practitioners may bill for their services separately provided they are identified on the ThGH provider's enrollment agreement.

APRNs cannot provide clinical supervision of ThGHs.

The Supervising Practitioner, who is a licensed physician with a specialty in psychiatry or licensed psychologist, shall provide 24-hour, on-call coverage 7 days per week. The Supervising Practitioner shall see the client, prescribe the type of care provided, and, if the services are not time-limited by the prescription, review the need for continued care every 14 days.

Although the Supervising Practitioner does not have to be on the premises when his/her client is receiving covered services, the Supervising Practitioner shall assume professional responsibility for the services provided and assure that the services are medically appropriate. Therapy (individual, group, and family) and ongoing psychiatric assessment and intervention (by a psychiatrist) are required of ThGH, but provided and billed separately by the ThGH provider on behalf of the licensed practitioners for direct time spent.

**32-007.04 Pretreatment Assessment (PTA):** ThGH providers of shall review the referral PTA from the practitioner recommending the therapeutic group home services prior to accepting the client into the program. The Pretreatment Assessment shall meet all the requirements as identified in 471 NAC 32-001.02. The referral PTA shall be the document which provides clinical information to support Medical Necessity to the therapeutic group home and to establish that ThGH is the most appropriate service to meet the client's treatment needs.

**32-007.04A Client Admission Criteria for Therapeutic Group Home Services:** All therapeutic group home services shall receive prior authorization by Medicaid or Medicaid's designee. The therapeutic group home shall provide medical necessity information which describes the problems and dysfunctions of the client consistent with the determination that ThGH is the most appropriate and least restrictive level of care for the client's recovery from their mental health and/or substance abuse condition.

In addition, the client's condition shall meet the following requirements:

1. The client has a DSM-4 (current version) diagnosis and/or substance abuse diagnosis utilizing the American Society of Addiction Medicine (ASAM) criteria necessitating this level of care.
2. The diagnosis excludes developmental disabilities and pervasive developmental disorders as primary conditions for referral into the program.
3. There shall be clinical evidence that the client has:
  - a. Significant impairment in functioning, across settings, including the home, the school and community.
  - b. Clear, behaviorally-defined treatment objectives that can reasonably be achieved in a ThGH setting, and there is no less restrictive environment in which the objectives can be safely accomplished.
4. The accessibility and/or intensity of currently available community supports and services are inadequate to meet the needs due to the severity of the client's impairments.
5. The client requires services and support to be available 7 days per week/24-hours per day to develop skills necessary for daily living to assist with planning and arranging access to a range of educational and therapeutic services and to develop the adaptive functional behaviors that would allow him or her to remain successful in his/her home and community and regularly attend and participate in a work experience, school or training.
6. The client requires the availability of crisis and/or mental health services 7 days per week/24-hours per day, with flexible scheduling and availability of other services and supports.
7. The client requires 24 hour care and supervision.

**32-007.05 Supervising Practitioner:** The Supervising Practitioner shall meet all of the requirements as identified in 471 NAC 32-001.03 and agree to provide services according to the requirements.

**32-007.06 Standards for Participation for Therapeutic Group Home Services:** ThGH providers must meet the requirements for enrollment of community-based programs.

**32-007.06A Provider Agreement:** The provider of therapeutic group homes shall complete Form MC-19, Medical Assistance Provider Agreement and submit the completed form to Medicaid for approval. Medicaid shall notify the facility in writing when enrollment is complete.

The provider shall review the standards of participation for community-based programs identified in 471 NAC 32-001.02 and comply with Medicaid's expectations for enrollment and complete the procedures as required.

Providers agree to provide cost information when required by Medicaid.

**32-007.07 Conditions of Participation for Community-Based Services:** Providers of ThGH shall review the conditions for enrollment of community-based programs and shall meet the requirements prior to enrollment as a provider as identified in 471 NAC 32-001.06 Conditions for Participation for Mental Health and/or Substance Abuse Community-Based Services.

**32-007.07A Location of Therapeutic Group Homes:** To ensure a more home-like setting, each location where clients live shall be in a residential community to facilitate community integration through education in a non-institutional setting, recreation, and maintenance of family connections. The living setting, daily activity and educational experience shall more closely resemble normal family existence than would be possible in a larger facility or institution. When possible, the setting shall be situated to allow ongoing participation of the client's family.

Providers shall develop an environment conducive to the client safely restoring previous levels of functioning and enhancing existing levels of functioning. In addition the provider shall maintain a community-based non-institutional environments. The location of the therapeutic group home shall meet the requirements at 471 NAC 32-001.04D.

In order to be approved as a therapeutic group home, the following requirements shall be met:

1. Adequate access to recreational facilities in both indoor and outdoor activities appropriate for the size and the scope of the program (these activities shall be provided onsite or through a contract for community living experience).
2. The doors to the unit and to the outside may be locked from the outside to allow for safety, but the doors shall be unlocked from the inside.
3. Kitchen and laundry facilities shall be easily accessible.
4. Staff offices shall be located in the facility.

5. Secure storage of any medication, hazardous cleaning materials and other products shall be appropriately stored.
6. A general living or lounge area shall be available to clients in the facility and the area shall be large enough to accommodate all of the clients served by the facility.
7. The facility shall provide a home-like atmosphere.
8. The program shall be staffed by awake personnel 24 hours a day.
9. Other requirements as listed in this chapter.

ThGHs are located in residential communities in order to facilitate community integration through education, recreation, and maintenance of family connections. The facility shall provide daily recreational activities for all clients, but these recreational activities are not considered a part of the 21 required treatment hours.

**32-007.07B Eight Bed Limitation for Therapeutic Group Homes:** ThGH facilities shall not have more than 8 beds. All new construction, newly-acquired property/facility, or new provider organization shall comply with this bed limitation. Existing facilities providing ThGH services may not add beds if the bed total would exceed 8. (EXCEPTION: Facilities exceeding 16 beds may not enroll as a ThGH. Facilities with 9-16 bed capacity on the operative date of these regulations may enroll as a ThGH and may continue to be operative at that capacity until alterations are made. Any facility alterations shall comply with the 8 bed limit (e.g. a facility with 16 beds shall be reduced to 8 beds or less when alterations are complete.))

Each provider of therapeutic group homes (if they have multiple homes) shall ensure that they do not meet the definition of an Institution of Mental Disease (see definitions in 471 NAC 32-001).

Providers of therapeutic group homes shall review the conditions of enrollment for community-based therapeutic group homes. Providers shall meet requirements prior to enrollment as a provider of this service.

**32-007.08 Staffing Standards for Therapeutic Group Homes:** Staffing shall meet the requirements of 471 NAC 32-001.06 for licensed and non-licensed staff in community-based programs.

At least one staff member per shift is required to have a current CPR and First Aid certification.

ThGH staff shall be supervised by a licensed physician with a specialty in psychiatry or a licensed psychologist (Supervising Practitioner) with experience in evidence-based treatments. Staff includes Direct Care Staff and licensed practitioners whose scope of practice includes mental health and/or substance abuse

All staff not licensed shall have provider qualifications meeting at least the following:

1. Have a high school diploma or equivalent.
2. Be 21 years of age.

3. Have a minimum of 2 years of experience working with children, be equivalently qualified by education in the human services field, or have a combination of work experience and education with one year of education substituting for one year of experience.
4. Complete training according to a curriculum approved by Medicaid or its designee prior to providing the service.
5. Pass the child abuse check, adult abuse registry, and motor vehicle screens.
6. Be certified in: Crisis Prevention/Management (example: CPI, Mandt, etc.).
7. Be proficient in de-escalation techniques.

**32-007.08A Supervising Practitioner:** The therapeutic group home shall contract or employ a Supervising Practitioner who meets the requirements of a therapeutic group home identified in 471 NAC 32-001.03C. He/she shall review and comply with the requirements of a Supervising Practitioner identified in 471 NAC 32-001.03(A, B and D).

The Supervising Practitioner's responsibilities include, but are not limited to:

1. Reviewing the referral PTA and complete an initial diagnostic assessment at admission or within 24 hours of admission and prior to service delivery (Exception: When the ThGH Supervising Practitioner is the same psychiatrist or psychologist as the psychiatrist or psychologist who completed the referral PTA, the Initial Diagnostic Interview shall serve as the admission Initial Diagnostic Interview provided that:
  - a. The Initial Diagnostic Interview was completed within 30 days prior to admission;
  - b. The information in the Initial Diagnostic Interview is current and provides sufficient recommendations for the ThGH team to develop an initial plan of care);
2. Assuming accountability to direct the care of the client at the time of admission and during the entire ThGH stay.
3. Assisting in developing and supervising a comprehensive plan of care in the 10 days following admission.
4. Providing a review and continued supervision of the treatment plan by updating the plan at a minimum of every 14 days thereafter.
5. Providing clinical direction in the development of the treatment and recovery plan.
6. Providing a face-to-face assessment/service to the client at least every 14 days or more often as medically necessary.
7. Providing crisis management including supervision and direction to the staff to resolve any crisis of the client's condition.
8. Monitoring and supervising an aggressive plan to transition the client from the program into less intensive treatment services as medically necessary.

**32-007.08B ThGH Program/Clinical Director:** A program/clinical director shall be a licensed physician with a specialty in psychiatry, LMHP, licensed RN, licensed APRN, LIMHP, or licensed psychologist. Dual licensure (e.g., LMHP/LADC or LMHP/PLADC) is required for ThGH services when co-occurring conditions (mental health and substance abuse programs) occur.

A Program/Clinical Director shall be a fully licensed practitioner practicing within his/her scope and have two years of professional experience in a treatment setting similar to a ThGH.

Practitioners who meet the criteria of the program/clinical director may not also serve in the role of the program's therapist.

The responsibilities of a program/clinical director include, but are not limited to:

1. Overseeing, implementing, and coordinating treatment services.
2. Continually incorporating new clinical information and best practices into the program to assure program effectiveness and viability.
3. Overseeing the process to identify, respond to, and report crisis situations on a 24-hour per day, 7 day per week basis.
4. Clinical management for the program in conjunction with and consultation with the Supervising Practitioner.
5. Assuring confidentiality and quality organization and management of clinical records and other program documentation.
6. Applying and supervising the gathering of outcome data and determining the effectiveness of the program.

**32-007.08C ThGH Therapist:** A ThGH therapist shall be an LMHP, LIMHP, PLMHP, LADC, licensed psychologist, provisionally licensed psychologist, or a licensed APRN operating within his/her scope of practice.

The role and the responsibilities of the ThGH therapist include but are not limited to:

1. Reporting to the program/clinical director and Supervising Practitioner for clinical and non-clinical guidance and direction.
2. Communicating treatment issues to the Program/Clinical Director and to the Supervising Practitioner as needed.
3. Providing individual, group, family psychotherapy and/or substance abuse counseling.
4. Assisting in developing/updating treatment plans for clients in ThGH care in conjunction with the other multidisciplinary team members.
5. Providing assistance to direct care staff implementing the treatment plan when directed by the Program/Clinical Director.
6. Providing clinical information to the multidisciplinary team and attends treatment team meetings.
7. Providing continuous and ongoing assessment to assure clinical needs of clients and parent(s)/caregiver are met.

**32-007.08D Registered Nurse or Advanced Practicing Registered Nurse (RN or APRN):** Nursing services shall be provided by a licensed Registered Nurse or licensed APRN operating within his/her scope of practice. The RN or APRN shall have documented experience and training in the treatment of youth.

The responsibilities of a licensed Registered Nurse or a licensed APRN in the program include, but are not limited to:

1. Reports to the program/clinical director for programmatic guidance.
2. Relates to the physician with a specialty in psychiatry and the medical physician as necessary regarding medical, psychiatric, and physical treatment issues.
3. Provides nursing assessments on the first day of admission for each client.
4. Reviews all medical treatment orders and implements orders as directed.
5. Serves as a member of the multidisciplinary treatment team.
6. Provides medical intervention within his/her scope of practice and the registered nurse's scope of practice as necessary.
7. Manages the storage, delivery and dispensing of medication to clients as necessary.
8. Oversees medication, education and health education issues.
9. Abides by all state and federal regulations.
10. Coordinates psychiatric and medical care per physician's direction.

**32-007.08E Direct Care Staff:** The direct care staff shall have a bachelor's degree or higher in psychology, sociology, or related human service field and one year experience in the field or two years of course work in the human services field and two years of experience/training with demonstrated skills and competencies in treatment of clients with mental illness is acceptable.

The responsibilities of direct care staff include, but are not limited to:

1. Completing the initial program training and the competency check.
2. Having a clear understanding of the treatment plan and discharge plan.
3. Providing psychoeducational activities and interventions to support clients in developing social recreational and other independent living skills as appropriate.
4. Awareness of safety issues and providing safety intervention within the milieu.
5. Reporting all crisis or emergency situations to the program/clinical director or to the program's designee in the absence of the program/clinical director.
6. Understanding the program philosophy regarding behavior management and completing specific training for behavioral management and applies this philosophy in daily interactions with clients in ThGH care.
7. Understanding de-escalation techniques and has demonstrated the ability to implement those techniques effectively.

**32-007.09 Therapeutic Group Home Services and Program Requirements:** The following program components shall be available to all clients participating in the ThGH program. The following services shall be included and identified in the ThGH program and described in the ThGH proposal to be approved for participation in the Medicaid Program:

**32-007.09A Medically Necessary Psychotherapy and Substance Abuse**

**Counseling Services:** These services shall demonstrate active treatment for a clients with serious emotional disturbance or a substance abuse problem.

All clients need not partake in all treatment services, if the service/s is not appropriately beneficial to the client's need and treatment needs and active treatment. The treatment plan shall identify the reason for omission of individual, group, and family psychotherapy. In the absence of these psychotherapy services as a part of the client's ThGH plan the specific clinical reasons for omitting the treatment modality from the treatment plan shall be identified and documented.

The following services and frequency of services are minimum requirements:

1. Three hours of weekly Group Psychotherapy, Substance Abuse Counseling and one hour of Individual Psychotherapy and/or Substance Abuse Counseling.
2. Twice monthly Family Psychotherapy and/or Family Substance Abuse Counseling.
3. Psychoeducational Groups and Individual Psychoeducational therapy services may include, but are not limited to:
  - a. Crisis Intervention Plan and Aftercare Planning
  - b. Social Skills Building
  - c. Life Survival Skills
  - d. Substance Abuse Prevention Intervention
  - e. Self-care services
  - f. Recreational activity
  - g. Medication education and medication compliance groups
  - h. Health care issues group (may include nutrition, hygiene, and personal wellness)

**32-007.09B Medically Necessary Nursing Services:** A licensed Registered Nurse shall evaluate the particular nursing needs of each client by completing a nursing assessment within 24 hours of admission. Registered Nurses shall practice within their scope. In addition to the nursing assessments, responsibilities of the nurse include, but are not limited to, those responsibilities identified in 471 NAC 32-007.07D.

**32-007.09C Medically Necessary Psychological Diagnostic Services:** Testing and evaluation services shall be available. When provided these services shall reasonably be expected to contribute to clarifying the diagnosis and plan of care established for the individual client.

Testing and evaluation services may be performed by a Licensed Psychologist. A specially licensed psychologist, provisionally licensed psychologist or a licensed mental health practitioner acting within his/her scope of practice may provide testing and evaluation services under supervision as allowed by State law.

Medical necessity shall be documented by the program supervising practitioner.



**32-007.09D Medically Necessary Pharmaceutical Services:** Medications shall be dispensed by the program and pharmacy services shall be provided under the supervision of a registered pharmacy consultant or the program may contract for these services through an outside facility or provider. All medications shall be stored in a special locked storage space and administered only by a physician, registered nurse, licensed practical nurse or registered medication aide or other licensed practitioner who is authorized within his/her scope of practice to administer medications.

**32-007.09E Medically Necessary Dietary Services:** Meals shall be supervised by a registered dietitian based on the client's individualized dietary needs. ThGH may contract for these services through an outside facility or provider.

When dietary nutrition problems are identified on the client's active treatment plan, the dietician shall provide nutritional assistance as needed.

**32-007.10 Program Availability:** The ThGH shall be available 24 hours per day, 7 days per week in a structured and supportive living environment. Lengths of stay may range up to 6 months.

Lengths of stay at ThGHs homes that focus on transitioning or short-term crisis are typically in the 14-30 day range. For longer treatment episodes, lengths of stay may exceed up to 6 months.

Discharge shall be based on a client no longer making adequate improvement in the facility, other facilities being recommended, or lack of medical necessity for this level of care.

**32-007.11 Active Treatment:** Providers shall review 471 NAC 32-001.08 and meet all of the active treatment requirements for community-based treatment services.

Active treatment in a therapeutic group home begins with the completion of the Initial Diagnostic Interview completed by the Supervising Practitioner and the initial plan of care. The Supervising Practitioner involvement shall be such to clearly identify that they are directly involved with the care and direction of the treatment program provided to the clients.

**32-007.12 Treatment Plan:** Within 7 days of admission the comprehensive treatment plan shall be developed by the established multidisciplinary team of staff providing services for each client. Each treatment team member shall sign and indicate their attendance and involvement in the treatment team meeting.

The treatment team review shall be directed and supervised by the Supervising Practitioner at a minimum of every 14 days.

The client, the client's guardian/family shall be included as treatment planning members in the initial plan and in the update of treatment goals. The treatment team meeting shall identify any barriers to treatment and modify the plan in order to continue to facilitate active movement toward the time-limited treatment goals identified in the plan.

**32-007.13 Discharge Planning:** Average Length of stay ranges from 14 days to 6 months. ThGH programs focusing on transition or short-term crisis are typically in the 14 to 30 day range. Providers of therapeutic group homes shall understand the need for time-limited treatment and the goal of returning of the client to a less restrictive level of service as early as possible in the development of the plan.

Discharge planning begins at the date of admission and shall be continually addressed in the treatment team meetings. Providers shall apply all of the discharge planning requirements for community-based services identified in 471 NAC 32-001.08B.

Discharge shall be based on the client no longer making adequate improvement in this facility. Continued ThGH stay should be based on a clinical expectation that continued treatment in the ThGH can reasonably be expected to achieve treatment goals and improve or stabilize the client's behavior, such that this level of care will no longer be needed and the client can return to the community. Transition should occur to a more appropriate level of care if the client is not making progress toward treatment goals and there is no reasonable expectation of progress at this level of care.

**32-007.14 Staffing Hours and Ratios:** All staffing shall be adequate to meet the individualized treatment needs of the client and each staff shall meet the responsibilities outlined in the staffing requirements. Acceptable hours and ratios include:

1. Supervising Practitioner: Supervising Practitioner hours shall be adequate to provide the necessary direct services and to meet the administrative and clinical responsibilities of supervision and of directing the care in a ThGH (the number of hours is dependent upon the size of program and the unique needs of each individual client).
2. Program Director: The program director shall have adequate hours to fulfill the expectations and responsibilities of the program/clinical director as described in this chapter.

3. Licensed Registered Nurse or Licensed APRN: The licensed RN's or APRN's hours shall be adequate to provide all of the necessary nursing services for all clients admitted to the program. A registered nurse or APRN shall be onsite and available to meet all of the nursing health care needs of the client during the client's therapeutic group home service.
4. Therapist: The ratio of the licensed practitioners to clients served shall be no greater than 1:12.
5. Direct Care Staff: The ratio of direct care staff to clients served shall be 1:4 with a minimum of two staff on duty per shift for an 8 bed capacity. This ratio may need to be increased if treatment interventions are delivered in the community and offsite or due to a level of acuity of the youth.

**32-007.15 Clinical Records:** Providers of therapeutic group homes shall review and comply with the clinical record requirements identified in 471 NAC 32-001.08(A and B) for requirements regarding clinical records.

**32-007.16 Documentation for Therapeutic Group Home Services:** Providers shall review and apply the requirements of 471 NAC 32-001.01A Documentation Requirements for Community-Based Services to the requirements for therapeutic group homes.

**32-007.17 Services to State Wards:** Providers shall be aware that there are special procedures regarding providing services to wards of the state. Providers shall review 471 NAC 32-001.09 Services to State Wards applied to these procedures to their practice.

Providers shall know the identity of the client's legal guardian at the time of admission, understand the relationship which exists within families, and know the requirements for providing family-based treatment.

**32-007.18 Inspections of Care:** Medicaid or Medicaid's designee shall review the treatment services of clients receiving ThGH services. Medicaid's review may consist of an onsite review as identified in 471 NAC 32-001.10 Inspections of Care (IOC) or a desk review in which the provider is required to submit certain clinical records as requested.

**32-007.19 Payment for Therapeutic Group Home Services:** Providers are referred to 471 NAC 32-001.12 for general payment information.

Reimbursement for services is based upon a Medicaid fee schedule established by the State of Nebraska. Except as otherwise noted, the State-developed fee schedule is the same for both governmental and private individual practitioners. It is applicable to all services reimbursed via a fee schedule.

The fee schedule and any annual/periodic adjustments to the fee schedule are published at <http://www.dhhs.ne.gov/med/provhome.htm> (The Department's Division of Medicaid and Long-Term Care website). The agency's rates are set as of July 1, 2011 and are effective for services provided on or after that date.

Where Medicare fees do not exist for a covered code, reimbursement is determined using a provider cost model designed to comply with the requirements of Section 1902(a)(30) of the Social Security Act 42 CFR 447.200 and 42 CFR 447.204. This cost model is based on Nebraska provider compensation studies, cost data, and fees from similar State Medicaid programs. Its major components include:

1. Employee-Related Expenses – Benefits, Employer Taxes (e.g., FICA, unemployment, and workers compensation)
2. Program-Related Expenses (e.g., supplies)
3. Provider Overhead Expenses

Provider enrollment and retention shall be reviewed periodically to ensure that access to care and adequacy of payments are maintained.

Room and board costs are not included in the Medicaid fee schedule.

**32-007.20 Billing Requirements and Procedure Codes:** Providers are referred to 471 NAC 32-001.12B.

**32-007.21 Services Not Covered in a Therapeutic Group Home:** Payment is not available for the following services:

1. For clients whose needs are social or primarily education and may be met at least lesser restrictive level of care
2. For clients whose primary diagnosis and functional impairment is acutely psychiatric in nature and the condition is not stable enough to allow him/her to participate or benefit from the program
3. For programs designed to provide Applied Behavior Analysis (ABA)
4. For primary symptomatology and dysfunctions due to a developmental disability
5. For clients that cannot benefit from therapeutic group home services

**32-007.22 Cost Not Included in the Therapeutic Group Home Service:** Therapeutic group home services are reimbursed for the treatment of unlicensed direct care staff or licensed practitioners who are providing psychoeducational services and are supervised by a licensed practitioner in the therapeutic group home milieu. Therapeutic group homes are also reimbursed for the treatment services provided by licensed practitioners who associate with the program. Licensed practitioners who provide mental health and/or substance abuse psychotherapy services are reimbursed when they are identified on the ThGH provider agreement. The psychotherapy services are billed by the ThGH agency and the licensed practitioner/s are reimbursed through the agency. The psychoeducational service and the supervision of the psychoeducational services are considered to be a part of the total fee for the ThGH service provided in the milieu as well as for treatment services.

If a client is enrolled with another managed care vendor for medical/surgical services, it may be necessary to pursue prior authorization for referral with that entity.

The following charges can be reimbursed separately from the therapeutic group home fee when the services are medically necessary, part of the client's overall treatment plan and are in compliance with other state and federal regulations:

1. Direct client services provided by the Supervising Practitioner.
2. Prescription drugs including Injectable medications.
3. Direct client services performed by a physician other than the physician directing the program.
4. All laboratory or physical health diagnostic procedures prescribed by a physician
5. Direct medication management services of a licensed physician whose specialty is psychiatry.
6. Treatment services for physical injury or illness provided by non-mental health practitioners operating within their scope of practice.
7. Licensed practitioners who provide mental health, psychotherapy and/or substance abuse counseling services are reimbursed separately provided they are identified on the therapeutic group home provider agreement and the services of the practitioner are billed by the agency.

**32-008 Psychiatric Residential Treatment Facilities (PRTFs) for Children/Adolescents:**

Psychiatric residential treatment facility services are clinically necessary services provided to a client who requires 24-hour professional care and treatment in a highly structured, closely supervised environment. Professional care and treatment means care and treatment identified as medically necessary and provided by individuals educated, trained, skilled and competent in the human services field to deliver those services which can reasonably be expected to reduce or eliminate the client's mental health and/or substance abuse dysfunctions.

Providers shall review all general requirements identified in 471 NAC 32-001.01 and comply with these general requirements. PRTF providers shall review the Service Definitions of 471 NAC 32-001 and particularly know the definitions regarding PRTF in this chapter.

Psychiatric residential treatment services shall be provided under the direction of a licensed physician with a specialty in psychiatry who is enrolled as a provider of Nebraska Medicaid.

Providers of PRTF shall adhere to a philosophy which believes that individuals can and do recover from their mental health and/or substance abuse symptoms and problems and can lead full and productive lives. Providers shall make every effort to encourage meaningful reintegration of a client into the community to diminish the use of other more restrictive treatment modalities.

PRTF providers shall:

1. Understand and be sensitive to the effects of psychological trauma
2. Understand the needs of trauma survivors
3. Screen for trauma symptoms and past history of traumatic events
4. Provide trauma-sensitive services and recognize that traumatization can occur if safe, effective, and responsive services are not available.

Psychiatric residential treatment facility services shall be family-centered, culturally competent, and developmentally appropriate. PRTF's shall incorporate a trauma informed philosophy in the treatment services and adapt a recovery-based philosophy for treatment services provided to this population.

Psychiatric Residential Treatment Facility (PRTF) services are available to clients under the age of 21 when the treatment is medically necessary and the need for care at this level has been identified on a Pretreatment Assessment (see 471 NAC 32-001.02).

Psychiatric Residential Treatment Facility services are covered for clients who are Medicaid-eligible. PRTF providers shall meet the Centers for Medicare and Medicaid (CMS) regulations for inpatient psychiatric services for individuals under age 21. The regulations are identified in the Federal Code of Regulations.

**32-008.01 Pretreatment Assessment:** Prior to the referral and prior to accepting a client, a PRTF considering a client for PRTF admission shall review a Pretreatment Assessment provided by a referral physician, preferably by a physician who has a specialty in psychiatry. The licensed psychiatrist/physician completing the PTA shall provide clinical information to justify this level of care and shall provide specific recommendations for treatment. The PRTF psychiatrist/physician completing the Initial Diagnostic Interview shall provide specific recommendations following the Initial Diagnostic Interview for treatment recommended during the PRTF stay and shall provide information to the initial information to PRTF treatment team.

**32-008.02 Medical Necessity:** Providers shall review and apply the conditions defined in Medical Necessity of 471 NAC 32-001.01A and B.

**32-008.03 Standards for Participation:** Enrollment requirements for hospitals who are interested in providing PRTF services shall meet the requirements of 471 NAC 32-001.04A for Community-Based Programs. The hospital operating the PRTF shall have met the standards of participation identified in 471 NAC 32-001.04B.

Providers of community-based non-hospital PRTF's located in the community shall meet the requirements of 471 NAC 32-001.04A. All physicians, including a physician with a specialty in psychiatry providing services in the facility shall be identified on the PRTF provider agreement and provide services in the PRTF shall be added to the staffing of the PRTF provider agreement in order to bill Medicaid for his/her services. At any time a physician not identified on the PRTF enrollment staffing of the provider agreement provides services in the PRTF, he/she shall be added to the staffing of the PRTF provider agreement. This requirement applies to hospital-operated and non-hospital operated PRTF's.

Providers shall agree at the time of enrollment to provide cost information upon the request of the Medicaid program.

**32-008.04 Conditions for Participation of Hospital-Based PRTF:** Providers of hospital-based PRTF shall meet the conditions of participation identified in 471 NAC 32-001.05.

**32-008.05 Conditions of Participation for Community-Based PRTF:** These programs shall meet the requirements of 471 NAC 32-001.05. Non-hospital operated PRTF's shall be in compliance with the conditions identified for community-based services.

**32-008.06 Location of PRTF:** PRTF's may be owned and operated by a hospital and may be located on the grounds of the hospital or the hospital may choose to operate the program in the community. Community-based PRTF's who are not owned by a hospital may be located at an appropriate facility that is conducive to provide PRTF services to the client.

All 24-hour treatment services provided in and by the PRTF's shall meet the requirements of a PRTF as defined in the Code of Federal Regulations.

Day treatment and outpatient services may be provided on the grounds of a PRTF when the youth receiving these services is living in the community in their biological home, foster home or some other non-treatment location and not living in an institution of 17 beds or more.

**32-008.07 Staffing Standards for PRTF's:** PRTF's shall meet the minimum staffing requirements identified by the following:

**32-008.07A Supervising Practitioner:** The PRTF Supervising Practitioner, who is a licensed physician with a specialty in psychiatry, shall:

1. Review the referral PTA and complete an initial diagnostic assessment at admission or within 24 hours of admission and prior to service delivery. (EXCEPTION: When the Supervising Practitioner of the PRTF is the same psychiatrist as the psychiatrist who completed the referral PTA, the Initial Diagnostic Interview shall serve as the admission Initial Diagnostic Interview provided that:
  - a. The Initial Diagnostic Interview was completed within 30 days prior to admission.
  - b. The information in the Initial Diagnostic Interview is current and provides sufficient recommendations for the PRTF team to develop an initial plan of care).
2. Assume accountability to direct the care of the client at the time of admission and during the entire PRTF stay.
3. Assist in developing and supervising a comprehensive plan of care in the 10 days following admission.
4. Provide a review and maintain supervision of the treatment plan by updating the plan at a minimum of every 14 days.
5. Provide clinical direction in the development of the treatment and recovery plan
6. Provide a face-to-face assessment/service to the client at least every 14 days (or more often as medically necessary).
7. Provide crisis management including supervision and direction to the staff to resolve any crisis of the client's condition.
8. Monitor and supervise an aggressive plan to transition the client from the program into less intensive treatment services as medically necessary.

**32-008.07B Program/Clinical Director:** A program/clinical director shall be a LMHP, licensed RN, licensed APRN, LIMHP, licensed physician with a specialty in psychiatry, or licensed psychologist. Dual-credentialing (e.g., LMHP/LADC or LMHP/PLADC) is required for PRTF services when co-occurring conditions (e.g. mental health and substance abuse) occur.

A Program/Clinical Director shall be a fully licensed practitioner practicing within his/her scope, and have two years of professional experience in the mental health treatment of clients.

This clinician has professional experience in a treatment setting similar to that for which the client is currently providing services of a program/Clinical Director.

Practitioners who meet the criteria of the program/clinical director may not also serve in the role of the program's therapist.

The Program/Clinical Director shall:



1. Oversee, implement, and coordinate treatment services.
2. Continually incorporate new clinical information and best practices into the program to assure program effectiveness and viability.
3. Oversee the process to identify, respond to, and report crisis situations on a 24-hour per day, 7 day per week basis.
4. Provide clinical management for the program in conjunction with and consultation with the Supervising Practitioner.
5. Assure quality organization and management of clinical records, other program documentation and confidentiality.
6. Apply and supervise the gathering of outcome data and determines the effectiveness of the program for the clients served.
7. Supervise all procedures and training regarding behavior management in the PRTF milieu, particularly regarding de-escalation techniques and the use of timeout, seclusion and restraint.

**32-008.07C PRTF Therapist:** A PRTF therapist shall be a licensed practitioner whose scope of practice includes mental health and/or substance abuse services, including a LMHP, LIMHP, PLMHP, LADC, licensed psychologist, provisionally licensed psychologist, licensed APRN, or licensed physician with a specialty in psychiatry. The licensed practitioner providing mental health and/or substance abuse services for clients in the treatment program shall operate within his/her scope of practice.

The therapist shall:

1. Report to the program/clinical director and Supervising Practitioner for clinical and non-clinical guidance and direction
2. Communicate treatment issues to the Program/Clinical Director and to the Supervising Practitioner as needed
3. Provide individual, group, family psychotherapy and/or substance abuse counseling
4. Assist in developing/updating treatment plans for clients in the PRTF in conjunction with the other multidisciplinary team members
5. Provide assistance to direct care staffing implementing the treatment plan when directed by the Program/Clinical Director
6. Provide clinical information to the multidisciplinary team and attend treatment team meetings.
7. Provide continuous and ongoing assessment to assure clinical needs of clients and parent(s)/caregiver are met.
8. Provide individual, group and family therapy.

**32-008.07D Registered Nurse or Advanced Practicing Registered Nurse (RN or APRN):** Nursing services shall be provided by a Registered Nurse or APRN licensed by the State in which she or he practices. The nurse shall operate within his/her scope of practice and shall have documented experience and training in the treatment of clients. The PRTF shall provide onsite nursing coverage by a registered nurse 7 days per week, 365 days per year during the awake hours and provide a minimum of on-call availability during sleep hours. The APRN shall practice within his/her scope, however, the APRN cannot bill his/her services separately. The cost of an APRN service is covered in the per diem rate.

The licensed Registered Nurse or licensed APRN shall:

1. Report to the program/clinical director for programmatic guidance.

2. Relate to the licensed physician whose specialty is psychiatry and medical physician as necessary regarding medical, psychiatric, and physical treatment issues.
3. Provide nursing assessments on the first day of admission for each client.
4. Review all medical treatment orders and implements orders as directed.
5. Serve as a member of the multidisciplinary treatment team and participate in treatment team meetings.
6. Provide medical intervention within his/her scope of practice as necessary.
7. Manage the storage, delivery and dispensing of medication to clients as necessary.
8. Oversee and provide medication, education and client compliance and other health education issues.
9. Abide by all state and federal regulations.
10. Coordinate psychiatric and medical care per a physician's direction.
11. Comply with the responsibilities for the role of a registered nurse in the seclusion and restraint regulations identified for PRTF's by the Centers for Medicaid and Medicare.

**32-008.07E Direct Care Staff:** Direct care staff shall have a bachelor's degree or higher in psychology, sociology, or related human service field and one year work experience in the human services field or two years of course work in the human services field and two years of experience/training with demonstrated skills and competencies in treatment of clients with mental illness is acceptable. These requirements for direct care staff become operative for staff hired on or after the operative date of this regulation.

Direct Care Staff shall:

1. Complete the initial program training and the competency check.
2. Clearly understand the treatment plan and discharge plan.
3. Provide psychoeducational activities and interventions to support clients in developing social recreational and other independent living skills as appropriate
4. Provide continual supervision to clients in the program.
5. Maintain awareness of safety issues and provide safety intervention within the milieu.
6. Report all crisis or emergency situations to the program/clinical director or to the program's designee in the absence of the program/clinical director.
7. Understand the program philosophy regarding behavior management, complete specific training for behavioral management, and apply this philosophy in daily interactions with clients.
8. Understand de-escalation techniques and demonstrate the ability to implement those techniques effectively.

**32-008.07F Covered PRTF Services:** PRTF services are covered when all of the following conditions are met:

1. The service is recommended by a licensed physician with a specialty in psychiatry, who has completed a Pretreatment Assessment.
2. The Pretreatment Assessment recommends the client for inpatient psychiatric residential treatment facility services.
3. The Pretreatment Assessment contains specific recommendations for the care that the client needs to receive at the PRTF.

**32-008.08 Prior Authorization for PRTF's:** In order for any part of the 24-hour treatment service to be Medicaid reimbursed on the campus of a PRTF the client shall meet prior authorization requirements for PRTF level of care.

Medicaid or Medicaid's designee shall assure that the program meets the PRTF requirements and that the youth who are admitted meet the medical need for this level of care through Certification of Need for PRTF services.

An independent team of practitioners which include a psychiatrist determine medical need and certify that:

1. Ambulatory care resources available in the community do not meet the treatment needs of the recipient
2. Proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician
3. The services can reasonably be expected to improve the recipient's condition or prevent further regression so that the services shall no longer be needed
4. The certification specified satisfies the utilization control requirement for physician certification in this subchapter.

**32-008.09 PRTF Services and Program Requirements:** Providers of PRTF services shall provide 42 hours of treatment of psychotherapy and other treatment interventions per week. All clients need not partake in all treatment services, if the treatment service is not appropriately beneficial to the client's need and the treatment needs and active treatment. The treatment plan shall identify a reason for omitting individual, group or family psychotherapy. Absence of psychotherapy services and it's a part of the client's PRTF active treatment plan shall be identified on the treatment plan and the clinical reason for the absence of the particular treatment service shall be identified.

The following services and frequency of services shall be available to the client:

1. Twice weekly individual psychotherapy and/or substance abuse counseling;
2. Daily group psychotherapy and/or substance abuse counseling;
3. Weekly family psychotherapy and/or family substance abuse counseling. A family therapy session shall be provided on the day of admission and the day prior to discharge;
4. Occupational therapy;
5. Physical therapy;
6. Speech therapy;
7. Laboratory services; and
8. Transportation.

Hospital-operated PRTFs shall also provide dental, vision, and diagnostic/radiology (x-ray).

Additional psychoeducational services shall be available and shall be modified to meet the unique treatment needs of the client in the client's active treatment plan.

1. Crisis intervention and aftercare planning;
2. Life survival skills;
3. Social skills building;
4. Substance abuse prevention interventions;
5. Self-care services;
6. Medication education, compliance and information regarding the effectiveness of medication.
7. Health care issues which may include nutrition, hygiene and personal wellness;
8. Recreational activity (recreational activity is not considered in 42 hours per week of therapy but healthful outcomes of recreation and exercise may be a part of a psycho-educational group service).

**32-008.10 Program Availability:** A PRTF shall be available 24 hours a day, 7 days a week, 365 days per year with 24-hour awake staffing.

**32-008.11 Active Treatment In a PRTF:** Providers shall meet all of the active treatment requirements of 471 NAC 32-001.08.

**32-008.12 Treatment Planning:** Providers shall review and comply with the requirements of transition and discharge planning as identified in 471 NAC 32-001.08A. Treatment plans shall be reviewed each 14 days following the initial plan of care. Providers shall meet the requirements of CMS regarding individual plan of care identified in the CFR. The plan of care shall:

1. Be based on a diagnostic evaluation that includes examination of medical, educational, social, behavioral and developmental aspects of the recipient's situation and reflects the need for inpatient psychiatric care.
2. Be developed by a team of professionals in consultation with the recipient and his parents, legal guardian or other's whose care he will be released to after discharge.
3. State treatment objectives.
4. Prescribe an integrative program of therapies, activities and experiences design to meet these objectives; and
5. Include an appropriate timeframe post-discharge plans and coordination of inpatient services with partial discharge plans and related community activities to ensure continuity of care with the recipient's family, school and community upon discharge.

The individual plan of care shall be developed by the interdisciplinary team of physicians and/or personnel who are employed by and provide services to the client in the facility. The team must include one of the following:

1. A licensed physician with a specialty in psychiatry; or
2. A licensed psychologist who has a doctorate degree and a physician licensed to practice medicine or osteopathy; or
3. A physician licensed to practice medicine or osteopathy with a specialized training and experience in the diagnosis and treatment of mental diseases and a licensed psychologist who has a master's degree in clinical psychology;

The team also should include one of the following:

1. A certified social worker, with specialized experience and training in mental health services;
2. A licensed registered nurse with specialized training or one year experience in treating mentally ill individuals;
3. An licensed occupational therapist who has specialized training or one year of experience in treating mentally ill individuals;
4. A licensed psychologist.

**32-008.13 Clinical Records in a PRTF:** Providers shall meet the requirements of 471 NAC 32-001.08C and those records shall be available to Medicaid.

**32-008.14 Documentation Requirements for PRTF:** Providers shall meet the documentation requirements for hospitals as identified in 471 NAC 32-001.08C when services are hospital-based and shall meet the documentation requirements for community-based services as per 471 NAC 32-001.08A when services are located in the community.

**32-008.15 Services to State Wards:** Providers shall know the requirements specific for treatment of state wards described in 471 NAC 32-001.09.

**32-008.16 Inspections of Care:** Providers may be required to provide information regarding the services that are provided in a PRTF. This may be completed by Medicaid or Medicaid's designee through an inspection of care or by a request of the provider to provide documentation for offsite review.

**32-008.17 Payment for PRTF's Billing Requirements and Procedure Codes:** See 471 NAC 32-001.15 regarding procedure codes for billing for PRTF's.

**32-008.18 Non-Covered Services in a PRTF:** Payment is not available for the following PRTF services:

1. For clients whose needs are social and primarily educational and may meet the need for a lesser restrictive level of care.
2. For clients whose primary diagnosis and functional impairment is more acutely psychiatric in nature and his/her condition is not stable enough to allow him/her to participate in or benefit from services.
3. Clients needing a program designed to provide applied behavioral analysis (ABA) for primary symptomatology and dysfunction due to a developmental disorder that the client cannot benefit from the PRTF services.
4. Physicians who are not identified on the PRTF enrollment document and whose services are not identified on the Active Treatment Plan.
5. Other practitioner services who are not identified on the PRTF enrollment document and whose services are not a part of the Active Treatment Plan.

**32-008.19 Cost Not Included in a PRTF:** All medical and psychiatric services provided in the PRTF by the PRTF shall be covered except the following services:

1. The services of medical physicians for medical care may be billed separately and is not included in the PRTF cost;
2. The services provided by a physician whose specialty is psychiatry who is contracted or employed to provide the psychiatric services in a PRTF are not included in the PRTF payment and may be billed separately;
3. The cost of medications prescribed to a client in a PRTF are not included in the cost covered in the PRTF payment.

**32-008.20 Procedure Codes:** Providers are referred to the fee schedule for procedure codes and billing information.

**32-009 Psychiatric Partial Hospitalization Services for Children/Adolescents:** Psychiatric partial hospitalization services are medically necessary non-residential psychiatric treatment services provided to a client in a hospital setting when the client lives in the community.

Psychiatric services shall be community-based, family-centered and developmentally appropriate and shall meet the requirements of 471 NAC 32-001.01A General Requirements. Providers of hospital psychiatric services shall adhere to these principles.

The care and treatment of a partial hospital client with a primary psychiatric diagnosis shall be under the direction of a licensed physician, preferably with a specialty in psychiatry, who is enrolled as a Medicaid provider with the Department.

Psychiatric partial hospitalization services shall receive prior authorization by the Department-contracted peer review organization or management designee. In addition, out-of-state psychiatric partial hospitalizations shall be approved by the Department.

This service is available for clients who are Medicaid-eligible and meet the medical necessity requirements for partial hospitalization level of care.

**32-009.01 Provider Agreement:** Providers shall meet the standards for hospitals that provide psychiatric services as identified in 471 NAC 32-001.04B as identified for hospitals.

**32-009.02 Standards for Participation for Psychiatric Partial Hospitalization Service Providers:** Providers are referred to 471 NAC 32-001.05 for standards applicable to all psychiatric hospitals or acute care hospitals who provide psychiatric services in a distinct part of the hospital.

**32-009.03 Staffing Standards for Participation:** Psychiatric partial hospitalization services shall have staff adequate in number and properly qualified to carry out partial hospitalization program for treatment for individuals who need further psychiatric stabilization, treatment, rehabilitation and recovery activities. The general standards for hospital staff are found in 471 NAC 32-001.05.

PPHS staff shall also meet the following standards:

**32-009.03A Hospital Personnel:** Hospitals that provide psychiatric partial hospitalization services shall be staffed with an adequate number of qualified professional, technical, support personnel, and consultants to carry out an intensive and comprehensive treatment program that includes, but is not limited to:

1. Evaluation of individual and family needs.

2. Establishment of individual and family treatment goals.
3. Implementation, directly or by arrangement, of a broad-range psychiatric treatment program including, at minimum, the professional, psychiatric, medical, nursing, social services, psychological, psychotherapy, psychiatric rehabilitation, and recovery therapies required to carry out an individual treatment plan for each patient and their family.

The following standards shall be met:

1. Qualified professional psychiatric staff shall be available to evaluate each patient at the time of admission, including diagnosis of any intercurrent disease. Services necessary for the evaluation include:
  - a) Biopsychosocial assessment by a multi-disciplinary team within 24 hours of admission
  - b) Psychiatric diagnostic evaluation by the attending psychiatrist within 24 hours of admission
  - c) Nursing assessment by a licensed registered nurse within 24 hours of admission
  - d) Substance abuse assessment when appropriate
  - e) Laboratory, radiological, and other diagnostic tests as necessary
  - f) A physical examination including a complete neurological examination when indicated within 24 hours of admission by a licensed physician
2. The number of qualified professional personnel and direct care staff, including licensed registered nurses and Licensed Mental Health Practitioners and technical and supporting personnel, shall be adequate to ensure representation of the disciplines necessary to establish short-range and long-term goals and to plan, carry out, and periodically revise a treatment plan for each client. They shall meet the following standards:
3. Qualified staff shall be available to provide treatment intervention; social interaction/experiences; and education regarding psychiatric issues such as medication management, nutrition, signs and symptoms of illness, substance abuse education, appropriate nursing interventions and structured milieu therapy. Available services shall include individual, group, and family therapy; group living experiences; occupational and recreational therapy; and other prescribed activities to maintain or increase the client's capacity to manage his/her psychiatric condition and activities.
4. The program shall have staff adequate to provide a treatment milieu that is a safe, organized, structured environment at the least restrictive level of care needed to meet the individualized treatment needs of the client.
5. The hospital shall have adequate staff in numbers to provide a program available at least 5 days per week (but may be available up to 7 days per week). The program can be offered in half-day (3 hour) or a full-day (6 hour) sessions.

The provider shall have appropriately licensed practitioners to provide at a minimum twice weekly individual therapy, daily group therapy and weekly family psychotherapy.



**32-009.03B Medical Director of Psychiatric Partial Hospitalization Program:**

Psychiatric partial hospitalization services shall be under the supervision of a licensed physician with a specialty in psychiatry (Supervising Practitioner) who is identified as the Medical Director and is qualified to provide the clinical direction and the leadership required for a psychiatric partial hospitalization program. The number and qualifications of additional psychiatrists shall be adequate to provide essential psychiatric services.

The medical director may also serve as the attending psychiatrist for each client depending on the size of the program.

The following standards shall be met:

1. The medical director and any attending psychiatrist/s shall meet the training and experience requirements for a physician whose specialty is psychiatry and licensed to practice in the state where services are provided.
2. The program shall identify a covering or alternative physician whose specialty is psychiatry when the medical director is not available to provide direction and supervision of the direct care of the client and the treatment program.
3. The physician whose scope of practice is psychiatry, his personal involvement in all aspects of psychiatric care shall be documented in the client's medical record (e.g., physician's orders, progress notes, nurse's notes).
4. The medical director/attending physician whose specialty is psychiatry shall be available; in person or by telephone, or by fax; to provide assistance and direction to the treatment team as needed.

**32-009.03C Availability of Physicians and Other Medical Consultation:** Physicians and other appropriate professional consultants (e.g. medical, psychopharmacological, dental, and emergency medical services) shall be available to provide medical, surgical, diagnostic, and treatment services, including specialized consultations.

**32-009.03D Advanced Practice Registered Nurses (APRNs):** Licensed APRNs may provide medical services and treatment in a partial hospital psychiatric program when:

1. The licensed APRN is practicing within his/her scope of practice.
2. The APRN has an integrated practice agreement with an attending physician whose specialty is psychiatry of the client.
3. The APRN and psychiatrist have identified their roles and responsibilities of their professional relationship in the program at the time of enrollment.
4. The APRN provides medically necessary services that are not a duplication of those provided by and are an essential requirement of the attending psychiatrist.
5. The APRN is enrolled as a provider of Medicaid.

**32-009.04 Program Standards for Participation:** Psychiatric partial hospitalization services for clients under the age of 21 shall have available licensed practitioners and direct care staff with specific, identified duties and responsibilities to meet the acute and rehabilitative psychiatric needs of the clients being served.

The following positions and services are required:

**32-009.04A Program/Clinical Director:** Shall be a fully licensed practitioner such as a psychiatrically trained registered nurse (RN), psychiatrically trained advanced practice registered nurse (APRN), a Licensed Mental Health Practitioner (LMHP), licensed independent mental health practitioner (LIMHP), or a licensed psychologist who is skilled and knowledgeable enough to provide leadership and clinical direction to the treatment team.

The Program/Clinical Director shall:

1. Oversee, implement, and coordinate all treatment services and activities provided during program hours
2. Incorporate new clinical information and best practices into the program to assure effectiveness, viability, and safety
3. Oversee the process to identify, respond to, and report crisis situations during program hours as well as develop an on-call process to manage crisis situations when the program is not in session
4. Be responsible, (in conjunction with the medical director psychiatrist) for the program's clinical management by representation in the multidisciplinary treatment team meetings providing supervision to all program professional and direct care staff
5. Communicate with the attending psychiatrist regarding the client's individual treatment needs
6. Assure quality organization, completion, and management of documentation in the clinical record
7. Assure confidentiality of all clinical information provided in the program
8. Oversee and be responsible for the safety of clients and staff.

**32-009.04B Nursing Services:** All nursing services shall be administered under the supervision of a licensed registered nurse who is qualified by education and experience for the supervisory role. The number of licensed registered nurses and other nursing personnel shall be adequate to formulate and carry out the nursing components of a treatment plan for each client.

The following standards shall be met:

1. The licensed registered nurse supervising the nursing program shall have a master's degree in psychiatric or mental health nursing or its equivalent from a school of nursing accredited by the National League for Nursing, or shall be qualified by education and experience in the care of the individual with mental illness, and have demonstrated competence to:

2. Provide a comprehensive nursing assessment.
3. Participate in interdisciplinary formulation of treatment plans.
4. Provide skilled nursing care and therapy.
5. Direct, supervise, and train others who assist in implementing and carrying out the nursing components of each client's treatment plan.

The staffing pattern shall ensure the direct nursing coverage by a licensed registered nurse during the hours that the program is in session:

1. Directs care necessary as required by the client's active treatment plan.
2. Directs, monitors and evaluates care performed by other nursing personnel.

The number of licensed registered nurses shall be adequate to formulate a nursing care plan in writing for each client and to ensure that the plan is carried out.

Licensed registered nurses and other nursing personnel shall maintain their education by continuing in-service and staff development programs for active participation in interdisciplinary meetings affecting the planning or implementation of nursing care plans for patients. The meetings include diagnostic conferences, treatment planning sessions, and meetings held to consider alternative services and transitioning to the most appropriate treatment service and community resources.

**32-009.04C Psychological Services:** Providers are referred to 42 CFR 482.62(e) regarding psychological services provided in a hospital. Psychological consultation shall be available by a qualified licensed psychologist capable of providing diagnostic and treatment services.

The following standards shall be met:

1. Psychologists, consultants, and supporting personnel shall be adequate in number and be qualified to assist in essential diagnostic formulations, and to participate in:
  2. Program development and evaluation of program effectiveness
  3. Training and research activities
  4. Therapeutic interventions, such as milieu, individual, or group therapy
  5. Interdisciplinary conferences and meetings held to establish diagnoses, goals, and treatment programs

Psychological testing shall be ordered and directed by a licensed physician whose specialty is psychiatry.

**32-009.04D Psychotherapy Services:** Licensed practitioners whose scope of practice includes mental health services shall be employed in the hospital to provide psychotherapy services according to the licensed practitioner's scope of practice and according to the individualized treatment plan for the client.

Licensed practitioners whose scope of practice does include the provision of mental health services may include psychologists, LMHPs, LIMHPs, and PLMHPs, and licensed APRNs.

Psychotherapy shall be available to each client and provided according to the client's individual treatment plan and the practitioner's scope of practice. Services shall be able to meet the unique needs of each client.

Psychotherapy services include:

1. Individual psychotherapy by a licensed practitioner whose scope of practice includes mental health services, to be provided a minimum two times weekly.
2. Group psychotherapy by a licensed practitioner whose scope of practice includes of mental health services, to be provided a minimum three times weekly.
3. Family psychotherapy by a licensed practitioner whose scope of practice includes mental health services , to be provided as appropriate and consented to by the client (with consent of the client, family therapy shall be provided at the frequency and intensity to meet the unique needs of client and the family).

**32-009.04E Licensed Addiction and Drug Abuse Services:** Substance abuse assessment and treatment shall be available to clients whose problems and symptoms indicate the possibility of or who currently have an established substance abuse problem, in addition to the primary psychiatric diagnosis.

Licensed practitioners whose scope of practice includes substance abuse services shall provide services within their scope of practice. Usually, services are provided by a licensed alcohol and drug counselor.

**32-009.04F Psychoeducational Services:** Psychoeducational services (e.g. medication education and management, activities of daily living, social skills development, recovery awareness and symptom management, education regarding diagnosis and treatment) shall be offered in the program and made available to clients on a daily basis.

Services shall be provided by a qualified professional or by a non-licensed staff person whose education and training provides competency to provide the service.

Medication education shall be provided by a licensed registered nurse.

**32-009.04G Case Management Services/Social Services Staff:** Case Management/social services shall be under the supervision of the program/clinical director and the hospital's director of social work.

Daily case management services are required for each client and shall be summarized in the client's clinical record.

The case management/social service staff shall be adequate in number and be qualified to fulfill responsibilities related to the specific needs of individual clients and their families. These responsibilities include, but are not limited to:

1. The development of community resources
2. Consultation with other staff and community agencies
3. Aggressive discharge planning and preparation for transitioning the client to a less restrictive, less intensive services according to the treatment plan

**32-009.04H Direct Care Staff:** The program shall have available direct care staff who are members of the multi-disciplinary team.

Direct care staff shall have completed the program's initial training program approved by and in compliance with JCAHO and the staff person shall have past the competency evaluation and continued ongoing training requirements. Direct care staff who have completed a Bachelor's degree (or two years post-high school education in the Human Services field and two years of experience working with individuals with a mental health or substance abuse diagnosis) are preferred. The staff shall know recovery principles and the effects of trauma-related symptoms.

Direct care staff shall:

1. Intervene in the treatment milieu
2. Provide safety and organized environment suitable for teaching symptom reduction and symptom management and learning de-escalation skills
3. Provide treatment interventions to the client which meet the specific psychiatric needs of the client as identified in the treatment plan
4. Demonstrate competency in applying the learned treatment interventions
5. Have direct knowledge of policies and procedures of the agency

**32-009.05 Coverage Criteria for Psychiatric Partial Hospitalization Services:** The Medicaid Program covers partial hospitalization psychiatric services for clients under the age of 21 when the services meet the criteria of 471 NAC 32-001 and when the following requirements are met:

1. The attending physician whose specialty is psychiatry shall personally evaluate the client face-to-face and document the psychiatric evaluation and diagnosis formulation within 24 hours of admission.
2. The attending physician whose specialty is psychiatry assumes accountability to direct the care of the client at the time of admission.
3. The client shall be treated by a physician whose specialty is psychiatry or APRN personally and face-to-face a minimum of four of five times per week (more often, if medically necessary) and the interaction shall be documented in the client's clinical record.
4. The attending physician whose specialty is psychiatry describes the medical necessity and active treatment requirements for the client.

5. The attending physician whose specialty is psychiatry provides certification. Recertification shall be provided by the psychiatrist or APRN as per the client's needs for psychiatric partial hospitalization services.
6. The attending physician whose specialty is psychiatry provides clinical supervision of the multi-disciplinary treatment team and conducts treatment team planning meetings as necessary to meet the individualized treatment needs of the client.

**32-009.06 Professional and Technical Components for Hospital Diagnostic and Therapeutic Services:** For regulations regarding professional and technical components for diagnostic and therapeutic hospital services, the elimination of combined billing, and non-physician services and items provided to hospital patients, see 471 NAC 10-003.05C, 10-003.05D, 10-003.05E, and 10-003.05F.

**32-009.07 Prior Authorization Procedures:** All psychiatric partial hospitalization admissions shall receive prior authorization by the Department-contracted peer review organization or management designee. If the admission is approved, the Department-contracted peer review organization or management designee shall assign a specific prior-authorization number.

Providers shall follow the Department-contracted peer review organization or management designee guidelines for facilitating prior authorization and continued stay review. Continued stay authorization is provided at a frequency appropriate for this short-term partial hospitalization program by the Department-contracted peer review organization or management designee.

**32-009.08 Documentation in the Client's Clinical Record:** The medical records maintained by a hospital permit determination of the degree and intensity of the treatment provided to clients who receive services in a psychiatric partial hospital program. Clinical records shall stress the psychiatric components of the record, including the history of findings and treatment provided for the psychiatric condition for which the client is hospitalized.

All documents from the client's medical record submitted to the Department shall contain sufficient information for identification (that is, client's name, date of service, provider's name).

The clinical record shall be legible and include:

1. Identification data, including the client's legal status (e.g., voluntary admission, Board of Mental Health commitment, court mandated).
2. A provisional or admitting diagnosis which is made on every patient at the time of admission and includes the diagnoses of intercurrent diseases as well as the psychiatric diagnoses.
3. The complaint of others regarding the client, as well as the client's comments.
4. The psychiatric evaluation written in descriptive, not interpretive fashion that includes a medical history containing a record of mental status with notes regarding:
  - a. The onset of illness.
  - b. The circumstances leading to admission.

- c. The client's attitudes and behavior.
  - d. An estimate of intellectual functioning, memory functioning, and orientation.
  - e. An inventory of the client's strengths.
  - f. A complete neurological examination, when indicated, recorded at the time of the admitting physical examination.
5. A biopsychosocial history sufficient to provide data on the client's relevant past history, present situation, social support system, community resource contacts, along with other information relevant to appropriate treatment and discharge planning.
  6. A family assessment. This document may be a part of the biopsychosocial assessment.
  7. Reports of consultations, psychological evaluations, electroencephalograms, dental records, and special studies.
  8. The client's treatment plan and treatment plan reviews.
  9. The treatment received by the client, documented in a manner and with enough frequency to ensure that all active therapeutic efforts (e.g.; individual, group, and family psychotherapy; drug therapy; milieu therapy; occupational therapy; recreational therapy; nursing care; and other therapeutic interventions) are included.
  10. Progress notes recorded by the psychiatrist, physician, nurse, social worker, and, when appropriate, others significantly involved in active treatment modalities. Progress notes shall contain a concise assessment of the client's progress and recommendations for revising the treatment plan as indicated by the client's condition (frequency is determined by the condition of the client, but nursing staff shall record progress notes daily, and they shall be recorded at each contact by a psychiatrist, physician and all other treatment staff).
  11. The psychiatric diagnosis contained in the final diagnosis written in the terminology of the current American Psychiatric Association's Diagnostic and Statistical Manual (DSM)
  12. Transition and discharge planning documentation including relapse and crisis prevention planning.
  13. Proof of family and community involvement.
  14. The discharge summary, including a recapitulation of the client's hospitalization, recommendations for appropriate services concerning follow-up, and a brief summary of the client's condition on discharge.

**32-009.09 Certification and Recertification by Psychiatrists for Psychiatric Partial Hospital Program Services:** For clients admitted to a partial hospital psychiatric program, a physician whose specialty is psychiatry certification by written order for admission is required at the time of admission.

The psychiatrist's certification or recertification statement shall document the medical necessity for the admission to and continued hospitalization for short-term psychiatric partial hospitalization services, based on a current evaluation of the client's condition.

Medicaid pays for covered psychiatric partial hospitalization services only if the physician whose specialty is psychiatry certifies, (and the physician whose specialty is psychiatry or APRN recertifies at designated intervals), the medical necessity for the admission to and continued hospitalization for those services. Appropriate supporting material may be required.

**32-009.10 Hospital Utilization Review (UR):** A site visit by Medicaid staff for purposes of utilization review may be required for further clarification of the mental health services provided to an identified client. See 471 NAC 10-012 ff.

**32-009.11 Payment for Psychiatric Partial Hospitalization Services:** See 471 NAC 10-010D.

**32-009.12 Billing:** Providers shall submit claims for psychiatric partial hospitalization services on Form HCFA-1450 (UB-04). Providers shall enter the prior authorization number as required for sub-acute inpatient services.

**32-009.13 Other Regulations:** In addition to the policies regarding psychiatric services, all regulations in Title 471 NAC apply, unless stated differently in this section.

**32-009.14 Limitations:** For psychiatric partial hospitalization services, the following limitations apply:

1. Care shall be provided by and directly supervised by a licensed physician whose specialty is psychiatry and is licensed in the state where the service is delivered.
2. All psychiatric partial hospital services shall receive prior authorization from the Department.
3. Payment for psychiatric partial hospital services is made according to 471 NAC 10-010.03D.

**32-009.15 Documentation:** Additional documentation from the client's medical record may be requested by the Medicaid's psychiatric consultants prior to considering authorization of payment of psychiatric partial hospital services.



**32-010 Inpatient Mental Health and Substance Abuse Services:** Inpatient services are medically necessary services provided to an inpatient as defined in 471 NAC 10-001.02. Inpatient hospital mental health and substance abuse services in a psychiatric hospital or unit or substance abuse treatment unit are available to clients under the age of 21 when the client's condition meets requirements and the treatment is medically necessary.

Providers of inpatient hospital psychiatric services shall meet the requirements of 471 NAC 32-001.01A Family of Origins Component.

The care and treatment of an inpatient with a primary psychiatric or substance abuse diagnosis shall be under the direction of a licensed physician, preferably a physician whose specialty is psychiatry who meets the state's licensing criteria and is enrolled as a provider with Medicaid with a primary specialty in psychiatry.

Inpatient hospital services shall receive prior authorization by Medicaid or Medicaid's designee. In addition, out-of-state hospitalizations shall also be approved by the Department or its designee.

Inpatient services in a psychiatric hospital or unit or substance abuse treatment unit shall be family centered, community based, culturally competent, and developmentally appropriate.

Services for wards of the Department shall receive prior authorization from the Department and consent for treatment shall be obtained from the ward's case manager or the case manager's supervisor.

**32-010.01 Provider Participation and Enrollment:** Hospitals providing mental health and substance abuse services shall meet the Standards of Participation identified in 471 NAC 32-001.04A2.

**32-010.02 Standards for Participation for Hospitals Providing Inpatient Mental Health and Substance Abuse Service:** The standards for participation of hospitals providing acute inpatient mental health and substance abuse services are referred to standards of participation identified in 471 NAC 32-001.04B.

**32-010.03 Staffing Standards for Participation:** A hospital providing psychiatric and substance abuse services is referred to 471 NAC 32-001.04B. The hospital shall have staff adequate in number and qualified to carry out an active program of evaluation and treatment for individuals who need psychiatric stabilization, treatment, and recovery services in a hospital licensed to provide psychiatric services

The hospital shall meet the following standards:

**32-010.03A Hospital Personnel:** Hospitals which provide inpatient psychiatric or substance abuse services shall be staffed with enough qualified professional, technical, and supporting personnel, and consultants to carry out an intensive and comprehensive active treatment program that includes evaluation of individual and family needs in relation to the client's mental health or substance abuse condition, establishment of individual and family treatment goals and implementation, directly or by arrangement, of a broad-range therapeutic program including, at least, professional medical, surgical, nursing, social work, psychological, and activity therapies required to carry out an individual treatment plan for each patient and their family regarding the client's treatment needs. Family participation in treatment does not create Medicaid eligibility for family members. The following standards shall be met:

Qualified professional and technical personnel shall be available to evaluate each patient at the time of admission, including diagnosis of any intercurrent disease. Services necessary for the evaluation include:

1. Psychiatric diagnostic evaluation by a licensed physician whose specialty is psychiatry and enrolled with Medicaid as a provider of mental health services.
2. Biopsychosocial Assessment, including a family assessment by the multidisciplinary team of practitioners
3. A nursing assessment by a licensed registered nurse
4. A substance abuse assessment when appropriate
5. A physical examination including a complete neurological exam
6. Laboratory radiological and other diagnostic tests as necessary

The number of qualified professional personnel, including consultants and technical and supporting personnel, shall be adequate to ensure representation of the disciplines necessary to establish short-range and long-term goals and to plan, carry out, and periodically revise a treatment plan for each client based on scientific interpretation of:

1. The degree of physical disability and indicated remedial or restorative measures (e.g., nutrition, nursing, physical medicine, and pharmacological therapeutic interventions). The degree of psychological impairment and appropriate measures to be taken to relieve treatable distress and to compensate for nonreversible impairments where found.
2. Appropriate nursing measures and nursing interventions.
3. The capacity for social interaction, and appropriate nursing measures and milieu therapy to be undertaken (e.g., group living experiences, occupational and recreational therapy, and other prescribed activities) to maintain or increase the individual's capacity to manage activities of daily living.
4. The environmental and physical limitations required to protect the client's health and safety with a plan to compensate for these deficiencies and to develop the client's potential for return to his/her own home, a foster home, a skilled nursing facility, a community mental health center, or other alternatives to full-time hospitalization.

**32-010.03B Director of Inpatient Services and Medical Staff:** Inpatient mental health services shall be under the supervision of a clinical director, service chief, or the equivalent who is qualified to provide the leadership required for an intensive treatment program.

The number and qualifications of licensed physicians whose specialty is psychiatry shall be adequate to provide essential mental health services.

The following standards shall be met:

1. The clinical director shall be a licensed physician with a specialty in psychiatry, and enrolled with Medicaid as a provider of mental health services. The clinical director, service chief, or equivalent shall meet the training and experience requirements for examination by the American Board of Psychiatry and Neurology or the American Osteopathic Board of Neurology and Psychiatry
2. The medical staff shall be qualified legally, professionally, and ethically for the positions to which they are appointed
3. The number of physicians shall be commensurate with the size and scope of the treatment program
4. The physician's personal involvement in all aspects of the client's care shall be documented in the client's medical record (e.g., physician's orders, progress notes, nurses notes)
5. The clinical director shall be available, in person or by telephone, to provide assistance and direction as needed.

**32-010.03C Licensed Advanced Practice Registered Nurses (APRNs):** Licensed APRNs may provide medical care and treatment in an inpatient psychiatric hospital setting when:

1. The licensed APRN is practicing within his/her scope of practice.
2. The APRN has an integrated practice agreement with the attending physician whose specialty is psychiatry of the client.
3. The APRN and physician whose specialty is psychiatry have identified roles and responsibilities in their professional relationship (the relationship shall be defined at the time of enrollment with the Medicaid Program).
4. The APRN provides medically necessary services that are not a duplication of those required by and provided by the attending physician whose specialty is psychiatry.
5. The APRN is an enrolled Medicaid provider.

**32-010.03D Availability of Physicians and Other Personnel:** Licensed physicians and other appropriate professional personnel shall be available at all times to provide necessary medical, surgical, diagnostic, and treatment services, including specialized services. If medical, surgical, diagnostic, and treatment services are not available within the hospital qualified consultants or attending physicians shall be immediately available, or a satisfactory arrangement shall be established for transferring patients to a general hospital enrolled as Medicaid providers.

**32-010.03E Nursing Services:** Nursing services shall administered be under the direct supervision of a licensed registered nurse who is qualified by education and experience for the position.

The number of licensed registered nurses, licensed practical nurses, and other nursing personnel shall be adequate to formulate and carry out the nursing components of a treatment plan for each client.

The following standards shall be met:

1. The licensed registered nurse supervising the nursing program shall have a master's degree in psychiatric or mental health nursing or its equivalent from a school of nursing accredited by the National League for Nursing, or shall be qualified by education or experience in the care of the mentally ill or substance abusers, and have demonstrated competence to:
  2. Complete a comprehensive nursing assessment
  3. Participate in interdisciplinary formulation of treatment plans
  4. Give skilled nursing care and therapy and
  5. Direct, supervise, and train others who assist in implementing and carrying out the nursing components of each client's treatment plan

The staffing pattern shall ensure the availability of a licensed registered nurse 24 hours each day for:

1. Direct care as identified on the client's active treatment plan
2. Supervising care performed by other nursing personnel
3. Assigning nursing care activities not requiring the services of a professional nurse to other nursing service personnel according to the client's needs and competence in appropriation of the nursing staff available

The number of licensed registered nurses, including nurse consultants, shall be adequate to formulate a nursing care plan in writing for each client and to ensure that the plan is carried out.

Licensed registered nurses and other nursing personnel shall be prepared by continuing in-service and staff development programs for active participation in interdisciplinary meetings affecting the planning or implementation of nursing care plans for patients. The meetings include diagnostic conferences, treatment planning sessions, and meetings held to consider alternative facilities and community resources.

**32-010.03F Psychological Services:** The psychological services shall be under the supervision of a licensed psychologist. The psychology staff, including consultants, shall be adequate in numbers and be qualified to plan and carry out assigned responsibilities.

The following standards shall be met:

1. The psychology department or service shall be provided by or under the supervision of a licensed psychologist who is contracted by or enrolled by the hospital
2. Psychologists, consultants, and supporting personnel shall be adequate in number and be qualified to assist in essential diagnostic formulations, and to participate in:

- a. Program development and evaluation of program effectiveness.
- b. Training and program evaluation activities.
- c. Therapeutic interventions (e.g., milieu, individual, family, and group psychotherapy).
- d. Interdisciplinary conferences and meetings held to establish diagnoses, goals, and treatment programs.

3. Psychotherapy shall be ordered and directed by a psychiatrist/physician.

**32-010.03G Social Work Services and Staff:** Social work services shall be under the supervision of a qualified social worker. The social work staff shall be adequate in numbers and be qualified to fulfill responsibilities related to the specific needs of individual clients and their families, the development of community resources, and consultation with other staff and community agencies.

The following standards shall be met:

1. The director of the social work department or service shall have a master's degree from an accredited school of social work, shall meet the experience requirements for certification by the Academy of Certified Social Workers, and shall be appropriately licensed or certified by the Department's Division of Public Health, Licensing Unit
2. Social work staff, including other social workers, consultants, and other assistants or case aides shall have adequate numbers and qualifications to:
  - a. Conduct preadmission evaluations.
  - b. Provide psychosocial data for diagnosis and treatment planning, and for direct therapeutic services to patients, patient groups, or families to develop community resources, including family or foster care programs to conduct appropriate social work program evaluation and training activities and to participate in interdisciplinary conferences and meetings concerning diagnostic formulation and treatment planning, including identification and utilization of other facilities and alternative forms of care and treatment.
3. Social work staff shall participate in discharge planning and implementation. Social work staff shall connect with community support to arrange follow-up care and assist the client with the specific goals of the discharge plan.

**32-010.03H Qualified Therapists, Certified Drug/Alcohol Counselors, Consultants, Volunteers, Assistants, and Aides:** Qualified therapists, consultants, volunteers, assistants, or aides shall have sufficient numbers and qualifications to provide comprehensive therapeutic activities (e.g. occupational, recreational, and physical therapy) as needed, to ensure that appropriate treatment is provided to each client, and to establish and maintain a therapeutic milieu.

The following standards shall be met:

1. Substance Abuse Counseling Services shall be provided by licensed drug/alcohol abuse counselors.
2. At a minimum, the program should have available licensed mental health practitioners to provide twice weekly individual psychotherapy, daily group therapy and weekly family psychotherapy services.
3. Occupational therapy services shall be provided under the supervision of a licensed occupational therapist who is a graduate of an occupational therapy program approved by the Council on Education of the American Medical Association. In the absence of a full-time, fully-qualified occupational therapist a licensed occupational therapy assistant may function as the director of the activities program with consultation from a fully-qualified licensed occupational therapist.
4. When physical therapy is offered, the services shall be provided by or under the supervision of a licensed physical therapist who is a graduate of a physical therapy program approved by the Council on Medical Education of the American Medical Association in collaboration with the American Physical Therapy Association or its equivalent.
5. In the absence of a full-time, fully-qualified physical therapist, physical therapy services shall be available by arrangement with a certified local hospital, or by consultation or part-time services furnished by a fully-qualified licensed physical therapist.
6. Recreational or activity therapy services shall be available under the direct supervision of a member of the staff who has demonstrated competence in therapeutic recreation programs.
7. Other occupational therapy, recreational therapy, activity therapy, and physical therapy assistants or aides shall be directly responsible to qualified supervisors and shall be provided special on-the-job training to fulfill assigned functions
8. The total number of rehabilitation personnel, including consultants, shall be sufficient to:
  - a. Permit adequate representation and participation in interdisciplinary conferences and meetings affecting the planning and implementation of activity and rehabilitation programs, including diagnostic conferences.
  - b. Maintain all daily scheduled and prescribed activities, including maintenance of appropriate progress records for individual clients.
  - c. Volunteer service workers shall be:
  - d. Under the direction of a paid professional supervisor of volunteers.
  - e. Provided appropriate orientation and training.
  - f. Available daily in sufficient numbers to assist clients and their families in support of therapeutic activities.

**32-010.04 Coverage Criteria for Inpatient Psychiatric Hospital Services:** The Nebraska Medical Assistance Program covers inpatient mental health services for clients under the age of 21 when the services meet the criteria in 471 NAC 32-001 and these additional criteria:

1. Before admission to the inpatient psychiatric hospital or prior to authorization for payment, the attending physician or staff physician shall make a personal face-to-face medical evaluation of each client's need for care in the hospital. The attending physician shall complete a psychiatric evaluation and diagnostic formulization
2. The client shall be treated personally and face-to-face by the physician or by an APRN under the established practice agreement with the physician whose specialty is psychiatry six out of seven days, and the interaction shall be documented in the client's medical record
3. The physician, preferably a physician with a specialty in psychiatry provides certification of need for acute inpatient hospital services within the first 24 hours of care. Recertification of the client's need for continued inpatient treatment shall be completed by the psychiatrist or by an advanced practice registered nurse
4. A physician with a specialty in psychiatry defines the medical necessity and active treatment requirements for the stay
5. The treatment plan shall be developed and supervised by a multidisciplinary team under the direction and supervision of the psychiatrist. The plan shall be implemented upon admission and shall be reviewed daily or more often if medically necessary by the multidisciplinary team. The treatment plan shall meet the medical necessity and active treatment requirements in 471 NAC 32-001
6. Therapeutic passes for clients with primary psychiatric or substance abuse diagnoses from hospitals which provide inpatient services. Therapeutic passes are an essential part of the treatment of some clients. Documentation of the client's continued need for acute inpatient care shall follow the overnight therapeutic passes. The hospital is not reimbursed for therapeutic passes or leave days.
7. The hospital is not reimbursed for unplanned leave of absence days from an inpatient hospital. If a client returns to the hospital after an unplanned leave of absence, the hospital shall contact the appropriate agency to obtain prior authorization for the admission.

**32-010.05 Professional and Technical Components for Hospital Diagnostic and Therapeutic Services:** Regulations regarding professional and technical components for diagnostic and therapeutic hospital services, the elimination of combined billing, and non-physician services and items provided to the client are found in 471 NAC 10-003.05D, 471 NAC 10-003.05E and 471 NAC 10-003.05F.

**32-010.06 Educational Services:** Educational services, when required by law, shall be available, though are not necessarily provided by the hospital. Educational services shall be only one aspect of the treatment plan, not the primary reason for admission or treatment.

Educational services are not reimbursed through Medicaid.

**32-010.07 Coverage Criteria:** Medicaid covers inpatient hospital psychiatric services when one or more of the following problems are present:

1. The client needs a specific form of acute mental health or substance abuse treatment that can only be provided in the hospital (and the structured, restrictive environment of the hospital is necessary for the client's treatment and recovery)
2. Specific observations are needed for evaluation and disposition
3. Specific observations are needed for following treatment, or control of behavior is necessary for effective somatic therapy or psychotherapy
4. The client's current condition is a serious threat to his/her adaptation to life and continuing developmental process, and hospitalization at this time is necessary to control this factor
5. The client is experiencing mental health and/or substance abuse symptoms, the magnitude of which is not tolerable to self or society and that cannot be alleviated through treatment at a less intensive level of care
6. The client has a clear history of excessive use of alcohol and/or other mood altering substances that cannot be treated at a less intensive level of care
7. The client is unable to be cared for by self or others, due to a diagnosable major mental health or substance abuse disorder
8. The client requires and receives "active treatment" as defined in 471 NAC 32-001.08
9. Ambulatory care services in the community do not meet the treatment needs of the client

**32-010.08 Guidelines for Interpretation:** Admission of a client to an acute care facility or an acute level of care may be made only after all resources at a less restrictive level have been explored and deemed inappropriate.

The following are not accepted as adequate medical indicators for hospital inpatient admission:

1. Non-availability of foster home, group home, halfway house, residential treatment or other placement alternatives.
2. Admission to support or arrange placement in foster home, group home, halfway house, or residential treatment.
3. Admission solely for emergency placement or protective custody.
4. Admission due to failure of current placement.



5. Admission due to lack of caregiver's parenting skills.
6. Reason for acute level of care is to obtain Medicaid benefits that would otherwise not be reimbursed.
7. Admission to avoid placement in the criminal justice system.
8. Admission for conduct disorders or behavioral issues that do not demonstrate an imminent danger to self or others.
9. Truancy.
10. Admission to support the need for alternative educational needs or for school phobia.
11. Social and family problems, including placement for runaways.
12. Psychometric evaluation including mental retardation and learning disabilities.

**32-010.09 Prior Authorization for Services:** Admissions shall receive prior authorization by the Department or its designee.

**32-010.10 Documentation in the Client's Medical Record:** Providers of acute inpatient psychiatric and substance abuse services are referred to 471 NAC 32-001.08B for requirements regarding medical records.

**32-010.11 Certification and Recertification by Psychiatrists/Physicians for Inpatient Hospital Services:** For clients admitted to a hospital, a licensed physician's certification by written order for admission is required at the time of admission for inpatient services. All admissions for clients shall receive prior authorization by the Department-contracted review organization.

Medicaid pays for covered inpatient hospital services only if a licensed physician with a specialty in psychiatry initially certifies the medical necessity for the services of the hospital inpatient stay.

Recertification may be provided by a licensed physician whose specialty is psychiatry or a licensed APRN who has a practice agreement with the physician whose specialty is psychiatry and recertification occurs at designated intervals during the hospital stay. Appropriate supporting material may be required.

The certification or recertification statement shall document the medical necessity for the admission to and continued hospitalization for inpatient mental health or substance abuse treatment, based on a current evaluation of the client's condition.

For wards of the Department's Children and Family Services, the facility shall provide documentation to the ward's case manager upon request. Failure to do so could result in nonpayment of services.

**32-010.12 Failure to Certify or Recertify:** If a hospital fails to obtain the required certification and recertification statements in an individual case, Medicaid shall not make payment for the care and treatment of the client.

**32-010.13 Hospital Utilization Review (UR):** A site visit by Medicaid staff or their designee for purposes of utilization review may be periodically required for further clarification of treatment services. See 471 NAC 1-012 ff.

**32-010.14 Payment for Inpatient Hospital Mental Health or Substance Abuse Services:** See 471 NAC 10-010.03D.

**32-010.15 Billing:** Providers shall submit claims for inpatient hospital services on Form CMS-1450 or the standard electronic Health Care Claim: Institutional transaction (ASC X12N 837).

**32-010.16 Other Regulations:** In addition to the regulations regarding mental health and substance abuse services, all regulations in the Nebraska Medicaid regulations apply, unless stated differently in this section.

**32-010.17 Limitations:** For inpatient mental health and substance abuse services, the following limitations apply:

1. Care shall be provided and supervised by a licensed physician for mental health and for substance abuse conditions.
2. All inpatient hospital services shall receive prior authorization by the Department-contracted peer review organization or management designee.

**32-010.18 Form Completion:** Inpatient mental health and substance abuse service providers shall:

Complete Form MC-19 (Medical Assistance Provider Agreement) and be approved and enrolled with the Department as a provider of inpatient hospital services (class or care 06). Submit all claims for inpatient hospital services an appropriately completed Form CMS-1450 or the standard electronic Health Care Claim: Institutional transaction (ASC X12N 837). Enter an authorization number developed by the Department's management designee. The authorization number is entered on the claim form.

Payment for approved services is made to the hospital.

**32-010.19 Exceptions:** Additional documentation from the client's medical record may be requested by Medicaid or its designee prior to considering authorization of payment.