

NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES  
NOTICE OF PUBLIC HEARING

August 15, 2019  
1:00 PM. Central Time  
Gold's Building – Room 534  
1033 O Street, Lincoln, Nebraska

The purpose of this hearing is to receive comments on the adoption of amendments to and repeal of the following regulations:

The following regulation is proposed for AMENDMENT:

Title 471 NAC 20 – *Adult Psychiatric, Substance Use Disorder, and Medicaid Rehabilitation Option (MRO)*.

The proposed changes will streamline the regulations, conform to current policy and remove duplicative language from the regulations, and combine current Chapters 20 and 35 into one chapter of regulation. The proposed amendment to combine the chapters does not change the scope of work.

The following regulation is proposed for REPEAL in its entirety. The relevant and needed portions of the current Chapter 35 are being included in the proposed amendments to Chapter 20.

Title 471 NAC 35 – *Rehabilitative Psychiatric Services*.

Authority for these regulations is found in Neb. Rev. Stat. § 81-3117(7).

Interested persons may attend the hearing and provide verbal or written comments or mail, fax or email written comments, no later than the day of the hearing to: DHHS Legal Services, PO Box 95026, Lincoln, NE 68509-5026, (402) 742-2382 or [dhhs.regulations@nebraska.gov](mailto:dhhs.regulations@nebraska.gov), respectively.

A copy of the proposed changes is available online at <http://www.sos.ne.gov>, or by contacting DHHS at the mailing address or email above, or by phone at (402) 471-8417. The fiscal impact statement for these proposed changes may be obtained at the office of the Secretary of State, Regulations Division, 1201 N Street, Suite 120, Lincoln, NE 68508, or by calling (402) 471-2385.

Auxiliary aids or reasonable accommodations needed to participate in a hearing can be requested by calling (402) 471-8417. Individuals with hearing impairments may call DHHS at (402) 471-9570 (voice and TDD) or the Nebraska Relay System at 711 or (800) 833-7352 TDD at least 2 weeks prior to the hearing.

## FISCAL IMPACT STATEMENT

Agency: <b>Department of Health and Human Services</b>	
Title:471	Prepared by:Alex Zimmer
Chapter:20	Date prepared:6.4.19
Subject:Adult Psychiatric, Substance Use Disorder and Medicaid Rehabilitative Option	Telephone:402.471.9752

Type of Fiscal Impact:

	State Agency	Political Sub.	Regulated Public
No Fiscal Impact	( <input checked="" type="checkbox"/> )	( <input checked="" type="checkbox"/> )	( <input checked="" type="checkbox"/> )
Increased Costs	( <input type="checkbox"/> )	( <input type="checkbox"/> )	( <input type="checkbox"/> )
Decreased Costs	( <input type="checkbox"/> )	( <input type="checkbox"/> )	( <input type="checkbox"/> )
Increased Revenue	( <input type="checkbox"/> )	( <input type="checkbox"/> )	( <input type="checkbox"/> )
Decreased Revenue	( <input type="checkbox"/> )	( <input type="checkbox"/> )	( <input type="checkbox"/> )
Indeterminable	( <input type="checkbox"/> )	( <input type="checkbox"/> )	( <input type="checkbox"/> )

Provide an Estimated Cost & Description of Impact:

State Agency:

Political Subdivision:

Regulated Public:

If indeterminable, explain why:

## FISCAL IMPACT STATEMENT

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No Fiscal Impact	( <input checked="" type="checkbox"/> )	( <input checked="" type="checkbox"/> )	( <input checked="" type="checkbox"/> )
Increased Costs	( <input type="checkbox"/> )	( <input type="checkbox"/> )	( <input type="checkbox"/> )
Decreased Costs	( <input type="checkbox"/> )	( <input type="checkbox"/> )	( <input type="checkbox"/> )
Increased Revenue	( <input type="checkbox"/> )	( <input type="checkbox"/> )	( <input type="checkbox"/> )
Decreased Revenue	( <input type="checkbox"/> )	( <input type="checkbox"/> )	( <input type="checkbox"/> )
Indeterminable	( <input type="checkbox"/> )	( <input type="checkbox"/> )	( <input type="checkbox"/> )

Provide an Estimated Cost & Description of Impact:

State Agency:

Political Subdivision:

Regulated Public:

If indeterminable, explain why:

TITLE 471            NEBRASKA MEDICAL ASSISTANCE PROGRAM SERVICES

CHAPTER 20        ADULT PSYCHIATRIC, SUBSTANCE USE DISORDER, AND MEDICAID  
REHABILITATION OPTION (MRO)

001. SCOPE AND AUTHORITY. The regulations govern the services provided under Nebraska's Medicaid program as defined by Nebraska Revised Statute (Neb. Rev. Stat.) §§ 68-901 et seq.

002. DEFINITIONS. For the purpose of these rules and regulations, the following definitions apply:

002.01 ACUTE INPATIENT PSYCHIATRIC SERVICES. Acute inpatient psychiatric services provide medically necessary, intensive assessment, psychiatric treatment and support to individuals with a diagnosis listed in the Diagnostic Statistical Manual-5 (DSM-5) or co-occurring disorder experiencing an acute exacerbation of a psychiatric condition. The acute inpatient setting is equipped to serve patients at high risk of harm to self or others and in need of a safe, secure, lockable setting. The purpose of services provided within an acute inpatient setting is to stabilize the individual's acute psychiatric conditions.

002.02 ANNUAL SUPERVISION. Annual supervision is the critical oversight of mental health or substance use disorder services provided by a practitioner who requires supervision.

002.03 ASSERTIVE COMMUNITY TREATMENT (ACT). Assertive Community Treatment is a evidence based Medicaid rehabilitative option (MRO) service that provides an intensive multidisciplinary team based community based approach for the treatment of severe and persistent mental illness.

002.04 COMMUNITY SUPPORT. Community support is a Medicaid rehabilitative option (MRO) service that focuses on reducing disability resulting from severe and persistent mental illness, building supports and restoring functional skills.

002.05 CO-OCURRING DISORDERS. The presence of a mental health and a substance use disorder diagnosis.

002.06 CRISIS OUTPATIENT. Crisis outpatient individual or family therapy is an immediate, short-term treatment service provided to an individual with urgent psychotherapy needs.

002.07 CULTURAL COMPETENCE. An ongoing process by which individuals and systems respond respectfully and effectively to people of all cultures, languages, classes, races, sexes, ethnic backgrounds, religions, sexual orientations, abilities and other diversity factors in a manner that recognizes, affirms and values the worth of individuals, families and communities and protects and preserves the dignity of each, including awareness, acceptance and respect of differences and continuing self-assessment regarding culture.

002.08 DAY REHABILITATION. Day rehabilitation is a community based Medicaid rehabilitative option (MRO) service targeting functional disability and risk factors resulting from a severe and persistent mental illness, and is designed to provide individualized treatment and recovery, inclusive of psychiatric rehabilitation and support.

002.09 DAY TREATMENT. Day treatment is part of a continuum of care designed to prevent hospitalization or to facilitate the movement of the individual in an acute psychiatric or substance use disorder setting to a status in which the individual is capable of functioning within the community with less frequent contact with the psychiatric or substance use disorder health care provider.

002.10 ELECTROCONVULSIVE THERAPY (ECT). Electroconvulsive Therapy (ECT) is a treatment where a medically controlled electric current is applied to either or both sides of the brain for the purpose of producing a seizure that is modulated by anesthesia and muscle relaxants in order to provide relief from severe, acute, and debilitating symptoms of a mental illness.

002.11 EVIDENCE BASED PRACTICES. The use of current best evidence in making decisions about the care of the individual patient, including integrating individual clinical expertise and client values with the best available external clinical evidence from systematic research.

002.12 FAMILY ASSESSMENT. Family assessment is the gathering and organizing of information that involves exploration of family structure and composition as well as member relationships, characteristics, interactions and dynamics. The family assessment looks at internal and external factors that affect the family, identifies family strengths and needs, and recommends objectives to be addressed by the treatment plan.

002.13 FAMILY THERAPY. A face-to-face treatment session in which an identified individual and the individual's nuclear or extended family interact with a practitioner for the purpose of improving the functioning of the family system and decrease or eliminate the mental health or substance abuse symptoms experienced by the family. Family therapy without the individual present is allowable when the therapy is clearly focused on the treatment related to the individual. Family therapy without the identified individual is not appropriate for treating other family members regarding their individual issues or for couples counseling.

002.14 FUNCTIONAL BEHAVIOR ASSESSMENT (FBA). A Functional Behavioral Assessment (FBA) refers to a range of strategies used in the process of determining causes for significant behavioral disruption and how the behavior relates to the environment.

002.15 GROUP THERAPY. A face-to-face treatment session between an individual and a licensed practitioner in the context of a group setting of at least three and no more than 12 individuals with a focus on a common mental health or substance use disorder issue or need.

002.16 INDIVIDUAL THERAPY. A face-to-face active treatment session between an individual and an appropriately licensed practitioner for the purpose of improving the mental health or substance abuse symptoms that are significantly impairing the individual's functioning in at least one life domain such as family, social, occupational or educational. Services must be treatment focused and not rehabilitative or habilitative in nature.

002.17 INITIAL DIAGNOSTIC INTERVIEW: An assessment that determines the presence or absence of a mental health disorder, identifies an individual's problems and needs, develops goals and objectives, determines appropriate strategies and methods of intervention and includes a history, mental status and a disposition.

002.18 INTENSIVE OUT PATIENT (IOP). Intensive outpatient (IOP) services are non-residential, intensive, structured interventions consisting of counseling and education to improve the mental health or substance use disorder and related behaviors that may significantly interfere with functioning in at least one life domain.

002.19 INTERDISCIPLINARY TEAM (IDT). A team composed of members from different healthcare professions with specialized skills and expertise who collaborate to make treatment recommendations that facilitate quality patient care.

002.20 MEDICATION MANAGEMENT. Medication management is a service provided by licensed practitioners whose scope of practice includes the monitoring and prescribing of psychopharmacologic agents.

002.21 MEDICALLY NECESSARY NURSING SERVICES. Medical services directed by a registered Nurse (RN) or advanced practice registered nurse (APRN) who evaluates the particular medical nursing needs of each individual and provides the medical care and treatment indicated on the treatment plan, which is approved by the supervising practitioner.

002.22 MEDICAL NECESSITY. Medical necessity is established when the mental health or substance use treatment services are necessary to diagnose, treat, cure or prevent regression of significant functional impairments resulting from symptoms of a mental health or substance use disorder diagnosis.

002.23 MEDICAID REHABILITATIVE OPTION (MRO). A category of rehabilitative services for individuals experiencing severe and persistent mental illness.

002.24 OBSERVATION ROOM. Emergency psychiatric observation is a secure, medically supervised service provided in a hospital setting for evaluation and stabilization of acute psychiatric or substance use disorder symptoms.

002.25 PEER SUPPORT. Peer support is an evidence based practice that helps people recover from mental illness or substance use disorder with the assistance of someone who has similar lived experience. Peer support is recovery oriented and client driven. Services

are supportive interventions designed to assist the individual to initiate and maintain the process of long-term recovery and resiliency to improve health and wellness outcomes for individuals diagnosed with a mental health or substance use disorder.

002.26 PSYCHOLOGICAL TESTING AND EVALUATION. Psychological testing and evaluation is the administration and interpretation of standardized tests used to assess an individual's psychological and cognitive functioning. Psychological testing must be standardized, valid and reliable.

002.27 PSYCHIATRIC RESIDENTIAL REHABILITATION. Psychiatric residential rehabilitation is a Medicaid Rehabilitative Option (MRO) service that provides individualized treatment and recovery inclusive of psychiatric rehabilitation and support for individuals with a severe and persistent mental illness in a residential setting.

002.28 SECURE PSYCHIATRIC RESIDENTIAL REHABILITATION. Secure psychiatric residential rehabilitation is a Medicaid Rehabilitative Option (MRO) service that provides individualized treatment and recovery for individuals demonstrating a high-risk for harm to self or others who are in ended of a secure environment inclusive of psychiatric rehabilitation and support for individuals with a severe and persistent mental illness in a residential setting.

002.29 SEVERE AND PERSISTENT MENTAL ILLNESS. A group of severe mental health disorders resulting in serious functional impairments which substantially interfere with, or limits one or more life activities.

002.30 SUBACUTE INPATIENT PSYCHIATRIC SERVICES. Hospital based services to provide stabilization, engage the individual in comprehensive treatment, rehabilitation and recovery activities, and transition them to the least restrictive setting as rapidly and safely as possible.

002.31 SUBSTANCE USE DISORDER. Substance-use disorders are patterns of symptoms that are diagnosable and treatable resulting from the use of a substance that one continues to take, despite experiencing problems as a result.

002.32 SUBSTANCE USE DISORDER (SUD) ASSESSMENT. An evaluation through utilization of validated tools to guide the process of the assessment in determining if a substance use disorder exists and if so, what appropriate level of intervention is recommended. This assessment must include screening for co-occurring disorder and referrals to a licensed clinician capable of diagnosing and treating co-occurring mental health and providing substance user disorder services.

002.33 SUBSTANCE USE DISORDER (SUD) DUAL DISORDER RESIDENTIAL. Dual disorder residential services provides highly structured, integrated treatment to individuals with a primary Substance Use Disorder (SUD) and a co-occurring psychiatric disorder in a restrictive treatment environment in order to stabilize acute symptoms and engage the individual in a program of maintenance, treatment, rehabilitation and recovery.

002.34 SUBSTANCE USE DISORDER (SUD) HALFWAY HOUSE. Halfway house is a community based twenty four hour structured supportive living, treatment and recovery facility

for adults transitioning from a more intensive level of care and reintegrating back to the community.

002.35 SUBSTANCE USE DISORDER (SUD) INTERMEDIATE RESIDENTIAL CO-OCCURRING. Intermediate residential is a facility based service for individuals diagnosed with a primary substance use disorder (SUD) who are in need of a more supportive environment to address the pervasiveness of dependence and its impact on the individual's life.

002.36 SUBSTANCE USE DISORDER (SUD) SOCIAL DETOXIFICATION. Social detoxification is an emergency intervention provided to individuals experiencing acute intoxication with a goal of physiologically restoring the individual when medical treatment is not necessary.

002.37 SUBSTANCE USE DISORDER (SUD) THERAPEUTIC COMMUNITY. Therapeutic community is a highly structured residential service that provides psychosocial skill building and therapeutic strategies to treat Substance Use Disorder (SUD).

002.38 THERAPEUTIC CRISIS INTERVENTION. Treatment crisis intervention is a facility based service for individuals in need of a structured setting designed to stabilize, provide safety, and restore an individual to a level of functioning requiring a less restrictive level of care.

002.39 THERAPEUTIC INJECTION. The injection of a drug for the purpose of treating a disease or medical condition.

002.40 TRAUMA INFORMED CARE. Involves understanding, recognizing, and responding to the effects of trauma while emphasizing physical, psychological and emotional safety for both individuals and providers, which helps survivors rebuild a sense of control and empowerment.

002.41 TREATMENT PLAN. A written, comprehensive plan of care to address mental health and substance use disorder symptoms identified in the Initial Diagnostic Interview or Substance Use Assessment. It is developed with input from the person served and identified caregivers when possible.

### 003. PROVIDER REQUIREMENTS.

003.01 GENERAL PROVIDER REQUIREMENTS. To participate in Medicaid, providers of adult's mental health, substance use disorder and Medicaid rehabilitation option (MRO) treatment services must comply with all applicable provider participation requirements codified in 471 NAC 2 and Chapter 3. In the event that provider participation requirements in 471 NAC 2 or Chapter 3 conflict with requirements outlined in this chapter, the individual provider participation requirements in this chapter govern.

003.02 SERVICE SPECIFIC PROVIDER REQUIREMENTS.



003.02(A) FAMILY COMPONENT. Providers must encourage family members to be involved in the assessment of the individual, the development of the treatment plan, and all aspects of the individual's treatment including therapy, transition and discharge planning, except when family member involvement is prohibited by the individual or applicable law. Providers must be available to schedule meetings and sessions in a flexible manner to reasonably accommodate a family's schedule, including weekends or evenings. Family involvement, or lack of family involvement, must be documented by the provider in the clinical record. For State wards of the Department, the Department must also be involved in all phases of treatment and discharge planning.

003.02(B) CULTURAL COMPETENCE. Providers must provide services that demonstrate cultural competence, are linguistically competent, and are competent in trauma informed care.

003.02(C) STAFFING STANDARDS FOR ADULT MENTAL HEALTH, SUBSTANCE USE DISORDER AND MEDICAID REHABILITATION OPTION (MRO) SERVICES. Services must be provided by licensed practitioners whose scope of practice includes mental health and substance use disorder:

- (1) Physician;
- (2) Physician assistant;
- (3) Advanced practice registered nurse (APRN);
- (4) Licensed psychologist;
- (5) Provisionally licensed psychologist;
- (6) Doctor of Philosophy (PhD) candidate: A student in a Doctor of Philosophy (PhD) program who has bypassed the master's degree but has completed at least 30 credit hours to satisfy a master's degree requirement and is actively enrolled in a Doctor of Philosophy (PhD) program;
- (7) Psychologist assistant: An individual with a master's degree in psychology who is able to score psychological testing under the supervision of a licensed psychologist;
- (8) Licensed independent mental health practitioner (LIMHP);
- (9) Licensed mental health practitioner (LMHP);
- (10) Provisionally licensed mental health practitioner (PLMHP);
- (11) Licensed alcohol and drug counselor (LADC);
- (12) Provisionally licensed alcohol and drug counselor (PLADC);
- (13) Certified peer support provider;
- (14) Community treatment aid;
- (15) Community support worker; and
- (16) Direct care staff.

003.02(C)(i) PRACTITIONERS REQUIRING SUPERVISION. Individuals in these categories may only practice under the supervision of a qualifying supervising practitioner:

- (1) Licensed mental health practitioner (LMHP);
- (2) Provisionally licensed mental health practitioner (PLMHP);
- (3) Registered nurse (RN);
- (4) Provisionally licensed psychologist;
- (5) Doctor of Philosophy (PhD) candidate;

- (6) Psychologist assistant;
- (7) Provisionally licensed alcohol drug counselor (PLADC);
- (8) Community support worker;
- (9) Certified peer support provider; and
- (10) Direct care staff.

003.02(D) SUPERVISING PRACTITIONER QUALIFICATIONS. A supervising practitioner must be:

- (1) A licensed physician;
- (2) A licensed psychologist;
- (3) A licensed independent mental health practitioner (LIMHP);and
- (4) Licensed alcohol and drug counselor (LADC) for substance use disorder.

003.02(D)(i) RESPONSIBILITIES OF SUPERVISING PRACTITIONER. A supervising practitioner must:

- (1) Be available, in person or remotely, to provide assistance and direction as needed during the time the services are being provided;
- (2) Approve and supervise recipient's assessment and treatment plan. This requires a face-to-face assessment;
- (3) Direct patient care by reviewing and approving individual specific treatment plans and progress notes within the timelines specified for each level of care, not to exceed 90 days; and
- (4) Ensure treatment provided meets best practice standards of care.

003.02(E) DIRECT CARE STAFF. Providers employing direct care staff must ensure the direct care staff are 20 years of age or older and meet at least one of the following requirements:

- (i) Actively pursuing education in human services; or
- (ii) Two years of education in the human services field or a combination of work experience and education with one year of work experience substituting for one year of education.

003.02(F) PROVIDER ENROLLMENT. See 471 NAC 2.

003.02(F)(i) MANAGED CARE ENROLLMENT. See 471 NAC 1.

003.02(G) CLINICAL RECORDS. Each provider must maintain a complete and legible clinical record for each individual that demonstrates medical necessity and provides detailed documentation of all treatment services rendered. The clinical record must contain documentation sufficient to justify reimbursement, and must be maintained in a manner that would allow a person not familiar with the individual to evaluate the course of treatment. Failure to have sufficient documentation to justify the level of reimbursement may result in denial or recoupment of payments made for services lacking sufficient documentation.

003.02(G)(i) Clinical records must include:

- (1) The supervising practitioner's orders;
- (2) The initial diagnostic interview (IDI);

- (3) Referrals made on behalf of the individual, including for any recommended medical care;
- (4) Progress notes;
- (5) Assessments;
- (6) Treatment plans; and
- (7) Discharge summary.

003.02(G)(ii) RECORD RETENTION. A provider must maintain clinical records in a secure location for a minimum of seven years after the date of service.

003.02(G)(iii) CONFIDENTIALITY OF RECORDS. A provider must ensure the confidentiality of all individual records, in accordance with applicable law.

003.02(H) QUALITY ASSURANCE AND UTILIZATION REVIEW. A provider must fully cooperate with any review conducted by Medicaid to determine the quality of care and services provided.

003.02(H)(i) Utilization Review (UR). Every 30 days, providers must conduct a utilization review (UR) which consists of:

- (1) Medical necessity of admissions and continued treatment;
- (2) Utilization of professional services provided;
- (3) Quality patient care provided; and
- (4) Effective and efficient utilization of available health facilities and service

003.02(I) STANDARDS FOR PARTICIPATION FOR SUBACUTE AND ACUTE INPATIENT HOSPITAL PSYCHIATRIC SERVICE PROVIDERS. A hospital that provides subacute or acute inpatient hospital psychiatric services must meet the following standards for participation:

- (i) Be maintained for the care and treatment of patients with primary psychiatric disorders;
- (ii) Be licensed or formally approved as a hospital by the Nebraska Department of Health and Human Services, Division of Public Health, or if the hospital is located in another state, the officially designated authority for standard-setting in that state;
- (iii) Meet the conditions of participation in Medicare for psychiatric hospitals;
- (iv) Have in effect a utilization review plan applicable to all Medicaid individuals;
- (v) Have clinical records that are sufficient to document medical necessity for the service and permit the Department to determine the degree and intensity of treatment furnished to the individual; and
- (vi) Be accredited by a nationally recognized accrediting body.

003.02(J) STANDARDS FOR PARTICIPATION FOR INTENSIVE OUTPATIENT (IOP).

003.02(J)(i) AGENCY STANDARDS. An agency must employ a clinical director to supervise staff and programming consistent with State licensure, accreditation, and regulations. The agency must identify an on-call system of licensed practitioners available for after hour's crisis management.

003.02(J)(ii) CLINICAL DIRECTOR. A staff member providing clinical direction must be a:

- (1) Licensed physician;
- (2) Advanced practice registered nurse (APRN);
- (3) Licensed psychologist;
- (4) Provisionally licensed psychologists;
- (5) Licensed independent mental health practitioner (LIMHP);
- (6) Licensed mental health practitioners (LMHP); or
- (7) Licensed alcohol and drug counselor (LADC) for substance use disorder services only.

003.02(J)(iii) THERAPIST. An Intensive Outpatient (IOP) therapist must be a licensed practitioner whose scope of practice includes mental health or substance use services.

003.02(K) STANDARDS FOR PARTICIPATION FOR PEER SUPPORT.

003.02(K)(i) CERTIFICATION STANDARDS All providers of peer support services must obtain state or national certification as a certified peer support specialist. The certification must be maintained by completing continuing education requirements as identified by the certifying organization.

003.02(K)(ii) CLINICAL SUPERVISION. The supervising practitioner assumes professional responsibility for the services provided by the certified peer support specialist. A supervisor is limited to supervision of up to six certified peer support specialist. The supervising practitioner must be a:

- (1) Psychiatrist;
- (2) Advanced practice registered nurse (APRN) or Nurse Practitioner (NP);
- (3) Licensed psychologists;
- (4) Provisionally licensed psychologist;
- (5) Licensed independent mental health practitioner (LIMHP);
- (6) Licensed mental health practitioner (LMHP);
- (7) Provisionally licensed mental health practitioner (PLMHP); or
- (8) Licensed alcohol and drug counselor (LADC) or a provisionally licensed alcohol and drug counselor (PLADC) for substance use disorder only.

003.02(K)(iii) PEER SUPPORT PROVIDERS. Certified peer support specialist must:

- (1) Be 19 years of age or older;
- (2) Have lived experience as an individual diagnosed with a mental health or substance use disorder;
- (3) Be able to demonstrate personal health, wellbeing, and resiliency by maintaining sobriety, refraining from illicit drug use, and not requiring an inpatient level of treatment within the last year;
- (4) Have a high school diploma or equivalent with a minimum of two years of experience working in the behavioral health field; and
- (5) Complete a state or national training program.

003.02(L) STANDARDS OF PARTICIPATION FOR ELECTROCONVULSIVE THERAPY (ETC).

003.02(L)(i) STAFFING STANDARD. Staff must include:

- (1) Psychiatrist;
- (2) Registered nurse (RN), advanced practice registered nurse (APRN), or nurse practitioner (NP); and
- (3) Anesthesiology, medical doctor or certified registered nurse anesthetist (CRNA) there for the procedure and recovery if indicated.

004. SERVICE REQUIREMENTS.

004.01 GENERAL REQUIREMENTS. Providers must provide care that is trauma informed, family-centered, community-based, culturally competent, and developmentally appropriate in the least restrictive setting possible based on the client's current needs. More restrictive levels of care are covered only when all other resources have been considered and deemed to be inappropriate.

004.01(A) ELIGIBILITY. To be eligible for mental health or substance use treatment services set forth in this chapter an individual must:

- (i) Have a diagnosis of a mental health or substance use disorder of sufficient duration and intensity to meet diagnostic criteria specified within the current version of the Diagnostic Statistical Manual-5 (DSM-5);
- (ii) Have a mental health or substance use disorder which results in functional impairment that substantially interferes with or limits the individual's role or functioning within their family, school or community. Coexisting conditions such as organic brain disorders, developmental disabilities, intellectual disability, autism spectrum disorders, or behavioral disorders must be carefully evaluated in order to identify the functional impairments resulting from the mental health or substance use disorder diagnosis and those resulting from the coexisting condition. In the evaluation of coexisting conditions, evidence of the conditions will not automatically result in denial of eligibility; and
- (iii) The services meet medical necessity criteria.

004.01(B) MEDICAL NECESSITY. Medicaid covers mental health, substance use disorder and Medicaid Rehabilitative Option (MRO) services when they are medically necessary and provide active treatment. Providers must ensure treatment services are:

- (i) Provided in the least restrictive level of care that is appropriate to meet the needs of the individual;
- (ii) Supported by evidence that the treatment improves symptoms and functioning for the individual's mental health or substance use disorder diagnosis;
- (iii) Reasonably expected to improve the individual's condition or prevent further regression so that the services will no longer be necessary; and
- (iv) Required for reasons other than primarily for the convenience of the individual or the provider.

004.01(C) ACTIVE TREATMENT. Providers must provide treatment in an interactive face-to-face environment with the individual present. The treatment must be focused on

reducing or controlling the individual's mental health and substance use disorder symptoms which cause functional impairments, and promoting the individual's movement to recovery and wellbeing as defined by the individual, including moving to less restrictive treatment. Treatment must be rendered in the most time efficient manner consistent with sound clinical practice. Providers must deliver active treatment that is:

- (i) Provided under a treatment plan developed by the interdisciplinary treatment team based on a thorough evaluation of the individual's restorative needs and potentialities. The treatment plan must be retained in the individual's clinical record; and
- (ii) Reasonably expected to improve the individual's medical condition or to determine a diagnosis. The treatment must, at a minimum, be designed to correct or ameliorate the individual's symptoms to facilitate the healthiest state of wellbeing possible for the individual.

004.01(D) COORDINATION OF CARE. If the individual receives services from more than one mental health and substance use provider, these providers must coordinate their services. Coordination of care includes relevant medical care.

004.01(E) SPECIAL TREATMENT PROCEDURES. If an individual requires behavior management and containment beyond unlocked time outs or redirection, special treatment procedures may be utilized as specified below. Mechanical restraints and pressure point tactics are not allowed. Facilities must meet the following standards regarding special treatment procedures:

- (i) De-escalation techniques must be taught to staff and used appropriately before the initiation of special treatment procedures;
- (ii) Special treatment procedures may be used only when an individual's behavior presents a danger to self or others, or to prevent serious disruption to the therapeutic environment;
- (iii) The individual's treatment plan must address the use of special treatment procedures and have a clear plan to decrease the behavior requiring the special treatment procedure; and
- (iv) Attempts to de-escalate, the special treatment procedure and subsequent processing, must be documented in the clinical record and reviewed by the supervising practitioner.

004.01(E)(i)(1) DAY TREATMENT. Day treatment providers are limited to physical restraint and locked time out.

004.01(F) EVIDENCED BASED PRACTICE. Providers must provide treatment in accordance with clinically sound or evidence based practices. Experimental or investigational services are not covered.

004.02 COVERED SERVICES. The following services are covered services to the extent that they are provided by an enrolled provider within the scope of practice to an eligible individual, are medically necessary, and meet the specific requirements set forth for each service.

004.02(A) ASSESSMENTS.

004.02(A)(i) INITIAL DIAGNOSTIC INTERVIEW (IDI). The provider completing the Initial Diagnostic Interview (IDI) must document information on the client's history, mental status, disposition, and identify the client's current functioning level and treatment needs. Gathering this information may be a result of ordering and interpretation of medical laboratory or diagnostic studies and communication with the family or other sources. The provider must complete the Initial Diagnostic Interview (IDI), which, functions as the initial treatment plan until the comprehensive treatment plan is developed as described in this chapter. An Initial Diagnostic Interview (IDI) is required prior to the provision of other services identified in this chapter, with the exception of services provided for substance use disorder only. Providers of inpatient hospitalization and crisis intervention services must conduct an Initial Diagnostic Interview (IDI) during the course of treatment if one had not been done prior to initiation of services.

004.02(A)(i)(1) COMPONENTS OF AN INITIAL DIAGNOSTIC INTERVIEW (IDI). The provider must include the following components in the initial diagnostic interview (IDI):

- (a) Psychiatric Evaluation with relevant individual information, mental status exam and diagnosis;
- (b) Treatment needs and recommended interventions for the individual and family;
- (c) Identification of who needs to be involved in the individual's treatment;
- (d) An overall plan to meet the treatment needs of the individual including transitioning to lower levels of care and discharge planning;
- (e) A means to evaluate the individual's progress throughout their treatment and outcome measures at discharge;
- (f) Recommended linkages with other community resources;
- (g) Other areas that may need further evaluation.

004.02(A)(i)(2) LICENSED PRACTITIONERS. Licensed practitioners who are able to diagnose and treat major mental illness within their scope of practice must complete the Initial Diagnostic Interview (IDI).

004.02(A)(ii) ANNUAL SUPERVISION. The supervising practitioner must conduct supervision annually. This includes the following activities:

- (1) A face to face assessment with the individual taking part in the mental health treatment, at least annually, and more often if medically necessary;
- (2) Record reviews of the treatment plan and progress notes;
- (3) Discussions with the therapist, including recommendations to assure the treatment meets medical necessity and standards of care; and
- (4) The supervising practitioner must be available in person or by telephone to provide assistance as needed during the time services are being provided.

004.02(A)(iii) FUNCTIONAL BEHAVIOR ASSESSMENT (FBA). An Initial Diagnostic Interview (IDI), as described in this chapter, must be completed prior to the Functional

Behavioral Assessment (FBA), and must identify the need for the Functional Behavioral Assessment (FBA).

004.02(A)(iii)(1) FUNCTIONAL BEHAVIOR ASSESSMENT PROVIDERS. The following providers, operating in their scope of practice may conduct this assessment:

- (a) Licensed or provisionally licensed psychologist with specific training and expertise in conducting Functional Behavioral Assessments (FBA);
- (b) Licensed independent mental health practitioner (LIMHP);or
- (c) Board certified behavior analyst, under the supervision of a Psychologist or a licensed independent mental health practitioner.

004.02(A)(iii)(2) COMPONENTS OF THE FUNCTIONAL BEHAVIOR ASSESSMENT (FBA). The functional behavior assessment (FBA) must include, but is not limited to, the following components:

- (a) Reason for the assessment or presenting issue;
- (b) Relevant bio-psychosocial and developmental information;
- (c) Relevant treatment history and response to treatment efforts;
- (d) Identification of the disruptive behavior;
- (e) Definition of the behavior;
- (f) Identification of the contextual factors that contribute to the disruptive behavior, including affective and cognitive factors;
- (g) Strengths and resources the individual and family have;
- (h) Explanation of data collection methodology;
- (i) Data and assessment summary to include:
  - (i) A description of problem behaviors;
  - (ii) Identification of antecedents, predictors, consequences, and re-enforcers that maintain the behavior; and
  - (iii) Clinical formulation regarding the general condition under which the disruptive behavior usually occurs and probable behavioral and social consequences that serve to maintain the disruptive behavior; and
- (j) Targeted behavior management plan including the targeted problematic behavior, positive and negative reinforcement findings, behavior replacement or modification interventions, plan monitoring, data collection, and review schedule.

004.02(A)(iii)(3) REVIEW AND UPDATE. A Functional Behavioral Assessment (FBA) licensed provider must review and update the Functional Behavioral Assessment (FBA) at least annually, or as needed when there has been a break in service or new behavioral disturbances have manifested that were not previously assessed.

004.02(A)(iv) FAMILY ASSESSMENT. Medicaid covers a family assessment at the initiation of services. A Medicaid reimbursable family assessment is not conducted solely to determine the parenting capacity of parents or identified caregivers. Providers must include the following information in the family assessment:

- (1) The presenting problem;
- (2) Family history of mental illness or substance use;



- (3) Family dynamics;
- (4) Social support history;
- (5) Strengths of the family; and
- (6) Safety and capacity for daily activities.

004.02(A)(v) SUBSTANCE USE DISORDER ASSESSMENT. A licensed clinician must complete the substance use disorder services assessment prior to an individual receiving substance use disorder services. If the licensed clinician reviews a prior substance use disorder services assessment and determines it to be clinically relevant it can serve as the substance use disorder services. Substance use disorder services assessment for treatment. The assessment report is comprised of the following components:

- (a) The substance use disorder services assessment, screening tools, and scores;
- (b) A screening for co-occurring disorders and referrals to a licensed clinician capable of diagnosing and treating co-occurring mental health and substance use disorder services; and
- (c) A comprehensive biopsychosocial assessment.

004.02(A)(v)(1) SUBSTANCE USE DISORDER ADDENDUM. Medicaid covers one substance use disorder services addendum per treatment episode. The licensed clinician completing the substance use disorder services addendum must include information that has not been addressed in the clinical notes and capture information that covers the period of time outside of treatment.

004.02(B) COVERED OUTPATIENT MENTAL HEALTH AND SUBSTANCE USE DISORDER TREATMENT SERVICES.

004.02(B)(i) CRISIS OUTPATIENT. Providers of crisis outpatient therapy must develop a short-term plan that identifies interventions and a safety plan to address the individual's current needs for this service. The provider must include in the treatment plan recommendations for ongoing treatment services, if services appear to be medically necessary following stabilization. If services are to continue, the provider must perform or arrange for an Initial Diagnostic Interview (IDI) and develop a treatment plan in accordance with this chapter if one has not already been completed.

004.02(B)(i)(1) COVERAGE LIMITATIONS. An individual is eligible to receive crisis outpatient services of no more than two sessions per episode of crisis.

004.02(B)(ii) PSYCHOLOGICAL TESTING AND EVALUATION. An Initial Diagnostic Interview (IDI) must be completed and recommend the need for psychological testing. Testing services must be administered and scored by a licensed psychologist; or under the supervision of a licensed psychologist, by a provisionally licensed psychologist, a licensed psychological assistant or a psychological intern. All interpretation must be done by the licensed psychologist.

004.02(B)(ii)(1) TESTING RESULTS. The provider must include the following information in their documentation of the psychological testing results:

- (a) Demographic information;

- (b) Dates of services;
- (c) The presenting problem;
- (d) Results of the testing;
- (e) Interpretation and explanation of the validity of the results; and
- (f) Diagnostic recommendations derived from the testing.

004.02(B)(iii) INDIVIDUAL PSYCHOTHERAPY. A face-to-face active treatment session between an individual and an appropriately licensed practitioner for the purpose of improving the mental health or substance abuse symptoms that are significantly impairing the individual's functioning in at least one life domain, including family, social, occupational or educational. Services must be treatment focused and not rehabilitative or habilitative in nature. The provider must complete assessments and develop a treatment plan to address mental health or emotional issues. The treatment plan must be reviewed every 90 days or more often if clinically indicated.

004.05(B)(iv) GROUP PSYCHOTHERAPY. Providers of group psychotherapy must provide active treatment for a primary psychiatric disorder in which identified treatment goals, frequency and duration of service are a part of the individual's active treatment plan as described in this chapter.

004.05(B)(v) FAMILY PSYCHOTHERAPY. Providers of family therapy must include family members residing in the same household as the individual when clinically appropriate. Others significant to the individual or the family may also be in attendance at family psychotherapy if their attendance will be meaningful in improving family functioning. Providers of family psychotherapy must provide active treatment for a primary psychiatric disorder in which identified treatment goals, frequency and duration of service are a part of the individual's active treatment plan.

004.05(B)(vi) FAMILY PSYCHOTHERAPY WITHOUT THE IDENTIFIED INDIVIDUAL PRESENT. This service is intended to be used when having the identified individual present is clinically contraindicated. The provider's progress notes must reflect the focus on the session and the relevance to not having the identified individual present. Family therapy without the identified individual is not appropriate for treating other family members regarding their individual issues or for couples therapy.

004.05(B)(vii) INTENSIVE OUTPATIENT (IOP). Providers of Intensive Outpatient (IOP) must:

- (a) Provide nine or more hours per week of skilled treatment, with at least three hours of availability per day. The hours and days of treatment are to be reduced as clinically defined when an individual nears completion of the service;
- (b) Conduct assessments;
- (c) Develop of a treatment plan to address mental health or emotional issues related to the individual's physical or mental health needs within 14 days of admission;
- (d) Review treatment plans under clinical guidance with the individual and other approved family supports every 30 days or more often if clinically indicated;
- (e) Provide individual, group and family therapy;

- (f) Provide access to a licensed mental health or substance use professional for after hour's crisis management;
- (g) Provide services that may include family education, self-help group and support group orientation; and
- (h) Provide monitoring of stabilized comorbid medical and psychiatric conditions.

004.02(B)(vii)(1) ADMISSION CRITERIA. Individuals admitted to intensive outpatient (IOP) must:

- (a) Be assessed and meet the diagnostic criteria for a mental health or substance-related disorder as defined in the Diagnostic Statistical Manual-5 (DSM-5);
- (b) Have difficulty maintaining stability with a variety of outpatient services necessitating use of intensive outpatient (IOP) to enhance the opportunities and experiences known to improve the possibility of successful stability;
- (c) Of all reasonable options for active psychiatric treatment available to the individual, this service is the best choice for expecting a reduction in symptoms; and
- (d) For individuals who present with co-occurring mental health and substance use disorder symptoms and diagnoses, the provider will refer to the Patient Placement Criteria for Treatment of Substance-Related Disorders of the American Society of Addiction Medicine (ASAM) 3<sup>d</sup> edition, Intensive Outpatient Level 2.1.

004.02(B)(viii) MENTAL HEALTH AND SUBSTANCE USE DISORDER DAY TREATMENT SERVICES. Providers of day treatment services must:

- (a) Provide a minimum of three hours of service five days a week;
- (b) Conduct clinically appropriate assessments as determined necessary, to assess the individual for substance use disorders, eating disorders, sexually harmful behavior, or other specialized treatment needs;
- (c) Provide medically necessary psychotherapy and substance use disorder counseling services that demonstrate active treatment for the psychiatric or substance use disorder;
- (d) Provide medically necessary nursing services by a registered nurse who evaluates the particular medical nursing needs of each individual and provides for the medical care and treatment. In a hospital based day treatment setting, a nursing medical assessment must be completed within 24 hours of admission or the first business day;
- (e) Provide medically necessary psychological diagnostic services based on the individual's need for the service;
- (f) Provide medically necessary pharmaceutical services: If medications are dispensed by the agency, pharmacy services must be provided under the supervision of a registered pharmacy consultant; or the agency may contract for these services through an outside licensed or certified facility. All medications must be stored in a special locked storage space and administered only by a physician, registered nurse (RN), licensed practical nurse (LPN), or by a staff person approved by the Nebraska Department of Health and Human Services, Division of Public Health as a medication aide;

- (g) Provide medically necessary dietary services. If meals are provided by a day treatment agency, services must be supervised by a registered dietitian, based on the individual's unique diet needs. Day treatment agencies may contract for these services through an outside facility or provider;
- (h) Develop a treatment plan within the first 10 days after the individual's admission to the service. Providers must review and revise the treatment plan at least every 30 days or more often if necessary. The treatment plan must be signed by the supervising practitioner for day treatment services;
- (i) Provide after hour's on-call access to a licensed practitioner for after hour's crisis management; and
- (j) Must allow for brief crisis stabilization, and have a written plan for immediate admission or readmission for appropriate inpatient services, if necessary. The written plan must include a cooperative agreement with a psychiatric or substance use hospital or distinct part of a hospital as outlined in this chapter.

004.02(B)(viii)(1) OPTIONAL SERVICES. The agency must provide two of the following optional services. The individual must have a need for the services, the supervising practitioner must order the services, and the services must be a part of the individual's treatment plan. The therapies must be restorative in nature, not prescribed for conditions that have plateaued or cannot be significantly improved by the therapy, or which would be considered maintenance therapy.

- (a) Services provided or supervised by a licensed or certified therapist may be provided under the supervision of a qualified consultant or the agency may contract for these services from a licensed or certified professional as listed below:
  - (i) Recreational therapy;
  - (ii) Speech therapy;
  - (iii) Occupational therapy, if prescribed as an activities therapy;
  - (iv) Vocational skills therapy; or
  - (v) Self-care services: Services that are oriented toward activities of daily living and personal hygiene, supervised by a registered nurse (RN) or occupational therapist. This includes, but is not limited to, toileting, bathing, and grooming;
- (b) Educational services provided by a teacher specially trained to work with individuals experiencing mental health or substance use disorders (Services, when required by law, will be available, though not necessarily provided by the day treatment agency. Educational services must be only one aspect of the treatment plan, not the primary reason for admission or treatment. Educational services are not eligible for payment by Medicaid, and do not apply towards the three hour requirement identified in this chapter;
- (c) Social work provided by a bachelor level social worker;
- (d) Social skills building;
- (e) Life survival skills; or
- (f) Substance use prevention, intervention, or treatment by an appropriately certified alcohol and drug use counselor.

004.02(B)(viii)(2) SUPERVISING PRACTITIONER FOR DAY TREATMENT SERVICES. Supervising practitioners of day treatment agencies must:

- (a) Be present and assume responsibility for all individuals and care provided. If the supervising practitioner is present on a part-time basis, one of the clinical staff professionals acting within the scope of practice standards of the Nebraska Department of Health and Human Services, Division of Public Health must assume delegated professional responsibility for the agency and must be present at all times when the agency is providing services;
- (b) Supervise all psychotherapy and substance use counseling services provided by clinical staff and non-clinical activities provided by direct care staff;
- (c) Meet personally with the individual for evaluation every 30 days, or more often, as medically necessary. The 30-day update visit is not included in the day treatment per diem, and can be covered and reimbursed separately; and
- (d) Ensure the agency has a description of each of the services and treatment modalities available and is fully staffed and supervised during hours of operation.

004.02(B)(viii)(3) ADMIT CRITERIA FOR DAY TREATMENT SERVICES. Providers of day treatment services must have evidence that individuals meet eligibility criteria outlined in this chapter and:

- (a) The individual must have sufficient need for active treatment at the time of admission to justify the expenditure of the individual's and agency's time, energy, and resources;
- (b) The individual's must be stable enough to allow them to participate in the program and not be disruptive or harmful to other agency participants or staff members; and
- (c) Of all reasonable options for active treatment available to the individual, treatment in this agency must be the best choice for expecting a reasonable improvement in the individual's condition.

004.02(B)(viii)(4) DOCUMENTATION IN THE INDIVIDUAL'S CLINICAL RECORD. Providers of day treatment services must ensure the clinical records demonstrate medical necessity.

004.02(B)(viii)(5) COSTS NOT INCLUDED IN THE DAY TREATMENT FEE. The following services can be covered independently of the day treatment fee when the services are necessary, part of the individual's overall treatment plan, and permitted by applicable law:

- (a) Direct individual services performed by the supervising practitioner;
- (b) Prescription medications, including injectable medications;
- (c) Direct individual services performed by a physician other than the supervising practitioner; and
- (d) Treatment services for a physical injury or illness provided by other professionals.

004.02(B)(ix) OBSERVATION ROOM. When appropriate for brief crisis stabilization, observation room services may be used subject to the following limitations:

- (a) A trauma-informed psychiatric assessment beginning with a face-to-face assessment and continuing with an emergency psychiatric observation level of care during a period of less than 24 hours is performed;
- (b) A Substance Use Disorder (SUD) screening is completed during the observation period;
- (c) A health screening and nursing assessment must be conducted by a registered nurse (RN); or a licensed practical nurse (LPN) under the supervision of a registered nurse (RN).
- (d) A discharge plan, with emphasis on crisis intervention and referral for relapse prevention and other services, must be developed under the direction of a physician; and
- (e) Medication evaluation and management services must be provided.

004.02(B)(ix)(1) STAFFING STANDARDS. All staff must meet hospital accreditation guidelines and the Division of Public Health licensure standards:

004.02(B)(x) PSYCHIATRIC NURSING. The psychiatric registered nurse (RN) or the advanced practitioner registered nurse (APRN) offer primary care services to the psychiatric population in the primary residence of the individual. The nurses assess, diagnose, and treat individuals with psychiatric disorders or the potential for such disorders. A physician's order is required to initiate this service for individuals who are unable to access office-based services.

004.02(B)(x)(1) TREATMENT PLANNING. The treatment plan is developed and reviewed every 60 days by the interdisciplinary team, the individual, their family and significant others as appropriate, in addition to the supervising practitioner. Updates and reviews of the plan must be signed by all of those involved in the review.

004.02(B)(x)(2) SERVICE STANDARD. Services must include medication administration, assistance in setting up a medication system, teaching and monitoring of medication, and observation of the physical wellbeing in relation to medication side effects. This service is not intended to replace the direct involvement of a physician for the psychiatric treatment of the individual. Individuals must have on-call access to a psychiatric provider on a 24-hour, seven-day per week basis.

004.02(B)(xi) PEER SUPPORT SERVICES. Providers of peer support services must:

- (a) Ensure services are directly for the benefit of the individual;
- (b) Ensure services are provided in the individual's natural environment, home, or other appropriate community location;
- (c) Provide peer support in an individual or group settings;
- (d) Provide person-centered recovery, culturally competent and focused support and ensure the treatment plan reflects the needs and preferences of the individual;

- (e) Assist the individual to implement the goals and objectives identified in the treatment plan;
- (f) Assist the individual to develop skills and access community resources to enhance and improve the health of the individual;
- (g) Leverage lived experience to assist the individual to develop coping skills and problem solving strategies to improve their self-management of a mental illness or substance use disorder;
- (h) Be an advocate for the individual; and
- (i) Model recovery and wellness principles to empower the individual to identify and initiate steps towards goals identified on the treatment plan.

004.02(B)(xi)(1) SUPERVISION OF PEER SUPPORT SERVICES. Peer support services must be delivered under the direction and supervision of a clinical supervisor. The supervising practitioner for peer support services must:

- (a) Coordinate care and document collaboration in the progress notes at least twice per month.
- (b) Be available at all times for consultation with the peer support provider;
- (c) Perform a face-to-face session with the individual within 30 days of initiating peer support services; and
- (d) Conduct a face-to-face session every 60 days thereafter to monitor the individual's progress toward meeting goals.

004.02(B)(xi)(2) TREATMENT PLAN. In addition to the requirements identified at 004.01(D) providers of peer support services must ensure the treatment plan:

- (a) Includes wellness and crisis prevention plans that define early warning signs and triggers;
- (b) Is completed within 30 days of initiating peer support services;
- (c) Is reviewed and updated every 90 days or more often if clinically necessary; and
- (d) Is reviewed and signed by the peer support provider, the individual receiving services and the clinical supervisor.

004.02(B)(xii) MEDICATION MANAGEMENT. Providers of medication management must conduct an assessment that includes a relevant history and medical decision making regarding initiating or adjusting pharmacological agents. Practitioners providing this service must do so within the limits of their scope of practice according to the Department of Health and Human Services, Division of Public Health.

004.02(B)(xiii) THERAPEUTIC INJECTION. Medicaid covers injection of a drug for the purpose of treating a disease or medical condition. Practitioners providing this service must do so within the limits of their scope of practice according to the Department of Health and Human Services, Division of Public Health.

004.02(B)(xiv) ELECTROCONVULSIVE THERAPY (ECT).

004.02(B)(xiv)(1) ELECTROCONVULSIVE THERAPY STANDARDS. The following standards must be met for Electroconvulsive Therapy:

- (a) A clinical summary must be completed prior to provision of

electroconvulsive therapy (ECT) and identify a diagnoses listed in the Diagnostic Statistical Manual-5 (DSM-5). This summary must include the following:

- (i) Current symptoms, which are of a severity supporting the use of electroconvulsive therapy (ECT);
  - (ii) Psychiatric history and current mental status;
  - (iii) Current functioning including the individual's past response to electroconvulsive therapy (ECT) and medication trials; and
  - (iv) Medical history and a current examination focusing on neurological, cardiovascular and pulmonary systems, medical status, medications, dental status, and laboratory tests including electrocardiogram, if any, within 30 days prior to initiation of electroconvulsive therapy (ECT).
- (b) Anesthetic evaluation performed by an anesthesiologist or other qualified anesthesiology professional that identifies the individual's responses to anesthetic inductions, previous complications or risks, and recommendations for modification to the individual's medications or standard anesthetic techniques.
- (c) Development of an individualized treatment plan prior to treatment that includes all of the following components:
- (i) Specific medications to be administered during electroconvulsive therapy (ECT);
  - (ii) Choice of electrode placement during electroconvulsive therapy (ECT);
  - (iii) Stimulus dosing using a recognized method to produce an adequate seizure while minimizing adverse cognitive side effects; and
  - (iv) Continuous physiologic monitoring during electroconvulsive therapy (ECT) treatment, addressing:
    - (1) Seizure duration, including missed, brief or prolonged seizures;
    - (2) Electroencephalographic activity;
    - (3) Vital signs;
    - (4) Oximetry;
    - (5) Cardiovascular effects;
    - (6) Respiratory effects, including prolonged apnea; and
    - (7) Other monitoring specific to the needs of the individual.

004.02(B)(xiv)(2) POST ELECTROCONVULSIVE THERAPY (ECT) STABILIZATION AND RECOVERY SERVICES. Providers of electroconvulsive therapy (ECT) must provide:

- (a) Medically supervised stabilization services in the treatment area until vital signs and respiration are stable and no adverse effects are observed; and
- (b) Recovery services under the supervision of the anesthesia provider with continuous nursing observation and care; monitoring of vital signs including heart, respiration; pulse oximetry; and electrocardiogram if indicated.

004.02(B)(xv) THERAPEUTIC CRISIS INTERVENTION. The primary objective of the crisis stabilization service is to promptly conduct an assessment of the patient and to develop a treatment plan with emphasis on crisis intervention services necessary to stabilize and restore the patient to a level of functioning that requires a less restrictive level of care.



004.02(B)(xv)(1) SERVICE STANDARDS. Service standards for therapeutic crisis intervention must include:

- (a) Initial Diagnostic Interview (IDI) must be completed if one has not been completed within the preceding 12 months, or if one is not available;
- (b) Substance Use Disorder (SUD) assessment if deemed applicable;
- (c) Addiction treatment initiated and integrated into the treatment and recovery plan for co-occurring disorders as identified;
- (d) A crisis stabilization plan, must include relapse, crisis prevention, and discharge plan components;
- (e) Crisis stabilization, care management, medication management, and mobilization of family support and community resources; and
- (f) Ancillary service referral as needed.

004.02(B)(xv)(2) STAFFING STANDARDS. Practitioners providing this service must do so within the limits of their scope of practice according to the Department of Health and Human Services, Division of Public Health.

004.02(C) INPATIENT HOSPITAL PSYCHIATRIC SERVICES. The care and treatment of an inpatient with a primary psychiatric diagnosis must be under the direction of a psychiatrist or physician who is licensed by the state's licensing authority, and is enrolled as a provider with the Department with a primary specialty of psychiatry.

004.02(C)(i) GENERAL REQUIREMENTS FOR INPATIENT HOSPITAL PSYCHIATRIC SERVICES. The inpatient hospital facility must:

- (1) Maintain accurate clinical records that meet the requirements stated in this chapter;
- (2) Certify, and recertify at designated intervals, the medical necessity for the services of the hospital inpatient stay. The psychiatrist's or physician's certification or recertification statement must document the medical necessity for inpatient psychiatric treatment, based on a current evaluation of the individual's condition and admission and continued stay criteria outlined in this chapter;
- (3) Meet utilization review requirements in accordance with this chapter and 471 NAC 10. A site visit by Medicaid staff for purposes of utilization review may be required for further clarification;
- (4) Conduct necessary assessments: Initial Diagnostic Interview (IDI), nursing assessment, laboratory, radiological, substance use disorder, physical and neurological exams, and other diagnostic tests as necessary;
- (5) The attending psychiatrist must evaluate the individual face-to-face and document the psychiatric evaluation and diagnosis formulation within 24 hours of admission and a minimum of three times per week thereafter, or more often if medically necessary;
- (6) The attending psychiatrist must provide certification and recertification of the individual's need for inpatient psychiatric services and identify active treatment requirements for the individual;
- (7) The initial treatment plan must be developed upon admission and the comprehensive treatment plan must be developed within 72 hours by an

interdisciplinary team under the direction and supervision of the physician. Treatment plans must meet the requirements identified in in this chapter;

- (8) Provide psychiatric nursing interventions to patients 24 hours a day, seven days a week;
- (9) Ensure qualified staff provide treatment intervention, social interaction and experiences, education regarding psychiatric issues such as medication management, nutrition, signs and symptoms of illness, substance use education, recovery, appropriate nursing interventions and structured milieu therapy;
- (10) Provide services that include individual, group, and family therapy, occupational and recreational therapy and other prescribed activities to maintain or increase the individual's capacity to manage their psychiatric condition and activities of daily living; and
- (11) Provide medication management services for the provision and monitoring psychotropic medications.

004.02(C)(ii) SUBACUTE INPATIENT PSYCHIATRIC SERVICE REQUIREMENTS. Subacute inpatient psychiatric services must be provided by appropriate staff in accordance with applicable licensure, certification or accreditation requirements.

004.02(C)(ii)(1) ADMISSION CRITERIA. Providers of subacute inpatient psychiatric services must ensure individuals meet one or more of the following admission criteria:

- (a) The individual meets medical necessity for evaluation, stabilization, and treatment services;
- (b) The individual is at high risk to harm self or others;
- (c) The individual has active symptomatology consistent with a Diagnostic Statistical Manual-5 (DSM-5) diagnoses;
- (d) The individual has a high need for and the ability to respond to intensive structured intervention services; or
- (e) The individual is at high risk of relapse or symptom reoccurrence.

004.02(C)(ii)(2) CONTINUED STAY CRITERIA. Providers must ensure individuals meet one of the following continued stay criteria:

- (a) Continuation of symptoms or behaviors that required admission, and the judgment that a less intensive level of care and supervision would be insufficient to safely support the individual; or
- (b) The individual has not reached treatment goals but continues to show progress and willness to work toward achievement of treatment goals.

004.02(C)(ii)(3) TREATMENT PLAN. The subacute inpatient psychiatric facility must meet the requirements in accordance with this chapter and review the treatment plan three times a week.

004.02(C)(iii) ACUTE INPATIENT PSYCHIATRIC SERVICE REQUIREMENTS. Acute inpatient psychiatric services must be provided by appropriate staff in accordance with applicable licensure, certification or accreditation requirements.

004.02(C)(iii)(1) ADMISSION CRITERIA. Providers of acute inpatient psychiatric services must ensure individuals meet one or more of the following admission criteria:

- (a) The individual demonstrates acute exacerbation of symptomatology consistent with a Diagnostic Statistical Manual-5 (DSM-5) diagnosis, which requires and can reasonably be expected to respond to therapeutic intervention;
- (b) The individual requires 24 hour access to the full spectrum of psychiatric staffing in a controlled environment that may include but is not limited to medication monitoring and administration, therapeutic intervention, quiet room, restrictive safety measures, and suicidal or homicidal observation and precautions;
- (c) Due to the risk of mental health instability the need for confinement beyond 23 hours with intensive medical and therapeutic intervention is clearly indicated;
- (d) There is a clear and reasonable inference of imminent serious harm to self or others as evidenced by having any one of the following:
  - (i) An imminent plan or intent to harm self or others;
  - (ii) Recent attempts to harm self or others with continued risk due to poor impulse control or an inability to plan reliably for safety;
  - (iii) Violent, unpredictable or uncontrolled behavior related to the behavioral health disorder that represents an imminent risk of serious harm to self or others; or
  - (iv) An imminently dangerous inability to care adequately for personal physical needs or to participate in such care due to disordered, disorganized or bizarre behavior; or
- (e) The individual requires an acute psychiatric assessment technique or intervention that unless managed in an inpatient setting could potentially lead to serious imminent and dangerous deterioration of the individual's general medical or mental health.

004.02(C)(iii)(2) CONTINUED STAY CRITERIA. The acute inpatient psychiatric provider must ensure the individual meets one of the following continued stay criteria:

- (a) Continuing evidence of symptoms or severe behaviors reflecting significant risk, imminent danger, or actual demonstrated danger to self or others; requiring suicide or homicide precautions, close observation;
- (b) Monitoring and adjustment of psychotropic medication(s) related to lack of therapeutic effect or complication(s) in the presence of complicating medical and psychiatric conditions necessitating 24-hour medical supervision and supported by medical record documentation;
- (c) Persistence of psychotic symptoms and continued temporary, not chronic, inability of the individual to perform the activities of daily living or meet their basic needs for nutrition and safety due to a psychiatric disorder or the temporary mental state of the individual; or
- (d) Continued need for 24-hour medical supervision, reevaluation or diagnosis of an individual exhibiting behaviors consistent with an acute psychiatric disorder.

004.02(C)(iii)(3) TREATMENT PLAN. The acute inpatient psychiatric facility must meet the requirements at in this chapter and review the treatment plan weekly.

004.02(D) SUBSTANCE USE DISORDER COVERED SERVICES

004.02(D)(i) ADULT SUBSTANCE USE DISORDER (SUD). Medicaid covers adult Substance Use Disorder (SUD) services rendered in accordance with the American Society of Addiction Medicine (ASAM) 3<sup>rd</sup> edition. Adult Substance Use Disorder (SUD) services are provided exclusively through the Nebraska Medicaid Managed Care Program in accordance with Nebraska Administrative Code (NAC) Title 482.

004.02(D)(ii) ADMISSION CRITERIA. The following admission criteria pertains to each Substance Use Disorder (SUD) service:

- (1) There is an expectation that the individual has the capacity to make progress toward treatment goals;
- (2) The individual is assessed as meeting the diagnostic criteria for a substance related disorder as listed in the of the Diagnostic Statistical Manual-5 (DSM-5) as published by the American Psychiatric Association; and
- (3) The individual, who is identified to need Dual Diagnosis Enhanced program services, is assessed as meeting the diagnostic criteria listed in the Diagnostic Statistical Manual-5 (DSM-5) as published by the American Psychiatric Association for a mental disorder as well as a substance-related disorder.

004.02(D)(iii) TREATMENT PLANNING. An initial treatment plan must be implemented upon completion of the substance use assessment and will drive the first 30 days of service. The comprehensive treatment plan is to be developed within 30 days for the service, and will include recommendations made in the initial substance use disorder assessment and any other assessments completed following admission.

004.02(D)(iv) SPECIFIC SUBSTANCE USE DISORDER COVERED SERVICES REQUIREMENTS.

004.02(D)(iv)(1) INDIVIDUAL SUBSTANCE USE DISORDER COUNSELING. Providers of individual substance use disorder counseling must:

- (a) Ensure the individual meets Patient Placement Criteria for Treatment of Substance-Related Disorders of the American Society of Addiction Medicine (ASAM) 3<sup>rd</sup> edition;
- (b) Conduct necessary assessment;
- (c) Develop a treatment plan to address substance use needs;
- (d) Coordinate care with other treating professionals for individuals with a co-occurring diagnosis; and
- (e) Ensure services are treatment focused and not rehabilitative or habilitative in nature.

004.02(D)(iv)(2) GROUP SUBSTANCE USE DISORDER COUNSELING. Providers of group substance use disorder counseling must:

- (a) Ensure the individual meets Patient Placement Criteria for Treatment of Substance-Related Disorders of the American Society of Addiction Medicine (ASAM) 3<sup>rd</sup> edition;
- (b) Develop and document in the treatment plan the need for group substance use disorder counseling; and
- (c) Ensure services are treatment focused and not rehabilitative or habilitative in nature.

004.02(D)(iv)(3) FAMILY SUBSTANCE USE DISORDER COUNSELING. Providers of family substance use disorder counseling must:

- (a) Ensure the individual meets Patient Placement Criteria for Treatment of Substance-Related Disorders of the American Society of Addiction Medicine (ASAM) 3<sup>rd</sup> edition;
- (b) Conduct or obtain a comprehensive family assessment;
- (c) Focus on the individual's substance use disorder needs and the family as a system;
- (d) Develop and document in the treatment plan the need for family substance use disorder counseling; and
- (e) Ensure goals and objectives are designed to increase the functional level of the identified individual and the individual's family related to substance use.

004.02(D)(iv)(4) INTENSIVE OUTPATIENT (IOP). Providers of intensive outpatient (IOP) must:

- (a) Provide nine or more hours per week of skilled treatment, with at least three hours of availability per day. The hours and days of treatment are to be reduced as clinically defined when an individual nears completion of the service;
- (b) Conduct assessments;
- (c) Develop of a treatment plan to address mental health or substance use needs, or emotional issues related to the individual's physical or mental health needs within 14 days of admission;
- (d) Review treatment plans under clinical guidance with the individual and other approved family supports every 30 days or more often if clinically indicated;
- (e) Provide individual, group, and family therapy;
- (f) Provide access to a licensed mental health or substance use professional for after hours crisis management;
- (g) Provide services that may include family education, self-help group, and support group orientation; and
- (h) Provide monitoring of stabilized comorbid medical and psychiatric conditions.

004.02(D)(iv)(4)(i) ADMISSION CRITERIA. The intensive outpatient (IOP) program must:

- (1) Ensure the individual meets the diagnostic criteria for a mental health or substance-related disorder as defined in the Diagnostic Statistical Manual-5 (DSM-5);

- (2) Ensure the individual has difficulty maintaining stability with a variety of outpatient services, necessitating use of intensive outpatient (IOP) to enhance the opportunities and experiences known to improve the possibility of successful stability;
- (3) Ensure that of all reasonable options for active psychiatric or substance use disorder treatment available to the individual, this service is the best choice for expecting a reduction in symptoms; and
- (4) Ensure individuals who present with co-occurring mental health and substance use disorder symptoms and diagnoses meet each of the six of the Patient Placement Criteria for Treatment of Substance-Related Disorders of the American Society of Addiction Medicine (ASAM) 3rd edition dimensions for level 2.1 programs.

004.02(D)(iv)(5) ADULT SUBSTANCE USE PEER SUPPORT Providers of peer support services must:

- (a) Ensure services are directly for the benefit of the individual;
- (b) Ensure services are provided in the individual's natural environment, home, other appropriate community location;
- (c) Provide peer support in an individual or group settings;
- (d) Provide person-centered recovery, culturally competent and focused support and ensure the treatment plan reflects the needs and preferences of the individual;
- (e) Assist the individual to implement the goals and objectives identified in the treatment plan;
- (f) Assist the individual to develop skills and access community resources to enhance and improve the health of the individual;
- (g) Leverage lived experience to assist the individual to develop coping skills and problem solving strategies to improve their self-management of a mental illness or substance use disorder;
- (h) Be an advocate for the individual; and
- (i) Model recovery and wellness principles to empower the individual to identify and initiate steps towards goals identified on the treatment plan.

004.02(D)(iv)(5)(i) SUPERVISION OF PEER SUPPORT SERVICES. Peer support services must be delivered under the direction and supervision of a clinical supervisor in accordance with this chapter. The supervising practitioner for peer support services must:

- (1) Coordinate care and document collaboration in the progress notes at least twice per month.
- (2) Be available at all times for consultation with the peer support provider;
- (3) Perform a face-to-face session with the individual within 30 days of initiating peer support services; and
- (4) Conduct a face-to-face session every 60 days thereafter to monitor the individual's progress toward meeting goals.

004.02(D)(iv)(5)(ii) TREATMENT PLAN. In addition to the requirements identified at 004.01(D) providers of peer support services must ensure the treatment plan:

- (1) Includes wellness and crisis prevention plans that define early warning signs and triggers;
- (2) Is completed within 30 days of initiating peer support services;
- (3) Is reviewed and updated every 90 days or more often if clinically necessary; and
- (4) Is reviewed and signed by the peer support provider, the individual receiving services and the clinical supervisor.

004.02(D)(iv)(6) DUAL SUBSTANCE USE DISORDER DAY TREATMENT ADULT.

004.02(D)(iv)(6)(a) SERVICE STANDARDS. Providers must provide for:

- (i) Individualized treatment and recovery plan, including discharge and relapse prevention, developed under clinical supervision with the client within 14 days of admission;
- (ii) Review and update of the treatment and recovery plan with the client and other family or supports every seven days or more often as medically indicated;
- (iii) Monitoring co-occurring mental health problems to include providing for, or arranging for psychiatric services to meet the needs of the individual;
- (iv) Monitoring to promote successful reintegration into regular, productive daily activity such as work, school or family living;
- (v) Consultation or referral for general medical, psychiatric, psychological, nutritional and laboratory needs; and
- (vi) A referral system for needs identified but not available through the day treatment program.

004.02(D)(iv)(6)(b) THERAPIES AND INTERVENTIONS. Dual substance use disorder day treatment services must include:

- (i) Day treatment programs are offered four or more days per week for at least three hours, typically with support available in the evenings and on weekends;
- (ii) Provision for 20 hours of skilled treatment per week in a structured program;
- (iii) Skilled treatment will include individual, family group psychotherapy, psycho-educational groups, motivational enhancement engagement strategies, and peer support;
- (iv) Emergency services available 24-hours a day, seven days a week when the program is not in session;

004.02(D)(iv)(6)(c) STAFFING STANDARDS. Staff must meet the following requirements:

- (i) The Clinical Director is an registered nurse, licensed psychologist, licensed independent mental health practitioner, licensed mental health professional or a licensed alcohol and drug counselor working with the program and responsible for all clinical decisions and to provide consultation and support to care staff and the client;

- (ii) Appropriately licensed and credentialed professionals working within their scope of practice to provide substance use disorder treatment

004.02(D)(iv)(7) ADULT SUBSTANCE USE DISORDER (SUD) SOCIAL DETOXIFICATION. This service has the capacity to provide a safe residential setting with staff present for observation and implementation of physician approved protocols designed to physiologically restore the individual from an acute state of intoxication when medical treatment for detoxification is not necessary. For admission to the program an individual must present in an intoxicated state and meet American Society of Addiction Medicine (ASAM) dimensional criteria for admission.

004.02(D)(iv)(7)(a) THERAPIES AND INTERVENTIONS. Service therapies and interventions must include:

- (i) A biopsychosocial medical screening conducted by an appropriately trained staff at admission with ongoing monitoring as needed with licensed medical consultation available.
- (ii) The implementation of physician approved protocols;
- (iii) An addiction focused history must be obtained and reviewed with the physician if protocols indicate concern;
- (iv) Monitoring of self-administered medication;
- (v) Sufficient screening must be completed to determine the level of care in which the individual should be placed, and for the individualized care plan to address treatment priorities identified in American Society of Addiction Medicine (ASAM) Dimensions 2 through 6;
- (vi) The detoxification staff must initiate a plan of care for the individual at the time of intake;
- (vii) Daily assessment of individual progress through detoxification and any treatment changes;
- (viii) Medical evaluation and consultation is available 24 hours per day;
- (ix) Consultation and a referral for general medical, psychiatric, psychological, or other needs must be provided;
- (x) Interventions must include a variety of educational sessions and motivational and enhancement strategies for the individual and their family;
- (xi) Individual participation must be based on the medical biopsychosocial condition and ability of the individual; and
- (xii) The program must assist individuals in establishing social supports to enhance recovery;

004.02(D)(iv)(7)(b) Staffing Requirements. Staff must include:

- (i) Clinical director who is an licensed mental health professional, licensed independent mental health professional, or licensed psychologist or licensed alcohol and drug counselor providing consultation and support to care staff and the individuals;
- (ii) The clinical director will also continually incorporate new clinical information and best practices into the program to assure program effectiveness and viability, and assure quality organization and



- management of clinical records, and other program documentation;
- (iii) Clinical director to direct care staff ratio as needed to meet all responsibilities;
  - (iv) Two awake direct care staff overnight;
  - (v) The licensed and non licensed practitioners will be knowledgeable about the biological and psychosocial dimensions of substance use disorder; and
  - (vi) Special training and competency evaluation are required in carrying out physician developed protocols.

004.02(D)(iv)(8) ADULT SUBSTANCE USE DISORDER (SUD) DUAL DISORDER RESIDENTIAL (CO-OCCURRING DIAGNOSIS-ENHANCED). Dual disorder residential treatment is for adults with a primary Substance Use Disorder (SUD) and a co-occurring psychiatric disorder requiring a more restrictive treatment environment. This service is highly structured, based on acuity, and provides primary, integrated treatment to further stabilize acute symptoms and engage the individual in a program of maintenance, treatment, rehabilitation and recovery. Dual disorder residential must provide active treatment for a primary Substance Use Disorder (SUD) diagnosis listed in the current version of the Diagnostic and Statistical Manual (DSM) published by the American Psychiatric Association (APA). The individual must be assessed as meeting specifications in all of six American Society of Addiction Medicine (ASAM) criteria dimensions.

004.02(D)(iv)(8)(a) SERVICE STANDARD. The service must include:

- (i) Development of an initial treatment and rehabilitation plan within 24 hours to guide the first seven days of treatment;
- (ii) The comprehensive individualized treatment and rehabilitation plan including discharge and relapse prevention, developed under clinical supervision with the individual within seven days of admission;
- (iii) Review and update of the treatment and rehabilitation plan under clinical supervision with the individual and other approved family supports every 30 days or more often as needed;
- (iv) A nursing assessment by a registered nurse (RN) or a licensed practical nurse (LPN) under registered nurse (RN) supervision, is to be completed within 24 hours of admission. The assessment must include recommendations for further physical examination if necessary;
- (v) Individual substance use disorder or psychiatric services as clinically indicated;
- (vi) Drug screenings as clinically indicated;
- (vii) Education on medication management as appropriate;
- (viii) Consultation or referral for general medical needs; and
- (ix) Discharge planning to promote successful reintegration into daily activities such as work, school or family living, including the establishment of each individual's social supports to enhance recovery.

004.02(D)(iv)(8)(b) THERAPIES AND INTERVENTIONS. Service therapies and interventions must include 42 hours of the following:

- (i) Individual, family, and group psychotherapy and Substance Use Disorder (SUD) therapy;
- (ii) Educational and recreational groups;
- (iii) Twenty four hour crisis management;
- (iv) Family education;
- (v) Self-help group and support group orientation;
- (vi) Individual drug screenings services as clinically indicated;
- (vii) Education on medication management; and
- (viii) Consultation and referral for general medical needs.

004.02(D)(iv)(8)(c) STAFFING STANDARDS. Service staff may include:

- (i) The clinical must be a physician, physician assistant, psychiatrist, advanced practice registered nurse (APRN), licensed independent mental health practitioner (LIMHP), licensed mental health practitioner (LMHP) or a licensed psychologist;
- (ii) The clinical director must be a physician, physician assistant, psychiatrist, advanced practice registered nurse (APRN), licensed independent mental health practitioner (LIMHP), licensed mental health practitioner (LMHP) or a licensed psychologist;
- (iii) A consulting physician or an advanced practice registered nurse (APRN) is required to be available as necessary;
- (iv) A registered nurse (RN) or licensed practical nurse (LPN), under the supervision of a registered nurse (RN) with substance use disorder (SUD) and psychiatric treatment experience is preferred;
- (v) The clinicians are licensed, credentialed, and work within their scope of practice to provide co-occurring substance use disorder (SUD) and mental health treatment. They are also knowledgeable about the biological and psychosocial dimensions of substance use disorder (SUD). All clinicians are to be dually licensed; however one of the licenses may be provisional;
- (vi) Direct care staff; and
- (vii) Optional program staff may include recreation therapists or social workers.

004.02(D)(iv)(8)(c)(1) STAFFING RATIO. The staff will be required to fulfill the following:

- (a) Clinical director to direct care staff ratio as needed to meet responsibilities;
- (b) One to six direct care staff to individual served during waking hours;
- (c) One to eight therapist or licensed clinician to individuals served;
- (d) One awake staff for each ten individuals during individual sleep hours, overnight, with on-call availability for emergencies, two awake staff overnight for 11 or more individuals served; and
- (e) On-call availability of medical and direct care staff and licensed clinicians 24/7.

004.02(D)(iv)(9) ADULT SUBSTANCE USE DISORDER (SUD) SHORT TERM RESIDENTIAL. This is a highly structured short term substance use residential

treatment program that provides comprehensive residential services for adults with a Substance Use Disorder (SUD).

004.02(D)(iv)(9)(a) SERVICE STANDARD. The service must include:

- (i) An initial treatment and rehabilitation plan developed within 24 hours to guide the first seven days of treatment;
- (ii) The comprehensive individualized treatment and rehabilitation plan including discharge and relapse prevention, developed under clinical supervision with the individual within seven days of admission;
- (iii) Review and update of the treatment and rehabilitation plan under clinical supervision with the individual and other approved family supports within seven days of admission, and every seven days thereafter; and
- (iv) A nursing assessment by a registered nurse (RN) or a licensed practical nurse (LPN) under registered nurse (RN) supervision, is to be completed within 24 hours of admission. The assessment must include recommendations for further physical examination if necessary.

004.02(D)(iv)(9)(b) THERAPIES AND INTERVENTIONS: Must include 42 hours of the following:

- (i) Individual, family, and group psychotherapy and substance use disorder (SUD) therapy;
- (ii) Educational and recreational groups; substance use disorder (SUD)
- (iii) Twenty four hours crisis management, family education, self-help group and support group orientation;
- (iv) Drug screenings as clinically indicated;
- (v) Education on medication management;
- (vi) Consultation and referral for general medical needs;
- (vii) Other services should include 24 hours crisis management, family education, self-help group and support group orientation, all of which are included in the minimum of 42 hours per week; and
- (viii) Discharge planning to promote successful reintegration into daily activities such as work, school or family living, including the establishment of each individual's social supports to enhance recovery.

004.02(D)(iv)(9)(c) STAFFING STANDARDS. Service staff must include:

- (i) The clinical director must be a physician, physician assistant, psychiatrist, advanced practice registered nurse (APRN), licensed independent mental health practitioner (LIMHP), licensed mental Health Practitioner (LMHP) or a Licensed Psychologist;
- (ii) The clinicians are licensed, credentialed, and work within their scope of practice to provide co-occurring Substance Use Disorder (SUD) and mental health treatment. They are also knowledgeable about the biological and psychosocial dimensions of Substance Use Disorder (SUD). All clinicians are to be dually licensed; however one of the licenses may be provisional;
- (iii) Direct care staff; and

- (iv) Optional program staff may include recreation therapists or social workers.

004.02(D)(iv)(9)(d) STAFFING RATIO. The staff will be required to fulfill the following:

- (i) Clinical director to direct care staff ratio as needed to meet responsibilities;
- (ii) One to eight direct care staff to individual served during waking hours
- (iii) One to eight therapist or licensed clinician to individuals served;
- (iv) One awake staff for each ten individuals during individual sleep hours, overnight, with on-call availability for emergencies, two awake staff overnight for 11 or more individuals serve; and
- (v) On-call availability of medical and direct care staff and licensed clinicians 24/7

004.02(D)(iv)(10) ADULT SUBSTANCE USE DISORDER (SUD) LONG TERM RESIDENTIAL. Intended for adults with a primary Substance Use Disorder (SUD) for whom shorter term treatment is inappropriate, either because of the pervasiveness of the impact of Substance Use Disorder (SUD) on the individual's life or because of a history of repeated short-term or less restrictive treatment failures. This service provides psychosocial skill building through a set of longer term, highly structured treatment strategies that define progress toward individual change and rehabilitation. The individual's progress is to be marked by advancement through these phases to less restriction and more personal responsibility.

004.02(D)(iv)(10)(a) SERVICE STANDARDS. The service must include:

- (i) A treatment and rehabilitation plan including discharge and relapse prevention must be developed under clinical supervision within seven days of admission to guide the first 30 days of treatment. This plan is to be reviewed and updates every 30 days or more often as clinically indicated
- (ii) Therapies and interventions should include a minimum of 30 hours of individual, family, and group Substance Use Disorder (SUD) therapy, and educational groups;
- (iii) Program is characterized by slower paced interventions purposefully repetitive to meet special individual treatment needs;
- (iv) Monitoring to promote successful reintegration into regular, productive daily activity which may include but is not limited to work, school or family living;
- (v) Other services could include 24 hours crisis management, family education, self-help group and support group orientation;
- (vi) Monitoring stabilized co-occurring psychiatric problems; and
- (vii) Consultation and referral for general medical, psychiatric, and psychological needs.

004.02(D)(iv)(10)(b) STAFFING STANDARDS. Staff must meet the following standards:

- (i) The Clinical director may be a physician, physician assistant, psychiatrist, Advanced Practitioner Registered Nurse (APRN), Licensed Independent Mental Health Practitioner (LIMHP), Licensed Mental Health Practitioner (LMHP) or a Licensed Psychologist. The clinical director is a licensed clinician with demonstrated work experience and education and training in Psychiatry Mental Health and addictions who is responsible for all clinical decisions, consultation with direct care staff; incorporating new clinical information, best practices, quality, organization, and management of clinical records; and
- (ii) The clinicians are licensed, credentialed, and working within their scope of practice to provide co-occurring Substance Use Disorder (SUD) and psychiatric treatment and
- (iii) On-call availability of direct care staff and licensed clinicians 24/7.

004.02(D)(iv)(10)(b)(1) STAFFING RATIO. The staff must be in the following ratio:

- (a) Clinical director to direct care staff ratio as needed to meet all responsibilities;
- (b) One awake staff for each ten individuals during sleep hours (overnight) with on-call availability for emergencies, two awake staff overnight for 11 or more individuals served; and
- (c) One to ten therapist to individual.

004.02(D)(iv)(11) ADULT SUBSTANCE USE DISORDER (SUD) INTERMEDIATE RESIDENTIAL. Intended for adults with a primary Substance Use Disorder (SUD) for whom shorter term treatment is inappropriate, either because of the pervasiveness of the impact of dependence on the individual's life or because of a history of repeated short-term or less restrictive treatment failures. Typically, this service is more supportive than therapeutic communities and relies less on peer dynamics in its treatment approach.

004.02(D)(iv)(11)(a) SERVICE STANDARD. The service must include:

- (i) An initial treatment and rehabilitation plan developed within the first 24 hours to guide the first seven days of treatment. The comprehensive individualized treatment and rehabilitation plan, including discharge and relapse prevention, developed under clinical supervision with the individual within seven days of admission
- (ii) The treatment and rehabilitation plan must be reviewed with the individual and other family and supports, under clinical supervision, every 30 days or more often as needed;
- (iii) Therapies and interventions should include 30 hours per week of individual, family, and group Substance Use Disorder (SUD) therapy, and educational groups.
- (iv) The program is characterized by slower paced interventions purposefully repetitive to meet special individual treatment needs.
- (v) Monitoring must be used to promote successful reintegration into regular, productive daily activity which may include but is not limited to work, school or family living; and

(vi) Other services may include 24 hours crisis management, family education, self-help group and support group orientation.

004.02(D)(iv)(11)(b) STAFFING STANDARDS. Service Staff must fulfill the following:

- (i) Clinical Director may be an Advanced Practitioner Registered Nurse (APRN), Licensed Independent Mental Health Practitioner (LIMHP), Licensed Mental Health Practitioner, Licensed Alcohol and Drug Counselor (LADC), or licensed psychologist to provide clinical supervision, consultation and support to all program staff and the Medicaid eligible individuals they serve. This individual will also continually incorporate new clinical information and best practices into the program to assure program effectiveness and viability, and assure quality organization and management of clinical records, and other program documentation;
- (ii) Appropriately licensed and credentialed professionals working within their scope of practice to provide substance use disorder treatment who are knowledgeable about the biological and psychosocial dimensions of substance use disorder; and
- (iii) Other program staff may include RNs, LPNs, recreation therapists or social workers.
- (iv) On-call availability of direct care staff and licensed clinicians 24/7.

004.02(D)(iv)(11)(b)(1) STAFFING RATIO. Staff must be in the following ratios:

- (a) Clinical director to direct care staff ratio as needed to meet all responsibilities;
- (b) One to ten direct care staff to individuals served during all waking hours;
- (c) One to ten therapist to individuals;
- (d) One awake staff for each ten individuals during sleep hours, overnight, with on-call availability for emergencies, two awake staff overnight for 11 or more individuals served.

004.02(D)(iv)(12) ADULT SUBSTANCE USE DISORDER (SUD) HALFWAY HOUSE LEVEL. A transitional, 24-hour structured supportive living, treatment and rehabilitation facility located in the community for adults seeking reintegration into the community generally after primary treatment at a more intense level. This service provides safe housing, structure and support affording individuals an opportunity to develop and practice their interpersonal and group living skills, strengthen rehabilitation skills, reintegrate into their community, and find or return to employment or further education.

004.02(D)(iv)(12)(a) SERVICE STANDARDS. The service must include:

- (i) Individualized treatment or recovery plan, including discharge and relapse prevention, developed under clinical supervision with the individual within 14 days of admission;

- (ii) Review and update of the treatment or recovery plan with the individual and other approved family or supports every 30 days or more often as medically indicated;
- (iii) Monitoring to promote successful reintegration into regular, productive daily activity such as work, school or family living;
- (iv) Other services could include 24 hours crisis management, family education, self-help group and support group orientation;
- (v) Monitoring stabilized co-occurring mental health problems;
- (vi) Consultation or referral for general medical, psychiatric, and psychological needs;
- (vii) Provides a minimum of eight hours of skilled treatment and recovery focused services per week including therapies or interventions such as individual, family, and group psychotherapy; educational groups; motivational enhancement; and engagement strategies; and
- (viii) On-call availability of direct care staff and licensed clinicians 24/7.

004.02(D)(iv)(12)(b) STAFFING STANDARDS. Service staff must fulfill the following:

- (i) Clinical Director must be an Advanced Practitioner Registered Nurse (APRN), Registered Nurse (RN), Licensed Independent Mental Health Practitioner (LIMHP), Licensed Mental Health Practitioner, Licensed Alcohol and Drug Counselor (LADC), or licensed psychologist -is responsible for all clinical decisions and to provide consultation and support to care staff and the individuals they serve.

004.02(D)(iv)(12)(b)(1) STAFFING RATIO. Staff must be in the following ratios:

- (a) Clinical director to direct care staff ratio as needed to meet all responsibilities;
- (b) One to ten direct care staff to individuals served during all waking hours;
- (c) One to twelve therapist to individuals;
- (d) One to twelve awake overnight staff during sleep hours, overnight, with on-call availability for emergencies, two awake staff overnight for 11 or more individuals served; and
- (e) One to ten therapist to individual.

004.02(E) MEDICAID REHABILITATION OPTION COVERED SERVICES.

004.02(E)(i) MEDICAID REHABILITATION OPTION COVERED SERVICES GENERAL. Medicaid covers community rehabilitative psychiatric services to rehabilitate individuals experiencing severe and persistent mental illnesses. The services must be medically necessary, include active treatment and clinically, be the most appropriate level of treatment for the individual. Rehabilitative psychiatric services are medically necessary when those services can reasonably be expected to increase or maintain the level of functioning in the community of clients with severe and persistent mental illness.

004.02(E)(i)(1) ADMISSION CRITERIA. The Psychiatric Medicaid Rehabilitation Option (MRO) requirements for admission are:

- (a) Have a diagnosis consistent with a long standing serious and persistent mental illness, as identified in the current edition of the Diagnostic Statistical Manual (DSM), with symptoms and functional deficits of sufficient severity and duration that it is expected to cause significant, ongoing, and disabling functional impairments. Have symptoms and functional deficits that are related to the primary diagnosis.
- (b) Have the capacity to benefit from rehabilitation treatment to the degree service will no longer be necessary;
- (c) Be at significant risk of continuing in a pattern of either institutionalization or living in a severely dysfunctional way if needed psychiatric services are not provided;
- (d) Have maintained a pattern of symptoms and functional deficits for 12 months or longer or is likely to endure for 12 months or longer and must result in a degree of limitation that seriously interferes with the individual's ability to function independently in an appropriate manner in two of three functional areas:
  - (i) Vocation and education: The individual demonstrates an inability to be employed without extensive supports. There is evidence of deterioration or decompensation resulting in their inability to establish or pursue educational goals within normal time frames or without extensive support;
  - (ii) Social skills: The individual demonstrates repeated inappropriate or inadequate social behavior or only behaves appropriately with extensive supports. The individual is unable to participate in adult activities without extensive support and limits their involvement to special activities established for persons with mental illness or a history of dangerousness to self or others; and
  - (iii) Activities of daily living: The individual demonstrates an inability to consistently perform the range of practical daily living tasks required for basic adult functioning.

004.02(E)(i)(2) SEVERE AND PERSISTENT MENTAL ILLNESS. Clients with severe and persistent mental illness must meet the following criteria:

- (a) The client is age 21 and over;
- (b) The client has a primary diagnosis of schizophrenia, major affective disorder, or other major mental illness under the current edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association. Developmental disorders, or psychoactive substance use disorders may be included if they co-occur with the primary mental illnesses listed above;
- (c) The client has a persistent mental illness as demonstrated by the presence of the disorder for the last 12 months or which is expected to last 12 months or longer and will result in a degree of limitation that seriously interferes with the client's ability to function independently in an appropriate and effective manner in two of three functional areas, vocational or education, social skills, activities of daily living.



- (i) Functional limitations in the area of vocational or education abilities are defined as:
  - (1) An inability to be consistently employed or an ability to be employed only with extensive supports, except that a person who can work but is recurrently unemployed because of acute episodes of mental illness is considered vocationally impaired;
  - (2) Deterioration or decompensation resulting in an inability to establish or pursue educational goals within a normal time frame or without extensive supports;
  - (3) An inability to consistently and independently carry out home management tasks, including household meal preparation, washing clothes, budgeting, and child care tasks and responsibilities;
- (ii) Functional limitations in the area of Social Skills and abilities are defined as:
  - (1) Repeated inappropriate or inadequate social behavior or an ability to behave appropriately or adequately only with extensive or consistent support or coaching or only in special contexts or situations, such as social groups organized by treatment staff; or
  - (2) Consistent participation in adult activities only with extensive support or coaching and when involvement is mostly limited to special activities established for persons with mental illness or other persons with interpersonal impairments; or
  - (3) A history of dangerousness to self or others.
- (iii) Functional limitations in the area of Activities of Daily Living are defined as an inability to consistently perform the range of practical daily living tasks required for basic adult functioning in the community, in three of five areas listed below:
  - (1) Grooming, hygiene, washing of clothes, and meeting nutritional needs;
  - (2) Care of personal business affairs;
  - (3) Transportation and care of residence;
  - (4) Procurement of medical, legal, and housing services; or
  - (5) Recognition and avoidance of common dangers or hazards to self and possessions.
- (d) The client is at significant risk of continuing in a pattern of either institutionalization or living in a severely dysfunctional way if needed mental health services are not provided, and this pattern has existed for one year or longer and is likely to endure for one year or longer; and
- (e) The client does not have a primary diagnosis of substance abuse or substance dependency or developmental disabilities.

004.02(E)(i)(3) ASSESSMENT. Initial diagnostic assessment (IDI) or a substance use disorder (SUD) assessment must be completed within 12 months prior to admission. The assessment serves as the treatment plan for the first 30 days until the treatment and rehabilitation plan of care is developed.

004.02(E)(i)(4) TREATMENT AND REHABILITATION PLAN. Treatment and Rehabilitation plan is developed by the interdisciplinary team based on a thorough

evaluation of the individual's restorative needs and potentialities. The plan is reviewed is to be reviewed according to the specifics of each of the service.

004.02(E)(i)(5) DISCHARGE PLAN. Discharge planning must begin upon admission to services and be consistent with the goals and objectives identified in the treatment and rehabilitation plan. The plan must address the needs and recommendations for the individual upon discharge from the current service.

004.02(E)(i)(6) STAFFING REQUIREMENTS. Rehabilitative programs must provide staff to deliver rehabilitative psychiatric services and staff may be either licensed practitioners operating within their scope of practice or direct care staff and peer support specialists.

004.02(E)(i)(7) CLINICAL SUPERVISION. Unlicensed practitioners must practice under the supervision of a licensed clinician. Clinical supervisors must be a:

(a) Licensed psychologist;

(b) Provisionally licensed psychologist; or

(c) Licensed independent mental health practitioner (LIMHP).

004.02(E)(i)(8) COMMUNITY SUPPORT CLINICAL SUPERVISOR. Community Support workers will have monthly supervision by the Community Support Clinical Supervisor.

004.02(E)(i)(9) PEER SUPPORT SPECIALIST. Peer support specialists may be a staffing component of the Community support, Assertive Community Treatment and Day Rehabilitation programs.

004.02(E)(i)(10) PROVIDERS. Providers of the Medicaid rehabilitation option programs must be led by individuals trained in the provision of rehabilitation principles.

004.02(E)(i)(10)(a) STAFF. All Staff are trained in the principles of rehabilitation and recovery. Direct contacts with the client that focus on the development of skills or the management of other activities are identified on the Individual Treatment, Rehabilitation, and Recovery Plan.

004.02(E)(ii) COMMUNITY SUPPORT MENTAL HEALTH AND SUBSTANCE USE DISORDER. Mental health community support and substance use community support are rehabilitative services for individuals with severe and persistent mental illness.

004.02(E)(ii)(1) ADMISSION CRITERIA. In addition to the admission criteria outlined in this chapter one on one direction in regards to the clients rehabilitation needs with a paraprofessional is required.

004.02(E)(ii)(2) TREATMENT AND REHABILITATION PLAN. The plan must be reviewed and updated every 90 days or more often as medically indicated.

004.02(E)(ii)(3) HOURS OF SERVICE DELIVERY. The provider must have

established hours of service delivery that ensure program staff availability and accessibility to the treatment and rehabilitation needs of each individual client. Scheduled services must include evening and weekend hours, and access to a licensed mental health practitioner 24 hours a day and 7 days per week.

004.02(E)(ii)(4) SERVICE STANDARDS. The community support program must:

- (a) Provide or develop the necessary services and supports to enable clients to reside in the community;
- (b) Maximize the client's community participation, community and daily living skills, and quality of life;
- (c) Facilitate communication and coordination between mental health rehabilitation providers that serve the same client;
- (d) Decrease the frequency and duration of hospitalization;
- (e) Assist the individual in self-advocacy and achieving community and social integration;
- (f) Provide active rehabilitation and support interventions with focus on activities of daily living, education, budgeting, medication compliance and self-administration (as appropriate and part of the overall treatment and rehabilitation plan), relapse prevention, social skills, and other independent living skills that enable the individual to reside in their community;
- (g) Provide service coordination and case management activities, including coordination or assistance in accessing medical, psychological, psychiatric, social, education, transportation and linkages to other community services identified in the treatment and rehabilitation plan;
- (h) Develop and implement strategies to encourage the individual to become engaged and remain engaged in necessary Substance Use Disorder(SUD) and psychiatric treatment services as recommended and included in the treatment and rehabilitation plan;
- (i) Assist the client in the developing, evaluating and updating a crisis and relapse prevention plan;
- (j) Participate with, and report to treatment team on the individual's progress and response to interventions community support intervention in the identified in the plan; and identified in the treatment and rehabilitation plan;
- (k) Provide therapeutic support and intervention to the individual in time of crisis; and
- (l) In the event of an inpatient hospital stay, facilitate in cooperation with an inpatient treatment provider and the individual transition back in to the community.

004.02(E)(iii) DAY REHABILITATION. Day rehabilitation services are designed to provide individualized treatment and recovery, inclusive of psychiatric rehabilitation and support for individuals with a severe and persistent mental illness or co-occurring disorders who are in need of a day program operating with variable hours. The intent of the service is to enhance and maintain the individual's ability to function in community settings, decrease the frequency and duration of hospitalization and support the individual in the rehabilitation process so that the individual can be successful in a community living setting of their choice. This is a facility based service.

004.02(E)(iii)(1) SERVICE STANDARDS. The program must provide:

- (a) An initial treatment and rehabilitation plan to guide the first 30 days of treatment should be developed within 72 hours of admission; and
- (b) A Substance Use Disorder (SUD) assessment must be completed as needed;
- (c) Comprehensive treatment and rehabilitation and plan, developed under clinical guidance within 21 days of the Initial Diagnostic Interview (IDI);
- (d) A review and update, of the treatment, rehabilitation, and discharge plan every 90 days; and
- (e) The on-site capacity to provide referrals for ancillary service as needed, medication administration or self-administration, symptom management, nutritional support, social, vocational, and life-skills building activities, self-advocacy, peer support services, recreational activities, and other independent living skills that enable the individual to reside in their community.

004.02(E)(iii)(2) PROGRAM AVAILABILITY. Providers must directly provide or otherwise demonstrate that each client has on-call access to a licensed mental health practitioner on a 24 hour, 7 days per week basis.

004.02(E)(iv) ASSERTIVE COMMUNITY TREATMENT (ACT). Assertive community treatment is intended to help clients stabilize symptoms, improve level of functioning, and enhance the sense of well-being. Services provided will focus on treatment and rehabilitation of the effects of serious mental illness, as well as support and assistance in meeting such basic human needs as housing, transportation, education, and employment as necessary for client satisfaction with services and increased quality of life. The goal of the program is to provide assistance to individuals in maximizing their recovery, to ensure client directed goal setting, to assist clients in gaining hope, and provide assistance in helping clients become respected and valued members of their community.

004.02(E)(iv)(1) ADMISSION CRITERIA. See this chapter for general admission criteria. Assertive Community Treatment (ACT) specific admission criteria include:

- (a) Have a history of high utilization of psychiatric inpatient and emergency services;
- (b) The individual has had less than satisfactory response to previous levels of treatment and rehabilitation interventions; and
- (c) Individuals are disabled by severe and persistent mental illness and are unable to remain stable in community living without high intensity services.

004.02(E)(iv)(2) Discharge Criteria. The assertive community treatment (ACT) Program is intended to provide services over a long period of time. Clients admitted to the service who demonstrate continued need for treatment, rehabilitation, or support must not be discharged in the following situations:

- (a) Geographic Relocation: The client moves outside the team's geographic area of responsibility. In such cases, the provider must arrange for transfer of mental health service responsibility to a provider wherever the client is

moving. To meet this responsibility, the provider must maintain contact with the client until this service transfer is arranged.

004.02(E)(iv)(3) ASSERTIVE COMMUNITY TREATMENT TEAM RESPONSIBILITIES. Assertive Community Treatment (ACT) is provided by a self-contained clinical team which:

- (a) Assumes overall responsibility and clinical accountability for clients disabled by severe and persistent mental illness by directly providing treatment, rehabilitation and support services and by coordinating care with other providers;
- (b) Does not refer clients to outside service providers when services are identified as a responsibility of the ACT program;
- (c) Provides services on a long-term basis with continuity of care givers; and delivers most of the services outside program offices;
- (d) Emphasizes, relationship building, and individualization of services;
- (e) Provides psychiatric treatment and rehabilitation that is culturally sensitive; and
- (f) Shares team roles expecting each staff member to know all the clients and assist in assessment, treatment planning, and care delivery as needed.

004.02(E)(iv)(4) SERVICE STANDARDS. The program must include:

- (a) An Initial Diagnostic Interview (IDI) must be completed. If the Initial Diagnostic Interview (IDI) was completed within 12 months prior to admission, a practitioner working within their scope of practice must review and update as necessary. The Initial Diagnostic Interview (IDI) serves as the treatment plan for the first 30 days until the comprehensive plan of care is developed;
- (b) A substance use disorder (SUD) assessment must be completed as needed;
- (c) A comprehensive treatment and rehabilitation plan, developed under clinical guidance within 21 days of the Initial Diagnostic Interview (IDI);
- (d) A review of the individual's treatment and rehabilitation, plan every six months, whenever there is a change in psychiatric condition or level of functioning during the individual's course of treatment, or more often as necessary to actively review progress and make necessary revisions to the individual's goals;
- (e) The individual in active involvement in the development of the treatment and rehabilitative plan goals. With the permission of the individual, the Assertive Community Treatment (ACT) Team will involve, friends, family members or social networks in the formulation of Individual s plan.
- (f) Individual, family, and group therapy to assist the individual to gain skills to understand—and maintain relationships, conflict identification and resolution, and maintenance of relationships;
- (g) Medication management services which include prescribing, delivery, administration and monitoring of medications;
- (h) Crisis intervention services as necessary;
- (i) Direct assistance in obtaining basic necessities such as transportation,

medical appointments, food, utilities and housing;

- (j) The provision of supportive interventions that focus on activities of daily living, social functioning, and community living skills and referrals to support groups;
- (k) Positive peer role modeling and peer support; and
- (l) Daily interdisciplinary team meetings to include, reviewing the functional status and needs of individuals, proactively identifying issues and concerns, and reviewing clinical issues.

004.02(E)(iv)(5) HOURS OF OPERATION AND AVAILABILITY OF SERVICES. The assertive community treatment team must be available to provide treatment, rehabilitation, and support interventions 24 hours per day, seven days per week, 365 days a year. The team must be able to:

- (a) Meet the clients' needs at all hours of the day including evenings, weekends, and holidays; providing services at the time that is most appropriate for the individual;
- (b) Operate a minimum of 12 hours per day and eight hours each weekend day and every holiday;
- (c) Psychiatric coverage must be available at all times. If availability of the team psychiatrist during all hours is not feasible alternative psychiatric backup must be arranged.

004.02(E)(iv)(6) STAFFING STANDARDS. An assertive community treatment (ACT) team may contain:

- (a) A psychiatrist at least 16 hours a week;
- (b) Team leader, must have a master's degree in nursing, social work, psychiatric rehabilitation, psychology, or be a psychiatrist or a physician extender;
- (c) Mental health professional;
- (d) Licensed or provisionally licensed psychologist;
- (e) Licensed independent mental health practitioner (LIMHP);
- (f) Licensed mental health practitioner (LMHP);
- (g) Provisionally licensed mental health practitioner (PLMHP);
- (h) Registered nurse (RN);
- (i) Licensed alcohol and drug counselor (LADC) or a provisionally licensed alcohol and drug counselor (PLADC);
- (j) Certified peer support specialist;
- (k) Vocational specialist with at least one year training and experience in vocational rehabilitation and support;
- (l) Substance use disorder (SUD) specialists with at least one year training and experience in substance use disorder (SUD) treatment;

004.02(E)(iv)(7) PRINCIPLES. All staff must be educated and trained in rehabilitative principles, and trauma informed care.

004.02(E)(iv)(8) ADDITIONAL STAFF. If the assertive community treatment (ACT) team serves more than 50 individuals then the following additional staff members are needed:

- (a) At least one additional registered nurse and psychiatric professional;
- (b) A full time Certified Peer Support Specialist; and
- (c) For every additional eight individuals, the Psychiatrist must be available an additional 2.6 hours.

004.02(E)(v) PSYCHIATRIC RESIDENTIAL REHABILITATION. Psychiatric residential rehabilitation is designed to provide individualized treatment inclusive of psychiatric rehabilitation and support for individuals with a severe and persistent mental illness or co-occurring disorders. The individuals that meet admission criteria are in need of rehabilitation activities within a residential setting and the, intent of the service is to support the individual so that they can be successful in a community living setting of their choice.

004.02(E)(v)(1) ADMISSION CRITERIA. Psychiatric residential rehabilitation specific criteria include:

- (i) Functional deficits of such intensity requiring professional interventions in a 24 hour psychiatric residential setting;
- (ii) Requires 24-hour awake staff to assist with psychiatric rehabilitation.

004.02(E)(v)(2) SERVICE STANDARDS. The program must provide:

- (i) An Initial Diagnostic Interview (IDI) must be completed. If the initial diagnostic interview (IDI) was completed within 12 months prior to admission, a practitioner working within their scope of practice must review and update as necessary to ensure the information is reflective of the individual's current status and functioning. The Initial Diagnostic Interview (IDI) serves as the treatment plan for the first 30 days until the comprehensive plan of care is developed;
- (ii) An initial treatment and rehabilitation must be developed within 72 hours of admission to guide the first 14 days of treatment;
- (iii) A Substance Use Disorder (SUD) assessment must be completed as needed;
- (iv) A comprehensive treatment, and rehabilitation plan, developed under clinical guidance within 30 days of the Initial Diagnostic Interview (IDI);
- (v) Review of the treatment, rehabilitation and discharge plan with the individual, other approved family and supports, and the clinical supervisor every 90 days or more often as needed. The treatment and discharge plan must be updated as medically indicated;
- (vi) The ability to arrange for psychiatric services, general medical, pharmacology, psychological, dietary, pastoral, emergency medical, recreation therapy, laboratory and other diagnostic and treatment services;
- (vii) Therapeutic milieu offering 25 hours of staff led active treatment, and rehabilitation activities seven days a week; and a minimum of 20 hours per week of additional off-site rehabilitation, vocational, and educational activities.
- (viii) The on-site capacity to provide medication administration or self-administration, symptom management, nutritional support, social, vocational, and life-skills building activities, self-advocacy, peer support

- services, recreational activities, and other independent living skills that enhance the individual's ability to reside in their community; and
- (ix) Referrals for services and supports, as needed, to enhance the individual's independence in the community.

004.02(E)(v)(3) STAFFING STANDARD. Psychiatric residential rehabilitation services must have clinical direction by a:

- (a) Licensed psychologist;  
(b) Advanced practice registered nurse (APRN);  
(c) Registered nurse (RN);  
(d) Licensed independent mental health practitioner (LIMHP); or  
(e) Licensed mental health practitioner (LMHP);

004.02(E)(v)(3)(i) PSYCHIATRIC RESIDENTIAL REHABILITATION SERVICES STAFF. Staff must be:

- (1) Appropriately licensed and credentialed professionals working within their scope of practice; and  
(2) Psychiatric residential rehabilitation direct care staff must meet the requirements of a direct care staff.

004.02(E)(vi) SECURE PSYCHIATRIC RESIDENTIAL REHABILITATION. Secure residential treatment is intended to provide individualized recovery, psychiatric rehabilitation, and support for individuals demonstrating a high-risk for harm to self or others and in need of a secure, rehabilitative therapeutic environment. Length of service is individualized and based on clinical criteria for admission and continuing stay, as well as the individual's ability to make progress on treatment and rehabilitation goals. An individual may decline continuation of the service, unless under psychiatric board commitment, court order, or at the direction of their legal guardian. The Secure Psychiatric Residential Rehabilitation Program is designed to:

- (1) Increase the individual's functioning while improving psychiatric stability so that the individual can eventually live successfully and safely in a less restrictive residential setting;  
(2) Decrease the frequency and duration of hospitalization;  
(3) Decrease or eliminate all high risk, unsafe behavior to self or others; and  
(4) Improve the individual's ability to function independently.

004.02(E)(vi)(a) ADMISSION CRITERIA. In addition to general admission criteria in this chapter the individual has to meet the following:

- (i) The individual must have a high risk of relapse or symptoms reoccurrence, as evidenced by the following:
- (1) Active symptomology consistent with a diagnosis in the current version of the Diagnostic and Statistical Manual (DSM) as published by the American Psychiatric Association diagnoses;  
(2) High need for professional structure, intervention and observation;  
(3) High risk for re-hospitalization without 24-hour supervision; and  
(4) Unable to safely reside in less restrictive residential setting and requires 24-hour supervision.
- (ii) The individual must meet one of the following criteria:



- (1) The individual presents with a high risk of danger to self which is evidenced by any of the following:
  - (a) Attempts to harm self, which are life threatening or could cause disabling permanent damages with continued risk without 24-hour behavioral monitoring;
  - (b) Suicidal ideation; or
  - (c) A level of suicidality that cannot be safely managed without 24-hour behavioral monitoring; and
  - (d) At risk for severe self-neglect resulting in harm or injury; or
- (2) High risk of danger to others as a result of a diagnosis in the current Diagnostic and Statistical Manual (DSM) as published by the American Psychiatric Association, as evidenced by either life threatening action with continued risk without 24-hour behavioral supervision and intervention or harmful ideation.

004.02(E)(vi)(b) SERVICE STANDARDS. The program must offer structured, planned treatment and rehabilitation services as prescribed by the individualized treatment, and rehabilitation plan. The following services must be available and offered to the individual:

- (i) History and physical within 24 hours of admission by a physician or advanced practice registered nurse (APRN). A history and physical may be accepted from previous provider if completed within the last three months. An annual physical is required;
- (ii) Initial Diagnostic Interview (IDI) within 24 hours of admission;
- (iii) A nursing assessment must be completed within 24 hours of admission; twenty four hour medically necessary nursing services provided by an advanced practice registered nurse (APRN) or registered nurse (RN) with psychiatric experience;
- (iv) Other assessments as needed;
- (v) An individual recovery, discharge and relapse prevention plan developed with input from the interdisciplinary team, the individual and their chosen supports within 14 days of admission. The treatment plan must be reviewed weekly by the individual and the interdisciplinary team;
- (vi) Consultation services available for general medical, dental, pharmacology, psychological, dietary, pastoral, emergency medical, recreation therapy, laboratory and other diagnostic services as needed;
- (vii) Face-to-face or Telehealth visits with a psychiatrist at a minimum of every 14 days or as often as medically necessary;
- (viii) Access to on-call, licensed psychiatric professionals 24 hours a day and seven days a week;
- (ix) Forty two hours of active treatment provided to each individual weekly, seven days per week;
- (x) Access to community-based rehabilitation and social services to assist in transition to community living;
- (xi) Medication management, and education;
- (xii) Individual, group, and family therapy and substance use disorder (SUD) treatment as appropriate;

- (xiii) Life skill services which may include but is not limited to daily living, social skills, community living, transportation, peer support services, vocational, financial planning, legal assistance and self-advocacy;
- (xiv) Appropriate staff coverage to provide the services identified above.

004.02(E)(vi)(c) TREATMENT SERVICES. The program must offer structured, planned treatment and rehabilitation services as prescribed by the individualized treatment, and rehabilitation plan. The following services must be available and offered to the client:

- (i) Individual Psychotherapy;
- (ii) Group Psychotherapy;
- (iii) Family Therapy, consent from the client must be documented prior to the involvement of the family and delivery of the service; and
- (iv) Psychoeducational services, such as medical education by a registered nurse and skill development groups by a trained and skilled staff able to facilitate these groups supervised by a licensed mental health practitioner.

004.02(E)(vi)(d) ASSESSMENTS. The following assessments must be completed:

- (i) A comprehensive mental health and substance use disorder assessment by a licensed mental health practitioner practicing within their professional scope must occur prior to admission;
- (ii) Following admission and within 24 hours of stay, an assessment by the program's psychiatrist must be completed;
- (iii) A history and physical must be completed by a physician or advanced practice registered nurse (APRN) within 24 hours of admission or one must be completed within 60 days of admission and available in the clinical record;
- (iv) A nursing assessment must be completed by a registered nurse within 24 hours of admission; and
- (v) A functional assessment must be completed initially upon admission and annually with continued stay at this level of service.

004.02(E)(vi)(e) STAFFING STANDARDS. Staff may include:

- (i) Medical director must be a psychiatrist;
- (ii) Program director may be:
  - (a) Advanced practitioner registered nurse (APRN);
  - (b) Licensed mental health practitioner (LMHP);
  - (c) Licensed independent mental health practitioner (LIMHP); or
  - (d) Licensed clinical psychologist therapist practicing within their scope of practice.
- (iii) Register nurse (RN) with psychiatric experience; and
- (iv) Psychiatric residential rehabilitation direct care staff who must meet the requirements of a direct care staff.

004.02(E)(vi)(e)(1) STAFFING RATIO. Staffing ratio in a secure psychiatric residential setting must meet the following criteria:

- (a) One direct care staff to four individuals during individual awake hours, day and evening shifts;
- (b) One awake staff to six individuals with on-call availability of additional support staff during individual sleep hours, overnight; and
- (c) One therapist to eight individuals.

005. NON-COVERED SERVICES. Medicaid does not cover mental health, substance use disorder or rehabilitative services for adult individuals under the following circumstances:

- (A) Services provided in an out-of-state facility, except as outlined in 471 NAC 1, Services Provided Outside of Nebraska;
- (B) Services provided to individuals living in long term care facilities;
- (C) Services provided to individuals whose needs are social or educational and may be met through a less structured program;
- (D) Services provided to individuals whose primary diagnosis and functional impairment are psychiatric in nature but are not stable enough to allow them to participate in and benefit from the program; or
- (E) Services provided to individuals whose behavior may be very disruptive or harmful to other program participants or staff members.
- (F) Leave days of any type from any program.

005.02 INSTITUTE FOR MENTAL DISEASE. Nebraska Medicaid does not cover services provided to clients over age 20 and under age 64 who are being treated in an Institute for Mental Disease.

## 006 BILLING AND PAYMENT.

### 006.01 BILLING.

006.01(A) GENERAL BILLING REQUIREMENTS. Providers must comply with all applicable billing requirements codified in 471 NAC 3. In the event that individual billing requirements in 471 NAC 3 conflict with billing requirements outlined in this chapter, the individual billing requirements in this chapter will govern.

### 006.01(B) SPECIFIC BILLING REQUIREMENTS

006.01(B)(i) DAY REHABILITATION SERVICES. Day rehabilitation services must be billed in 15-minute increments for a direct care staff and, three to six hours per day, three to five days per week based on a per diem.

### 006.02 PAYMENT.

006.02(A) SPECIFIC PAYMENT REQUIREMENTS. Payment for services must be based upon rates established by Medicaid, as described further throughout this chapter, and may be increased or decreased based on legislative appropriations or budget directives from the Nebraska Legislature. Providers may be required to report their costs on an annual basis or as needed.

006.02(A)(i) MEDICAID DOES NOT PAY FOR PSYCHIATRIC SERVICES THAT ARE CHRONIC OR CUSTODIAL. Psychiatric services may be covered when treating an acute exacerbation of a long-term or chronic condition. The provider must document medical necessity and active treatment for each individual.

006.02(A)(ii) LIMITATIONS ON THE REIMBURSEMENT. Because regulations prohibit federal financial participation in the reimbursement of services to individuals age 21 to 64 in an Institute for Mental Disease (IMD), Medicaid eligibility for individuals who are admitted to an Institute for Mental Disease (IMD) for longer than 15 days will be closed.

## 20-000 PSYCHIATRIC SERVICES FOR INDIVIDUALS AGE 21 AND OLDER

20-001 General Requirements for Psychiatric Services: Effective July 1, 1995, the requirements of this chapter apply to all psychiatric services for individuals age 21 and older provided under the Nebraska Medical Assistance Program (NMAP).

Mental health and substance abuse services (MH/SA) are provided as a managed care benefit for all Nebraska Medicaid Managed Care (NMMCP) clients. The benefit includes the Client Assistance Program (CAP). Clients may access five services annually with any CAP-enrolled provider without prior authorization. All other MH/SA services must be prior authorized.

20-001.01 Philosophy of Care: The Department's philosophy is that all care provided to clients must be provided at the least restrictive and most appropriate level of care. More restrictive levels of care will be used only when all other resources have been explored and deemed to be inappropriate.

20-001.02 Non-Discrimination: The Department believes that each person, regardless of race, color, sex, age, religion, national origin, disability, sexual orientation, or marital status possesses inherent worth and value. The Department expects services to be provided in a way that shows respect and support for such diversity. Providers must be aware of the issues which may arise and ask for consultation or make referrals as needed.

20-001.03 Family of Origin Component: Care must address family concerns and, whenever possible, involve the family in treatment planning, therapy, and transition/discharge planning. Family may include biological, step, foster, or adoptive parents; siblings or half siblings; and Sreextended family members, as appropriate. Family involvement, or lack thereof, must be documented in the clinical record. For adults who choose not to have family members involved or for whom the treating professional deems family involvement inappropriate or harmful, that information must be documented in the medical record.

Providers must encourage family members to be involved in the assessment of the client, the development of the treatment plan, and all aspects of the client's treatment unless prohibited by the client, through legal action, or because of federal confidentiality laws.

Providers must be available to schedule meetings and sessions in a flexible manner to accommodate and work with a family's schedule. This includes the ability to schedule sessions at a variety of times including weekends or evenings.

The provider must document their attempts to involve the family in treatment plan development and treatment plan reviews. A variety of communication means should be considered. These may include, but should not be limited to, including the family via conference telephone calls, using registered letters to notify the family of meetings, and scheduling meetings in the evening and on weekends.

~~20-001.04 Community-Based Care: Care must be community-based and, when appropriate, must involve a representative from the client's community support system. This may include areas such as education, social services, law enforcement, religion, medical, and other mental health or substance abuse professionals. Community involvement must be documented in the clinical record. This documentation must include any lack of cooperation or resistance from the community support system.~~

~~20-001.05 Developmentally Appropriate Care: Care must address the client's biological, psychological, and social development. Therapeutic interventions must be congruent with the findings of the developmental level of the client, based on comprehensive psychiatric and psychological assessments.~~

~~20-001.06 Culturally Competent Care: Providers of psychiatric services for individuals age 20 and over must be culturally competent. This includes awareness, acceptance, and respect of differences and continuing self-assessment regarding culture. Cultural competence also 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 hire unbiased employees, seek advice and consultation from the minority community, and actively decide whether or not they are capable of providing services to clients from other cultures. They provide support for staff to become comfortable working in cross-cultural situations and understand the interplay between policy and practice and are committed to policies that enhance services to diverse clientele.~~

~~20-001.07 Dually Diagnosed Clients: The treatment provider must incorporate the needs of the "dually diagnosed" client and provide active treatment for clients with concurrent or secondary complicating problems. The "dually diagnosed" clients may have problems such as substance abuse, eating disorder symptoms, developmental delays, or mental retardation. Dual diagnosis treatment is the simultaneous and integrated treatment of coexisting disorders.~~

~~20-001.08 Coordinated Services: If a client is receiving services from more than one psychiatric provider, the providers must assure coordination of all services. That coordination must be documented in the client's medical record. Coordination of services is required as part of the overall treatment plan must be covered in one unified treatment plan, and is not billable as a separate service.~~

20-001.09 Provider Enrollment

20-001.09A Provider Agreement: A provider of psychiatric services for individuals age 21 and over must complete Form MC-19 or Form MC-20, "Medical Assistance Provider Agreement," and submit the completed form to the Department for approval. Specific requirements for each type of care are listed in the respective subpart. The provider must meet all of these standards in order to be enrolled with NMAP. The Department is the sole determiner of which providers are approved for participation in this program. The provider will be advised in writing when their participation is approved. (A separate application must be submitted for each particular service and each service will be approved separately.)

Refer to the Standards for Participation section in each subpart.

20-001.09B Provider Enrollment Status: The provider enrollment process allows for three types of provider enrollment status based on information from the provider and other sources. The Department must notify the provider of the status assigned. The types of provider enrollment are -

1. Provisional status: A provider who has recently established services within this chapter or who is new to the NMAP will be enrolled with a provisional status. After a minimum of one year of services, the Department may choose to grant ongoing status to the provider.
  - a. Grounds for terminating a provider agreement are further defined in 471 NAC 2-002.03, "Reasons for Sanctions."
  - b. Providers may appeal the decision to terminate a provider enrollment. The appeal process is described in 471 NAC 2-003, "Provider Hearings."
2. Ongoing status: A provider may establish ongoing status after a minimum of one year of service within the Medicaid guidelines.
3. Probationary status: A provider may be placed on probationary status when there are deficiencies in meeting Medicaid guidelines or there are other concerns about the provider's program or practices. While on probationary status, a provider may be required to work with Medicaid staff to develop a corrective action plan. This plan must be submitted to Medicaid staff for approval.
  - a. Grounds for terminating a provider agreement are further defined in 471 NAC 2-002.03, "Reasons for Sanctions."
  - b. Providers may appeal the decision to place a provider on probationary status. The appeal process is described in 471 NAC 2-003, "Provider Hearings."
  - c. The probationary status will be evaluated by Medicaid staff on a frequency based on the situation. At these evaluations, a provider's enrollment may be terminated, placed on further probation, or returned to ongoing status. Providers may appeal these decisions as described in 471 NAC 2-003, "Provider Hearings."

- d. ~~If the deficiencies are not causing immediate jeopardy or compromising the safety of the clients, then the facility can continue to participate in Medicaid. A prohibition of new admissions may occur if—~~
- ~~(1) There are allegations of abuse or neglect under investigation in relation to the program or its staff;~~
  - ~~(2) The quality of treatment is significantly compromised by the deficiencies; or~~
  - ~~(3) The provider is violating any laws, regulations, or code of ethics governing their program.~~

~~20-001.09C Updates: The provider must send to the Department an update of the services provided in its facility and the current list of staff each year during the anniversary quarter of the provider's enrollment in Nebraska Medicaid as a provider of psychiatric services for individuals age 21 and over. This information must also be sent to the Department if a provider makes changes in how they provide a service. These changes and updates must be indicated on Form MC-19 or Form MC-20, "Medical Assistance Provider Agreement."~~

~~20-001.10 Out-of-State Services: See 471 NAC 1-002.01F. In addition, potential out-of-state providers of Chapter 20 services must have a specific plan of how they will meet the family and community requirements. This plan must be approved by the Department to become a provider of NMAP services.~~

~~20-001.11 Quality Assurance and Utilization Review: All providers participating in NMAP have agreed 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 may perform quality assurance and utilization review activities, such as on-site visits, to verify the quality of service. If the provider or the services do not meet the standards of this chapter and the specific level of care, the provider may be subject to administrative sanctions under 471 NAC 2-002 ff. or denial of provider agreement for good cause under 471 NAC 2-001.02A. The Department may request a refund for all services not meeting Chapter 20 requirements.~~

~~If the clients are in immediate jeopardy, the sanctions may be imposed under 471 NAC 2-002.05 without a hearing.~~



20-001.12 Service Definitions: The following definitions of service apply within this chapter:

Individual Psychotherapy: A face-to-face treatment session between the client and the appropriate mental health professional for an acceptable primary psychiatric diagnosis. (No additional reimbursement is made for medication checks performed by a physician in the course of individual psychotherapy.)

Group Psychotherapy: A face-to-face treatment session, requiring professional expertise, between the client and the appropriate mental health professional in the context of a group setting of at least three and not more than twelve clients. Group psychotherapy must provide active treatment for a primary psychiatric diagnosis. NMAP does not cover: groups that are primarily supportive or educational in nature, or the services of a co-therapist.

Family Assessment: A comprehensive family assessment must be completed during the initiation of services. This must be completed by a mental health professional with training and experience in family systems.

Family Psychotherapy: A face-to-face treatment session, requiring professional expertise, between the client (identified patient), the nuclear and/or extended family, and the appropriate mental health professional. These services must focus on the family as a system and include a comprehensive family assessment. The specific objective of treatment must be to alter the family system to increase the functional level of the identified patient. This therapy must be provided with the appropriate family members and the identified patient. The focus of the services must be on systems within the family unit. Therapists of families with more than one provider must communicate with and coordinate services with any other provider for the family or individual family members. Coordination of services is required as part of the overall treatment plan and is not billable as a separate service. Duplicate or co-therapist services will not be reimbursed. The client must be eligible for NMAP and have an acceptable primary psychiatric diagnosis.

Services of Psychiatric Resident Physicians: Psychiatric resident physicians may provide psychotherapy services and medication checks when these services are directly supervised by the attending psychiatrist. The resident's supervising psychiatrist must sign the Department approved treatment planning document for services provided by the resident physician. The resident physician may not supervise services of allied health therapists, licensed mental health practitioners, or qualified R.N.'s. Resident physician services must be billed using the appropriate CPT/HCPCS procedure codes.

~~Observation Room Services (23:59):~~ When appropriate for brief crisis stabilization, outpatient hospital observation up to 23 hours 59 minutes in an emergency room or acute hospital may be used as follows: An outpatient is defined as a person who has not been admitted as an inpatient but is registered on the hospital records as an outpatient and receives services. NMAP covers observation room services under the following conditions:

- ~~1. Since this service has the potential to become an inpatient hospitalization, the claim will be reviewed according to the standards of care for inpatient hospitalization in 471 NAC 20-007;~~
- ~~2. If a patient receives 24 or more hours of continuous outpatient care, that patient is defined as an inpatient regardless of the hour of admission, whether s/he used a bed, and whether s/he remained in the hospital past midnight or the census-taking hour;~~
- ~~3. When the patient reaches 24 hours of continuous outpatient care, all inpatient medical review prior authorization requirements noted in 471 NAC 20-007 and 20-008 apply; and~~
- ~~4. The services must be billed as an outpatient hospital psychiatric service on Form CMS-1450 or the standard electronic Health Care Claim: Institutional transaction (ASC X12N 837).~~

~~20-001.13 Psychiatric Therapeutic Staff Standards:~~ Psychiatric therapeutic staff for adult services must meet the following requirements:

- ~~1. Supervising Practitioners: All psychiatric services must be provided under the supervision and direction of a supervising practitioner. The following are the professional designations of those who qualify as a supervising practitioner:
  - ~~a. Physician: Must be licensed as a physician by the Nebraska Department of Health and Human Services, Division of Public Health or the appropriate licensing agency in the state in which s/he practices and must be enrolled with NMAP with a primary specialty of psychiatry.~~
  - ~~b. Licensed Psychologist: Must be a licensed psychologist by the Nebraska Department of Health and Human Services, Division of Public Health or the appropriate licensing agency of the state in which s/he practices and must be enrolled with NMAP with a primary specialty of clinical psychology.~~
  - ~~c. Licensed Independent Mental Health Practitioners (LIMHP) (effective December 1, 2008 and after).~~~~

~~Definition and Practice of Supervision: Supervision by the supervising practitioner is defined as the critical oversight of a treatment activity or course of action. This includes, but is not limited to, review of treatment plan and progress notes, client specific case discussion, periodic assessments of the client (as defined in each section), and diagnosis, treatment intervention or issue specific discussion. The supervising practitioner is a source of information and guidance for all members of the treatment team and their participation in services as an essential ingredient for all members of the treatment team. The critical involvement of the supervising practitioner must be reflected in the Initial Diagnostic Interview, the treatment plan, and the interventions provided.~~

~~The supervising practitioner (or their designated and qualified substitute) must be available, in person or by telephone, to provide assistance and direction as needed during the time the services are being provided.~~

~~Supervisory contact may occur in a group setting.~~

~~Supervision is not billable by either the therapist or the supervising practitioner as it is considered a mandatory component of the care.~~

~~Psychiatric resident physicians, physician assistants and Advanced Practice Registered Nurses may not supervise allied health therapists for Medicaid services.~~

~~Effective December 1, 2008, Licensed Independent Mental Health Practitioners may supervise other licensed practitioners.~~

~~The supervising practitioner must periodically evaluate the therapeutic program and determine if treatment goals are being met and if changes in direction or emphasis are needed.~~

- ~~2. Psychiatrically trained physician extenders may not supervise services in place of the physician, but may provide direct care as allowed by the scope of practice guidelines set by the Nebraska Department of Health and Human Services, Division of Public Health and the practice agreement of each individual. A copy of the practice agreement must be submitted at the time of application for enrollment.~~
- ~~3. Licensed Independent Mental Health Practitioners (LIMHP) may provide direct care as allowed by the scope of practice guidelines set by Nebraska Department of Health and Human Services, Division of Public Health.~~
- ~~4. Allied Health Therapists: All psychotherapy services provided by allied health therapists must be prescribed by the supervising practitioner and provided under his/her supervision. All allied health therapists must have knowledge of the interactional systems within families.  
Allied health therapists include:
  - ~~a. Specially Licensed Psychologists: Persons who are specially licensed as psychologists through the Nebraska Department of Health and Human Services, Division of Public Health or the appropriate licensing agency of the state in which s/he practices;~~
  - ~~b. Licensed Mental Health Practitioners: Persons who are licensed as mental health practitioners by the Nebraska Department of Health and Human Services, Division of Public Health or the appropriate licensing agency of the state in which s/he practices;~~~~

- c. Provisionally Licensed Mental Health Practitioners: Practitioners who are licensed as a provisional mental health practitioner by the Nebraska Department of Health and Human Services, Division of Public Health or the appropriate licensing agency of the State in which s/he practices.
  - d. Qualified Registered Nurse: A registered nurse (R.N., R.N. with Bachelor's, Masters, or Ph.D., or certification as a psychiatric clinical specialist or nurse practitioner by the American Nurse Association) who is licensed by the Nebraska Department of Health and Human Services, Division of Public Health or the appropriate licensing agency of the state in which s/he practices;
  - e. Qualified Mental Health Professional/Masters Equivalent: A holder of a master's degree in a closely related field that is applicable to the bio/psycho/social sciences or to treatment for persons who are mentally ill and is actively pursuing licensure as a mental health practitioner as allowed by the Nebraska Department of Health and Human Services, Division of Public Health; or a Ph.D. candidate who has bypassed the master's degree but has sufficient hours to satisfy a master's degree requirement.
5. Any Medicaid provider who is licensed by the Nebraska Department of Health and Human Services, Division of Public Health and has a substantiated disciplinary action filed against the license that limits the provision of services will not be allowed to provide NMAP services. If a provider is licensed by another state, substantiated disciplinary action filed against that license that limits the provision of services will be cause for termination as an NMAP provider.

20-001.14 Payment Limitations: Payment for psychiatric services for individuals age 21 and older under NMAP is limited to payment for medically necessary psychiatric services for medically necessary primary psychiatric diagnoses.

NMAP does not pay for psychiatric services that are chronic or custodial. Psychiatric services may be covered when treating an acute exacerbation of a long-term or chronic condition. The provider must document medical necessity and active treatment for each client. Documentation is kept in the client's medical record.

20-001.15 Medical Necessity: Medically necessary services are services provided at an appropriate level of care which are based on documented clinical evaluations including a comprehensive diagnostic workup and supervising practitioner ordered treatment.

Biopsychosocially necessary treatment interventions and supplies are those which are:

1. Consistent with the behavioral health condition and conducted with the treatment of the client as the primary concern;
2. Supported by sufficient evidence to draw conclusions about the treatment intervention's effects of behavioral health outcomes;
3. Supported by evidence demonstrating the treatment intervention can be expected to produce its intended effects on behavioral health outcomes;
4. Supported by evidence demonstrating the intervention's intended beneficial effects on behavioral health outcomes outweigh its expected harmful effects;
5. Cost effective in addressing the behavioral health outcome;
6. Determined by the presentation of behavioral health conditions, not necessarily by the credentials of the service provider;

7. Not primarily for the convenience of the client or the provider;
8. Delivered in the least restrictive setting that will produce the desired results in accordance with the needs of the client.

Behavioral health conditions are the diagnoses listed in the current version of the Diagnostic and Statistic Manual as published by the American Psychiatric Association. (The NMAP does not reimburse for services for diagnoses of developmental disabilities, mental retardation, or V codes as part of this chapter.)

Behavioral health outcomes mean improving adaptive ability, preventing relapse or decompensation, stabilization in an emergency situation, or resolving symptoms.

20-001.16 Active Treatment: Active treatment is provided under an individualized treatment plan developed by the professional staff as required for each level of care. The plan must be based on a face-to-face comprehensive evaluation of the client's restorative needs and potentialities for a primary psychiatric diagnosis. An isolated service, such as a single session with the required professional 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 must be reasonably expected to improve the client's condition or to determine a psychiatric diagnosis. The treatment must, at a minimum, be designed to reduce or control the client's psychiatric symptoms to facilitate the client's movement to a less restrictive environment within a reasonable period of time.

The kinds of services that meet this requirement include individual and group psychotherapy, family therapy, drug therapy, and adjunctive therapies, such as occupational therapy, recreational therapy, and speech therapy. These services must be face-to-face to meet the active treatment criteria. The adjunctive therapeutic services must be expected to improve the client's behavioral health condition. If the only activities prescribed for the client are primarily diversional in nature, (i.e., to provide some social, educational, or recreational outlet for the patient), NMAP does not consider the services as active treatment to improve the client's behavioral health condition.

The administration of a drug or drugs does not by itself necessarily constitute active treatment (i.e., the use of mild tranquilizers, sedatives, antidepressants, or antipsychotics solely to alleviate anxiety, insomnia, depression, or psychotic symptoms).

The active treatment services must be supervised, directed, and evaluated by a supervising practitioner. The supervising practitioner's participation in the services is an essential ingredient of active treatment. The services of other qualified professionals (i.e., occupational therapists, recreational therapists, speech therapists, etc.) must be prescribed by a supervising practitioner to meet the specific needs of the client. The supervising practitioner must evaluate the therapeutic program and determine if treatment goals are being met and if changes in direction or emphasis are needed on a regular basis through a face-to-face session, as defined for the level of care being provided. The evaluation must be based on periodic consultations and conferences with all current treatment staff, reviews of the client's clinical record, and regularly scheduled face-to-face client interviews as required for the level of care being provided.

20-001.17 Treatment Plans: A treatment plan must be established for each client. The treatment plan is a comprehensive plan of care formulated by the clinical staff under the direction of a supervising 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 identified needs, reduce problem behaviors, and improve overall functioning.

The treatment plan must be based upon an assessment of the client's problems and needs in the areas of emotional, behavioral, and skills development. The treatment plan must be individualized to the client and must include the specific problems, behaviors, or skills to be addressed; clear and realistic goals and objectives; services, strategies, and methods of intervention to be implemented; criteria for achievement; target dates; methods for evaluating the client's progress; and the responsible professional.

The goals and objectives documented on the treatment plan must reflect the recommendations from the Initial Diagnostic Interview, the supervising practitioner and the therapist. The treatment interventions provided must reflect these recommendations, goals, and objectives. Evaluation of the treatment plan by the therapist and the supervising practitioner should reflect the client's response to the treatment interventions based on the recommendations, goals and objectives.

A treatment plan must be developed for every client within the time frames specified for each type of service and must 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 Medicaid reimbursable.

The treatment plan must be reviewed and updated by the treatment team according to the client's level of functioning. Minimum time frames for treatment plan reviews are dependent on the type of service. Refer to each individual service description for the review requirements. 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 psychiatric services. The supervising practitioner and treatment team members must sign and date the treatment plan at each treatment plan review.

If the client is receiving services from more than one psychiatric provider, these agencies must coordinate their services and develop one overall treatment plan for the client or family. This treatment plan is used by all providers working with the client or family.

~~20-001.18 Transition and Discharge Planning: Whenever a client is transferred from one level of care to another, transition and discharge planning must be performed and documented by the treating providers, beginning at the time of admission.~~

~~Providers must meet the following standards regarding transition and discharge planning:~~

- ~~1. Transition and discharge planning must begin on admission;~~
- ~~2. Discharge planning must 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 must address the client's need for ongoing treatment to maintain treatment gains and to continue normal physical and mental development following discharge;~~
- ~~4. Discharge planning must include identification of and clear transition into developmentally appropriate services needed following discharge;~~
- ~~5. Treatment providers must make or facilitate referrals and applications to the next level of care or treatment provider;~~
- ~~6. The current provider must arrange for prompt transfer of appropriate records and information to ensure continuity of care during transition into the next level of care; and~~
- ~~7. A written transition and discharge summary must be provided as part of the medical record.~~

~~20-001.19 Clinical Records: Clinical records must be arranged in a logical order such that the clinical information can be easily reviewed, audited, and copied. Each provider must maintain accurate, complete, and timely records and must always adhere to procedures that ensure the confidentiality of clinical data.~~

~~Treatment provided to the client must be written legibly or typed 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 it. If three separate individuals cannot understand the information written in a record because of handwriting that is difficult to read, the program must provide a readable format. Reimbursement for services may be denied if claims and/or medical records are not legible. Recoupment of previous payments for services may result if appropriate, legible, and complete records are not maintained for the client.~~

~~Providers of psychiatric services to individuals age 21 and older must comply with Department requests to review clinical records. This review may be of photocopies or on-site at the discretion of Department staff.~~

~~20-001.20 Inspections of Care: Under 42 CFR 456, Subpart I, the Department's inspection of care team must periodically inspect the care and services provided to clients in any level of care under the following policies and procedures.~~

~~20-001.20A Inspection of Care Team: The inspection of care team must meet the following requirements:~~

- ~~1. The inspection of care team must have a psychiatrist who is knowledgeable about the level of care s/he is reviewing, plus other appropriate mental health and social service personnel;~~
- ~~2. The team must be supervised by a psychiatrist, but coordination of the team's activities remains the responsibility of the Division of Medicaid and Long-Term Care;~~
- ~~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, but may review care in any other facility or institution.~~
- ~~4. A psychiatrist member of the team may not inspect the care of a client for whom s/he is the attending psychiatrist.~~
- ~~5. There must be a sufficient number of teams so located within the state that on-site inspections can be made at appropriate intervals for each facility or provider caring for clients.~~
- ~~6. A primary consumer, secondary consumer, or family member may be included in the inspection of care team at the discretion of the Department.~~

~~20-001.20B Frequency of Inspections: The inspection of care team must determine, based on the quality of care and services being provided and the condition of clients, at what intervals inspections will be made. However, the inspection of care team must inspect the care and services provided to each client at least annually, and/or more frequently as determined by the Inspection of Care team.~~

~~20-001.20C Notification Before Inspection: No facility or provider may be notified of the time of inspection more than 48 hours before the scheduled arrival of the inspection of care team. The Inspection of Care team may inspect a facility/provider with no prior notice, at their discretion.~~

~~20-001.20D Personal Contact With and Observation of Recipients and Review of Records: The team's inspection must include-~~

- ~~1. Personal contact with and observation of each client;~~
- ~~2. Review of each client's medical record; and~~
- ~~3. Review of the facility's or provider's policies as they pertain to direct patient care for each client being reviewed in the inspection of care, in accordance with 42 CFR 456.611(b)(1).~~



~~20-001.20E Determinations by the Team: The inspection of care team must determine in its inspection whether -~~

- ~~1. The services available are adequate to -
  - a. Meet the health needs of each client; and
  - b. Promote his/her maximum physical, mental, and psychosocial functioning;~~
- ~~2. It is necessary and desirable for the client to remain in that level of care; and~~
- ~~3. It is feasible to meet the client's health needs through alternative institutional or noninstitutional services.~~

~~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 will be determined by the inspection of care team and will be noted in the inspection of care report.~~

~~20-001.20F Basis for Determinations: Under 42 CFR 456.610, in making the determinations by the team on the adequacy and appropriateness of services and other related matters, the team will determine what items will be considered in the review. This will include, but is not limited to, items such as whether -~~

- ~~1. The psychiatric and medical evaluation, any required social and psychological evaluations, and the plan of care are complete and current; the plan of care, and when required, the plan of rehabilitation are followed; and all ordered services, including dietary orders, are provided and properly recorded.;~~
- ~~2. The attending physician reviews prescribed medications at least every 30 days;~~
- ~~3. Test or observations of each client indicated by his/her medication regimen are made at appropriate times and properly recorded;~~
- ~~4. Psychiatrist, nurse, and other professional progress notes are made 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 rehabilitative services, as evidenced by -
  - a. A planned program of activities to prevent regression; and
  - b. Progress toward meeting objectives of the plan of care;~~
- ~~7. The client needs any services that are not furnished by the facility or through arrangements with others; and~~
- ~~8. The client needs continued placement in the facility or there is an appropriate plan to transfer the client to an alternate method of care, which is the least restrictive, most appropriate environment that will still meet the client's needs.~~
- ~~9. Involvement of families and/or legal guardians (see 471 NAC 20-001).~~
- ~~10. The facility's or provider's standards of care and policy and procedures meet the requirements for adequacy, appropriateness, and quality of services as they relate to individual Medicaid clients, as required by 42 CFR 456.611(b)(1).~~

~~20-001.20G Reports on Inspections:~~ The inspection of care team must submit a report to the Director of the Division of Medicaid and Long-Term Care on each inspection. The report must 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; and~~
- ~~2. Specific findings about individual clients in the facility.~~

The report must include the dates of the inspection and the names and qualifications of the team members. The report must not contain the names of clients; codes must be used. The facility will receive a copy of the codes.

~~20-001.20H Copies of Reports:~~ Under 42 CFR 456.612, the Department must send a copy of each inspection report to-

- ~~1. The facility or provider inspected;~~
- ~~2. The facility's utilization review committee;~~
- ~~3. The Nebraska Department of Health and Human Services, Division of Public Health;~~
- ~~4. The Nebraska Department of Health and Human Services, Division of Medicaid and Long-Term Care; and~~
- ~~5. Other licensing agencies or accrediting bodies at the discretion of the review team.~~

If abuse or neglect is suspected, Medicaid staff must make a referral to the appropriate investigative body.

~~20-001.20J Facility or Provider Response:~~ Within 15 days following the receipt of the inspection of care team's report, the facility must respond to the review team's coordinator in writing, and must include the following information in the response:

- ~~1. A reply to any inaccuracies in the report. Written documentation to substantiate the inaccuracies must be sent with the reply. The Department will take appropriate action to note this in a follow-up response to the facility;~~
- ~~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; and~~
- ~~5. Projected dates of completion on each of the above;~~

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

~~At the facility's or provider's request, copies of the facility's or provider's response will be sent to all parties who received a copy of the inspection report in 471 NAC 20-001.20H.~~

~~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.~~

~~The Department will take appropriate action based on confirmed documentation on inaccuracies.~~

~~20-001.20K Department Action on Reports: The Department will take corrective action as needed based on the report and recommendations of the team submitted under this subpart.~~

~~20-001.20L Appeals: See 471 NAC 2-003 and 465 NAC 2-001.02 and 2-006.~~

~~20-001.20M Failure to Respond: If the facility or provider fails to submit a timely and/or appropriate response, the Department may take administrative sanctions (see 471 NAC 2-002) or may suspend Medicaid payment for an individual client or the entire payment to the facility or provider.~~

~~20-001.21 Procedure Codes: Providers must use HCPCS/CPT procedure codes when submitting claims to the Department for Medicaid services. Procedure codes used by Medicaid are listed in the Nebraska Medicaid Practitioner Fee Schedule (see 471-000-532).~~

~~20-001.22 Initial Diagnostic Interview: For services in this chapter to be covered by Medicaid, the necessity of the service for the client must be established through an Initial Diagnostic Interview. For services in this chapter to be covered by Medicaid, the client must have a diagnosable mental health disorder of sufficient duration to meet diagnostic criteria specified within the current Diagnostic and Statistics Manual of the American Psychiatric Association that results in functional impairment which substantially interferes with or limits the person's role or functioning within the family, job, school, or community. This does not include V-codes or developmental disorders.~~

~~The Initial Diagnostic Interview is used to identify the problems and needs, develop goals and objectives, and determine appropriate strategies and methods of intervention for the client. This comprehensive plan of care will be outlined in the individualized treatment plan and should reflect an understanding of how the individual's particular issues will be addressed with the service. The Initial Diagnostic Interview must occur prior to the initiation of treatment interventions and must include a baseline of the client's current functioning and treatment needs. **EXCEPTION:** Clients receiving acute inpatient hospital services are not required to receive an Initial Diagnostic Interview before services are initiated. Providers of the acute services must facilitate or perform the Initial Diagnostic Interview.~~

~~The licensed practitioner of the healing arts who is able to diagnose and treat major mental illness within his/her scope of practice must complete the Initial Diagnostic Interview within four weeks of the initial session with the therapist.~~

Initial Diagnostic Interview

1. Psychiatric Evaluation with relevant client information, mental status exam and diagnosis;
2. Recommendations:
  - a. Treatment needs and recommended interventions for client and family;
  - b. Identification of who needs to be involved in the client's treatment;
  - c. Overall plan to meet the treatment needs of the client including transitioning to lower levels of care and discharge planning;
  - d. A means to evaluate the client's progress throughout their treatment and outcome measures at discharge;
  - e. Recommended linkages with other community resources;
  - f. Other areas that may need further evaluation.

Initial Diagnostic Interviews that are incomplete will not be reimbursable.

20-001.22A Involvement of the Supervising Practitioner: The supervising practitioner must meet face to face with the client to complete the Initial Diagnostic Interview. The supervising practitioner must work with the staff person to develop the recommendations. The supervising practitioner must sign the assessment document.

20-001.22B Payment for Initial Diagnostic Interview: Payment for the Initial Diagnostic Interview outlined in the previous section is made according to the Nebraska Medicaid Practitioner Fee Schedule (see 471-000-532). Practitioners must use the national code sets to bill for the Initial Diagnostic Interview. The reimbursement for these codes includes interview time, documentation review, and the writing of the report and recommendations.

Providers of the Initial Diagnostic Interview must bill on claim form CMS-1500 or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837). The completed Initial Diagnostic Interview must be included in the client file and available for review upon request. Failure to produce documentation of an Initial Diagnostic Interview upon request, or lack of inclusion in the client file determined during review, must be cause for claim denial and/or refund.

Medicaid will provide reimbursement for one Initial Diagnostic Interview per treatment episode. Addendums may be included if additional information becomes available. If the client remains involved continuously in treatment for more than one year, reimbursement for an Initial Diagnostic Interview may be available annually. If the client leaves treatment prior to a successful discharge and returns for further treatment, the provider must assess the need for an addendum or a new Initial Diagnostic Interview. A second Initial Diagnostic Interview within a year must be prior authorized. Practitioners must use national code sets to bill for this activity.

For further instructions on billing for outpatient mental health and substance abuse services, please see 471 NAC 20-002.12.

20-001.22C Procedure Codes and Descriptions for Initial Diagnostic Interviews: HCPCS/CPT procedure codes used by Medicaid are listed in the Nebraska Medicaid Practitioner Fee Schedule (see 471-000-532).

20-001.22D Distribution of the Initial Diagnostic Interview: Providers must distribute complete copies of the Initial Diagnostic Interview to other treatment providers in a timely manner when the information is necessary for a referral and the appropriate releases of information are secured.

~~20-002 Outpatient Psychiatric Services:~~ Note: All requirements in 471 NAC 20-001 apply to outpatient psychiatric services.

~~20-002.01 Covered Outpatient Psychiatric Therapeutic Services:~~ Nebraska Medical Assistance Program covers the following outpatient psychiatric therapeutic services for clients age 21 and older as defined in 471 NAC 20-001.12:

- ~~1. Psychiatric evaluation;~~
- ~~2. Psychological evaluation;~~
- ~~3. Psychological testing;~~
- ~~4. Individual Psychotherapy;~~
- ~~5. Group Psychotherapy (a group overview must be approved by Medicaid prior to billing for this service);~~
- ~~6. Family Psychotherapy Services;~~
- ~~7. Family Assessment;~~
- ~~8. Medication checks by a physician or a physician extender;~~
- ~~9. Electroconvulsive Therapy.~~

~~Treatment for chemical dependency is not covered for clients age 21 and older.~~

~~Skilled nursing services for the monitoring of medications is available through Home Health Agencies (see 471 NAC 9-000).~~

~~20-002.02 Psychiatric Therapeutic Staff Standards:~~ The following psychiatric therapeutic staff may provide services and must meet the requirements as defined in 471 NAC 20-001.13

- ~~1. Physician;~~
- ~~2. Licensed Psychologist;~~
- ~~3. Physician extenders;~~
- ~~4. Licensed Independent Mental Health Practitioner;~~
- ~~5. Allied Health Therapists.~~

~~20-002.02A Location of Services:~~ Outpatient psychiatric services by qualified staff may be provided in -

- ~~1. A licensed community mental health program which meets the criteria for approval by the Joint Commission on Accreditation of Healthcare Organizations, CARF, COA, or AOA;~~
- ~~2. A licensed and certified hospital which provides psychiatric services and which~~
  - ~~a. Is maintained for the care and treatment of patients with primary psychiatric disorders;~~

- b. Is licensed or formally approved as a hospital by the Nebraska Department of Health and Human Services, Division of Public Health, or if the hospital is located in another state, the officially designated authority for standard - setting in that state;
  - c. Is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or AOA;
  - d. Has licensed and certified psychiatric beds;
  - e. Meets the requirements for participation in Medicare for psychiatric hospitals; and
  - f. Has in effect a utilization review plan applicable to all Medicaid clients;
3. A licensed and certified hospital which provides acute medical services and which-
- a. Is maintained for the care and treatment of patients with acute medical disorders;
  - b. Is licensed or formally approved as a hospital by the Nebraska Department of Health and Human Services, Division of Public Health, or if the hospital is located in another state, the officially designated authority for standard - setting in that state;
  - c. Is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or AOA;
  - d. Meets the requirements for participation in Medicare for acute medical hospitals; and
  - e. Has in effect a utilization review plan applicable to all Medicaid clients;
4. A physician's private office;
5. A licensed psychologist's private office;
6. An allied health therapist's private office;
7. The client's home;
8. Nursing homes; or
9. Rural Mental Health Clinics or Federally Qualified Health Centers.

Therapy is not reimbursable in any other location.

20-002.03 Provider Agreement: A provider of psychiatric outpatient services must complete a provider agreement, and submit the form to the Department for approval:

- 1. Independent psychiatric service providers (physicians, licensed psychologists) must complete Form MC-19, "Medical Assistance Provider Agreement." The provider agreement issued to the supervising practitioner (or clinic) is used to claim services provided by allied health therapists who are in his/her employ or supervision.  
For outpatient psychiatric services provided through a group practice, the Provider Agreement must be kept current by providing the Department with:
  - a. The termination date of any therapist leaving the group practice;
  - b. The initial employment date of any therapist joining the group practice;
  - c. A current resume detailing education and clinical experience for each application for allied health therapists.



- ~~2. Hospitals as defined in 471 NAC 20-002.02A providing outpatient psychiatric services must complete Form MC-20, "Medical Assistance Hospital Provider Agreement."~~

~~Providers are responsible for verifying that allied health therapists, physicians, physician extenders, and licensed psychologists are appropriately licensed for the correct scope of practice.~~

~~20-002.03A Geographically Deprived Areas: A geographically-deprived area is an area where a psychiatrist is not available in the community, or within a reasonable driving distance of the community, to provide services. A physician who is qualified, skilled, and experienced in the diagnosis and treatment of psychiatric disorders may serve as an alternative to a psychiatrist for outpatient services in a geographically-deprived area. A resume detailing the physician's mental health education and experience must accompany the provider agreement. When outpatient psychiatric services are provided under these conditions, the physician is subject to all policy requirements outlined for psychiatrists. Psychiatric services provided by the attending physician, other than a psychiatrist, are limited to the following:~~

~~Psychotherapy services provided in a physician's office which do not exceed six months without documented consultation between the physician providing the service and a psychiatrist.~~

~~20-002.04 Coverage Criteria for Outpatient Psychiatric Services: The Nebraska Medical Assistance Program covers outpatient psychiatric therapeutic services listed in 471 NAC 20-002.01 when the services are medically necessary and provide active treatment as defined in 471 NAC 20-001.15 and 20-001.16.~~

~~Medical necessity and active treatment for outpatient services is documented through the use of the Department's approved treatment planning document (471 NAC 20-002.06) which must be developed by a licensed practitioner and supervising practitioner based on a thorough evaluation of the client's restorative needs and potentialities for a primary psychiatric diagnosis.~~

~~20-002.04A Services Provided by Allied Health Therapists: Services provided by Allied Health Therapists (as defined in 471 NAC 20-001.13) must be prescribed and provided under the direction of a supervising practitioner. Supervision must meet the active treatment criteria in 471 NAC 20-001.16.~~

~~Definition and Practice of Supervision: Supervision by the supervising practitioner is defined as the critical oversight of a treatment activity or course of action. This includes, but is not limited to, review of treatment plan and progress notes, client specific case discussion, periodic assessments of the client (annually, or more often if necessary), and diagnosis, treatment intervention or issue specific discussion. The supervising practitioner is a source of information and guidance for all members of the treatment team and their participation in services as an essential ingredient for all members of the treatment. The critical involvement of the supervising practitioner must be reflected in the Initial Diagnostic Interview, the treatment plan, and the interventions provided.~~

~~The supervising practitioner (or their designated and qualified substitute) must be available, in person or by telephone, to provide assistance and direction as needed during the time the services are being provided.~~

~~Supervisory contact may occur in a group setting.~~

~~Supervision is not billable by either the therapist or the supervising practitioner as it is considered a mandatory component of the care.~~

~~Psychiatric resident physicians and physician extenders may not supervise allied health therapists for Medicaid services.~~

~~The supervising practitioner must periodically evaluate the therapeutic program and determine if treatment goals are being met and if changes in direction or emphasis are needed.~~

~~The supervising practitioner must personally re-evaluate the client through a face-to-face contact annually or more often, if necessary.~~

~~20-002.05 Initial Diagnostic Interview: Before a client is accepted for treatment, an Initial Diagnostic Interview must be completed.~~

~~The supervising practitioner must evaluate the client within four weeks of the initial contact with the therapist, or sooner if necessary. If the client does not continue with therapy sessions past the fourth session or does not attend the assessment session with the supervising practitioner, the therapist must review the specific case with the supervising practitioner, to establish a diagnosis and confirm that the interventions were appropriate. For clients continuing in therapy, reimbursement will not be available for more than four sessions until the client is assessed by the supervising practitioner.~~

~~20-002.06 Treatment Planning: When treatment is initiated, the provider must work with the client and family (at the client's discretion) to develop the treatment plan. If the client is accepted for treatment, the treatment plan must be completed within two sessions of the assessment by the supervising practitioner and is based on the following:~~

- ~~1. The client must have sufficient need for active psychiatric treatment at the time the psychiatric service provider accepts the client; and~~
- ~~2. The treatment must be the best choice for expecting reasonable improvement in the client's psychiatric condition.~~

~~The goals and objectives documented on the treatment plan must reflect the recommendations from the Initial Diagnostic Interview, the supervising practitioner and the therapist. The treatment interventions provided must reflect these recommendations, goals, and objectives. Evaluation of the treatment plan by the therapist and the supervising practitioner should reflect the client's response to the treatment interventions based on the recommendations, goals and objectives.~~

~~The provider must document their attempts to involve the family in treatment plan development and treatment plan reviews. A variety of communication means should be considered. These may include, but should not be limited to, including the family via conference telephone calls, using registered letters to notify the family of meetings, and scheduling meetings in the evening and on weekends.~~

~~Providers must be available to schedule meetings and sessions in a flexible manner to accommodate and work with a family's schedule. This includes the ability to schedule sessions at a variety of times including weekends or evenings.~~

~~Providers must encourage family members to be involved in the assessment of the client, the development of the treatment plan, and all aspects of the client's treatment unless prohibited by the client, through legal action, or because of federal confidentiality laws.~~

~~20-002.06A Treatment Planning Document Update: The treatment plan must be reviewed and updated every 90 days, or more frequently if indicated. The client's clinical record must include the supervising practitioner's comments on the client's response to treatment and changes in the treatment plan. The supervising practitioner must review and sign off on the updated treatment plan prior to its initiation. Changes in the treatment plan must be noted on the current treatment planning document. In addition, the psychiatric service provider must complete an updated treatment planning document annually, or more frequently if necessary, to reflect changes in treatment needs. A copy of the current treatment planning document must be maintained in the client's medical record.~~

~~For services provided under the supervision of a supervising practitioner, the signature of the supervising practitioner on the treatment planning document indicates his/her agreement that the scheduled treatment interventions are appropriate.~~

~~20-002.07 Documentation in Client's Clinical Records: All documents submitted to Medicaid must contain sufficient information for identification (i.e., client's name, dates, and time of service, provider's name). Documentation must be legible. The client's medical record must also include—~~

- ~~1. The Initial Diagnostic Interview;~~
- ~~2. The treatment plan, (including the initial document, updates, and current);~~
- ~~3. The client's diagnosis. A provisional or interim psychiatric diagnosis must be established by the supervising practitioner at the time the client is accepted for treatment. This diagnosis must be reviewed and revised as a part of the treatment plan;~~
- ~~4. A chronological record of all psychiatric services provided to the client, the date performed, the duration of the session, and the staff member who conducted the session;~~
- ~~5. A chronological account of all medications prescribed, the name, dosage, and frequency to be administered and client's response;~~
- ~~6. A comprehensive family assessment.~~
- ~~7. A clear record of family and community involvement;~~
- ~~8. Documentation verifying coordination with other therapists when more than one provider is involved with the client/family; and~~
- ~~9. Transition/discharge planning.~~

~~20-002.08 Transition/Discharge Planning Services: Providers of outpatient psychiatric services must meet the transition/discharge planning requirements noted in 471 NAC 20-001.18.~~

~~20-002.09 Utilization Review: Payment for outpatient psychiatric services is based on adequate legible documentation of medical necessity and active treatment. All outpatient claims are subject to utilization review before payment. Illegible documentation may result in denial of payment (see 471 NAC 20-001.19).~~

~~Additional documentation from the client's clinical record may be requested prior to considering authorization of payment when the treatment plan does not adequately document medical necessity or active treatment.~~

#### ~~20-002.10 Guidelines for Specific Services~~

~~20-002.10A Psychological Testing and Evaluation Services: Testing and evaluation services must reasonably be expected to contribute to the diagnosis and plan of care established for the individual client. Medical necessity must be documented.~~

~~Testing and evaluation services may be performed by a licensed psychologist, or by a specially licensed psychologist or a master's level person approved to administer psychological testing under the supervision of a licensed psychologist.~~

~~If testing and evaluation services are provided by a licensed, non-certified psychologist, the services must be ordered by a supervising practitioner. The treatment plan must be signed by the supervising practitioner.~~

~~A copy of the testing narrative summary must be kept in the client's clinical record. If the evaluation is court ordered, the provider must note this on the treatment plan and include documentation of medical need for the service. Payment is made according to the Nebraska Medicaid Practitioner Fee Schedule.~~

~~20-002.10B Grandparented Masters Psychologists: Services provided by master's level clinical psychologists whose certification has been grandparented by the Department of Health and Human Services, Division of Public Health may be covered under 471 NAC 20-002. Documentation of the grandparented status may be required.~~

~~20-002.10C Medication Checks: Medication checks may only be done when medically necessary. When a physician provides psychotherapy services, medication checks are considered a part of the psychotherapy service.~~

~~The supervising physician may provide a medication check when a licensed psychologist or an allied health therapist provides the psychotherapy service. Only physicians and psychiatrically trained physician extenders may provide medication checks.~~

~~20-002.10D After-Care: After care as defined by the American Psychiatric Association is a complex system of services including, but not limited to, psychotherapy, medication checks, and social, rehabilitative, and educational services required and necessary to deinstitutionalize the chronic patient who has undergone extended hospital treatment and care. This "service package" does not meet the criteria of active treatment and is not covered by the Nebraska Medical Assistance Program. Individually-identified services may be claimed under the appropriate HCPCS/CPT procedure code and are subject to the active treatment standard.~~

~~20-002.10E 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, refer to 471 NAC 10-003.05C, 10-003.05D, 10-003.05E, and 10-003.05F.~~

~~20-002.10F Travel to the Home of Individuals Who Have Handicaps: If a client has a handicapping physical condition that prevents them from traveling to a mental health clinic or office, the provider may request prior authorization to bill for mileage to the client's home. The following requirements must be met:~~

- ~~1. The provider requests prior authorization before the initiation of services;~~
- ~~2. The treatment must meet the criteria for active treatment and medical necessity;~~
- ~~3. The client's handicapping physical condition prevents their travel to the mental health clinic or office; and~~
- ~~4. The client's home is more than 30 miles from the clinic or office.~~

~~This information must be provided, in writing, to the Medicaid Central Office staff or their designee for consideration.~~

~~20-002.10G Family Assessment: NMAP covers family assessments used to identify the functional level of the family unit and the system changes that would influence this functional level. This includes interviews with the client and collateral parties.~~

20-002.11 Payment for Outpatient Psychiatric Services

~~20-002.11A Payment for Outpatient Psychiatric Services in a Hospital: Payment for outpatient psychiatric services is made according to Nebraska Medicaid Practitioner Fee Schedule. The Nebraska Medical Assistance Program (NMAP) pays for covered outpatient mental health services, except for laboratory services, at the lower of-~~

- ~~1. The provider's submitted charge; or~~
- ~~2. The allowable amount for that procedure code in the 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; or~~
  - ~~c. The reasonable charge for the procedure as determined by the Division of Medicaid and Long-Term Care (indicated as "BR" by report or "RNE" -rate not established in the fee schedule).~~

~~20-002.11B Revisions of the Fee Schedule: The Department 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. 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; and~~
- ~~4. Adjust the allowable amount when the Division of Medicaid and Long-Term Care determines that the current allowable amount is-~~
  - ~~a. Not appropriate for the service provided; or~~
  - ~~b. Based on errors in data or calculation.~~

~~The Department may issue revisions of the Nebraska Medicaid Practitioner Fee Schedule during the year that it is effective. Providers will be notified of the revisions and their effective dates.~~

20-002.12 Billing Requirements: For outpatient psychiatric service providers, the following requirements must be met.

1. Community mental health programs providing outpatient psychiatric services must submit all claims for outpatient services on an appropriately completed Form CMS-1500 (see 471-000-64) or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837).

Payment for approved outpatient psychiatric services provided by employees of a community mental health program is made to the facility.

2. Hospitals providing outpatient psychiatric services must 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).

All M.D. services must be submitted on an appropriately completed CMS-1500.

Payment for approved outpatient psychiatric services provided by employees of a hospital is made to the facility.

3. Independent providers of outpatient psychiatric services (psychiatrist or clinical psychologist in a private office who is not an employee of a hospital or community mental health center) must submit all claims for outpatient psychiatric services provided in their private office on an appropriately completed Form CMS-1500 (see 471-000-64) or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837).

Payment for approved outpatient psychiatric services provided in an independent provider's private office is made to the provider as identified on the provider agreement.



~~20-002.12A Documentation for Claims: For outpatient psychiatric services, unless otherwise instructed by Medicaid or their designee, the following documentation must be kept in the client's file for each claim:~~

- ~~1. The initial treatment plan; or~~
- ~~2. An updated version of the treatment plan completed every 90 days.~~

~~For psychological testing and evaluation services, unless otherwise instructed by Medicaid, the following information must be kept in the client's file:~~

- ~~1. The treatment plan;~~
- ~~2. Medical necessity for the service documented on the treatment plan;~~
- ~~3. The documentation that the evaluation services will reasonably be expected to contribute to the diagnosis and plan of care established for the individual client; and~~
- ~~4. A narrative of the testing results.~~

~~20-002.13 Procedure Codes and Descriptions: HCPCS/CPT procedure codes used by NMAP are listed in the Nebraska Medicaid Practitioner Fee Schedule (see 471-000-532).~~

~~20-003 Adult Day Treatment Psychiatric Services: Psychiatric day treatment is a service in a continuum of care designed to prevent hospitalization or to facilitate the movement of the acute psychiatric client to a status in which the client is capable of functioning within the community with less frequent contact with the psychiatric health care provider.~~

Day treatment services must meet all requirements in 471 NAC 20-001.

~~20-003.01 Covered Day Treatment Services: Psychiatric day treatment programs must provide the following mandatory services and at least two of the following optional services. Payment for both mandatory services and optional services is included in the rate for day treatment. Providers must not make any additional charges to the Department or to the client.~~

~~20-003.01A Mandatory Services: The following services must be included in a program for psychiatric day treatment to be approved for participation in the Nebraska Medical Assistance Program. See 471 NAC 20-001 for definitions.~~

- ~~1. Medically Necessary Psychotherapy Services: These services must demonstrate active treatment of a patient with a psychiatric condition. These services are subject to program limitations and must be provided by professionals operating within the appropriate scope of practice.
  - ~~a. Individual Psychotherapy;~~
  - ~~b. Group Psychotherapy;~~
  - ~~c. Family Psychotherapy;~~
  - ~~d. Family Assessment if appropriate;~~~~
- ~~2. Medically Necessary Nursing Services: Services directed by a Registered Nurse who evaluates the particular medical nursing needs of each client and provides for the care and treatment that is indicated by the Department approved treatment planning document approved by the supervising practitioner.~~
- ~~3. Medically Necessary Psychological Diagnostic Services: Testing and evaluation services must 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. If testing and evaluation services are provided by a specially licensed psychologist or approved Master's level person, the services must be ordered by a supervising practitioner. Medical necessity must be documented by the supervising practitioner. Reimbursement for psychological Diagnostic Services is included in the per diem and will not be reimbursed for separately.~~

4. ~~Medically Necessary Pharmaceutical Services:~~ If medications are dispensed by the program, pharmacy services must be provided under the supervision of a registered pharmacy consultant; or the program may contract for these services through an outside licensed/certified facility. All medications must be stored in a special locked storage space and administered only by a physician, registered nurse, or licensed practical nurse.
5. ~~Medically Necessary Dietary Services:~~ If meals are provided by a day treatment program, services must be supervised by a registered dietitian, based on the client's individualized medical diet needs. The program may contract for these services through an outside licensed certified facility.
6. Transition and discharge planning must meet the requirements of 471 NAC 20-001.18.

~~20-003.01B Optional Services:~~ The program must provide two of the following optional services. The client must have a need for the services, a supervising practitioner must order the services, and the services must be a part of the client's treatment plan. The therapies must be restorative in nature, not prescribed for conditions that have plateaued or cannot be significantly improved by the therapy, or which would be considered maintenance therapy. In appropriate circumstances, occupational therapy may be covered if prescribed as an activities therapy in a psychiatric program:

1. ~~Services provided or supervised by a licensed or certified therapist may be provided under the supervision of a qualified consultant or the program may contract for these services from a licensed/certified professional as listed below:~~
  - a. ~~Recreational Therapy;~~
  - b. ~~Speech Therapy;~~
  - c. ~~Occupational Therapy;~~
  - d. ~~Vocational Skills Therapy;~~
  - e. ~~Self-Care Services:~~ Services supervised by a registered nurse or occupational therapist who is oriented toward activities of daily living and personal hygiene. This includes toileting, bathing, grooming, etc.
2. ~~Social Work provided by a bachelor's level social worker: Social services to assist with personal, family, and adjustment problems which may interfere with effective use of treatment, i.e., case management type services.~~
3. ~~Social Skills Building;~~
4. ~~Life Survival Skills.~~

~~20-003.01C Special Treatment Procedures in Day Treatment: If a client needs behavior management and containment beyond unlocked time outs or redirection, special treatment procedures may be utilized. Special treatment procedures in day treatment are limited to physical restraint, and locked time out (LTO). Mechanical restraints and pressure point tactics are not allowed.~~

~~Facilities must meet the following standards regarding special treatment procedures:~~

- ~~1. De-escalation techniques must be taught to staff and used appropriately before the initiation of special treatment procedures;~~
- ~~2. Special treatment procedures may be used only when a client's behavior presents a danger to self or others, or to prevent serious disruption to the therapeutic environment; and~~
- ~~3. The client's treatment plan must address the use of special treatment procedures and have a clear plan to decrease the behavior requiring LTO or physical restraints.~~

~~These standards must be reflected in all aspects of the treatment program. Attempts to de-escalate, the special treatment procedure and subsequent processing must be documented in the clinical record and reviewed by the supervising practitioner.~~

#### 20-003.02 Standards for Participation

~~20-003.02A Provider Standards: Providers of day treatment services must meet the following standards:~~

- ~~1. Non-Hospital Based Day Treatment: A center providing day treatment must be-~~
  - ~~a. Appropriately licensed by the Nebraska Department of Health and Human Services, Division of Public Health; and~~
  - ~~b. Accredited by JCAHO, CARF, COA, or AOA.~~
- ~~2. Hospital Based Day Treatment: A hospital providing on-site day treatment must~~
  - ~~a. Be licensed or formally approved as a hospital by the Nebraska Department of Health and Human Services, Division of Public Health;~~
  - ~~b. Be accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or AOA;~~
  - ~~c. Meet the requirements for participation in Medicare; and~~
  - ~~d. Have in effect a utilization review plan applicable to all Medicaid clients.~~

~~When hospitals provide services in freestanding facilities, the freestanding facility must be appropriately licensed by the Nebraska Department of Health and Human Services, Division of Public Health.~~

20-003.02B Service Standards:

1. ~~The program must provide a minimum of three hours of services five days a week, which is considered a half day for billing purposes. A minimum of six hours a day is considered a full day of service. Services may not be prorated for under three (or six) hours of services;~~
2. ~~A designated supervising practitioner must be responsible for the psychiatric care in a day treatment program. The supervising practitioner must be present on a regularly-scheduled basis and must assume clinical responsibility for all patients. If the supervising practitioner is present on a part-time basis, one of the following must assume delegated professional responsibility for the program and must be present at all times when the program is providing services:~~
  - a. ~~A licensed physician;~~
  - b. ~~A licensed psychologist;~~
  - c. ~~Licensed Independent Mental Health Practitioner; or~~
  - d. ~~An allied health therapist;~~
3. ~~Any supervising practitioner may refer a client to a day treatment program, but all treatment must be prescribed and directed by the program supervising practitioner;~~
4. ~~All treatment must be conducted under the supervision of the supervising practitioner in charge of the program;~~
5. ~~Psychotherapy Staff: See 471 NAC 20-001 for definitions.~~
  - a. ~~Physician;~~
  - b. ~~Licensed Psychologist;~~
  - c. ~~Licensed Independent Mental Health Practitioner; and~~
  - d. ~~Allied health therapists. All psychotherapy services provided by allied health therapists must be prescribed by the supervising practitioner and provided under his/her supervision. The supervising practitioner's personal involvement in all aspects of the client's psychiatric care must be documented in the client's medical record (i.e., physician's orders, progress notes, nurses notes).~~
6. ~~Admission Criteria: The following criteria must be met for a client's admission to a psychiatric day treatment program:~~
  - a. ~~The client must have sufficient medical need for active psychiatric treatment at the time of admission to justify the expenditure of the client's and program's time, energy, and resources; and~~
  - b. ~~Of all reasonable options for active psychiatric treatment available to the client, treatment in this program must be the best choice for expecting a reasonable improvement in the client's psychiatric condition.~~

- ~~7. Pre-Admission Evaluation: Before the client is admitted to the program, the supervising practitioner must complete an Initial Diagnostic Interview to validate the appropriateness of care. When a client is transferred from inpatient hospital care to day treatment, the inpatient evaluation and discharge summary documenting the rationale of transfer as part of the treatment plan serves the same purpose as the Initial Diagnostic Interview. The evaluation must be filed in the client's medical record. The pre-admission evaluation must include
  - ~~a. A clinical assessment of the health status and related psychological, medical, social, and educational needs of the client; and~~
  - ~~b. A determination of the range and kind of services required.~~The supervising practitioner must personally complete an Initial Diagnostic Interview which must be used to develop the plan of care if all admission criteria have been met;~~
- ~~8. Treatment Plan: The program supervising practitioner must determine the psychiatric diagnosis and prescribe the treatment, including the modalities and the professional staff to be used. He/she must be responsible and accountable for all evaluations and treatment provided to the client.~~

~~The goals and objectives documented on the treatment plan must reflect the recommendations from the Initial Diagnostic Interview, the supervising practitioner and the therapist. The treatment interventions provided must reflect these recommendations, goals, and objectives. Evaluation of the treatment plan by the therapist and the supervising practitioner should reflect the client's response to the treatment interventions based on the recommendations, goals and objectives.~~

~~The treatment plan must be completed upon the client's admission to the program;~~

- ~~9. At least every 30 days thereafter, a treatment plan review must be conducted by the multi-disciplinary team, including the supervising practitioner. The treatment plan reviews must be documented. The treatment plan must be signed by the program supervising practitioner for day treatment services;~~
- ~~10. The supervising practitioner must personally evaluate the client every 30 days, or more often, as medically necessary. This evaluation must occur in a one-to-one, face-to-face session separate from the treatment plan review;~~

- ~~11. Every 30 days a utilization review must be conducted per 471 NAC 20-003.07. This review must be documented on the treatment plan. Utilization review is not required for the calendar month in which the client was admitted;~~
- ~~12. The program must have a description of each of the services and treatment modalities available. This includes psychotherapy services, nursing services, psychological diagnostic services, pharmaceutical services, dietary services, and other psychiatric day treatment services.
  - ~~a. The program must have a description of how the family-centered requirement in 471 NAC 20-001 will be met, including a complete description of any family assessment and family psychotherapy services.~~~~

~~Providers must encourage family members to be involved in the assessment of the client, the development of the treatment plan, and all aspects of the client's treatment unless prohibited by the client, through legal action, or because of federal confidentiality laws.~~

~~Providers must be available to schedule meetings and sessions in a flexible manner to accommodate and work with a family's schedule. This includes the ability to schedule sessions at a variety of times including weekends or evenings.~~

~~The provider must document their attempts to involve the family in treatment plan development and treatment plan reviews. A variety of communication means should be considered. These may include, but should not be limited to, including the family via conference telephone calls, using registered letters to notify the family of meetings, and scheduling meetings in the evening and on weekends;~~

- ~~\_\_\_\_\_ b. The program must have a description of how the community-based requirement in 471 NAC 20-001 will be met;~~
- ~~\_\_\_\_\_ c. The program must state the qualifications, education, and experience of each staff member and the therapy services each provides.;~~
- ~~\_\_\_\_\_ d. The program must have a daily schedule covering the total number of hours the program operates per day. The schedule must be submitted to the Department for approval. The program must be fully staffed and supervised during the time the program is available for services, and must provide at least three hours of approved treatment for each day services are provided. This schedule must be updated annually, or more frequently if appropriate;~~

13. ~~Outpatient Observation: When appropriate for brief crisis stabilization, outpatient observation up to 23 hours 59 minutes in an emergency room or acute hospital may be used as follows:  
An outpatient is defined as a person who has not been admitted as an inpatient but is registered on the hospital records as an outpatient and receives services (rather than supplies alone). If a patient receives 24 or more hours of continuous outpatient care, that patient is defined as an inpatient regardless of the hour of admission, whether s/he used a bed and whether s/he remained in the hospital past midnight or the census-taking hour, and all inpatient medical review prior-authorization requirements apply;~~
14. ~~The program must have a written plan for immediate admission or readmission for appropriate inpatient psychiatric services, if necessary. The written plan must include a cooperative agreement with a psychiatric hospital or distinct part of a hospital, as outlined in 471 NAC 20-007. A copy of this agreement must accompany the provider application and agreement.~~

~~20-003.03 Provider Agreement: A provider of psychiatric day treatment services must complete a provider agreement and submit the form to the Department for approval. The provider must attach to the provider application and agreement a written overview of the program including philosophy, objectives, policies and procedures, confirmation that the requirements in 471 NAC 20-001 and 471 NAC 20-002 are met and any other information requested by Medicaid staff. Staff must meet the standards outlined in 471 NAC 20-001.13; and:~~

1. ~~Community mental health programs and licensed mental health clinics must complete Form MC-19, "Medical Assistance Provider Agreement," and submit the completed form to the Department for approval. A Department approved cost reporting document (FA-20) must also be submitted. The provider application and agreement must be renewed annually to coincide with the submittal of the cost report. Satellites of community mental health programs must bill the Department through their main community mental health program, unless the satellite has a separate provider number under Medicare. A satellite of a community mental health program that has a separate provider number under Medicare must complete a separate provider agreement. All claims submitted to the Department by these satellites must be filed under the satellite's Medicaid provider number. The facility must have in effect a utilization review plan applicable to all Medicaid clients.~~
2. ~~Hospitals must complete Form MC-20, "Medical Assistance Hospital Provider Agreement," and submit the completed form to the Department for approval. A Department approved cost reporting document (FA-20) must also be submitted.~~

~~20-003.03A Annual Update: The program must update the provider agreement, program overview, and cost report annually and whenever requested by the Division of Medicaid and Long-Term Care.~~



~~20-003.04 Coverage Criteria for Day Treatment Psychiatric Services: The Nebraska Medical Assistance Program covers psychiatric day treatment services for clients 21 and over when the services meet the requirements in 471 NAC 20-001.~~

~~The client must be observed and interviewed by the program supervising practitioner at least every 30 days or more frequently if medically necessary and the interaction must be documented in the client's medical record.~~

~~20-003.04A Services Not Covered Under Medicaid: Payment is not available for psychiatric day treatment services for clients-~~

- ~~1. Receiving services in an out-of-state facility, except as outlined in 471 NAC 1-002, Services Provided Outside Nebraska;~~
- ~~2. Living in long term care facilities or Institutes for Mental Disease;~~
- ~~3. Whose needs are social or educational and may be met through a less structured program;~~
- ~~4. Whose primary diagnosis and functional impairment is psychiatric in nature but is not stable enough to allow them to participate in and benefit from the program; or~~
- ~~5. Whose behavior may be very disruptive and/or harmful to other program participants or staff members.~~

~~20-003.05 Documentation in the Client's Clinical Record: All documents submitted to Medicaid must contain sufficient information for identification (i.e., client's name, dates of service, provider's name) and must be legible. Each client's clinical record must contain the following documentation:~~

- ~~1. The supervising practitioner's orders;~~
- ~~2. The Initial Diagnostic Interview and referral documented by the supervising practitioner;~~
- ~~3. The treatment plan;~~
- ~~4. The team progress notes, recorded chronologically. The frequency is determined by the client's condition, but the team's progress notes must be recorded at least weekly. The progress notes must contain a concise assessment of the client's progress and recommendations for revising the treatment plan, as indicated by the client's condition, and discharge planning;~~
- ~~5. Documentation indicating compliance with all requirements in 471 NAC 20-001;~~
- ~~6. The program's utilization review committee's abstract or summary; and~~
- ~~7. The discharge summary.~~

~~20-003.06 Transition and Discharge Planning: Each provider must meet the 471 NAC 20-001 requirements for transition and discharge planning.~~

20-003.07 Utilization Review (UR): Each program is responsible for establishing a utilization review plan and procedure which meets the following guidelines. A site visit by Medicaid staff for purposes of utilization review may be required for further clarification.

20-003.07A Components of UR: Utilization review must provide—

1. Timely review (at least every 30 days) of the medical necessity of admissions and continued treatment;
2. Utilization of professional services provided;
3. High quality patient care; and
4. Effective and efficient utilization of available health facilities and services.

20-003.07B UR Overview: An overview of the program's utilization review process must be submitted with the provider application and agreement before the program is enrolled as a Medicaid provider. The overview must include—

1. The organization and composition of the utilization review committee which is responsible for the utilization review function;
2. The frequency of meetings (not less than once a month);
3. The type of records to be kept; and
4. The arrangement for committee reports and their dissemination, including how the supervising practitioner is informed of the findings.

20-003.07C UR Committee: The utilization review committee must consist of a supervising practitioner and at least two mental health practitioners (as defined in 471 NAC 20-001). A licensed psychologist may replace one of the allied health staff members. The committee's reviews may not be conducted by any person whose primary interest in or responsibility to the program is financial or who is professionally involved in the care of the client whose case is being reviewed. At the Department's discretion, an alternative plan for facilities that do not have these resources readily available may be approved.

20-003.07D Basis of Review: The review must be based on—

1. The identification of the individual client by appropriate means to ensure confidentiality;
2. The identification of the supervising practitioner;
3. The date of admission;
4. The diagnosis and symptoms;
5. The supervising practitioner plan of treatment; and
6. Other supporting materials (progress notes, test findings, consultations) the group may deem appropriate.

20-003.07E Contents of Report: The written report must contain—

1. An evaluation of treatment, progress, and prognosis based on—
  - a. Appropriateness of the current level of care and treatment;
  - b. Alternate levels of care and treatment available; and
  - c. The effective and efficient utilization of services provided;
2. Verification that—
  - a. Treatment provided is documented in the client's record;
  - b. All entries in the client's record are signed by the person responsible for entry. The supervising practitioner must sign all orders; and
  - c. All entries in the client's record are dated;
3. Recommendations for—
  - a. Continued treatment;
  - b. Alternate treatment/level of care; and
  - c. Disapproval of continued treatment.
4. The date of the review;
5. The names of the program utilization review committee members; and
6. The date of the next review if continued treatment is recommended.

— A copy of the admission review and the extended stay review must be attached to all claims for psychiatric services submitted to the Department for payment.

20-003.08 Payment for Psychiatric Day Treatment Services: Payment for psychiatric day treatment services will be based upon rate setting by the Department.

Payment rates for psychiatric day treatment services for individuals age 21 and older will be on a unit basis. Rates are set annually, for the period July 1 through June 30. Rates are set prospectively for this period, and are not adjusted during the rate period.

Providers are required to report their costs on an annual basis. Providers may choose any fiscal year end that they desire. Providers desiring to enter the program who have not previously reported their costs, or that are newly operated, are to submit a budgeted cost report, estimating their anticipated annual costs.

Providers must submit cost and statistical data on Form FA-20. The provider must submit one original Form FA-20 to the Department within 90 days of the close of fiscal year, or change in ownership or management. One 15-day extension may be granted under extenuating circumstances if requested, in writing, prior to the date. Providers must compile data based on generally accepted accounting principles and the accrual method of accounting based on the provider's fiscal year. Financial and statistical records for the period covered by the cost report must be accurate and sufficiently detailed to substantiate the data reported. All records must be readily available upon request by the Department for verification. If the provider fails to file a cost report as due, the Department will suspend payment. At the time the suspension is imposed, the Department will send a letter informing the provider that no further payment will be made until a proper cost report is filed.

In setting payment rates, the Department will consider those costs which are reasonable and necessary for the active treatment of the clients being served. Such costs will 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 requirements and discharge planning.

The Department does not guarantee that all costs will be reimbursed. The Form FA-20 cost reporting document is used by the Department only as a guide in the rate setting process. Actual costs incurred by the providers may not be entirely reimbursed.

20-003.08A Payment Rates for Psychiatric Day Treatment Services Provided by State-Operated Facilities: Psychiatric day treatment centers operated by the State of Nebraska will be reimbursed for all reasonable and necessary costs of operation, excluding educational services. State-operated centers will receive an interim payment rate, with an adjustment to actual costs following the cost reporting period.

20-003.08B Unallowable Costs: The following costs are not allowable:

1. Provisions for income tax;
2. Fees paid board of directors;
3. Non-working officers' salaries;
4. Promotion expense, except for promotion and advertising as allowed in HIM-15. Yellow Page display advertising is not allowable; one Yellow Page informational listing is allowable;
5. Travel and entertainment, other than for professional meetings and direct operations of the day treatment program. This may include costs of motor homes, boats, and other recreational vehicles, including operation and maintenance expenses; 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 the Department 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 clients' physicians or dentists, drugs, laboratory services, radiology services, or services provided by similar independent licensed providers, except services provided by state operated facilities. These exclusions are paid separately;
13. Return on equity;
14. Costs for services which occurred in a prior or subsequent fiscal year are unallowable;

15. Expenses for equipment, facilities, and programs (e.g., recreation, trips) provided to clients which are determined by the Department not to be reasonably related to the efficient production of service because of either the nature or amount of the particular service;
16. Costs of amusements, social activities, and related expenses for employees and governing body members are unallowable, except when part of an authorized client treatment program;
17. Costs of alcoholic beverages are unallowable;
18. Costs resulting from violations of, or failure to comply with federal, state, and local laws and regulations are unallowable;
19. Costs relating to lobbying or attempts to influence/promote legislative action by local, state, or federal government are unallowable; and
20. Costs of lawsuits or other legal or court proceedings against the Department, or its employees, or State of Nebraska are unallowable.

~~20-003.08C Suspension or Termination of License: The Department does not make payment for care provided after 30 days following the date of expiration or termination of the provider's license or certificate to operate under Title XIX. The Department does not make payment for care provided to individuals who were admitted after the date of expiration or termination of the provider's license or certificate to operate under Title XIX.~~

~~20-003.08D Appeal Process: Final administrative decision or inaction in the rate setting process is subject to administrative appeal. The provider may request an appeal, in writing, from the Director for a hearing within 90 days of the decision or inaction. Regulations for appeals and fair hearings are contained in 465 NAC 2-001.02 and 2-006 ff.~~

~~20-003.08E Administrative Finality: An administrative decision or inaction in the allowable cost determination process, which is otherwise final, may be reopened by the Department within three years of the date of notice of the decision or inaction.~~

~~"Reopening" is an action taken by the Director to re-examine or question the correctness of a determination or decision which is otherwise final. The Director is the sole authority for deciding whether to reopen an administrative decision or inaction. The action may be taken -~~

1. On the initiative of the Department within the three-year period;
2. In response to a written request of a provider or other entity within the three-year period. Whether the Director will reopen a determination, which is otherwise final, depends on whether new and material evidence has been submitted, a clear and obvious error has been made, or the determination is found to be inconsistent with any law, regulations and rulings, or general instructions; or
3. Any time fraud or abuse is suspected.

~~A provider has no right to appeal a finding by the Director that a reopening or correction of a determination or decision is not warranted.~~

~~20-003.09 Record Retention:~~ The provider must retain financial records, supporting documents, statistical records, and all other pertinent records related to the cost report for a minimum of five years after the end of the report period. The Department must retain all cost reports for at least five years after receipt from the provider.

~~20-003.10 Billing Requirements:~~ For day treatment services, the following requirements must be met:

- ~~1. Providers of non-hospital based day treatment services must submit claims for day treatment services on an appropriately completed Form CMS-1500 (see 471-000-64) or the standard electronic Health Care Claim: Professional transaction (ASC X12N-837).~~

~~Payment for approved day treatment services is made to the facility.~~

- ~~2. Providers of hospital based day treatment services must submit claims for services on an appropriately completed Form CMS-1450 or the standard electronic Health Care Claim: Institutional transaction (ASC X12N-837).~~

~~Payment for approved hospital based day treatment services is made to the hospital.~~

~~20-003.10A Documentation for Claims:~~ The following documentation, kept in the client's file, is required for all claims for day treatment services:

- ~~1. Initial Diagnostic Interview;~~
- ~~2. Supervising practitioner orders;~~
- ~~3. Nurses' notes; and~~
- ~~4. Progress notes for all disciplines.~~

~~All claims are subject to utilization review by the Department prior to payment. Reimbursement may be denied if claims and/or documentation are illegible (see 471 NAC 20-001.19).~~

~~20-003.10B Exception:~~ Additional documentation from the client's medical record may be requested by the Department prior to considering authorization of payment. Progress notes for other Medicaid clients may be requested when the treatment report does not adequately explain family psychotherapy or medical necessity cannot be determined.

~~20-003.11 Procedure Codes and Descriptions for Psychiatric Day Treatment:~~ HCPCS/CPT procedure codes used by Medicaid are listed in the Nebraska Medicaid Practitioner Fee Schedule (see 471-000-532).

~~20-003.12 Costs Not Included in the Day Treatment Fee: The mandatory and optional services are considered to be part of the fee for day treatment services. The following charges can be reimbursed separately from the day treatment fee when the services are necessary, part of the client's overall treatment plan, and in compliance with NMAP 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; and~~
- ~~4. Treatment services for a physical injury or illness provided by other professionals.~~

~~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.~~

~~20-004, 20-005 (Reserved)~~

~~20-006 Adult Subacute Inpatient Hospital Psychiatric Services: Subacute inpatient hospital psychiatric services for clients 21 and over are medically necessary short-term psychiatric services provided to a client. The care and treatment of a subacute inpatient with a primary psychiatric diagnosis must be under the direction of a Nebraska licensed psychiatrist who meets the state's licensing criteria and is enrolled as a Medicaid provider with the Department. Subacute inpatient hospital psychiatric services must be prior authorized by the Department contracted peer review organization or management designee. In addition, out-of-state subacute hospitalizations must be approved by the Department.~~

~~20-006.01 Provider Agreement: A hospital that provides subacute inpatient psychiatric services must complete Form MC-20, "Medical Assistance Hospital Provider Agreement," (see 471-000-91) and submit the completed form to the Department for approval and enrollment as a Medicaid provider of subacute inpatient hospital psychiatric services. The hospital must submit with the provider agreement:~~

- ~~1. A complete description of the psychiatric program and the elements of the program (i.e., policies and procedures, staffing, services, etc.);~~
- ~~2. A statement of the total number of licensed inpatient psychiatric beds, designated as subacute psychiatric beds that are approved by the Nebraska Department of Health and Human Services, Division of Public Health or agency in the state in which the facility is located; a listing of the bed numbers for those licensed psychiatric beds; and the size of the proposed subacute inpatient psychiatric unit;~~
- ~~3. Documentation that the subacute inpatient program meets the family-centered, community-based requirements in 471 NAC 20-001;~~
- ~~4. A description of how individual, group, and family psychotherapy services as well as other psycho-educational and rehabilitation services will be provided;~~
- ~~5. A description of how the subacute inpatient hospital psychiatric services will interface with community services for discharge planning and service provision after discharge;~~
- ~~6. A copy of the most recent Joint Commission Accreditation of Healthcare Organizations (JCAHO) or the American Osteopathic Association (AOA) accreditation survey; and~~
- ~~7. Any other information requested.~~

~~Any facility requesting a provider agreement must make the facility available for an on-site review before issuance of a provider agreement.~~



~~20-006.02 Standards for Participation for Subacute Inpatient Hospital Psychiatric Service Providers: A hospital that provides subacute inpatient hospital psychiatric services must meet the following standards for participation to ensure that payment is made only for subacute inpatient psychiatric treatment. The hospital or unit of an acute care hospital:~~

- ~~1. Is maintained for the care and treatment of patients with primary psychiatric disorders;~~
- ~~2. Is licensed or formally approved as a hospital by the Nebraska Department of Health and Human Services Division of Public Health, or if the hospital is located in another state, the officially designated authority for standard setting in that state;~~
- ~~3. Is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or by the American Osteopathic Association (AOA);~~
- ~~4. Meets the requirements for participation in Medicare for psychiatric hospitals;~~
- ~~5. Has in effect a utilization review plan applicable to all Medicaid clients;~~
- ~~6. Must have medical records that are sufficient to permit the Department to determine the degree and intensity of treatment furnished to the client;~~
- ~~7. Must meet staffing requirements the Department finds necessary to carry out an active treatment program (see 471 NAC 20-006.03);~~
- ~~8. Must encourage the client and family members to be involved in the assessment of the client, the development of the treatment plan, and all aspects of the client's treatment unless prohibited by the client, through legal action, or because of federal confidentiality laws;~~
- ~~9. Must be available to schedule meetings and sessions in a flexible manner to accommodate and work with a family/guardian/caretaker schedule. This includes the ability to schedule sessions at a variety of times including weekends or evenings; and~~
- ~~10. Must document their attempts to involve the client and the family in treatment plan development and treatment plan reviews. A variety of communication means should be considered to involve family. These may include, but should not be limited to, including the family via conference telephone calls, using registered letters to notify the family of meetings, and scheduling meetings in the evening and on weekends.~~

~~20-006.03 Staffing Standards for Participation: Subacute inpatient psychiatric hospital must have staff adequate in number and qualified to carry out a subacute psychiatric program for treatment for individuals who are in need of further psychiatric stabilization, treatment, rehabilitation, and recovery activities. The hospital must meet the following standards.~~

~~1. Hospital Personnel: Hospitals that provide subacute inpatient psychiatric services must be staffed with the number of qualified professional, technical, and supporting personnel, and consultants required to carry out an intensive and comprehensive treatment program that includes evaluation of individual and family needs; establishment of individual and family treatment goals; and implementation, directly or by arrangement, of a broad range psychiatric treatment program including, at least, 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 must be met:~~

~~a. Qualified professional psychiatric staff must be available to evaluate each patient at the time of admission, including diagnosis of any intercurrent disease. Services necessary for the evaluation include:~~

~~(1) Initial Diagnostic Interview;~~

~~(2) Nursing assessment by a licensed registered nurse;~~

~~(3) Substance abuse assessment as appropriate;~~

~~(4) Laboratory, radiological, and other diagnostic tests as necessary; and~~

~~(5) A physical examination including a complete neurological examination when indicated within 24 hours after admission by a licensed physician.~~

~~b. The number of qualified professional personnel and paraprofessionals, including licensed professional staff and technical and supporting personnel, must 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.~~

~~(1) Qualified staff must be available to provide treatment intervention, social interaction and experiences, 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 must include individual, group, and family therapy, group living experiences, occupational and recreational therapy and other prescribed activities to maintain or increase the individual's capacity to manage his/her psychiatric condition and activities of daily living. A minimum of 42 structured, scheduled, and documented treatment hours are required per week.~~

~~(2) The program must provide environmental and physical limitations required to protect the client's health and safety with a plan to develop the client's potential for return to his/her home, supervised adult living, or skilled nursing facility. The treatment milieu must be a safe, organized, structured environment at the least restrictive level of care to meet the individualized treatment needs of the client.~~

- ~~2. Medical Director of Subacute Inpatient Psychiatric Services: Subacute inpatient psychiatric services must be under the supervision of a psychiatrist (supervising practitioner) who is identified as medical director and is qualified to provide the clinical direction and the leadership required for an intensive psychiatric subacute inpatient treatment program. The number and qualifications of additional psychiatrists must 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 must be met:
  - ~~a. The medical director and any attending psychiatrist/s must meet the training and experience requirements for a psychiatrist licensed to practice in the state where services are provided;~~
  - ~~b. The program must identify a covering or alternative psychiatrist when the medical director is not available to provide direction and supervision of the direct care of the client and the treatment program;~~
  - ~~c. The psychiatrist's personal involvement in all aspects of the client's psychiatric care must be documented in the client's medical record (i.e., physician's orders, progress notes, nurses notes);~~
  - ~~d. The medical director/attending psychiatrist must be available, in person or by telephone, to provide assistance and direction to the treatment team as needed.~~~~
- ~~3. Availability of Physicians and Other Medical Consultation: Physicians and other appropriate professional consultants such as medical, psychopharmacological, dental, and emergency medical services must be available to provide medical, surgical, diagnostic, and treatment services, including specialized services. If medical, surgical, diagnostic, and treatment services are not available within the hospital, qualified physician consultants or attending physicians must be immediately available, or a satisfactory arrangement must be established for transferring patients to a general hospital certified for Medicare.~~

~~20-006.04 Program Standards for Participation: Subacute inpatient psychiatric services must have available licensed professionals and paraprofessionals 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:~~

- ~~1. Program/Clinical Director: Must be a fully licensed clinician such as a psychiatric registered nurse (RN), psychiatric advanced practice registered nurse (APRN), or a licensed mental health practitioner (LMHP) who is skilled and knowledgeable to provide leadership and clinical direction to the treatment team.~~

~~The duties and responsibilities of a program/clinical director are:~~

- ~~a. Oversee, implement, and coordinate all treatment services and activities provided within the program 24 hours a day;~~
- ~~b. Incorporate new clinical information and best practices into the program to assure effectiveness, viability and safety;~~
- ~~c. Oversee the process to identify, respond to and report crisis situations on a 24-hour per day, 7-day per week basis;~~

- d. Be responsible, (in conjunction with the medical director/attending psychiatrist) for the program's clinical management by representation in the multidisciplinary treatment team meetings providing supervision to all program professionals and paraprofessional staff;
  - e. Communicate with the attending psychiatrist regarding individual treatment needs of the client;
  - f. Assure quality organization and management of clinical record documentation and confidentiality; and
  - g. Oversee and be responsible for the safety of clients and staff.
2. Nursing Services: All nursing services must be under the supervision of a registered professional nurse who is qualified by education and experience for the supervisory role. The number of registered professional nurses and other nursing personnel must be adequate to formulate and carry out the nursing components of a treatment plan for each client. The following standards must be met:
- a. The registered professional nurse supervising the nursing program must 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 must be qualified by education and experience in the care of the individual with mental illness, and have demonstrated competence to:
    - (1) Provide 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;
  - b. The staffing pattern must ensure the direct nursing coverage by a registered professional nurse 24 hours each day for:
    - (1) Direct care; and
    - (2) Supervising care performed by other nursing personnel;
  - c. The number of registered professional nurses must be adequate to formulate a nursing care plan in writing for each client and to ensure that the plan is carried out; and
  - d. Registered professional nurses and other nursing personnel must 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 services and transitioning to the most appropriate treatment service and community resources.
3. Psychological Services: Psychological services must be available through employment or contractual arrangement with a licensed psychologist. Psychological consultation must be available by a qualified licensed psychologist capable of providing diagnostic and treatment services. The following standards must be met:

- ~~a. Psychologists, consultants, and supporting personnel must 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 research activities;~~
  - ~~(3) Therapeutic interventions, such as milieu, individual, or group therapy; and~~
  - ~~(4) Interdisciplinary conferences and meetings held to establish diagnoses, goals, and treatment programs; and~~~~
- ~~b. Psychological testing must be ordered and directed by a psychiatrist.~~
- ~~4. Psychotherapy Services: Licensed clinicians must be employed in the facility to provide psychotherapy services according to the therapist's scope of practice and according to the individualized treatment plan for the client. Licensed clinicians may include psychologists (Ph.D.), licensed mental health practitioners (LMHP), licensed alcohol and drug counselors (LADC), and advanced practice registered nurses (APRNS). Individual, group, and family psychotherapy must be available to each client and provided according to the client's individual treatment plan. Services must be able to meet the unique needs of each client. Minimum requirements for psychotherapy offered and available to the client are:
  - ~~a. Individual therapy minimum two times weekly;~~
  - ~~b. Group therapy minimum three times weekly;~~
  - ~~c. Family therapy and intervention as appropriate and consented to by the client. With consent of the client, family therapy must be provided at the frequency and intensity to meet the unique needs of client and the family.~~~~
- ~~5. Licensed Addiction and Drug Abuse Services: Substance abuse assessment and treatment must be available to clients whose problems and symptoms indicate the possibility of or an established substance abuse problem, in addition to the primary psychiatric diagnosis. Licensed clinicians able to provide assessment and treatment of substance abuse problems must provide services according to and within their scope of practice. Usually, services are provided by a licensed alcohol and drug counselor.~~
- ~~6. Psycho Educational Services: Psychoeducational services, such as medication education, activities of daily living, social skill development must be offered in the program and providers must have psychoeducational services available to clients on a daily basis. Services may include education for diagnosis, treatment and relapse, life skills, medication management and symptom management. Services must be provided by a qualified professional or paraprofessional staff. Medication education must be provided by a registered nurse. Other psychoeducational services may be provided by a paraprofessional whose education and training provides competency to provide the service.~~
- ~~7. Case Management Services/Social Services Staff: Case Management/social services must be under the supervision of the program/clinical director. The case management/social service staff must be adequate in numbers 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:
  - ~~a. The development of community resources;~~
  - ~~b. Consultation with other staff and community agencies;~~~~

- ~~c. Aggressive preparation for transitioning the client to the next level of service and safe living environment according to the treatment plan.  
Daily case management services are required for each client and must be summarized in the client's clinical record.~~
- ~~8. Ancillary Services: Recreational or activity therapy services must be available and offered to the client daily and directly supervised by the program/clinical director who has supervisory responsibility to the entire treatment team and the services they provide.~~
- ~~9. Psychiatric Technicians: The program must have available paraprofessional staff who are members of the multi-disciplinary team.  
The role and responsibility of the psychiatric technician is to:
  - ~~a. Intervene in the treatment milieu;~~
  - ~~b. Provide treatment interventions to the client which meet the specific psychiatric needs of the client as identified in the treatment plan;~~
  - ~~c. Demonstrate competency in applying the learned treatment interventions;~~
  - ~~d. Have direct knowledge of policies and procedures of the agency.~~~~

~~Psychiatric Technicians must have completed the program's initial training program and continued ongoing training requirements. Seventy-five percent of the psychiatric technician staff must have completed a BS/BA degree in the Human Services field or have five years experience providing health care services.~~

~~20-006.05 Coverage Criteria for Subacute Inpatient Psychiatric Hospital Services: The Nebraska Medical Assistance Program covers subacute inpatient hospital psychiatric services for clients age 21 and over when the services meet the criteria in 471 NAC 20-001 and when the following requirements are met:~~

- ~~1. The attending psychiatrist must personally and face-to-face evaluate the client and document the psychiatric evaluation and diagnosis formulation within 24 hours of admission;~~
- ~~2. The attending psychiatrist assumes accountability to direct the care of the client at the time of admission;~~
- ~~3. The client must be treated by a psychiatrist personally and face-to-face a minimum of three times per week or more often, if medically necessary and the interaction must be documented in the client's clinical record;~~
- ~~4. The attending psychiatrist describes the medical necessity and active treatment requirements for the client;~~
- ~~5. The attending psychiatrist provides certification and recertification of the client's need for subacute inpatient psychiatric services; and~~
- ~~6. Clinical supervision of the multi-disciplinary treatment team and treatment team planning meetings as necessary to meet the individualized treatment needs of the client.~~

~~20-006.06 Treatment Planning: An initial treatment plan must be implemented upon admission. The master/comprehensive treatment plan must be developed within 72 hours and reviewed by the treatment team a minimum of three times weekly. The master/comprehensive treatment plan must be developed from the recommendations made by the attending psychiatrist who has provided face-to-face evaluation of the client and the input from all other assessments completed following admission to subacute inpatient treatment services. Comprehensive treatment plans must meet medical necessity requirements.~~

~~Discharge planning must be a part of the comprehensive treatment plan. Discharge planning must be specific, realistic and individualized for the client from the time of admission and revised as medically necessary with treatment planning reviews.~~

~~20-006.07 Therapeutic Passes and Unplanned Leave of Absence: Therapeutic passes for clients with a primary psychiatric diagnosis from a subacute inpatient psychiatric hospital are a part of treatment transitioning. Therapeutic passes are an essential part of the treatment of some psychiatric clients. Documentation of the client's continued need for psychiatric care must follow the overnight therapeutic passes.~~

~~Unplanned leaves of absence from subacute inpatient psychiatric care occur at times but are not reimbursable services to the program. The Department contracted peer review organization or management designee must be notified immediately when the client returns.~~

~~20-006.08 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.~~

~~20-006.09 Criteria for Subacute Inpatient Psychiatric Hospital Services: One or more of the following criteria must be present:~~

- ~~1. The client can benefit from longer-term evaluation, stabilization, and treatment services;~~
- ~~2. The client is at moderate to high risk to harm self/others;~~
- ~~3. The client has active symptomatology consistent with the current version of the American Psychiatric Association's Diagnostic and Statistical Manual (DSM) (axes I-V) diagnoses;~~
- ~~4. The client has the ability to respond to intensive structured intervention services;~~
- ~~5. The client is at moderate to high risk of relapse or symptom reoccurrence;~~
- ~~6. The client has high need of professional structure and intervention services;~~
- ~~7. The client can be treated with short term intensive intervention services.~~

~~20-006.10 Prior Authorization Procedures: All subacute inpatient psychiatric admissions must be prior authorized by the Department contracted peer review organization or management designee. If the admission is approved, the Department contracted peer review organization or management designee must assign a specific prior authorization number. Providers must 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 subacute program by the Department contracted peer review organization or management designee.~~

~~20-006.11 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 subacute inpatient psychiatric program. Clinical records must stress the psychiatric components of the record, including history of findings and treatment provided for the psychiatric condition for which the client is hospitalized. The clinical record must be legible and include:~~

- ~~1. The identification data, including the client's legal status (i.e., 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, including a medical history, which contains a record of mental status and notes the onset of illness, the circumstances leading to admission, attitudes, behavior, estimate of 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, recorded at the time of the admitting physical examination;~~
- ~~6. Reports of consultations, psychological evaluations, electroencephalograms, dental records, and special studies;~~
- ~~7. The client's treatment plan and treatment plan reviews;~~
- ~~8. The treatment received by the client, which is documented in a manner and with a frequency to ensure that all active therapeutic efforts, such as individual, group, and family psychotherapy, drug therapy, milieu therapy, occupational therapy, recreational therapy, nursing care, and other therapeutic interventions, are included;~~



- ~~11. Progress notes which are recorded by the psychiatrist or physician, 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 must be recorded daily by nursing staff, and at each contact by psychiatrist or physician and by all other treatment staff. Progress notes must contain a concise assessment of the client's progress and recommendations for revising the treatment plan as indicated by the client's condition;~~
- ~~12. The psychiatric diagnosis contained in the final diagnosis written in the terminology of the current American Psychiatric Association's Diagnostic and Statistical Manual (DSM);~~
- ~~13. Therapeutic leave days prescribed by the psychiatrist under the treatment plan. The client's response to time spent outside the hospital must be entered in the client's hospital clinical record;~~
- ~~14. Transition and discharge planning documentation including relapse and crisis prevention planning;~~
- ~~15. Proof of family and community involvement;~~
- ~~16. 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.~~

~~All documents from the client's medical record submitted to the Department must contain sufficient information for identification (that is, client's name, date of service, provider's name).~~

~~20-006.12 Certification and Recertification by Psychiatrists for Subacute Inpatient Hospital Psychiatric Services: The Department pays for covered subacute inpatient hospital psychiatric services only if a psychiatrist certifies, and recertifies at designated intervals, the medical necessity for the admission to and continued hospitalization for subacute inpatient psychiatric treatment services. Appropriate supporting material may be required. The psychiatrist's certification or recertification statement must document the medical necessity for the admission to and continued hospitalization for short-term inpatient psychiatric treatment, based on a current evaluation of the client's condition.~~

~~For clients admitted to a subacute program, a psychiatrist's certification by written order for admission is required at the time of admission.~~

~~20-006.12A Failure to Certify or Recertify:~~ If a hospital fails to obtain the required certification and recertification statements for the client's stay, the Department will not make payment for the services that are not certified.

~~20-006.13 Hospital Utilization Review (UR):~~ See 471 NAC 10-012 ff. A site visit by Medicaid staff for purposes of utilization review may be required for further clarification.

~~20-006.14 Payment for Subacute Inpatient Hospital Psychiatric Services:~~ See 471 NAC 10-010.03D3.

~~20-006.14A Billing:~~ Providers must submit claims for subacute inpatient hospital psychiatric services on Form HCFA-1450 (UB-04). Providers must enter the prior authorization number as required for subacute inpatient services.

~~20-006.15 Other Regulations:~~ In addition to the policies regarding psychiatric services, all regulations in Title 471 NAC apply, unless stated differently in this section.

~~20-006.16 Limitations:~~ For subacute inpatient hospital psychiatric services, the following limitations apply:

- ~~1. Care must be provided by and directly supervised by a licensed psychiatrist. The psychiatrist must be licensed in the state where the service is being delivered.~~
- ~~2. All subacute inpatient hospital psychiatric services must be prior authorized; and~~
- ~~3. Payment for subacute inpatient hospital services is made according to 471 NAC 10-010.03D.~~

~~20-006.17 Documentation:~~ Additional documentation from the client's medical record may be requested by the Department's psychiatric consultants prior to considering authorization of payment of subacute psychiatric care.

~~20-006.18 Emergency Protective Custody (EPC) in a Subacute Inpatient Program: A hospital may be reimbursed for clients under an EPC order in an acute care hospital without designated psychiatric beds for an average of three to five days, up to seven days under the following conditions:~~

- ~~1. The hospital is licensed by the Nebraska Department of Health and Human Services Division of Public Health;~~
- ~~2. The hospital is accredited by the Joint Commission on the Accreditation of Health Care Organizations or the American Osteopathic Association;~~
- ~~3. The admitting and attending physician is a psychiatrist;~~
- ~~4. The hospital provides a setting that is separate from the rest of the hospital activities and is a safe, therapeutic environment;~~
- ~~5. The hospital provides an active treatment program in the form of assessment and diagnostic interventions;~~
- ~~6. The hospital EPC program is approved by the Department's Medicaid staff; and~~
- ~~7. The hospital EPC program meets all other standards for inpatient hospital psychiatric care.~~

~~20-007 Adult Inpatient Hospital Psychiatric Services: Inpatient hospital psychiatric services for clients 21 and over are medically necessary psychiatric services provided to an inpatient as defined in 471 NAC 10-000. The care and treatment of an inpatient with a primary psychiatric diagnosis must be under the direction of a psychiatrist or physician who meets the state's licensing criteria and is enrolled as a provider with the Department with a primary specialty of psychiatry. Inpatient hospital psychiatric services must be prior authorized by the Department-contracted peer review organization or management designee. In addition, out-of-state hospitalizations must be approved by the Department.~~

~~20-007.01 Provider Agreement: A hospital which provides inpatient psychiatric services must complete Form MC-20, "Medical Assistance Hospital Provider Agreement," (see 471-000-91) and submit the completed form to the Department for approval and enrollment as a provider. The hospital must submit with the provider agreement-~~

- ~~1. A complete description of the psychiatric program and the elements of the program (i.e., policies and procedures, staffing, services, etc.);~~
- ~~2. A statement of the total number of licensed psychiatric beds, as approved by the Nebraska Department of Health and Human Services, Division of Public Health or agency in the state in which the facility is located; a listing of the bed numbers for those licensed psychiatric beds; and the size of the proposed psychiatric unit;~~
- ~~3. Documentation that the inpatient program meets the family-centered, community-based requirements in 471 NAC 20-001;~~
- ~~4. A description of how family psychotherapy services will be provided;~~
- ~~5. A description of how the hospital services will interface with community services for discharge planning and service provision after discharge;~~
- ~~6. A copy of the most recent JCAHO or AOA accreditation survey; and~~
- ~~7. Any other information requested.~~

~~Any facility requesting a provider agreement must make the facility available for an on-site review before issuance of a provider agreement.~~

20-007.02 Standards for Participation for Inpatient Hospital Psychiatric Service Providers:  
A hospital that provides inpatient hospital psychiatric services must meet the following standards for participation to ensure that payment is made only for active treatment. The hospital-

1. Is maintained for the care and treatment of patients with primary psychiatric disorders;
2. Is licensed or formally approved as a hospital by the Nebraska Department of Health and Human Services, Division of Public Health, or if the hospital is located in another state, the officially designated authority for standard setting in that state;
3. Is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or by the American Osteopathic Association (AOA);
4. Meets the requirements for participation in Medicare for psychiatric hospitals;
5. Has in effect a utilization review plan applicable to all Medicaid clients;
6. Must have medical records that are sufficient to permit the Department to determine the degree and intensity of treatment furnished to the client; and
7. Must meet staffing requirements the Department finds necessary to carry out an active treatment program (see 471 NAC 20-007.03).
8. Hospitals must encourage family members to be involved in the assessment of the client, the development of the treatment plan, and all aspects of the client's treatment unless prohibited by the client, through legal action, or because of federal confidentiality laws.
9. Hospitals must be available to schedule meetings and sessions in a flexible manner to accommodate and work with a family's schedule. This includes the ability to schedule sessions at a variety of times including weekends or evenings.
10. The hospital must document their attempts to involve the family in treatment plan development and treatment plan reviews. A variety of communication means should be considered. These may include, but should not be limited to, including the family via conference telephone calls, using registered letters to notify the family of meetings, and scheduling meetings in the evening and on weekends.

A distinct part of a hospital may be considered a psychiatric unit if it meets the standards for participation, even though the hospital of which it is a part does not.

~~20-007.03 Staffing Standards for Participation: The hospital must have staff adequate in number and qualified to carry out an active program of treatment for individuals who are provided services in the hospital. The hospital must meet the following standards.~~

- ~~1. Hospital Personnel: Hospitals which provide inpatient psychiatric services must 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 that includes evaluation of individual and family needs; establishment of individual and family treatment goals; and implementation, directly or by arrangement, of a broad range therapeutic program including, at least, professional psychiatric, medical, surgical, nursing, social work, psychological, and activity therapies required to carry out an individual treatment plan for each patient and their family. The following standards must be met:~~
  - ~~a. Qualified professional and technical personnel must be available to evaluate each patient at the time of admission, including diagnosis of any intercurrent disease. Services necessary for the evaluation include -~~
    - ~~(1) Laboratory, radiological, and other diagnostic tests;~~
    - ~~(2) Obtaining psychosocial data;~~
    - ~~(3) A complete family assessment (see 20-001 and 20-007.07, #7);~~
    - ~~(4) Carrying out psychiatric and psychological evaluations; and~~
    - ~~(5) Completing a physical examination, including a complete neurological examination when indicated, shortly after admission;~~
  - ~~b. The number of qualified professional personnel, including consultants and technical and supporting personnel, must 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, 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) 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 individual's capacity to manage activities of daily living; and~~
    - ~~(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.~~

- ~~2. Director of Inpatient Psychiatric Services and Medical Staff: Inpatient psychiatric services must 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 physicians must be adequate to provide essential psychiatric services. The following standards must be met:
  - ~~a. The clinical director, service chief, or equivalent must meet the training and experience requirements for a psychiatrist or a physician for NMAP;~~
  - ~~b. The medical staff must be qualified legally, professionally, and ethically for the positions to which they are appointed; and~~
  - ~~c. The number of physicians must be commensurate with the size and scope of the treatment program.~~
  - ~~d. The physician's personal involvement in all aspects of the client's psychiatric care must be documented in the client's medical record (i.e., physician's orders, progress notes, nurses notes).~~
  - ~~e. The physician must be available, in person or by telephone, to provide assistance and direction as needed.~~~~
- ~~3. Availability of Physicians and Other Personnel: Physicians and other appropriate professional personnel must 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 must be immediately available, or a satisfactory arrangement must be established for transferring patients to a general hospital certified for Medicare.~~
- ~~4. Nursing Services: Nursing services must be under the direct supervision of a registered professional nurse who is qualified by education and experience for the position. The number of registered professional nurses, licensed practical nurses, and other nursing personnel must be adequate to formulate and carry out the nursing components of a treatment plan for each client. The following standards must be met:
  - ~~a. The registered professional nurse supervising the nursing program must 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 must be qualified by education or experience in the care of the mentally ill, and have demonstrated competence to:
    - ~~(1) Participate in interdisciplinary formulation of treatment plans;~~
    - ~~(2) Give skilled nursing care and therapy; and~~
    - ~~(3) Direct, supervise, and train others who assist in implementing and carrying out the nursing components of each client's treatment plan;~~~~~~

- ~~b. The staffing pattern must ensure the availability of a registered professional nurse 24 hours each day for—
  - ~~(1) Direct care;~~
  - ~~(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 the preparation and competence of the nursing staff available;~~~~
- ~~c. The number of registered professional nurses, including nurse consultants, must be adequate to formulate a nursing care plan in writing for each client and to ensure that the plan is carried out; and~~
- ~~d. Registered professional nurses and other nursing personnel must 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.~~
- ~~5. Psychological Services: The psychological services must be under the supervision of a licensed psychologist. The psychology staff, including consultants, must be adequate in numbers and be qualified to plan and carry out assigned responsibilities. The following standards must be met:
  - ~~a. The psychology department or service must be under the supervision of a licensed psychologist;~~
  - ~~b. Psychologists, consultants, and supporting personnel must 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 research activities;~~
    - ~~(3) Therapeutic interventions, such as milieu, individual, or group therapy; and~~
    - ~~(4) Interdisciplinary conferences and meetings held to establish diagnoses, goals, and treatment programs;~~~~
  - ~~c. Psychotherapy must be ordered and directed by a physician; and~~~~
- ~~6. Social Work Services and Staff: Social work services must be under the supervision of a qualified social worker. The social work staff must 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 must be met:
  - ~~a. The director of the social work department or service must have a master's degree from an accredited school of social work and must meet the experience requirements for certification by the Academy of Certified Social Workers and, effective 9-1-94, must be licensed by the Nebraska Department of Health and Human Services, Division of Public Health as a mental health practitioner; and~~~~



- ~~b. Social work staff, including other social workers, consultants, and other assistants or case aides, must be qualified and numerically adequate to-~~
  - ~~(1) 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 research 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.~~
- ~~7. Qualified Therapists, Consultants, Volunteers, Assistants, Aides: Qualified therapists, consultants, volunteers, assistants, or aides must be sufficient in number to provide comprehensive therapeutic activities, including 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 must be met:~~
  - ~~a. Occupational therapy services must be provided preferably under the supervision of a graduate of an occupational therapy program approved by the Council on Education of the American Medical Association who is licensed by the Nebraska Department of Health and Human Services, Division of Public Health or is eligible for the National Registration Examination of the American Occupational Therapy Association. In the absence of a full-time, fully-qualified occupational therapist, an occupational therapy assistant may function as the director of the activities program with consultation from a fully-qualified occupational therapist;~~
  - ~~b. When physical therapy services are offered, the services must be given by or under the supervision of a qualified 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 and is licensed by the Nebraska Department of Health and Human Services, Division of Public Health. In the absence of a full-time, fully-qualified physical therapist, physical therapy services must be available by arrangement with a certified local hospital, or by consultation or part-time services furnished by a fully-qualified physical therapist;~~
  - ~~c. Educational Program Services: Services, when required by law, must be available. Educational Services must only be one aspect of the treatment plan, not the primary reason for admission or treatment. Educational services are not covered for payment by the Nebraska Medical Assistance Program;.~~
  - ~~d. Recreational or activity therapy services must be available under the direct supervision of a member of the staff who has demonstrated competence in therapeutic recreation programs;~~
  - ~~e. Other occupational therapy, recreational therapy, activity therapy, and physical therapy assistants or aides must be directly responsible to qualified supervisors and must be provided special on-the-job training to fulfill assigned functions;~~

~~f. The total number of rehabilitation personnel, including consultants, must 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; and~~

~~(2) Maintain all daily scheduled and prescribed activities, including maintenance of appropriate progress records for individual clients; and~~

~~g. Volunteer service workers must be—~~

~~(1) Under the direction of a paid professional supervisor of volunteers;~~

~~(2) Provided appropriate orientation and training; and~~

~~(3) Available daily in sufficient numbers to assist clients and their families in support of therapeutic activities.~~

~~20-007.04 Coverage Criteria for Inpatient Hospital Services: The Nebraska Medical Assistance Program covers inpatient hospital psychiatric services for clients age 21 and over when the services meet the criteria in 471 NAC 20-001 and when the following requirements are met:~~

- ~~1. The attending physician must personally and face-to-face evaluate the client and write the psychiatric evaluation and diagnosis formulation;~~
- ~~2. The client must be treated by a physician personally and face-to-face six out of seven days and the interaction must be documented in the client's clinical record;~~
- ~~3. A psychiatrist or physician for NMAP serves as the attending physician and defines the medical necessity and active treatment requirements noted in 471 NAC 20-001, "General Requirements";.~~
- ~~4. The treatment plan must be developed and supervised by a multi-disciplinary team under the direction and supervision of the physician. It must be implemented upon admission and must be reviewed every 30 days or more often if medically necessary by the multi-disciplinary team. Treatment plans must meet the medical necessity and active treatment requirements in 471 NAC 20-001;~~
- ~~5. Therapeutic passes for clients with primary psychiatric diagnoses from hospitals which provide psychiatric services. Therapeutic passes are an essential part of the treatment of some psychiatric clients. Documentation of the client's continued need for psychiatric care must follow the overnight therapeutic passes. Payment for hospitalization after a second pass is not available based on medical necessity. The hospital is not paid for therapeutic passes or leave days;~~
- ~~6. Unplanned leaves of absence from inpatient and psychiatric hospital care: The hospital is not paid for unplanned leave of absence days. The Department contracted peer review organization or management designee must be notified immediately when the client returns. Admission criteria will be applied. If approved, a new validation number will be issued to cover the days beginning with the day of return.~~

~~20-007.04A 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.~~

20-007.05 Admission Criteria for Inpatient Hospital Psychiatric Services: One or more of the following problems must be present:

1. — The patient needs a specific form of psychiatric treatment that can only be provided in the hospital and the structured environment of the hospital is necessary for the client's treatment;
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 disorder 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 patient is experiencing psychiatric symptoms, the magnitude of which is not tolerable to self or society and that cannot be alleviated through treatment;
6. — The patient is unable to be cared for by self or others, due to psychiatric disorder;
7. — All patients must require and receive "active treatment" as defined in 42 CFR 441.154, which is available only in an inpatient setting. Exception: Clients are 65 and older in an IMD (see 471 NAC 20-008); or
8. — Ambulatory care services in the community do not meet the treatment needs of the client. Note: In those communities where outpatient resources are not available, the community pattern of referral must be used when appropriate.

20-007.05A Guidelines for Interpretation: Admission of an individual age 21 and older 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 will not be accepted as adequate medical indicators for hospital inpatient admission:

1. — Non-availability of group home, halfway house, residential treatment or other placement alternatives;
2. — Admission to support or arrange placement in 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. — Reason for acute level of care is to obtain Medicaid benefits that would otherwise not be reimbursed;
6. — Admission to avoid placement in the criminal justice system;
7. — Admission for conduct disorders or behavioral issues that do not demonstrate an imminent danger to self or others;
8. — Social and family problems; and
9. — Psychometric evaluation including mental retardation and learning disabilities.

~~20-007.05A1 Patient Assessment: Admission to an acute care facility must meet elements #1 and #2 (listed below) plus at least one other element from this patient assessment section. The additional element must be as a result of the major psychiatric disorder referred to in element #1. In addition, one element from the acute services section must be met.~~

~~\* Elements #1 and #2 must be met on all admissions.~~

~~\*1. Documented evidence of a major psychiatric disorder that necessitates 24-hour medical supervision and daily physician contact.~~

~~\*2. Documented initial treatment plan with provisions for-~~  
a. ~~Resolution of acute medical problems;~~  
b. ~~Evaluation of, and needs assessment for, medications;~~  
c. ~~Protocol to ensure patient's safety;~~  
d. ~~Discharge plan initiated at the time of admission.~~

~~\* Plus one of the following:~~

~~3. Demonstrates imminent danger to self or others at the time of admission evidenced by at least one of the following:~~

~~a. Suicide attempt or specific suicide plan with access to means;~~  
~~b. Danger to others through a specific action or activity;~~  
~~c. Command hallucination with suicidal or homicidal content;~~  
~~d. Hallucinations, delusional behavior, or other bizarre psychotic behavior.~~

~~4. Presence of other behavior/symptoms to such a degree or in such a combination that acute care is the least restrictive treatment available as demonstrated by at least one of the following:~~

~~a. Physical aggression toward family, peers, or coworkers which could not be considered self protective;~~  
~~b. Explosive behavior without provocation or serious loss of impulse control;~~  
~~c. Dangerous, assaultive, uncontrolled or extreme impulsive behavior which puts the patient at significant risk, e.g., running into traffic, playing/setting fires, self-abuse, and which cannot be prevented in a non-acute setting;~~  
~~d. Severe impairment in concentration and/or hyperactivity;~~  
~~e. Behaviors consistent with an acute psychiatric disorder which may include significant mental status changes; and there is documented evidence that no medical condition would account for the symptoms;~~

~~5. Severe impairment in psychosocial functioning as demonstrated by at least one of the following:~~

~~a. Psychotic behavior, delusions, paranoia, or hallucinations;~~  
~~b. Severe decompensation and interference with baseline functioning;~~

6. Documented failure of current intensive outpatient treatment including two or more of the following indications:
  - a. Intensification or perseverance of severe psychiatric symptoms;
  - b. Noncompliance with medication regime;
  - c. Lack of therapeutic response to medication;
  - d. Lack of patient participation in or response to outpatient treatment modalities;
7. Admissions ordered by the court will be covered when accompanied by substantiation of medical necessity.

Documentation supports the need for controlled, clinical observation and psychiatric evaluation, where acute care is the least restrictive treatment alternative.

20-007.05A2 Acute Services:

Justification for Continued Stay: The patient must meet elements #1 and #2 plus two elements from 2 through 7 for the approval of continued stay.

\* Elements #1 and #2 must be met at all continued stay reviews.

1. Evidence of a major psychiatric disorder that necessitates 24-hour medical supervision and family physician contact.
2. A comprehensive treatment plan/clinical pathway of inpatient care must be completed within 72 hours of admission and implemented to facilitate the patient's progression toward living in a less supervised setting. Documentation must support the patient's and/or family's active involvement with the treatment goals and with revisions in the treatment plan as appropriate based on the patient's progress or lack of progress.

\* Plus two of the following:

3. Isolation, seclusion, or restraint procedures within the last 72 hours requiring 24-hour medical supervision and supported by medical record documentation.
4. Continuing evidence of symptoms and/or behaviors reflecting significant risk, imminent danger, or actual demonstrated danger to self or others; requiring suicide/homicide precautions (1:1), close observation, step down precautions (every 15-60 minute checks).
5. Monitoring/adjustment of psychotropic medication(s) related to lack of therapeutic effect/complication(s) in the presence of complicating medical and psychiatric conditions necessitating 24-hour medical supervision and supported by medical record documentation.

6. Persistence of psychotic symptoms and continued temporary (not chronic) inability of the patient to perform the activities of daily living or meet their basic needs for nutrition and safety due to a psychiatric disorder or the temporary mental state of the patient.
7. Continued need for 24-hour medical supervision, reevaluation and/or diagnosis of a patient exhibiting behaviors consistent with acute psychiatric disorder. Referral for physician review is necessary if symptoms are unimproved or worse within any seven-day interval.

20-007.05B Signs and Symptoms: In addition to the admission criteria, one or more of the following signs or symptoms of the problem must be present:

1. A suicide attempt that requires acute medical intervention or suicidal ideation with a lethal plan and the means to carry out this plan;
2. Psychiatric decompensation to a level in which the client is not able to communicate or perform life-sustaining activities of daily living;
3. Delusions or hallucinations that significantly impair the client's ability to communicate or perform life-sustaining activities of daily living;
4. Catatonia;
5. The presence of combined illnesses where neurological or other disease process coexists with a psychiatric disturbance, demanding special diagnostic or treatment interventions, which exceed non-hospital capacity;
6. Aggression to others causing physical injury or homicidal ideation with a lethal plan and the means to carry out the plan, that is the result of a severe emotional psychiatric decompensation; and
7. Medication initiation or change when the client has a documented history of reactions to psychotropic medications that have resulted in the need for acute medical care in a hospital or an emergency room.

20-007.06 Prior Authorization Procedures: All inpatient admissions must be prior-authorized by the Department-contracted peer review organization or management designee. Each client will have a specific prior-authorization number assigned by the Department-contracted peer review organization or management designee if the admission is approved. Providers should follow the Department's contracted peer review organization or management designee guidelines on facilitating prior authorization.

~~20-007.07 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 the hospital. For inpatient hospital psychiatric services, clinical records must stress the psychiatric components of the record, including history of findings and treatment provided for the psychiatric condition for which the client is hospitalized. The medical record must be legible and include -~~

- ~~1. The identification data, including the client's legal status (i.e., 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, including a medical history, which contains a record of mental status and notes the onset of illness, the circumstances leading to admission, attitudes, behavior, estimate of 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, recorded at the time of the admitting physical examination;~~
- ~~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 family assessment as described in 471 NAC 20-001;~~
- ~~8. Reports of consultations, psychological evaluations, electroencephalograms, dental records, and special studies;~~
- ~~9. The client's treatment plan and treatment plan reviews;~~
- ~~10. The treatment received by the client, which is documented in a manner and with a frequency to ensure that all active therapeutic efforts, such as individual, group, and family psychotherapy, drug therapy, milieu therapy, occupational therapy, recreational therapy, nursing care, and other therapeutic interventions, are included;~~
- ~~11. Progress notes which are recorded by the psychiatrist or physician, 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 must be recorded daily by nursing staff, and at each contact by psychiatrist or physician and by all other therapeutic staff (such as O.T., R.T.). Progress notes must contain a concise assessment of the client's progress and recommendations for revising the treatment plan as indicated by the client's condition;~~

- ~~12. The psychiatric diagnosis contained in the final diagnosis written in the terminology of the current American Psychiatric Association's Diagnostic and Statistical Manual;~~
- ~~13. Therapeutic leave days prescribed by the psychiatrist under the treatment plan. The client's response to time spent outside the hospital must be entered in the client's hospital clinical record;~~
- ~~14. Transition and discharge planning documentation;~~
- ~~15. Proof of family and community involvement;~~
- ~~16. A copy of the MC-14 certification; and~~
- ~~17. 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.~~

~~All documents from the client's medical record submitted to the Department must contain sufficient information for identification (i.e., client's name, date of service, provider's name).~~

~~20-007.08 Certification and Recertification by Psychiatrists for Inpatient Hospital Psychiatric Services~~

~~20-007.08A Certification and Recertification by Psychiatrists: The Department pays for covered inpatient hospital psychiatric services only if a psychiatrist or physician certifies, and recertifies at designated intervals, the medical necessity for the services of the hospital inpatient stay. Appropriate supporting material may be required. The psychiatrist's or physician's certification or recertification statement must document the medical necessity for the admission to and continued hospitalization for inpatient psychiatric treatment, based on a current evaluation of the client's condition.~~

~~\_\_\_\_\_ For clients admitted to a hospital, a psychiatrist's or physician's certification by written order for admission is required at the time of admission for inpatient services.~~



~~20-007.08B Failure to Certify or Recertify: If a hospital fails to obtain the required certification and recertification statements in an individual case, the Department must not make payment for the case.~~

~~20-007.09 Hospital Utilization Review (UR): See 471 NAC 10-012. A site visit by Medicaid staff for purposes of utilization review may be required for further clarification.~~

~~20-007.10 Payment for Inpatient Hospital Psychiatric Services: See 471 NAC 10-010.03.~~

~~20-007.10A Billing: Providers must submit claims for inpatient hospital psychiatric services on Form CMS-1450 or the standard electronic Health Care Claim: Institutional transaction (ASC X12N 837).~~

~~20-007.11 Other Regulations: In addition to the policies regarding psychiatric services, all regulations in the Nebraska Department of Health and Human Services Manual apply, unless stated differently in this section. For inpatient services provided by an IMD, public or private, see 471 NAC 20-008.~~

~~20-007.12 Limitations: For inpatient hospital psychiatric services, the following limitations apply:~~

- ~~1. Care must be supervised by a psychiatrist or physician. All inpatient hospital services must be prior authorized; and~~
- ~~2. Payment for inpatient hospital services is made according to 471 NAC 10-010.03.~~

~~20-007.13 Form Completion: Inpatient hospital psychiatric service providers must~~

- ~~1. Complete Form MC-20 and be approved and enrolled with the Department as a provider of inpatient hospital psychiatric services (class of care 06);~~
- ~~2. Submit all claims for inpatient hospital services on an appropriately completed Form CMS-1450 or the standard electronic Health Care Claim: Institutional transaction (ASC X12N 837);~~
- ~~3. Enter the review number from the Department contracted peer review organization or management designee as required.~~

~~Payment for approved services is made to the hospital.~~

~~20-007.14 Exceptions: Additional documentation from the client's medical record may be requested by the Department's psychiatric consultants prior to considering authorization of payment.~~

~~20-007.15 Emergency Protective Custody (EPC) in an Acute Care Hospital: Emergency Protective Custody (EPC) Services may be reimbursed in an acute care hospital without licensed psychiatric beds for an average of three to five days, up to seven days under the following conditions:~~

- ~~1. The hospital is licensed by the Nebraska Department of Health and Human Services, Division of Public Health;~~
- ~~2. The hospital is accredited by the Joint Commission on the Accreditation of Health Care Organizations or the American Osteopathic Association;~~
- ~~3. The admitting and attending physician is a psychiatrist;~~
- ~~4. The hospital provides a setting that is separate from the rest of the hospital activities and is a safe, therapeutic environment;~~
- ~~5. The hospital provides an active treatment program in the form of assessment and diagnostic interventions;~~
- ~~6. The hospital EPC program is approved by the Department's Medicaid staff; and~~
- ~~7. The hospital EPC program meets all other standards for inpatient hospital psychiatric care.~~

~~The exception for EPC services is available only to hospitals that do not have licensed psychiatric beds.~~

20-008 Inpatient Hospital Services for Clients 65 and Over in Institutions for Mental Disease (IMD's)

20-008.01 Legal Basis: The Nebraska Medical Assistance Program (NMAP) covers IMD services, for clients 65 and over, under 42 CFR 431.620(b), 435.1009; 440.140; 440.160; Part 441, Subparts C and D; Part 447, Subparts B and C; Part 456, Subparts D and I; and Part 482. The Department provides IMD services under the Family Policy Act, Sections 43-532 through 534, Reissue Revised Statute of Nebraska, 1943.

20-008.02 Definition of an IMD: 42 CFR 435.1009 defines an IMD as "an institution that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services. Whether an institution is an institution for mental diseases is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such. An institution for the mentally retarded is not an institution for mental diseases." This is limited to free-standing facilities which are not excluded units of acute care hospitals.

20-008.03 Standards for Participation: To participate in the NMAP, the IMD must -

1. Be in conformity with all applicable federal, state, and local laws;
2. Be licensed as a hospital by the Nebraska Department of Health and Human Services, Division of Public Health or the licensing agency in the state where the IMD is located;
3. Be certified as meeting the conditions of participation for hospitals in 42 CFR Part 482;
4. Be accredited by the Joint Commission of Accreditation of Healthcare Organizations (JCAHO) or the American Osteopathic Association (AOA), and submit a copy of the most recent accreditation survey with Form MC-20;
5. Meet the definition of an IMD as stated in 471 NAC 20-008.02 (above);
6. Meet the program and operational definitions and criteria contained in the Nebraska Department of Health and Human Services Manual;
7. Meet the current JCAHO or AOA standards of care; and
8. Meet all requirements in 471 NAC 20-001 except active treatment.

20-008.03A Provider Agreement: The provider must complete Form MC-20 and submit the form, along with a copy of its current JCAHO or AOA accreditation survey, program, policies, and procedures to the Department to enroll in NMAP as a provider. If approved, the Department notifies the IMD of its provider number.

20-008.03B Annual Update: With the annual cost report, the provider must submit a copy of all program information, their most recent license and accreditation certificates, and any other information specifically requested by the Department. Claims will not be paid if this has not been received and approved. This information must be submitted with a new copy of Form MC-20.

~~20-008.03C Monthly Reports: The IMD must submit a monthly report to the Division of Medicaid and Long-Term Care. The report must contain-~~

- ~~1. The names of all Medicaid clients admitted or discharged during the month; and~~
- ~~2. The date of each Medicaid client's admission or discharge.~~

~~The report must be submitted by the 15th of the following month.~~

~~20-008.03D Record Requirements: The regional center (or the local office for a client in a private facility) must enter the Form MC-9H document number in Form Locator 63 on each Form CMS-1450 or standard electronic Health Care Claim: Institutional transaction that is submitted to the Department.~~

~~Transfer to another IMD or readmission constitutes a new admission for the receiving facility.~~

~~20-008.03D1 An Individual Who Applies For NMAP While in the IMD: For an individual who applies for NMAP while in the IMD, the certification must be-~~

- ~~1. Made by the team that develops the individual plan of care (see 471 NAC 20-008.10);~~
- ~~2. Cover any period before application for which claims are made.~~

~~When Medicaid eligibility is determined, authorization for previous and continued care must be obtained from the Department contracted peer review organization or management designee.~~

~~20-008.04 General Definitions: The following definitions are used in this section:~~

~~Interdisciplinary Team: The team responsible for developing each client's individual plan of care. The team must include a board-eligible or board-certified psychiatrist. The team must also include at least two of the following:~~

- ~~1. A Licensed Mental Health Practitioner;~~
- ~~2. A registered nurse with specialized training or one year's experience in treating individuals with mental illness;~~
- ~~3. An occupational therapist who is licensed, if required by state law, and who has specialized training or one year's experience in treating mentally ill individuals; or~~
- ~~4. A licensed psychologist.~~

Inpatient Hospital Services for Individuals Age 65 or Older in Institutions for Mental Disease (IMD's): Services provided under the direction of a psychiatrist for the care and treatment of clients age 65 and older in an institution for mental disease that meets the requirements of 42 CFR 440.140.

Inspection of Care Team: The Department's inspection of care team, consisting of a psychiatrist knowledgeable about mental institutions, a qualified registered nurse, and other appropriate personnel as necessary who conduct inspection of care reviews under 42 CFR 456.600-614 and 471 NAC 20-001.20.

Medical Review Organization: A review body contracted by the Department, responsible for pre-admission certification and concurrent and retrospective reviews of care.

20-008.05 Admission Criteria: See 471 NAC 20-007.05.

20-008.06 Signs and Symptoms: In addition to the admission criteria, one or more of the following signs or symptoms of the problem must be present:

1. A suicide attempt that requires acute medical intervention or suicidal ideation with a lethal plan and the means to carry out this plan;
2. Psychiatric decompensation to a level in which the client is not able to communicate or perform life-sustaining activities of daily living;
3. Delusions or hallucinations that significantly impair the client's ability to communicate or perform life-sustaining activities of daily living;
4. Catatonia;
5. The presence of combined illnesses where neurological or other disease process coexists with a psychiatric disturbance, demanding special diagnostic or treatment interventions, which exceed non-hospital capacity;
6. Aggression to others causing physical injury or homicidal ideation with a lethal plan and the means to carry out the plan, that is the result of a severe emotional psychiatric decompensation; and
7. Medication initiation or change when the client has a documented history of reactions to psychotropic medications that have resulted in the need for acute medical care in a hospital or an emergency room.

20-008.07 Prior Authorization and Initial Certification Procedures: IMD services for clients age 65 or older must be prior-authorized as follows:

1. Admissions must be prior-authorized by the Department's contracted peer review organization or management designee. Providers should follow the Department contracted peer review organization or management designee guidelines on facilitating prior authorization. The MC-14 received from the peer review organization or management designee must be maintained in the client's medical record;
2. A psychiatrist must pre-certify, at the time of admission, that the client requires inpatient services in a psychiatric hospital. The psychiatrist must complete, sign, and date Form MC-14 within 48 hours after admission or at the time of application for medical assistance if this date is later than the date of admission. The 48-hour period does not include weekends or holidays. Copies of the admission notes and plan of care may be attached to the signed and dated Form MC-14 to certify that inpatient services are or were needed;
3. The facility must contact the client's local office for determination of medical eligibility. The local office must respond to the facility with
  - a. The medical eligibility effective date; and
  - b. The date eligibility was determined, if this date is later than the date of admission;
4. The facility must complete Form MC-9H, attach a copy of the completed Form MC-14, and forward to the Division of Medicaid and Long-Term Care. The facility must retain the original copy of Form MC-14 in the client's medical record;
5. The Division of Medicaid and Long-Term Care must review Form MC-14 and approve or reject the Form MC-14 findings within 15 days;
6. If rejected, the Division of Medicaid and Long-Term Care must return all forms to the facility with an explanation of the rejection;
7. If approved, the Division of Medicaid and Long-Term Care must complete Block #11 and the signature Block #18 of Form MC-9H. The white copy is retained in Central Office. The Division of Medicaid and Long-Term Care must send the pink and gold copies to the facility and the yellow copy to the local office;
8. The document number on Form MC-9H must be entered in Form Locator 63 on each Form CMS-1450 or standard electronic Health Care Claim: Institutional transaction submitted to the Department; and
9. When the client is discharged or expires, the facility must complete Form MC-10 to close the authorization. The facility must forward the white copy to the Division of Medicaid and Long-Term Care and the yellow copy to the local office, and retain the pink and gold copies. Within 48 hours after a client is discharged or expires, the facility must notify the local office in the client's county of finance.

~~20-008.08 Transfers: Transfer to another IMD or a readmission constitutes a new admission for the receiving facility. This procedure must be followed for each transfer or readmission.~~

~~20-008.09 Sixty-Day Recertification: A psychiatrist must recertify, in the client's record, the client's need for continued care in a mental hospital or need for alternative arrangements at least every 60 days after the initial certification.~~

~~20-008.10 Interdisciplinary Plan of Care: The psychiatrist and the facility interdisciplinary team must develop and implement an individual written plan of care for each client within 48 hours after the client's admission. This plan of care must be placed in the client's chart when completed. The written plan of care must include-~~

- ~~1. Diagnoses, symptoms, complaints, and complications indicating the need for admission;~~
- ~~2. A description of the client's functional level;~~
- ~~3. Objectives;~~
- ~~4. Any orders for-~~
  - ~~a. Medications;~~
  - ~~b. Treatments;~~
  - ~~c. Restorative and rehabilitative services;~~
  - ~~d. Activities;~~
  - ~~e. Therapies;~~
  - ~~f. Social services;~~
  - ~~g. Diet; and~~
  - ~~h. Special procedures recommended for the client's health and safety.~~
- ~~5. Plans for continuing care, including review and modification of the plan of care;~~
- ~~6. Appropriate medical treatment in the IMD every 60 days;~~
- ~~7. Appropriate social services every 60 days;~~
- ~~8. Family involvement; and~~
- ~~9. Plans for discharge, including referrals for outpatient follow-up care.~~

~~This requirement is met by completion of Form MC-14, which is retained in the client's record.~~

~~20-008.11 Facility Interdisciplinary Plan of Care Team Review: The attending or staff psychiatrist and other personnel involved in the client's care must review each plan of care at least every 90 days. The client's record must contain documentation of the 90-day interdisciplinary team review.~~

~~20-008.12 Admission Evaluation: IMD staff must develop an admission evaluation for each client within 30 days after the client's admission. This evaluation must be placed in the client's record when completed. The admission evaluation must include-~~

- ~~1. The Form MC-14;~~
- ~~2. A medical evaluation, including-~~
  - ~~a. Diagnosis;~~
  - ~~b. Summary of current medical findings;~~
  - ~~c. Medical history;~~
  - ~~d. Mental and physical functional capacity;~~
  - ~~e. Prognosis;~~
  - ~~f. The psychiatrist's recommendation concerning the client's admission to the mental hospital or the client's need for continued care in the mental hospital, if the client applies for NMAP while in the mental hospital;~~
- ~~3. A psychiatric evaluation;~~
- ~~4. A social evaluation;~~
- ~~5. An initial plan of care sufficient to meet the client's needs until the facility interdisciplinary team has developed the individual written plan of care.~~

~~20-008.13 Discharge Planning: The IMD must make available to the psychiatrist current information on resources available for continued out-of-hospital care of patients and must arrange for prompt transfer of appropriate medical and nursing information to ensure continuity of care upon the client's discharge. Under 42 CFR 441.102, when the client is approved for an alternate plan of care, the IMD is responsible for discharge planning. In cooperation with community regional mental health programs, the IMD must-~~

- ~~1. Initiate alternate care arrangements;~~
- ~~2. Assist in client transfer; and~~
- ~~3. Follow up on the client's alternate care arrangements.~~

~~When the client is being transferred to a long term care facility (NF or ICF/MR), the facility's staff must be included in the discharge process and must receive appropriate and adequate medical and nursing information to ensure continuity of care. The IMD must also contact the client's local office.~~



20-008.14 Payment for IMD Services: See 471 NAC 10-010.03 ff.

20-008.14A Therapeutic Passes from IMD Settings: For some psychiatric clients, therapeutic passes are an essential part of treatment. For those clients, documentation of the client's continued need for psychiatric care must follow the overnight therapeutic passes. Payment for hospitalization beyond a second pass is not available due to medical necessity.

20-008.14B Unplanned Leaves of Absence from IMD Settings: Payment for hospitalization during an unplanned leave of absence is not available. The Department contracted peer review organization or management designee must be notified immediately when the client returns. Admission criteria will be applied. If approved, a new validation number will be issued to cover the days beginning with the day of return.

TITLE 471 - NEBRASKA MEDICAL ASSISTANCE PROGRAM SERVICES

CHAPTER 35 - (Repealed)

## CHAPTER 35-000 REHABILITATIVE PSYCHIATRIC SERVICES

~~35-001 Introduction:~~ The Nebraska Medical Assistance Program (NMAP) covers rehabilitative psychiatric services to rehabilitate clients experiencing severe and persistent mental illnesses in the community and thereby avoid more restrictive levels of care such as inpatient psychiatric hospital or nursing facility. Rehabilitative psychiatric services for children age 20 and younger are covered under EPSDT treatment plans, as described in Chapter 32-000 of this Title. Rehabilitative psychiatric services for adults age 21 and older are covered under the rules and regulations of this chapter. The services must be medically necessary and the most appropriate level of treatment for the individual client. This does not include treatment for a primary substance abuse diagnosis.

~~35-001.01 Definition of Severe and Persistent Mental Illness:~~ Clients with severe and persistent mental illness must meet the following criteria:

- ~~1. The client is age 21 and over;~~
- ~~2. The client has a primary diagnosis of schizophrenia, major affective disorder, or other major mental illness under the current edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association. Developmental disorders, or psychoactive substance use disorders may be included if they co-occur with the primary mental illnesses listed above;~~
- ~~3. The client has a persistent mental illness as demonstrated by the presence of the disorder for the last 12 months or which is expected to last 12 months or longer and will result in a degree of limitation that seriously interferes with the client's ability to function independently in an appropriate and effective manner in two of three functional areas: Vocational/Education, Social Skills, Activities of Daily Living.
  - ~~a. Functional limitations in the area of Vocational/Education abilities are defined as:
    - ~~(1) An inability to be consistently employed or an ability to be employed only with extensive supports, except that a person who can work but is recurrently unemployed because of acute episodes of mental illness is considered vocationally impaired;~~
    - ~~(2) Deterioration or decompensation resulting in an inability to establish or pursue educational goals within a normal time frame or without extensive supports;~~
    - ~~(3) An inability to consistently and independently carry out home management tasks, including household meal preparation, washing clothes, budgeting, and child care tasks and responsibilities;~~~~
  - ~~b. Functional limitations in the area of Social Skills and abilities are defined as:
    - ~~(1) Repeated inappropriate or inadequate social behavior or an ability to behave appropriately or adequately only with extensive or consistent support or coaching or only in special contexts or situations, such as social groups organized by treatment staff; or~~~~~~

- ~~(2) Consistent participation in adult activities only with extensive support or coaching and when involvement is mostly limited to special activities established for persons with mental illness or other persons with interpersonal impairments; or~~
- ~~(3) A history of dangerousness to self or others.~~

- c. ~~Functional limitations in the area of Activities of Daily Living are defined as an inability to consistently perform the range of practical daily living tasks required for basic adult functioning in the community, in three of five areas listed below:~~
- ~~(1) Grooming, hygiene, washing of clothes, and meeting nutritional needs;~~
  - ~~(2) Care of personal business affairs;~~
  - ~~(3) Transportation and care of residence;~~
  - ~~(4) Procurement of medical, legal, and housing services; or~~
  - ~~(5) Recognition and avoidance of common dangers or hazards to self and possessions.~~
4. ~~The client is at significant risk of continuing in a pattern of either institutionalization or living in a severely dysfunctional way if needed mental health services are not provided, and this pattern has existed for one year or longer and is likely to endure for one year or longer; and~~
5. ~~The client does not have a primary diagnosis of substance abuse/substance dependency or developmental disabilities.~~

~~35-001.02 Definition of Medical Necessity: The NMAP uses the following definition of medical necessity:~~

~~"Health care services and supplies which are medically appropriate and-~~

- ~~1. Necessary to meet the basic health needs of the client;~~
- ~~2. Rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the covered service;~~
- ~~3. Consistent in type, frequency, 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 or her physician;~~
- ~~6. No more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency;~~
- ~~7. Of demonstrated value; and~~
- ~~8. No more intense level of service than can be safely provided.~~

~~The fact that the physician has performed or prescribed a procedure or treatment or the fact that it may be the only treatment for a particular injury, sickness, or mental illness does not mean that it is covered by Medicaid. Services and supplies which do not meet the definition of medical necessity set out above are not covered."~~

~~For purposes of covering rehabilitative psychiatric services under this Chapter, the following interpretative notes apply. Medical necessity for rehabilitative psychiatric services includes:~~

~~Health care services which are medically appropriate and-~~

- ~~1. Necessary to meet the psychiatric rehabilitation needs of the client;~~
- ~~2. Rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the covered service;~~
- ~~3. Consistent in type, frequency, duration of service with accepted principles of psychiatric rehabilitation;~~
- ~~4. Consistent with the diagnosis of the condition;~~
- ~~5. Required for means other than convenience of the client or his or her service provider(s);~~
- ~~6. No more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency;~~
- ~~7. Of demonstrated value; and~~
- ~~8. A no more intense level of service than can be safely provided.~~

~~For the purpose of this Chapter, rehabilitative psychiatric services are medically necessary when those services can reasonably be expected to increase or maintain the level of functioning in the community of clients with severe and persistent mental illness.~~

~~35-002 Provider Participation: To participate in NMAP as a provider of rehabilitative psychiatric services, a program must be certified by the Department of Health and Human Services under the applicable rules and regulations described in 204 NAC. The provider shall agree to contract with the Department of Health and Human Services for the provision of rehabilitative psychiatric services, and demonstrate the capacity to fulfill all the contractual requirements contained therein. The provider must also complete and sign Form MC-19 or Form MC-20, "Medical Assistance Provider Agreement," and be approved for enrollment in NMAP. In addition, eligible providers must also provide other documentation requested.~~

~~35-003 Nebraska Health Connection Services: Certain Medicaid clients are required to participate in the Nebraska Medicaid Managed Care Program (known as the Nebraska Health Connection). The Department developed the NHC to improve the health and wellness of Nebraska's Medicaid clients by increasing their access to comprehensive health services in a way that is cost effective to the State. The NHC was implemented on July 1, 1995. Enrollment in the NHC is mandatory for certain clients in designated geographic areas of the state. NHC clients will receive a Nebraska Medicaid Identification Card. Participation in NHC can be verified by accessing the Department Internet Access for Enrolled Providers ([www.dhhs.ne.gov/med/internetaccess.htm](http://www.dhhs.ne.gov/med/internetaccess.htm)); the Nebraska Medicaid Eligibility System (NMES) at 800-642-6092 (in Lincoln, 471-9580) (see 471-000-124); the Medicaid Inquiry Line at 877-255-3092 (in Lincoln 471-9128); or electronically using the standard Health Care Eligibility Benefit Inquiry and Response transaction (ASC X12N 270/271).~~

~~The NHC utilizes two models of managed care plans to provide the basic benefits package; these models are health maintenance organizations (HMO's) and primary care case management (PCCM) networks. The NHC also provides a mental health and substance abuse benefits package on a statewide basis available to all clients who are required to participate in NHC.~~

~~If a client is required to participate in the NHC, all services contained in the benefits package (MH/SA or medical) must be provided under the management of the managed care plan.~~

~~35-004 Covered Services:~~ Medicaid covers the following rehabilitative psychiatric services under the rules and regulations of this chapter:

- ~~1. Community Support;~~
- ~~2. Day Rehabilitation;~~
- ~~3. Psychiatric Residential rehabilitation.~~

~~For the purposes of meeting the requirements of 471 NAC 35-002, programs certified by the Department of Health and Human Services under 204 NAC 5 (effective date December 19, 1994) as Residential Support and/or Service Coordination providers shall be considered to be certified as Community Support providers.~~

~~35-004.01 Community Support:~~ The Community Support program is designed to:

- ~~1. Provide/develop the necessary services and supports to enable clients to reside in the community;~~
- ~~2. Maximize the client's community participation, community and daily living skills, and quality of life;~~
- ~~3. Facilitate communication and coordination between mental health rehabilitation providers that serve the same client; and~~
- ~~4. Decrease the frequency and duration of hospitalization.~~

~~Community support shall provide client advocacy, ensure continuity of care, support clients in time of crisis, provide/procure skill training, ensure the acquisition of necessary resources, to assist clients with spend downs and other financial insurance coverage programs and assists the client in achieving community/social integration. The community support program shall provide a clear focus of accountability for meeting the client's needs within the resources available in the community. The role(s) of the community support provider may vary based on client's needs. Community support is a service in which the client's contact occurs outside the program offices in community locations consistent with the individual client choice/need. Community support is frequently provided in the home and is not facility or office-based. Ninety-day treatment, rehabilitation and recovery team meetings are not considered to be a community support service. The frequency of contact between the community support provider and the client is individualized and adjusted in accordance with the needs of the client.~~

~~Prior to admission to a community support program, an Initial Diagnostic Interview shall be completed by an independently licensed practitioner (psychiatrist, psychologist, or LIMHP). The purpose of this assessment is to determine/verify the presence of a severe and persistent mental illness which requires psychiatric rehabilitation services. The document must include the need of the specific rehabilitation services necessary to meet the treatment and recovery goals of the client.~~

~~Community Support is a separate and distinct service, and may not be provided as a component of other Rehabilitative Psychiatric Services or Mental Health Outpatient Services. Agencies that provide more than one level of rehabilitative psychiatric or Mental Health Outpatient service shall have staff dedicated to the Community Support program. These~~



~~Community Support staff shall not provide any other rehabilitative psychiatric or treatment service to the client.~~

35-004.01A Program Components: The Community Support program shall —

- ~~1. Facilitate communication and coordination among the mental health rehabilitation providers serving the client;~~
- ~~2. Ensure that the client has a diagnosis of severe and persistent mental illness, as exhibited by the completion of an Initial Diagnostic Interview, no more than 12 months prior to admission to Community Support. The Initial Diagnostic Interview must identify the need for Community Support and outline the needed services and resources for the client.~~
- ~~3. Ensure completion of a strength-based needs assessment which may include skills inventories, interviews and other tools to develop treatment and rehabilitation plans which must be completed within 30 days of admission by the rehabilitation team or team members.~~
- ~~4. Ensure the completion of an Individual Treatment, Rehabilitation, and Recovery Plan for each client served. The Individual Treatment, Rehabilitation, and Recovery Plan shall be completed within 30 days following the admission of the client and reviewed and updated every 90 days or as often as clinically necessary thereafter while receiving services. The Individual Treatment, Rehabilitation, and Recovery Plan shall be based on the results of comprehensive assessments and is developed with the client's involvement and through an interdisciplinary team process. The Individual Treatment, Rehabilitation, and Recovery Plan shall include methods and interventions to address: activities of daily living, community living skills, budgeting, education, independent living skills, social skills, interpersonal skills, psychiatric emergency/relapse, medication management including recognition of signs of relapse and control of symptoms, mental health services, physical health care, vocational/educational: services, resource acquisition, and other related areas as necessary for successful living in the community.~~
- ~~5. Ensure the Individual Treatment, Rehabilitation, and Recovery Plan that encompasses the supportive/rehabilitative interventions that will be directly provided by the Community Support Program;~~
- ~~6. Identify the provision of services/interventions identified in the Individual Treatment, Rehabilitation, and Recovery Plan as the responsibility of other rehabilitative service providers;~~
- ~~7. Develop and implement strategies to assist the client in becoming engaged and remaining engaged in medically necessary mental health treatment and psychiatric rehabilitation services;~~
- ~~8. Provide service coordination and case management activities, including coordination or assistance in accessing medical, social, education, housing, transportation or other appropriate support services as well as linkage to other community services identified in the Individual Treatment, Rehabilitation, and Recovery Plan.~~
- ~~9. Facilitate communication between the treatment and rehabilitation providers and with the primary care physician/psychiatrist serving the client.~~

- ~~10. Monitor client progress of the services being received and participate in the revision of the Individual Treatment, Rehabilitation, and Recovery Plan as needed or at the request of the client;~~

- ~~11. Provide contact as needed with other service provider(s), client family member(s), and/or other significant people in the client's life to facilitate communication necessary to support the individual in maintaining community living;~~
- ~~12. Assist the client in the developing, evaluating and updating a crisis and relapse prevention plan. This plan shall be coordinated with any other rehabilitative service and include the client's natural supports. Provide therapeutic support and intervention to the client in time of crisis. If hospitalization is necessary, facilitate, in cooperation with the inpatient treatment provider, the client's transition back into the community upon discharge.;~~
- ~~13. Participate with and report to the treatment/rehabilitation team on the progress of the client in areas of medication compliance, relapse prevention, social skill acquisition, application, education, substance abuse, and ability to sustain community living.~~
- ~~14. Monitor medication compliance; and~~
- ~~15. Assist the client with all health insurance issues including Share of Cost eligibility issues. Ensures client understanding of financial benefits and procedures to use those benefits such as Medicaid spend downs, AABD, SSI and SSA, etc.~~

~~35-004.01B Admission and Discharge Criteria for Community Support Services~~

~~35-004.01C Admission Criteria:~~ Community Support Services shall be prior authorized by the Division of Medicaid and Long-Term Care or its designee. To be eligible for Community Support Services, the client shall meet all of the criteria described in 471 NAC 35-001.01 and the Community Support specific criteria identified by this prior authorization process.

~~35-004.01D Staffing Requirements:~~ Rehabilitative programs shall provide staff to deliver rehabilitative psychiatric services and staff may be either licensed practitioners operating within their scope of practice or skilled direct care staff that shall meet the following minimum standards:

- ~~1. Have demonstrated skills and competencies in working with people experiencing severe and persistent mental illness;~~
- ~~2. Have completed a staff training curriculum for initial orientation and completes a continuing education curriculum at intervals as defined and prepared by the providing agency. This curriculum and periodic updates shall be included in the program description submitted to the Division of Medicaid and Long-Term Care;~~
- ~~3. Licensed staff provide services as identified within their scope of practice; and~~
- ~~4. All staff are trained in the principles of recovery.~~

~~35-004.01E Clinical Staff:~~ The Community Support program shall have available a:

- ~~1. Licensed Clinical Supervisor:~~ The clinical supervisor shall qualify as a licensed practitioner and shall participate in the Individual Treatment, Rehabilitation, and Recovery Plan development and provide clinical supervision, consultation, and support. The Licensed Clinical Supervisor will review community support client's clinical needs and progress toward their goals with the community support worker every 30 days. The review should be completed preferably face-to-face. The review may be accomplished by the supervisor consulting with the community support worker on their assigned clients and providing clinical guidance or recommendations to better serve the client.
- ~~2. Other Consultants:~~ Consultation by licensed professionals for general medical, psychopharmacology, and psychological issues, as well, as overall program design and shall be available and accessed as necessary.

~~35-004.01F Direct Care Staff:~~ The Community Support program shall have Community Support staff who:

- ~~1. Direct Care staff having a bachelor's degree in psychology, sociology or related human services field or two years of course work in the human services field and two years of experience/training in the human services field or two years of lived recovery experience is acceptable. All community support workers shall be trained in rehabilitation and recovery principles and shall have demonstrated skills and competency. Each staff shall have demonstrated skills and competency in treatment with individuals with mental health diagnosis.~~
- ~~— Direct care staff employed by an agency before the effective date of these regulations will be considered to meet staffing requirements when the provider submits documentation identifying the name, address and the provider number, service provided, names of direct care staff employed before the effective date of the these regulations, and their date of hire. Documentation shall be submitted to Medicaid within 30 days following the effective date of these regulations. Staff hired on or after the effective date of these regulations shall meet the specified requirements identified in the above paragraph;~~
- ~~2. Receive monthly supervision by the Community Support Clinical Supervisor.~~

~~35-004.02 Program Availability:~~ The Community Support Program shall establish hours of service delivery that ensure program staff are accessible and responsive to the needs of the client. Scheduled services shall include evening and weekend hours. The Community Support Program shall directly provide or otherwise demonstrate that each client has on-call access to a licensed mental health practitioner on a 24 hour, 7 days per week basis. Access

~~to a licensed mental health practitioner shall be documented in the client's Individual Treatment, Rehabilitation, and Recovery Plan.~~

~~35-004.03 Contacts: The frequency of contact between the client and the Community Support worker shall be individualized and adjusted in accordance with the needs of the client. Community Support providers shall ensure that the amount of direct contact is sufficient to meet the client's needs as identified in the Individual Treatment, Rehabilitation, and Recovery Plan. Contacts may either be direct client contact or collateral contact.~~

- ~~1. Direct Client Contact. Direct client contacts are face-to-face services between the community support worker and the client. Direct contacts with the client that focus on the development of skills or the management of other activities are identified on the Individual Treatment, Rehabilitation, and Recovery Plan. Contacts shall occur in community settings and be medically necessary for the client's recovery. Face to face contact shall be individualized to the client's recovery needs and shall be identified in the client's Individual Treatment, Rehabilitation, and Recovery Plan in anticipated occurrences. Face to face contacts shall be calculated in 15 minute increments up to a maximum of 144 units per 180 days. In situations of client absence or unavailability for a scheduled contact, providers shall document the circumstances in which the scheduled face-to-face contact did not occur and the program's response to the lack of clients availability to participate in the community support intervention.~~
- ~~2. Collateral Contact. Collateral contacts are defined as contacts which occur outside the provider organization without the client present and are related to the client's Individual Treatment, Rehabilitation, and Recovery Plan. Collateral contacts shall be documented in the client's clinical record and are considered an essential supportive component to the client's treatment, recovery and rehabilitation plan but may not be billed as a separate service to Medicaid.~~

~~35-004.04 Clinical Documentation: Rehabilitative psychiatric service providers shall maintain a clinical record that is confidential, complete, accurate, and contains up-to-date information relevant to the client's care and services. The record shall sufficiently document assessments, Individual Treatment, Rehabilitation, and Recovery Plans and plan reviews, and important provider discussion. The clinical record shall document client contacts describing the nature and extent of the services provided, such that a clinician unfamiliar with the service can identify the client's service needs and services received. The documentation shall reflect the rehabilitative services provided, and is consistent with the goals in the treatment and recovery plan, and based upon the comprehensive assessment. The absence of appropriate, legible, and complete records may result in the recoupment of previous payments for services. Providers shall provide the clinical record in the English language, however, providers shall accommodate clients of other cultures and language in order that the client can completely participate in and understand their treatment and recovery rehabilitation program. Each entry shall identify the date, beginning and end time of the service and the location of service. The individuals in attendance shall be identified by name and relationship to the identified client and the name and title of the staff person providing the intervention and entering the information.~~





~~Clinical records shall be maintained at the provider's headquarters. Records shall be kept in a locked file when not in use. For purposes of confidentiality, disclosure of treatment information is subject to all the provisions of applicable State and Federal laws. The client's clinical record shall be available for review by the client (and his/her guardian with appropriate consent) unless there is a specific medically indicated reason to preclude this availability. The specific reason shall be documented in the clinical record and reviewed periodically.~~

35-004.04A The clinical record shall include, at a minimum:

- ~~1. Client identifying data, including demographic information and the client's legal status;~~
- ~~2. Assessment and Evaluations;
  - ~~a. Initial Diagnostic Interview completed prior to admission;~~
  - ~~b. Strength-based needs assessment;~~
  - ~~c. Other appropriate assessments.~~~~
- ~~3. Treatment and Recovery Plan and updates to plans;~~
- ~~4. Documentation of review of Client Rights with the client;~~
- ~~5. A chronological record of all services provided to the client. Each entry shall include the staff member who performed the service received. Each entry includes the date the service was performed, the duration of the service (beginning and end time), the place of the service, and the staff member's identity and legible signature, (name and title);~~
- ~~6. Documentation of the involvement of family and significant others;~~
- ~~7. Documentation of treatment and recovery services and discharge planning;~~
- ~~8. A chronological listing of the medications prescribed (including dosages and schedule) for the client and the client's response to the medication;~~
- ~~9. Documentation of coordination with other services and treatment providers;~~
- ~~10. Discharge summaries from previous levels of care;~~
- ~~11. Discharge summary (when appropriate); and~~
- ~~12. Any clinical documentation requirements identified in the specific service.~~

35-004.05 Provider Participation: ~~To participate as a Medicaid provider of psychiatric community support, the provider shall be enrolled as a provider of services according to Medicaid regulations. Providers shall contact the Medicaid Managed Care entity to credential into its network. The provider shall provide updates to the program information and staffing as necessary. The provider shall sign an agreement at the time of enrollment that states the provider will submit initial and annual cost information to Medicaid as a part of the enrollment. The cost information shall be updated upon request.~~

~~Community support providers shall be appropriately licensed when licensure is required to provide the service and the program shall have acquired national accreditation in JCAHO, CARF or COA as a condition for enrollment as a participating provider. Accreditation shall be maintained throughout the Medicaid participation period.~~



~~35-004.06 Clients' Rights:~~ Individual staff and the treatment and recovery team shall provide all services in a manner to support and maintain the client's rights with a continuous focus on client empowerment and movement toward recovery. Providers shall have written Client Rights and Responsibility policy and staff shall review client rights, responsibilities, and grievance procedures with each new client at admission, at treatment and recovery plan review and at the request of the client. This review shall be documented in the clinical record. Substance Abuse Treatment providers shall comply with all State and Federal Clients' Rights requirements.

Client rights shall be observed when receiving substance abuse services through Medicaid. The client has the right to:

- ~~1. Be treated with respect and dignity regardless of state of mind or condition;~~
- ~~2. Have privacy and confidentiality related to all aspects of care;~~
- ~~3. Be protected from neglect; physical, emotional or verbal abuse; and exploitation of any kind;~~
- ~~4. Be part of developing an individual treatment and recovery plan and decision-making regarding his/her treatment and rehabilitative services;~~
- ~~5. Refuse treatment or therapy (unless ordered by a mental health board or court);~~
- ~~6. Receive care which does not discriminate and is sensitive to gender, race, national origin, language, age, disability, and sexual orientation;~~
- ~~7. Be free of any sexual exploitation or harassment;~~
- ~~8. Voice complaints and file grievances without discrimination or reprisal and to have those complaints and grievances addressed; and~~
- ~~9. Receive such forms, instructions and assistance as needed to file a complaint or request a state fair hearing.~~

~~35-004.07 Billing for Community Support Services:~~ Community Support Services shall be billed in 15-minute increments for a maximum of 144 units per 180 days.

35-004.08 Day Rehabilitation: The Day Rehabilitation program is designed to-

1. Enhance and maintain the client's ability to function in community settings; and
2. Decrease the frequency and duration of hospitalization. Clients served in this program receive rehabilitation and support services to develop and maintain the skills needed to successfully live in the community. Day Rehabilitation is a facility-based program.

35-004.08A Program Components: The program shall provide:

1. Prevocational services including services designed to rehabilitate and develop the general skills and behaviors needed to prepare the client to be employed and/or engage in other related substantial gainful activity. The program does not provide training for a specific job or assistance in obtaining permanent competitive employment positions for clients.
2. Community living skills and daily living skills development.
3. Client skills development for self-administration of medication, as well as recognition of signs of relapse and control of symptoms.
4. Planned socialization and skills training and recreation activities focused on identified rehabilitative needs.
5. Skill building in the usage of public transportation and/or assistance in accessing suitable local transportation to and from the Day Rehabilitation program.
6. A scheduled program of services to clients for a minimum of five hours per day, five days per week. Specific services for each client will be individualized, based on client needs.
7. Directly provide or otherwise demonstrate that each client has on-call access to a mental health provider on a (24) hour, (7) days per week basis.

35-004.08B Supportive Services: The program provides the following supportive services for all active clients: referrals, problem identification/solution, and coordination of the Day Rehabilitative program with other services.

35-004.09 Psychiatric Residential Rehabilitation: The Psychiatric Residential Rehabilitation Program is designed to:

1. Increase the client's functioning so that s/he can eventually live successfully in the residential setting of his/her choice, capabilities and resources;
2. Decrease the frequency and duration of hospitalization.

The Psychiatric Residential Rehabilitation program provides skill building in community living skills, daily living skills, medication management, and other related psychiatric rehabilitation services as needed to meet individual client needs. Psychiatric Residential Rehabilitation is a facility-based, non-hospital or non-nursing facility program for persons disabled by severe and persistent mental illness, who are unable to reside in a less restrictive residential setting.

~~These facilities are integrated into the community, and every effort is made for these residences to approximate other homes in their neighborhoods.~~

~~35-004.09A Program Components: The program provides-~~

- ~~1. Community living skills and daily living skills development.~~
- ~~2. Client skills development for self-administration of medication, as well as recognition of signs of relapse and control of symptoms.~~
- ~~3. Skill building in the usage of public transportation and/or assistance in accessing suitable local transportation to and from the Psychiatric Residential Rehabilitation program.~~

~~35-004.09B Licensure Requirements: The program shall be licensed as a Residential Care Facility, Domiciliary, or Mental Health Center by the Department of Health and Human Services.~~

~~35-004.09C Staffing Requirements: The program must have the appropriate staff coverage to provide services for clients needing to remain in the residence during the day.~~

~~35-004.09D Bed Limitation: The maximum capacity for this facility shall not exceed 16 beds.~~

~~35-004.09E Supportive Services: The program provides the following supportive services for all active clients: referrals, problem identification/solution, and coordination of the Residential Rehabilitation program with other services the client may be receiving.~~

~~35-005 Referrals for Rehabilitative Psychiatric Services: Referrals for Rehabilitative Psychiatric Services will be directed to the Department or its designee. The referral must include documentation that establishes:~~

- ~~1. The client's Medicaid eligibility; and~~
- ~~2. How the client meets the definition of serious and persistent mental illness specified in 471 NAC 35-001.01.~~

~~35-006 Eligibility for Rehabilitative Psychiatric Services: To be eligible for Rehabilitative Psychiatric Services, the client must be eligible for Medicaid, meet the definition of severe and persistent mental illness, and be authorized by the Department or its designee for specific services.~~

~~35-007 Service Needs Assessment and Rehabilitative Psychiatric Service Recommendations: All clients determined eligible for rehabilitative psychiatric services must be assessed and have rehabilitative psychiatric service recommendations developed by a referring provider according to specified protocols.~~

~~35-008 Service Authorization:~~ The completed assessment and rehabilitative psychiatric service recommendations must be reviewed by the Department or its designee. A determination will be made to—

- ~~1. Approve the client for a specified level and duration of one or more rehabilitative psychiatric services;~~
- ~~2. Request additional information from the assessor; or~~
- ~~3. Deny the request for rehabilitative psychiatric services.~~

~~35-009 Plan Development:~~ Clients authorized for one or more of the rehabilitative psychiatric services (Community Support, Day Rehabilitation, Residential Rehabilitation) will be referred by the Department or its designee to the appropriate rehabilitative psychiatric services provider(s), consistent with client choice. Rehabilitative psychiatric service providers will be responsible for working with the client to—

- ~~1. Complete an assessment of the client's strengths and needs in that service domain according to the requirements of 204 NAC 5-004.05G and 204 NAC 5-004.05H2.~~
- ~~2. Develop, in conjunction with the client, an Individual Service Plan (ISP) for their respective service areas, according to the requirements of 204 NAC 5-004.05I.~~
- ~~3. Participate in developing, along with the client, the client's family members and/or significant others (as appropriate and with client consent), and other relevant community service providers, the client's Individual Program Plan (IPP) according to Department of Health and Human Services specified protocols.~~

~~The Community Support program will be assigned responsibility for IPP development and coordination unless otherwise determined by the Department or its designee.~~

~~35-010 Utilization Management:~~ The Department or its designee will provide utilization management for all rehabilitative psychiatric services. This will include the service authorization/service intensity functions identified in 471 NAC 35-008. In addition, the Department or its designee will authorize client IPP's and provide ongoing utilization review of the client's progress in relation to the IPP's. At least annually, clients in rehabilitative psychiatric services will be reassessed and new service recommendations will be reviewed and approved by the Department or its designee as described in 471 NAC 35-008.

~~35-011 Payment for Rehabilitative Psychiatric Services:~~ For services provided on or after April 1, 1995, NMAP pays for rehabilitative psychiatric services at established rates. Rates will not exceed the actual cost of providing rehabilitative psychiatric services.

~~35-012 Appeals and Fair Hearings:~~ A client has the right to appeal under 465 NAC 2-001.02 and 42 CFR 431, Subpart E. A provider has the right to appeal under 471 NAC 2-003. Hearings are conducted according to 465 NAC 6-000 and 42 CFR 431, Subpart E.

~~The Department is primarily responsible for the administrative duties of this function.~~





35-013 Assertive Community Treatment: The Assertive Community Treatment (ACT) Team provides high intensity services, available to provide treatment, rehabilitation, and support activities seven days per week, twenty-four hours per day, 365 days per year. The team has the capacity to provide multiple contacts each day as dictated by client need. The team provides ongoing continuous care for an extended period of time, and clients admitted to the service who demonstrate any continued need for treatment, rehabilitation, or support will not be discharged except by mutual agreement between the client and the team.

Assertive Community Treatment (ACT) is provided by a self-contained clinical team which:

1. Assumes overall responsibility and clinical accountability for clients disabled by severe and persistent mental illness by directly providing treatment, rehabilitation and support services and by coordinating care with other providers;
2. Does not refer clients to outside service providers when services are identified as a responsibility of the ACT program. See 471 NAC 35-013.04C Treatment, Rehabilitation, and Supportive Interventions;
3. Provides services on a long-term basis with continuity of care givers over time;
4. Delivers most of the services outside program offices;
5. Emphasizes outreach, relationship building, and individualization of services;
6. Provides psychiatric treatment and rehabilitation that is culturally sensitive and competent; and
7. Shares team roles expecting each staff member to know all the clients and assist in assessment, treatment planning, and care delivery as needed.

This model of integrated treatment, rehabilitation, and support services is intended to help clients stabilize symptoms, improve level of functioning, and enhance the sense of well being and empowerment. Services provided will focus on treatment and rehabilitation of the effects of serious mental illness, as well as support and assistance in meeting such basic human needs as housing, transportation, education, and employment as necessary for client satisfaction with services and increased quality of life. The goal of the program is to provide assistance to individuals in maximizing their recovery, to ensure client directed goal setting, to assist clients in gaining hope and a sense of empowerment, and provide assistance in helping clients become respected and valued members of their community.

#### 35-013.01 Admission and Discharge Criteria

35-013.01A Admission Criteria: NMAP covers ACT services for those persons disabled by severe and persistent mental illness who are unable to remain stable in community living without high intensity services. ACT services must be prior authorized by the Division of Medicaid and Long-Term Care or its designee. To be eligible for ACT services clients must meet all of the criteria described in 471 NAC 35-001.01, and demonstrate indicators of high need and utilization.

~~35-013.01B Discharge Criteria:~~ The ACT Program is intended to provide services over a long period of time. Clients admitted to the service who demonstrate continued need for treatment, rehabilitation, or support must not be discharged except by mutual agreement between the client and the ACT Team.

Discharge from the ACT Team occurs when the client and program staff mutually agree to termination of services. Specific documentation must be included in the client's clinical chart when a discharge occurs. Discharge may occur in the following situations:

- ~~1. Geographic Relocation:~~ The client moves outside the team's geographic area of responsibility. In such cases, the ACT Team must arrange for transfer of mental health service responsibility to a provider wherever the client is moving. To meet this responsibility, the ACT team must maintain contact with the client until this service transfer is arranged.
- ~~2. Significantly Improved Functioning:~~ The client demonstrates by functional assessment measurement the ability to function in all major role areas (i.e., work, social, self-care) with minimal assistance.
- ~~3. Client Requested Discharge:~~ Requested discharge despite the team's best efforts to develop an Individual Treatment, Rehabilitation, and Recovery Plan acceptable to the client. Efforts to develop an acceptable Individual Treatment, Rehabilitation, and Recovery Plan must be documented in the client's clinical record.
- ~~4. Hospitalization of the Client in an Institute for Mental Disease (IMD):~~ The NMAP is not able to reimburse for services provided to clients over age 20 and under age 64 who are being treated in an Institute for Mental Disease.

~~35-013.02 Staff Requirements:~~ Each ACT Team must provide a comprehensively staffed team, including a psychiatrist, team leader, a peer support person, and program assistants. The ACT Team must have among its staff individuals who are qualified to provide the required services. Each ACT Team must employ, at a minimum, the following number of clinical staff persons, peer support, and psychiatrists to provide the treatment, rehabilitative, and supportive services. Providers are responsible for verifying that staff are appropriately licensed or certified.

~~35-013.02A Staff Qualifications:~~ All clinical staff must be appropriately licensed or credentialed as required by the Department of Health and Human Services, Division of Public Health. All clinical staff must have at least two years of experience working with persons with serious and persistent mental illness. All clinical staff must maintain sufficient hours of continuing education to maintain certification or licensure.

~~35-013.02B Background Checks:~~ The employer of the ACT Team members is responsible and accountable for the activities and interventions of the ACT Team staff. The employer must consider which type of criminal background and Abuse/Neglect Central Registry checks are appropriate for their staff and how the

~~results impact hiring decisions. The use of criminal background and Abuse/Neglect Central Registry checks must be described in the employer's policy and procedure manual and be available for review.~~

~~35-013.02C Staff Configuration: The configuration of an ACT Team depends on the number of clients to be served. The ACT Team maintains a 1:10 staff to client ratio (the Team Psychiatrist, and APRN if used, and program assistant are not included in the ratio).~~

- ~~1. Minimum Staff Configuration: The following minimum staffing configuration must be met in each ACT Team regardless of the number of clients served. This configuration may serve up to 50 clients. The team must have at least one member who demonstrates competency in drug/alcohol abuse and dependence or is a licensed alcohol and drug counselor. The clinical staff must include:
  - ~~a. Team Psychiatrist: Psychiatric coverage at a minimum ratio of 16 hours per week. This psychiatry time must be spent exclusively on the ACT Team program activities. The minimum services which must be provided by the Team Psychiatrist are:
    - ~~(1) The initial in-depth psychiatric assessment and initial determination for medical/pharmacological treatment;~~
    - ~~(2) Individual Treatment, Rehabilitation, and Recovery Plan reviews;~~
    - ~~(3) Weekly clinical supervision; and~~
    - ~~(4) Participation in at least two daily meetings per week.~~~~
  - ~~b. Advanced Practice Registered Nurse (APRN): An APRN may provide coverage for existing psychiatry time while not replacing the team psychiatrist responsibility in the above services, provided that the APRN:
    - ~~(1) Is practicing within his/her scope of practice;~~
    - ~~(2) Has an integrated practice agreement with the team psychiatrist;~~
    - ~~(3) Defines the relationship with the psychiatrist and provides a copy of the integrated practice agreement between the team psychiatrist and the APRN at the time of enrollment, prior to the initiation of services, and at anytime the agreement is modified or terminated.~~~~
  - ~~c. Team Leader: Each ACT Team must have one full time Team Leader. The Team Leader must have at least a master's degree in nursing, social work, psychiatric rehabilitation, psychology, physician's assistant or is a psychiatrist. The Team Leader must have demonstrated clinical and administrative experience.~~
  - ~~d. Mental Health Professionals: Each team must have one full time Mental Health Professional. A Professional is defined as a person who has completed a Master's or Doctoral degree in a core mental health discipline, and has clinical training including internships and other supervised practical experiences in a clinical or rehabilitation setting.~~~~

- e. ~~Nursing Staff:~~ Each team must have one full time Registered Nurse.
- f. ~~Mental Health Worker:~~ Each team must have one Mental Health Worker who meets one of the following qualifications:
  - (1) ~~Is a licensed Alcohol and Drug Counselor;~~
  - (2) ~~Has a bachelor's degree in rehabilitation or a behavioral health field;~~

- (3) ~~Has a bachelors' degree in a field other than behavioral sciences or have a high school degree, and has work experience with adults with severe and persistent mental illness or with individuals with similar human services needs;~~  
~~OR~~
- g. ~~Additional Staff: Each team must have one additional full time staff person who meets the qualifications of the Mental Health Professional or Mental Health Worker.~~
- h. ~~Peer Support: Each team must have a half time coverage of peer support. This team member position must be a self-identified consumer of mental health services. The Peer Support staff must have training, experience, and ability to work with the team in carrying out appropriate aspects of the Individual Treatment, Rehabilitation, and Recovery Plan. The Peer Support staff must have a bachelor's degree or a high school diploma and either work experience with adults with severe and persistent mental illness, or be able to demonstrate the motivation, learning potential and interpersonal characteristics necessary to benefit from on-the-job training.~~
- i. ~~Support Staff: Each ACT Team must have at least one full-time support staff person.~~
2. ~~Expanded Staff Configuration: If an ACT Team will serve more than 50 clients, the following staff must be added:~~
- a. ~~Registered Nurse: Teams serving more than 50 clients must have at least one additional Registered Nurse to meet the nursing needs of the expanded population;~~
- b. ~~Peer Support: Teams serving more than 50 clients must have full time Peer Support;~~
- c. ~~Team Psychiatrist: Teams serving more than 50 clients must maintain additional psychiatric coverage of 2.6 hours for every eight clients; and~~
- d. ~~Mental Health Professionals: Teams serving more than 50 clients must have at least two Mental Health Professionals.~~
3. ~~Additional Staff: Teams serving more than 50 clients must maintain a minimum 1:10 staff to client ratio. This ratio excludes the Team Psychiatrist, and APRN if used, and the program assistant. The configuration of the ACT Team must reflect the needs of the client population.~~

~~35-013.02D Staffing Positions: Each ACT team must have qualified staff assigned to each of the following positions:~~

1. ~~Team Leader: The Team Leader is the clinical and administrative supervisor of the team and has overall responsibility and accountability for assuring that the requirements and functions as stated in these~~

~~regulations are met. The Team Leader also functions as a practicing clinician on the ACT Team. The Team Leader ensures that all clinical tasks are completed or rescheduled and manages team response to all emergencies or crisis situations in consultation with the Team Psychiatrist. This is a full time position.~~

- ~~2. Team Psychiatrist: The Team Psychiatrist functions must be provided by a psychiatrist who is Board-certified or Board-eligible on a full-time or part-time basis. The Team Psychiatrist position may be shared by more than one psychiatrist and/or an APRN (see 471 NAC 35-013.02C(a and b)). The Team Psychiatrist provides clinical services including psychiatric assessment, Individual Treatment, Rehabilitation, and Recovery Plan development and approval, psychopharmacologic and medical treatment, and crisis intervention to all ACT Team clients. The Team Psychiatrist is available 24 hours per day and seven days per week for crisis management. The Team Psychiatrist works with the Team Leader to monitor each client's clinical status and response to treatment, provides staff clinical supervision, and participates in the development of all Individual Treatment, Rehabilitation, and Recovery Plans. The rate of reimbursement for ACT programs that provide psychiatric coverage with less than 16 hours of a psychiatrist's time (psychiatrist and APRN combination) will be adjusted accordingly. (Please see the fee schedule for procedure code and rate).~~
- ~~3. Advanced Practice Registered Nurse: If an ACT Team includes an APRN to provide services included as part of the required team psychiatrist hours, the APRN must work collaboratively with the psychiatrist. An APRN is able to provide services, except for the mandatory services which must be delivered by the team psychiatrist as described in 471 NAC 35-013.02C(1a.). The Team Psychiatrist must be available for consultation and direction of the treatment activities provided by an APRN, within his/her scope of practice. Psychiatric 24/7 coverage must be documented via a written agreement between the psychiatrist and the APRN. A copy of the agreement must be sent to Medicaid at the time of enrollment.~~
- ~~4. Peer Support: The Peer Support staff performs clinical work based on their credentials and abilities.~~
- ~~5. Team Member: Team Members carry out treatment, rehabilitation, and support interventions consistent with their training and scope of licensure.~~
- ~~6. Program Assistant: The program assistant is a non-clinician responsible for working under the direction of the Team Leader to support all non-clinical operations of the ACT Team. This is a full time position and not considered in the staff to client ratio.~~

~~35-013.02E Staff Functions: The ACT Team must perform the following functions:~~

- ~~1. Clinical Supervision: Clinical Supervision is regular contact between a designated senior clinical supervisor and a member of the ACT Team to:
  - ~~a. Review the client's clinical status,~~
  - ~~b. Ensure appropriate treatment services are provided to the client, and~~
  - ~~c. Review and improve the ACT Team member's service provision.~~Clinical Supervision may occur during Daily Team Meetings, Individual Treatment, Rehabilitation, and Recovery Plan Meetings, side-by-side and face-to-face supervision sessions, and through a review of the~~



~~client's clinical record and in other appropriate activities. Clinical Supervision must be appropriately documented. The Team Leader and/or the psychiatrist is responsible for supervising and directing all ACT Team activities.~~

- ~~2. Crisis Intervention and Response: In addition to the client specific Crisis Intervention plans, the ACT Team must have a procedure to respond to~~

3. ~~emergencies and crises. This includes, but is not limited to, 24-hour crisis intervention availability.  
Assessment: Initial and updated assessments of the client must be provided as described in 471 NAC 35-013.04A. Appropriate staff must be assigned to this function based on individualized client need. The client and his/her family (as allowed by client permission) must be involved in all assessments.~~
4. ~~Treatment Planning: Initial and updated Individual Treatment, Rehabilitation, and Recovery Plans must be developed as described in 471 NAC 35-013.04B. In addition to the Team Leader and Team Psychiatrist, appropriate staff must be assigned to this function based on individualized client need. One specific staff person must be designated to document the Individual Treatment, Rehabilitation, and Recovery Plan for the clinical record. The client and his/her family (as allowed by client permission) must be involved in development, review, and revision of all Individual Treatment, Rehabilitation, and Recovery Plans.~~
5. ~~Individual Treatment, Rehabilitation, and Recovery Plan Coordination: Individual Treatment, Rehabilitation, and Recovery Plan Coordination is an organized process of coordination among the multi-disciplinary team in order to provide a full range of appropriate treatment, rehabilitation, and support services to a client in a planned, coordinated, efficient and effective manner, as outlined in the Individual Treatment, Rehabilitation, and Recovery Plan.~~
6. ~~Interventions: Based on individualized client need and preference and ACT Team qualifications, experience, and training, ACT Team members must be assigned to provide the active treatment, rehabilitative, and supportive services described in 471 NAC 35-013.04C.~~

### 35-013.03 ACT Program Organization

~~35-013.03A Hours of Operation, Coverage, and Availability of Services: The ACT Team must meet the following regulations related to availability and scheduling.~~

1. ~~Hours of Operation and Availability of Services: The ACT Team must be available to provide treatment, rehabilitation, and support interventions 24 hours per day, seven days per week, 365 days a year. The ACT Team must be able to:
  - a. ~~Meet the clients' needs at all hours of the day including evenings, weekends, and holidays;~~
  - b. ~~Provide services at the time that is most appropriate and natural for the client as described in the client's Individual Treatment, Rehabilitation, and Recovery Plan; and~~
  - c. ~~Operate a minimum of 12 hours per day and eight hours each weekend day and every holiday.~~~~
2. ~~Psychiatric Coverage: Psychiatric coverage must be available at all times. If availability of the Team Psychiatrist during all hours is not~~

~~feasible, alternative psychiatric backup (including the APRN) must be arranged.~~

~~The covering psychiatrist or APRN must have an orientation to the ACT Team concept and be supportive of its services. The covering psychiatrist or APRN must be able to get client specific information from an ACT Team member.~~

~~35-013.03B Service Intensity: The ACT Team services must be able to provide the level of service intensity as dictated by client need. Client need is determined through the severity of symptoms and problems in daily living and is documented in the client's Individual Treatment, Rehabilitation, and Recovery Plan. No other psychiatric service or psychiatric rehabilitation service may be reimbursed, except for acute and subacute inpatient hospitalization for assessment and stabilization, when prior authorized by Medicaid and Long-Term Care or its designee.~~

~~35-013.03C Place of Service: The ACT Team must provide most of the interventions and service contacts in the community, in non-office based settings.~~

~~35-013.03D Shared Responsibility: The responsibility of the total client caseload is shared by the entire ACT Team, even though team members may serve as a primary contact for certain clients. Over time, every team member gets to know every client and every client gets to know every team member.~~

~~35-013.03E Staff Communication and Planning: The ACT Team must use systems and methods for continuous daily communication and planning. These must include:~~

- ~~1. Daily Organizational Staff Meeting: A Daily Organizational Staff Meeting must be held to review the status of all program clients, update the Team on contacts provided in the past 24 hours and to communicate essential information on current events and activities as they relate to the interventions provided by the ACT Team.~~
- ~~2. Daily Team Assignment Schedule: The Daily Team Assignment Schedule must list all of the interventions that need to be provided on that day and the ACT Team member assigned to complete the intervention.~~
- ~~3. Daily Log: The Daily Log must be used to document that a client review has occurred.~~
- ~~4. Client Weekly Contact Schedule: The Client Weekly Contact Schedule must be a written schedule of all treatment, rehabilitation, and support interventions which staff must carry out to fulfill the goals and objectives in the client's Individual Treatment, Rehabilitation, and Recovery Plan.~~
- ~~5. Individual Treatment, Rehabilitation, and Recovery Plan Meetings: Individual Treatment, Rehabilitation, and Recovery Plan Meetings must be regularly scheduled meetings to identify and assess individual client needs/problems; to establish measurable long and short term treatment and service goals; to plan treatment and service interventions; and to assign staff persons responsible for providing the services if the client and their family are not able to participate, the meeting must include their~~

~~input. Appropriate support must be provided to maximize the participation of the client and their family. If necessary, the Individual Treatment, Rehabilitation and Recovery Plan should address any barriers to~~

participation. The ACT Team must conduct Individual Treatment, Rehabilitation, and Recovery Plan Meetings, under the supervision of the Team Leader and Team Psychiatrist.

35-013.04 Program Components and Interventions: Operating as a continuous treatment and rehabilitative service, the ACT Team must have the capability to provide assessment, comprehensive treatment, rehabilitation, and support services as a self-contained clinical service unit. Services must be available 24 hours a day, seven days a week, 365 days per year. Services must be provided by the most appropriate ACT Team members operating within their scope of practice. Services must include, but are not limited to:

35-013.04A Assessment and Evaluation

35-013.04A1 Initial Admission Assessment: Prior to accepting the client for admission, the ACT Team must assess and determine the appropriateness of the client for admission to the ACT Team program. The assessment must include a review of clinical information and client interview and may include additional assessment activities.

35-013.04A2 Comprehensive Assessment: The Comprehensive Assessment is unique to the ACT Program in its scope and completeness. A Comprehensive Assessment is the process used to evaluate a client's past history and current condition in order to identify strengths and problems, outline goals, and create a comprehensive Individual Treatment, Rehabilitation, and Recovery Plan. The Comprehensive Assessment reviews information from all available resources including past medical records, client self report, interviews with family or significant others if approved by the client, and other appropriate resources, as well as current assessment by team clinicians from all disciplines. A Comprehensive Assessment must be initiated and completed within 30 days after the client's admission to the ACT program, according to the following requirements:

1. Each assessment area must be completed by staff with skill and knowledge in the area being assessed and must be based upon all available information, including client self-reports, reports of family members and other significant parties, written summaries from other agencies, including police, courts, and outpatient and inpatient facilities, interviews with the client, and standardized assessment materials.
2. The Comprehensive Assessment must include a thorough medical and psychiatric evaluation and must identify client strengths as well as problems. The assessment must gather sufficient information to develop an Individual Treatment, Rehabilitation, and Recovery Plan.

~~3. The Comprehensive Assessment may be revised during a client's tenure in the ACT Program. Information may be added, revised, or clarified.~~

~~35-013.04B Individual Treatment, Rehabilitation, and Recovery Plan Development and Coordination: Individual Treatment, Rehabilitation, and Recovery Plan Development~~

~~and Coordination is a continuing process involving each client, the client's family, guardian, and/or support system as appropriate, and the team which individualizes service activity and intensity to meet client-specific treatment, rehabilitation and support needs. The written Individual Treatment, Rehabilitation, and Recovery Plan documents the client's goals and the services the client will receive in order to achieve them. The plan also delineates the roles and responsibilities of the team members who will carry out the services.~~

~~An Initial Individual Treatment, Rehabilitation, and Recovery Plan must be developed upon the client's admission to the ACT Team.~~

~~The Comprehensive Individual Treatment, Rehabilitation, and Recovery Plan must be developed for each client within 21 days of the completion of the Comprehensive Assessment. This Individual Treatment, Rehabilitation, and Recovery Plan will be developed and revised according to the following regulations:~~

~~35-013.04B1 — Comprehensive Individual Treatment, Rehabilitation, and Recovery Plan Development: A comprehensive Individual Treatment, Rehabilitation, and Recovery Plan is developed through an organized process of coordination among the multi-disciplinary team in order to provide a full range of appropriate treatment, rehabilitation, and support services to the client in a planned, coordinated, efficient and effective manner. The Comprehensive Individual Treatment, Rehabilitation, and Recovery Plan provides a systematic approach for meeting a client's needs, treatment rehabilitation, and support needs, and documenting progress on treatment, rehabilitation, and service goals.~~

~~The following key areas must be addressed in the Individual Treatment, Rehabilitation, and Recovery Plan based upon the individual needs of the client: symptom stability, symptom management and education, housing, activities of daily living, employment and daily structure, family and social relationships, and crisis support.~~

~~This plan must:~~

- ~~1. Identify the client's needs and problems;~~
- ~~2. List specific long and short term goals with specific measurable objectives for these needs and problems;~~
- ~~3. List the specific treatment and rehabilitative interventions and activities necessary for the client to meet these objectives and to improve his/her capacity to function in the community; and~~
- ~~4. Identify the ACT Team members who will be providing the intervention.~~



~~The Individual Treatment, Rehabilitation, and Recovery Plan must be developed in collaboration with the client and/or guardian, if any, and, when appropriate, the client's family.~~

~~The client's participation in the development of the Individual Treatment, Rehabilitation, and Recovery Plan must be documented. The plan must be signed by the client and the Team Psychiatrist.~~

~~35-013.04B2 Individual Treatment, Rehabilitation, and Recovery Plan Reviews: The ACT Team must review and revise the client's Individual Treatment, Rehabilitation, and Recovery Plan every six months, whenever there is a major decision point in the client's course of treatment, or more often if necessary. The Team Psychiatrist, Team Leader, and appropriate staff from the ACT Team must participate in each Individual Treatment, Rehabilitation, and Recovery Plan Review. The ACT Team must include the client in the review. Guardians and/or family members should be encouraged to participate, as allowed by the client.~~

~~The Individual Treatment, Rehabilitation, and Recovery Plan Review must be documented in the client's clinical record. This documentation must include a description of the client's progress and functioning since the last Individual Treatment, Rehabilitation, and Recovery Plan Review, the client's current functional strengths and limitations, a list of attendees, the discussion related to the Individual Treatment, Rehabilitation, and Recovery Plan, and any changes to the plan. The plan and review will be signed by the client and the Team Psychiatrist.~~

~~The signature of the Team Psychiatrist indicates this is the most appropriate level of care for the client and that the treatment, rehabilitative, and service interventions are medically necessary.~~

~~35-013.04B3 Client and Family Participation: The ACT Team is responsible for engaging the client in active involvement in the development of the treatment/service goals. With the permission of the client, ACT Team staff must involve pertinent agencies and members of the client's family and social network in the formulation of Individual Treatment, Rehabilitation, and Recovery Plans.~~

~~35-013.04C Treatment, Rehabilitative, and Supportive Interventions: The ACT Team must be able to provide treatment, rehabilitative, and supportive interventions to clients assigned to the ACT Team. The interventions are categorized into three areas and the specific application of each type of intervention must be based on the client's specific goals and objectives. The interventions must address the needs identified in the Comprehensive Assessment. While there are no requirements that the client receive a minimum number of a specific categories of intervention, the client must receive the interventions that are appropriate for their needs.~~

~~All interventions must be performed by professionals acting within the appropriate scope of practice.~~

35-013.04C1 Treatment Interventions:

1. Medical Assessment, Management, and Intervention: The ACT Team must provide the interventions necessary to treat the client's psychiatric and physical conditions.

- ~~2. Individual, Family, and Group Therapy or Counseling: The ACT Team must provide individual, family, and group therapy or counseling to assist the client to gain skills in interpersonal relationships, identify and resolve conflicts, and systematically work on identified individual goals. These interventions focus on lessening distress and symptomology, improving psychological defenses and role functioning, and increasing and reinforcing the client's understanding of and participation in treatment, rehabilitative services, and activities of daily living.~~
- ~~3. Medication: The ACT Team must provide the prescription, preparation, delivery, administration, and monitoring, of medications.~~
- ~~4. Crisis Intervention: The ACT Team must provide Crisis Intervention Services by assessing client needs that require immediate attention and initiate a resolution to the need.~~
- ~~5. Substance Abuse Services: The ACT Team must provide Substance Abuse Services to assist the client in achieving periods of abstinence and stability. The interventions include, but are not limited to assessment, individual and group counseling, education, and skill development. The interventions should help the client:
  - ~~a. Learn to identify substance use, effects, and patterns,~~
  - ~~b. Recognize the relationship between substance use, mental illness and psychotropic medications, and~~
  - ~~c. Develop motivation to eliminate or decrease substance use and coping skills or alternatives to minimize substance use.~~~~

35-013.04C2 Rehabilitative Interventions:

- ~~1. Symptom Management Skill Development: The ACT Team must provide Symptom Management Skill Development to help the client cope with and gain mastery over symptoms and functional impairments in the context of adult role functioning.~~
- ~~2. Vocational Skill Development: The ACT Team must provide Vocational Skill Development that includes individualized assessment and planning for employment based upon functional assessment and the client's needs, desires, interests and abilities.~~
- ~~3. Activities of Daily Living and Community Living Skill Development: The ACT Team must provide services to help the client rehabilitate their functional impairments and limitations related to activities of daily living and living in a community setting. The services will help clients carry out personal hygiene and grooming tasks, perform household activities, find housing which is safe and affordable, develop or improve money management skills, use available transportation, and have and effectively use a personal physician and dentist.~~

~~4. Social and Interpersonal Skill Development: The ACT Team must provide interventions to help the client rehabilitate their social functioning. The goals include, but are not limited to improved communication skills, developing assertiveness, developing social~~

skills and meaningful personal relationships, appropriate and productive use of leisure time, relating to others effectively, familiarity with available social and recreational opportunities and support groups, and increased use of such opportunities.

5. Leisure Time Skill Development The ACT Team must provide interventions to rehabilitate the client's ability to use leisure time appropriately.

35-013.04C3 Supportive Interventions:

1. Assistance: The ACT Team must provide support services, direct assistance, and coordination to ensure that the client obtains the basic necessities of daily life. These necessities include, but are not limited to: medical and dental services, safe, clean, affordable housing, financial support, social services, transportation, legal advocacy and representation, education, employment, food, and clothing.
2. Support: The ACT Team must provide support to clients, on a planned and "as needed" basis, to help them accomplish their personal goals, gain a sense of personal mastery and empowerment, and to cope with the stresses of day-to-day living. This includes interaction that focuses on decreasing distress, improving understanding and reinforcing the client's participation in services.
3. Family Involvement: The ACT Team will provide education, support and consultation to clients' families and other major supports, with client agreement and consent. The ACT Team must encourage family members and other major sources of support to be involved in the services received by the client unless prohibited by the client, through legal action, or because of confidentiality laws. This includes education about the client's illness and condition and the role of the family in the therapeutic process, intervention to resolve conflict, and ongoing communication and collaboration between the ACT Team and the client's family.
4. Positive Peer Role Modeling: The ACT Team will offer opportunities for positive peer role modeling and peer support including practical problem solving approaches to daily challenges, peer perspective on steps to recovery and support, mentoring toward greater independence, empowerment, and ability to manage severe symptomology.

35-013.05 National Accreditation and Certification: Providers must be nationally accredited under specific ACT Team standards, such as CARF (Commission on Accreditation of Rehabilitation Facilities), or must be actively pursuing accreditation in order to be enrolled. Providers that are actively pursuing accreditation with a national body must submit their

~~accreditation plan for consideration. Providers actively pursuing accreditation will be enrolled on a provisional status.~~

~~35-013.06 Clinical Documentation Requirements: Records must be kept in accordance with the national accreditation body surveying the provider. The clinical records for ACT Team services must include the following information:~~

- ~~1. Client identifying and demographic information;~~
- ~~2. Assessments and Evaluations;~~
- ~~3. Team Psychiatrist's orders;~~
- ~~4. Treatment, Rehabilitation and Service Planning;~~
- ~~5. Current Medications;~~
- ~~6. Progress and contact notes must be recorded by all ACT Team members providing services to the client;~~
- ~~7. Reports of consultations, laboratory results, and other relevant clinical and medical information;~~
- ~~8. Documentation of the involvement of family and other significant others; and~~
- ~~9. Documentation of transition and discharge planning.~~

~~35-013.06A Discharge Documentation: Documentation of discharge from the ACT program must included.~~

~~35-013.07 Performance Improvement and Program Evaluation: The ACT Team must have a performance improvement and program evaluation plan which meets the criteria for accreditation in the approved national accreditation organization. In addition, the program will participate in all aspects of statewide ACT evaluation projects.~~

~~35-013.08 Provider Enrollment: An ACT Team must complete Form MC-19, "Medical Assistance Provider Agreement," and submit the completed form and a program overview that addresses the requirements in these regulations to the Division of Medicaid and Long-Term Care for approval. The ACT Team must maintain written policies and procedures that document compliance with all of the standards and requirements in 471 NAC 35-002. The provider will be advised in writing when its participation is approved. Annual updates of enrollment may be required. The provider must submit updates of the identity and expertise of ACT Team members as new staff are added to the program.~~

~~35-013.09 Program Review: The ACT Team will be reviewed regularly by the Division of Medicaid and Long-Term Care or its designee.~~

~~35-013.10 Prior Authorization: Reimbursement for services from the ACT Team must be authorized by the Division of Medicaid and Long-Term Care or its designee.~~

~~35-013.11 Telehealth: ACT Team interventions may be provided via telehealth when provided according to the regulations 471 NAC 1-006.~~

~~35-013.12 Reimbursement and Billing Information: NMAP pays for assertive community treatment services at established rates. Providers must follow these billing requirements:~~

- ~~1. Claims for services provided by the ACT Team must be billed on an appropriately completed Form CMS-1500 or the standard electronic health~~



~~claim form Professional transition ASC X 12N 837 (see claim submission table 471-000-49);~~

- ~~2. Claims for ACT Team services must use the procedure codes determined by the Department; and~~

3. The unit of service for ACT Team reimbursement is one day.

~~35-013.13 Hospital Admissions:~~ In the event that a client requires hospitalization while receiving services from the ACT Team, NMAP will continue to reimburse the ACT Team services for up to 15 days per hospitalization. The ACT Team must maintain as much involvement with the client as possible, based on client preference and authorization to release information. This includes providing interventions to the client, participating in transition and discharge planning, and any other appropriate involvement.

~~35-013.14 Limitations on the Reimbursement for ACT Team Services:~~ The following situation limits NMAP reimbursement for ACT Team Services. Because regulations prohibit federal financial participation in the reimbursement of services to clients age 21 to 64 in an IMD (Institute for Mental Disease), Medicaid eligibility for clients who are admitted to an IMD for longer than 10 days will be closed.

~~35-014 Secure Psychiatric Residential Rehabilitation:~~ ~~Secure Psychiatric Residential Rehabilitation is a secure facility-based, non-hospital or non-nursing facility program for individuals disabled by severe and persistent mental illness, who are unable to reside in a less restrictive setting. These facilities are integrated into the community and provide programming in an organized, structured setting, including treatment and rehabilitation services and offer support to clients with a severe and persistent mental illness and/or co-occurring substance abuse disorders. These individuals demonstrate a moderate to high risk for harm to self/others and are in need of recovery, treatment, and rehabilitation services. The clients who are in need of this level of care have long standing limitations with limited ability to live independently over an extended period of time. These individuals have needed a high level of psychiatric intervention and have limitations in all three functional areas, vocational/educational, social skills and activities of daily living. See definitions in 471 NAC 35-001.01. The Secure Psychiatric Residential Rehabilitation program provides skill building and other related recovery oriented psychiatric rehabilitation services as needed to meet individual client needs. The Secure Psychiatric Residential Rehabilitation Program is designed to:~~

- ~~1. Increase the client's functioning while improving psychiatric stability so that s/he can eventually live successfully and safely in a less restrictive residential setting of his/her choice and capabilities;~~
- ~~2. Decrease the frequency and duration of hospitalization;~~
- ~~3. Decrease and/or eliminate all high risk, unsafe behavior to self or others; and~~
- ~~4. Improve the ability to function independently by improving ability to function.~~

~~35-014.01 Program Components:~~ ~~A secure psychiatric residential rehabilitation program provides a variety of on-site psychosocial rehabilitation and skill acquisition activities and treatment each day. The program must facilitate client driven skills training and activities as appropriate. A secure psychiatric residential rehabilitation program must provide services identified on the client specific Individual Treatment, Rehabilitation, and Recovery Plan, providing culturally-sensitive and trauma-informed care. The activities must include, but are not limited to:~~

- ~~1. Ongoing assessment;~~
- ~~2. Arrangement for general medical care including laboratory services, psychopharmacological services, psychological services, as necessary;~~
- ~~3. Provision of a minimum of 42 hours per week of on-site staff led psychosocial rehabilitation activities and skill acquisition;~~
- ~~4. Programming focused on relapse prevention, recovery, nutrition, daily living skills, social skill building, community living, substance abuse, education, medication education and self-administration, symptom management, and focus on improving the level of functioning to get to a less restrictive level of care;~~
- ~~5. Educational and vocational focus as appropriate; and~~
- ~~6. Access to community-based rehabilitation/social services to assist in transition to community as symptoms are managed and behaviors are stabilized.~~

35-014.01A Assessments: The following assessments must be completed:

1. ~~A comprehensive mental health and substance use disorder assessment by an independently licensed mental health practitioner must occur prior to admission.~~
2. ~~Following admission and within 24 hours of stay, an assessment by the program's psychiatrist must be completed.~~
3. ~~A history and physical must be completed by a physician or Advanced Practice Registered Nurse (APRN) within 24 hours of admission or one must be completed within 60 days of admission and available in the clinical record.~~
4. ~~A nursing assessment must be completed by a Registered Nurse within 24 hours of admission.~~
5. ~~A functional assessment must be completed initially upon admission and annually with continued stay at this level of service.~~

~~35-014.01B Individual Treatment, Rehabilitation, and Recovery Planning: An initial Individual Treatment, Rehabilitation, and Recovery Plan must be completed within 24 hours of admission. Secure Psychiatric Residential Rehabilitation Service providers must develop an individual treatment, rehabilitation, and recovery plan with the client within 30 days following admission to the program. The plan must include substance abuse issues. The client's family and/or guardian must be included in all assessment and treatment, rehabilitation, and recovery planning. The provider must make every effort to be available and responsive to the client's family and/or guardian to assist their involvement in the client's recovery. The plan must be reviewed and revised with the client, discussing and documenting the discharge plan a minimum of every 7 days according the following requirements.~~

~~35-014.01B1 Individual Treatment, Rehabilitation, and Recovery Plan: The master individual treatment, rehabilitation, and recovery plan must be based upon a comprehensive assessment and completed within 30 days of admission. This plan must:~~

- ~~1. Be oriented to the principles of recovery and meaningful client participation;~~
- ~~2. Apply the principles of recovery — to include meaningful client participation, and a life in the community of the client's choosing;~~
- ~~3. Incorporate and be consistent with best practices;~~
- ~~4. Include the client's individualized goals and expected outcomes;~~
- ~~5. Contain prioritized objectives that are measurable and time-limited;~~
- ~~6. Describe therapeutic interventions to be used in achieving the goals and objectives that are recovery-oriented, trauma-informed, and strength-based;~~
- ~~7. Identify staff responsible for implementing the therapeutic interventions;~~
- ~~8. Specify the planned frequency and duration of each therapeutic method;~~
- ~~9. Delineate the specific behavioral criteria to be met for discharge or transition to a lower level of care and reviewed weekly;~~
- ~~10. Include a plan developed with the client that includes strategies to avoid crisis or admission to a higher level of care using principles of recovery and wellness;~~
- ~~11. Include the signature of the client and/or parent/guardian;~~
- ~~12. Include health care proxy and trauma safety form when available and with client's consent;~~

- ~~13. Document that the individual treatment, rehabilitation, and recovery plan is completed within the timeframe specified in the program's policies and procedures;~~
- ~~14. Document that the plan has been reviewed, updated every 30 days, and revised according to client needs and progress; and~~
- ~~15. Document that the plan was reviewed by the program's treatment practitioners a minimum of every 30 days and that written revisions were approved, signed, and dated each 30 days by the program psychiatrist.~~

~~35-014.01C Treatment Services: The program must offer structured, planned treatment and rehabilitation services as prescribed by the individualized treatment, rehabilitation, and recovery plan. The following services must be available and offered to the client.~~

- ~~1. Individual Psychotherapy: An individual treatment and rehabilitation service between an identified client and a qualified licensed practitioner who focuses upon the identified goals of the individual treatment, rehabilitation, and recovery plan;~~
- ~~2. Group Psychotherapy: A service provided by a licensed clinician who is practicing within his/her scope of practice and provides a psychotherapy service in groups of no less than three and no more than twelve clients;~~
- ~~3. Family Therapy: Family therapy is a therapeutic service between the client and his/her family and a qualified licensed practitioner who provides intervention as identified by the family-focused goals of the individual treatment, rehabilitation, and recovery plan. Consent from the client must be documented prior to the involvement of the family and delivery of the service; and~~
- ~~4. Psychoeducational services, such as medical education by a registered nurse and skill development groups by a trained and skilled staff able to facilitate these groups supervised by a licensed mental health practitioner.~~

~~35-014.01D Supportive Services: The program must provide the following supportive services for all active clients: referrals as necessary, problem identification/solution, and coordination of the Secure Psychiatric Residential Rehabilitation program treatment and activities with other services the client may be receiving.~~

~~35-014.02 Staffing: The Secure Psychiatric Residential Rehabilitation provider must contract with or employ a licensed psychiatrist for the program. The psychiatrist's hours must be at a sufficient level to provide weekly direct contact with the client; to provide assessment; to review the individual treatment, rehabilitation, and recovery plan; to evaluate client's level of progress; to assist in eliminating barriers to recovery; and to provide psychiatric consultation as necessary on a 24/7 basis. Programs must have staff available in skill and numbers to meet the acuity of the clients being served. Programs must have ability to call staff back when necessary.~~

~~35-014.02A Staffing Standards: Secure Psychiatric Residential Rehabilitation providers must meet the following minimum staffing requirements. The program must employ a:~~

- ~~1. Program Director;~~



- ~~2. Licensed Mental Health Practitioner (LMHP) or a Licensed Mental Health Practitioner/Licensed Alcohol and Drug Counselor (LMHP/LADC). A dual Licensed Practitioner is preferred;~~
- ~~3. Registered nurse;~~
- ~~4. Direct care staff.~~

35-014.02A1 The Program Director must:

- ~~1. Be fully licensed as a Mental Health Practitioner (APRN, RN, LMHP, LIMHP or psychologist); and~~
- ~~2. Possess leadership, supervisory, and management skills.~~

35-014.02A1a Responsibilities of the Secure Psychiatric Residential Rehabilitation Program Director: The program director must:

- ~~1. Complete and sign a comprehensive Biopsychosocial Assessment for each client within 14 days of admission or delegate responsibility for the assessment to the program's licensed practitioner who functions as the therapist for the program;~~
- ~~2. Develop, approve, and sign an initial individual treatment, rehabilitation, and recovery plan within the first 24 hours of admission;~~
- ~~3. Supervise and participate in the development of a comprehensive individual treatment, rehabilitation, and recovery plan with the client and the program staff within 30 days of admission. The program director must approve and sign the plan prior to implementation;~~
- ~~4. Supervise the professional staff and direct care staff by on-site presence during programming;~~
- ~~5. Assure adequate staff training through initial and ongoing training sessions and provide supervision of staff competency checks;~~
- ~~6. Supervise and provide direction regarding all documentation requirements, including organization and completeness of clinical records; and~~
- ~~7. Supervise and direct the development and implementation of the discharge plan.~~

35-014.02A2 Responsibilities of the Registered Nurse: The registered nurse must:

- ~~1. Complete a nursing assessment within 24 hours of admission;~~
- ~~2. Participate in the development of the individual treatment, rehabilitation, and recovery plan and the plan updates;~~
- ~~3. Oversee and monitor daily medication administration;~~
- ~~4. Provide medication education as necessary;~~
- ~~5. Communicate with the psychiatrist and physician consultants as necessary;~~
- ~~6. Monitor, supervise, and oversee the program's daily activities in conjunction with and in the absence of the Program Director.~~





~~35-014.02A3 Responsibilities of the Mental Health Practitioner: The mental health practitioner must:~~

- ~~1. Complete a comprehensive assessment within 14 days of admission when this responsibility is delegated by the program director;~~
- ~~2. Participate in the development of the individual treatment, rehabilitation, and recovery plan and the updates;~~
- ~~3. Provide individual, group and family psychotherapy according to the client's individual treatment, rehabilitation, and recovery plan;~~
- ~~4. Communicate with the Program Director and psychiatrist regarding the clinical needs of the client as necessary;~~
- ~~5. Monitor, supervise, and oversee the program's daily treatment and activities in the absence of the Program Director as assigned by the Program Director;~~
- ~~6. Assist with aggressive discharge planning; and~~
- ~~7. Maintain a maximum staffing ratio of 1 to 8 clients.~~

~~35-014.02A4 Direct Care Staff: The Secure Psychiatric Residential Rehabilitation Program must employ direct care staff who:~~

- ~~1. Are on site and available to the clients at a ratio of one staff per four clients during awake hours and a minimum of one awake direct care per staff per six clients during overnight hours;~~
- ~~2. Staff to client ratios must be enhanced to meet client need as necessary.~~
- ~~3. Direct Care staff having a bachelor's degree in psychology, sociology or related human services field but two years of course work in the human services field and two years of experience/training or two years of lived recovery experience is acceptable. Each staff must have demonstrated skills and competency in treatment with individuals with mental health diagnosis.~~

~~35-014.03 Discharge Planning: Throughout a client's care and whenever the client is transitioned from one level of care to another, discharge planning must occur in advance of this discharge. It must include the client's and client's family/legal guardian's input and be documented in the client's clinical record. The plan must be recovery-oriented, trauma-informed, and strength-based.~~

~~Providers must meet the following standards regarding recovery and discharge planning:~~

- ~~1. Discharge planning must begin on admission to the service with input and participation of the client and client's family/guardian;~~
- ~~2. Discharge planning must include the client and family input and be consistent with the goals and objectives identified in the individual treatment, rehabilitation, and recovery plan and clearly documented in the clinical record;~~

- ~~3. Discharge planning must address the client's needs for ongoing services to maintain the gains and to continue as normal functioning as possible following discharge. A crisis/relapse/safety plan must be in place;~~

4. ~~Providers must make or facilitate referrals and applications to the next level of care and/or community support services, such as use of medications, housing, employment, transportation, and social connections;~~
5. ~~Providers must arrange for the prompt transfer of clinical records and information to ensure continuity of care; and~~
6. ~~A written discharge summary must be provided as part of the clinical record. It must identify the readiness for discharge and contain the signature of a fully licensed clinician and date of signature and must identify a summary of the services provided.~~

~~35-014.04 Clinical Documentation: Secure Psychiatric Residential Rehabilitation service providers must maintain a clinical record that is confidential, complete, accurate, and that contains up-to-date information relevant to the client's care and services. The record must sufficiently document comprehensive assessments; individual treatment, rehabilitation, and recovery plans; and plan reviews. The clinical record must document client contacts describing the nature and extent of the services provided, so that a clinician unfamiliar with the service is able to identify the client's service needs and services received. The documentation must reflect the rehabilitative services provided; that the care is consistent with the goals in the individual treatment, rehabilitation, and recovery plan; and that the care is based upon the comprehensive assessment. The absence of appropriate, legible, complete records may result in the recoupment of previous payments for services. Each entry must identify the date, beginning and ending time spent providing the service and location of service, and identify by name and title the staff person entering the information.~~

~~Clinical records must be maintained at the client's primary rehabilitation site. Records must be kept in a locked file when not in use. For purposes of confidentiality, disclosure of rehabilitation information is subject to all the provisions of applicable State and Federal laws. The client's clinical record must be available for review by the client (and his/her guardian with appropriate consent) unless there is a specific medically indicated reason to preclude this availability. The specific reason must be documented in the clinical record and reviewed periodically.~~

~~35-014.05 The clinical record must include, at a minimum:~~

1. ~~Client identifying data, including demographic information and the client's legal status;~~
2. ~~Assessment and Evaluations:~~
  - a. ~~Psychiatric assessment, including the name of the clinician and the date of the assessment;~~
  - b. ~~Comprehensive Assessment; and~~
  - c. ~~Other related assessments;~~
3. ~~The client's diagnostic formulation (including all five axes);~~
4. ~~The Individual Treatment, Rehabilitation, and Recovery Plan and updates to plans;~~
5. ~~Documentation of review of client rights with the client;~~
6. ~~A chronological record of all services provided to the client. Each entry must include the date the intervention was performed, the duration of the intervention~~

~~(beginning and ending time), the place of the service, and the staff member's identity and legible signature (name and title);~~

- ~~7. Documentation of the involvement of family and significant others;~~
- ~~8. Documentation of treatment and recovery services and discharge planning;~~
- ~~9. A chronological listing of the medications prescribed (including dosages and schedule) for the client and the client's response to the medication;~~
- ~~10. Documentation of coordination with other services and treatment providers;~~
- ~~11. Discharge summaries from previous levels of care;~~
- ~~12. Discharge summary (when appropriate); and~~
- ~~13. Any clinical documentation requirements identified in the specific service.~~

~~35-014.06 Clients' Rights: Individual staff and the treatment, rehabilitation, and recovery team must provide interventions in a manner that support and maintain the client's rights with a continuous focus on client empowerment and movement toward recovery. Secure Psychiatric Residential Rehabilitation programs must have written a client rights and responsibility policy. Staff must review client rights, responsibilities, and grievance procedures with each new client at admission and on an ongoing manner, and must document this review in the clinical record. Secure Psychiatric Residential Rehabilitation programs must comply with all state and federal clients' rights requirements.~~

~~The following rights apply to clients receiving secure psychiatric residential rehabilitation services through Medicaid. The client has the right to:~~

- ~~1. Be treated with respect and dignity regardless of state of mind or condition;~~
- ~~2. Have privacy and confidentiality related to all aspects of care;~~
- ~~3. Be protected from neglect; physical, emotional, or verbal abuse and exploitation of any kind;~~
- ~~4. Be part of developing an individual treatment, rehabilitation, and recovery plan and decision-making regarding his/her mental health treatment and rehabilitative services;~~
- ~~5. Refuse treatment or therapy (unless ordered by a mental health board or court);~~
- ~~6. Receive care which does not discriminate and is sensitive to gender, race, national origin, language, age, disability, and sexual orientation;~~
- ~~7. Be free of any sexual exploitation or harassment; and~~
- ~~8. Voice complaints and file grievances without discrimination or reprisal and to have those complaints and grievances addressed in a timely manner.~~

~~35-014.07 Provider Participation: To participate in Medicaid as a provider of secure psychiatric residential rehabilitation services, a program must be enrolled as a Nebraska Medical Assistance Program provider according to the Medicaid regulations. Providers must complete the credentialing into the Medicaid Managed Care network prior to providing services to Medicaid Managed Care beneficiaries. The provider must complete and sign Form MC-19, "Medical Assistance Provider Agreement," and be approved for enrollment in Medicaid. In addition, eligible providers must also provide documentation as requested. Providers must notify Medicaid and/or its designee of any substantive changes in the program or staff providing services. Providers are required to provide annual updates of program information and cost information to determine ongoing compliance with Medicaid~~

~~regulations. Providers must maintain documentation of policies and procedures that meet the standards and regulations described in this chapter.~~

~~35-014.08 Licensure and Accreditation Requirements:~~ The program must be licensed as a Mental Health Center by the Department of Health and Human Services, Division of Public Health, and it must be accredited by a national accrediting agency such as Commission on Accreditation of Health Care Organization (JCAHO), the Commission on Accreditation of Rehabilitation Facilities (CARF), or Council on Accreditation (COA). Providers must have maintained their licensure and accreditation as a condition for continued participation in Medicaid.

~~35-014.09 Bed Limitation:~~ The maximum capacity for the provider of secure psychiatric residential rehabilitation services must not exceed 16 beds. There must be no waiver of this regulation over the 16-bed limitation.

~~35-014.10 Treatment Prior Authorization:~~ All Secure Psychiatric Residential Rehabilitation Services must be prior authorized by the Division of Medicaid and Long-Term Care or its designee. These reviews include prior authorization and continued stay reviews. Referrals for Secure Psychiatric Residential Rehabilitation Services must be directed to the Division of Medicaid and Long-Term Care or its designee and must follow established protocols for prior authorization and utilization management.

~~35-014.11 Therapeutic Pass Days:~~ Therapeutic passes are an essential part of the rehabilitation process for clients involved in secure psychiatric residential rehabilitation services. Documentation of the client's continued need for secure psychiatric residential rehabilitation services must follow overnight therapeutic passes. Therapeutic passes must be indicated in the individual treatment, rehabilitation, and recovery plan as therapeutic passes become appropriate. Medicaid reimburses for 21 therapeutic pass days per client per calendar year when the client is on therapeutic leave for purposes of testing ability to function and transition to lesser level of care.

~~35-014.12 Hospitalizations:~~ In the event that a client does require hospitalization while in a secure psychiatric residential rehabilitation program, Medicaid will reimburse the Secure Psychiatric Residential Rehabilitation Program for up to ten days per hospitalization. This reimbursement is only available if the bed is not used by another client and the client returns to the bed occupied prior to hospitalization.

~~35-014.13 Inspections of Care (IOC):~~ The Division of Medicaid and Long-Term Care or its designee may periodically inspect the care which includes the treatment, rehabilitative, and recovery services provided to clients in each type of service. The Inspection of Care team will include staff who are knowledgeable about mental health and rehabilitative psychiatric services and may include clients and/or Division of Medicaid and Long-Term Care consultants.

~~The purpose of the Inspection of Care is to assess compliance with Medicaid regulations and provide technical assistance to providers.~~

~~The activities of the Inspection of Care may include, but are not limited to:~~



1. — Review of clinical documentation;
2. — Client interviews;

3. Program review with staff;
4. Review of physical plant;
5. Review of provider policy and procedures;
6. Staff interviews;
7. Financial and payroll records; and
8. Employment records of staff qualification and training issues.

After an Inspection of Care, the IOC team will develop a report summarizing the findings of the visit. If deficiencies are noted, providers must submit a plan of correction.

35-015 (RESERVED)

35-016 (RESERVED)

~~35-017 Community Support: Substance Abuse Community Support is a rehabilitative and supportive service for individuals with primary Axis I Diagnosis of Substance Dependence. Community Support Interventions provide direct rehabilitation and support services to individuals in the community to assist the individual in maintaining abstinence, stabilizing community living, and preventing exacerbation of symptoms and admissions to more restrictive levels of care. This service is not available for individuals who are also receiving level III or greater substance abuse treatment services. Services are based upon medical necessity as identified in the client's treatment and recovery plan and shall be provided in 15-minute increments.~~

~~35-017.01 Program Components: The Community Support Program shall:~~

- ~~1. Facilitate communication and coordination among all health care professionals providing services to the client;~~
- ~~2. Ensure completion of a strength-based needs assessment completion within 30 days of admission by the rehabilitation team or team member;~~
- ~~3. Develop and implement strategies to encourage the individual to become engaged and remain engaged in necessary substance use/abuse and mental health treatment services as recommended and included in the treatment/recovery plan;~~
- ~~4. Have access to the comprehensive substance use disorder assessment conducted by an independently licensed practitioner practicing within his/her scope updated within 30 days of admission into the program;~~
- ~~5. Participate with and report to the treatment and recovery team on the individual's progress and response to community support intervention in areas of relapse prevention of substance use/abuse and application of education and skills in the recovery environment;~~
- ~~6. Review and update the treatment and recovery plan and discharge plan with the individual and other approved family supports every 90 days or more often as clinically necessary;~~
- ~~7. Coordinate with the providers of mental health when the client has a co-occurring diagnosis and receiving mental health services by a licensed practitioner either located in the agency or in a separate program;~~
- ~~8. Assist in facilitating the transfer to and the transition to other levels of treatment service;~~
- ~~9. Assist in the development, evaluation, and update in a crisis and relapse plan with the client;~~
- ~~10. Provide contact as needed with other providers, client family members and other significant individuals in the client's life to facilitate communication necessary to support the individual in maintaining community living;~~
- ~~11. When prescribed, monitor medication compliance and report compliance issues as necessary;~~
- ~~12. Assist the client with all health insurance issues; and~~
- ~~13. Assist in the discharge plan for the client and support development of community-based resources.~~



~~35-017.02 Program Availability:~~ The community support program shall establish hours of service delivery that ensure program staff availability and accessibility to the treatment, rehabilitation, and recovery needs of the client. The frequency of face-to-face contacts with the client is based upon clinical need.

~~35-017.03 Staffing Requirements:~~ Community support programs shall employ a licensed practitioner to provide supervision of the community support program. The licensed practitioner shall supervise any individualized treatment and recovery service interactions provided by a community support worker. The Licensed Clinical Supervisor will review community support client's clinical needs and progress toward their goals with the community support worker every 30 days. The review should be completed, preferably face-to-face. The review may be accomplished by the supervisor consulting with the community support worker on their assigned clients and providing clinical guidance or recommendations to better serve the client. The community support worker shall have a minimum of bachelor's degree in psychology, sociology, or related human service field or two years of course work in a human service field and two years experience/training or two years of lived recovery experience with demonstrated skills and competencies in the provision of substance abuse services and demonstrated skill and competency in working with chronic substance dependence is acceptable.

Direct care staff employed by the agency before the effective date of these regulations will be considered to meet staffing requirements when the provider submits documentation identifying the name, address and provider number of the provider, service provided, names of direct care staff employed before the effective date of these regulations, and their date of hire. Documentation shall be submitted 30 days following the effective date of these regulations. Staff hired on or after the effective date of these regulations shall meet the specified requirements for direct care staff identified in the above paragraph;

~~35-017.04 Assessment and Treatment Planning:~~ Outpatient substance abuse treatment shall be delivered following the completion of comprehensive substance abuse assessment. Prior to delivery of services, an individual treatment and recovery plan shall be developed with the client. The plan shall be individualized, reviewed and approved by the client and therapist, and adjusted as clinically necessary.

~~35-017.05 Documentation:~~ Outpatient substance abuse treatment providers shall document in a summary the treatment service delivered in an individualized progress note. The note shall describe the treatment intervention provided, client's response to the intervention and the progress notes shall be placed in the client's clinical record. Documentation shall clearly reflect the implementation of the treatment and recovery plan. Discharge planning shall be an essential part of the treatment and recovery plan and the documentation of the progress toward discharge shall be documented in the clinical record.

~~35-017.06 Provider Enrollment:~~ Outpatient adult substance abuse providers shall contact the managed care entity when requesting approval in the managed care network as an adult substance abuse provider. Following approval, a substance abuse provider shall enroll as a provider of Medicaid services. Medicaid enrollment is necessary in order to complete credentialing process in the managed care network. Providers of outpatient services shall

~~provide annual cost information as a requirement by Medicaid at the time of enrollment and maintain any licensure requirements in order to continue participation with Medicaid.~~

~~35-017.07 Prior Authorization: All outpatient substance abuse treatment services shall be prior authorized by the Division of Medicaid and Long-Term Care or its designee before treatment service delivery.~~

~~35-017.08 Clients' Rights: Individual staff and the treatment and recovery team shall provide all services in a manner to support and maintain the client's rights with a continuous focus on client empowerment and movement toward recovery. Providers shall have written Client Rights and Responsibility policy and staff shall review client rights, responsibilities, and grievance procedures with each new client at admission, at treatment and recovery plan review and at the request of the client. This review shall be documented in the clinical record. Substance Abuse Treatment providers shall comply with all State and Federal Clients' Rights requirements.~~

~~Client rights shall be observed when receiving substance abuse services through Medicaid. The client has the right to:~~

- ~~1. Be treated with respect and dignity regardless of state of mind or condition;~~
- ~~2. Have privacy and confidentiality related to all aspects of care;~~
- ~~3. Be protected from neglect; physical, emotional or verbal abuse; and exploitation of any kind;~~
- ~~4. Be part of developing an individual treatment and recovery plan and decision-making regarding his/her treatment and rehabilitative services;~~
- ~~5. Refuse treatment or therapy (unless ordered by a mental health board or court);~~
- ~~6. Receive care which does not discriminate and is sensitive to gender, race, national origin, language, age, disability, and sexual orientation;~~
- ~~7. Be free of any sexual exploitation or harassment;~~
- ~~8. Voice complaints and file grievances without discrimination or reprisal and to have those complaints and grievances addressed; and~~
- ~~9. Receive such forms, instructions and assistance as needed to file a complaint or request a state fair hearing.~~

~~35-017.09 Payment for Community Support Abuse Treatment Services: Providers shall bill community support services in 15-minute increments for a maximum of 144 units for 180 days.~~