

**TITLE 471
SERVICES**

NEBRASKA MEDICAL ASSISTANCE PROGRAM

CHAPTER 20

**PSYCHIATRIC SERVICES FOR BENEFICIARIES AGE
21 AND OLDER**

001. SCOPE AND AUTHORITY. These regulations govern services provided under the Medical Assistance Act, Nebraska Revised Statute (Neb. Rev. Stat.) §§ 68-901 et seq.

002. DEFINITIONS. The following definitions apply:

002.01 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 beneficiary to a status in which the beneficiary is capable of functioning within the community with less frequent contact with the psychiatric health care provider.

002.02 ADULT INPATIENT HOSPITAL PSYCHIATRIC SERVICES. Inpatient hospital psychiatric services for beneficiaries 21 and over are medically necessary psychiatric services provided to an inpatient.

002.03 ADULT SUBACUTE INPATIENT HOSPITAL PSYCHIATRIC SERVICES. Subacute inpatient hospital psychiatric services for beneficiaries 21 and over are medically necessary short-term psychiatric services provided to a beneficiary.

002.04 ANNUAL SUPERVISION OF NEBRASKA MEDICAID ELIGIBLE BENEFICIARIES. Annual supervision includes a review of a beneficiary's treatment plan and progress notes, specific case discussion, and assessment of the beneficiary. This review should be completed annually or as often as is medically necessary.

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

002.06 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.

002.07 FAMILY PSYCHOTHERAPY. A treatment session requiring professional expertise between the beneficiary, the nuclear family, the extended family, or both, 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 beneficiary. This therapy must be provided with the appropriate family members and the

identified beneficiary. 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 beneficiary must be eligible for Nebraska Medicaid and have an acceptable primary psychiatric diagnosis. Crisis outpatient family therapy is an immediate, short-term treatment service provided to a family with urgent psychotherapy needs.

002.08 FUNCTIONAL FAMILY THERAPY (FFT). Functional family therapy (FFT) is family therapy targeted at youth. Functional family therapy (FFT) provides clinical assessment and treatment for the beneficiary and their family to improve communication, problem solving, and conflict management in order to reduce problematic behavior of the beneficiary.

002.09 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.

002.10 Group Psychotherapy. A treatment session, requiring professional expertise, between the beneficiary and the appropriate mental health professional in the context of a group setting of at least three and not more than 12 beneficiaries. Group psychotherapy must provide active treatment for a primary psychiatric diagnosis. Nebraska Medicaid does not cover groups that are primarily supportive or educational in nature or the services of a co-therapist.

002.11 Individual Psychotherapy. A treatment session between the beneficiary 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. Crisis outpatient individual therapy is an immediate, short-term treatment service provided to a beneficiary with urgent psychotherapy needs.

002.12 Inpatient Hospital Services for BENEFICIARIES Age 65 or Older in AN Institution for Mental Disease (IMD). Services provided under the direction of a psychiatrist for the care and treatment of beneficiaries age 65 and older in an institution for mental disease that meets the requirements of federal regulations.

002.13 INSPECTION OF CARE TEAM. The Department's inspection of care team, consisting of a psychiatrist knowledgeable about mental institutions, a qualified registered nurse (RN), and other appropriate personnel as necessary who conduct inspection of care reviews under federal regulations and this chapter.

002.14 INSTITUTION FOR MENTAL DISEASE (IMD). An institution for mental disease (IMD) is defined as an entity that primarily provides inpatient treatment for beneficiaries with mental diseases and is credentialed according to federal regulations.

002.15 INTERDISCIPLINARY TEAM. The interdisciplinary team is responsible for developing each beneficiary'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:

- (A) A licensed mental health practitioner (LMHP);
- (B) A registered nurse (RN) with specialized training or one year's experience in treating individuals with mental illness;
- (C) An occupational therapist (OT) who is licensed, if required by state law, and who has specialized training or one year's experience in treating mentally ill individuals; or
- (D) A licensed psychologist.

002.16 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.

002.17 MEDICAL REVIEW ORGANIZATION. A review body contracted by Nebraska Medicaid, responsible for pre-admission certification and concurrent and retrospective reviews of care.

002.18 OPIOID TREATMENT PROGRAM (OTP). An opioid treatment program (OTP) offers community-based outpatient addiction treatment for beneficiaries diagnosed with an opioid use disorder (OUD) and meeting level of care criteria. Opioid treatment programs (OTP) administer medications approved by the Food and Drug Administration (FDA) to treat opioid use disorder (OUD) and the alleviation of the adverse medical, psychological, or physical effects of opioid addiction.

002.19 OUTPATIENT. 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.

002.20 Services of Psychiatric Resident Physicians. Psychiatric resident physicians may only provide psychotherapy services and medication checks when these services are directly supervised by the attending psychiatrist. The resident's supervising psychiatrist must sign Nebraska Medicaid approved treatment planning document for services provided by the resident physician. The resident physician will not supervise services of allied health therapists, licensed mental health practitioners (LMHP), or qualified registered nurses (RNs). Resident physician services must be billed using the appropriate Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) procedure codes.

002.21 SUPERVISION. Supervision by the supervising practitioner is defined as the critical oversight of a treatment activity or course of action.

003. PHILOSOPHY OF CARE. Nebraska Medicaid's philosophy is that all care provided to beneficiaries 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.

004. NON-DISCRIMINATION. Nebraska Medicaid providers must comply with applicable federal civil rights laws and must not discriminate on the basis of race, color, national origin, age, sex or disability.

005. FAMILY OF ORIGIN COMPONENT. Care must address family concerns and, whenever possible, involve the family in treatment planning, therapy, and transition and discharge planning. Family may include biological, step, foster, or adoptive parents; siblings or half siblings; and extended 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.

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

005.02 FLEXIBLE SCHEDULING. 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.

005.03 TREATMENT PLAN. The provider must document their attempts to involve the family in treatment plan development and treatment plan reviews.

006. COMMUNITY BASED CARE. Care must be community-based and, when appropriate, must involve a representative from the beneficiary's community support system. Community involvement must be documented in the clinical record. This documentation must include any lack of cooperation or resistance from the community support system.

007. DEVELOPMENTALLY APPROPRIATE CARE. Care must address the beneficiary's biological, psychological, and social development. Therapeutic interventions must be congruent with the findings of the developmental level of the beneficiary, based on comprehensive psychiatric and psychological assessments.

008. CULTURALLY COMPETENT CARE. Providers of psychiatric services for beneficiaries 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, and by providing a variety of adaptations to service models in order to meet the needs of different cultural populations.

008.01 CULTURALLY COMPETENT PROVIDERS. 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 beneficiaries from other cultures. They provide support for staff to become comfortable working in cross-cultural situations, understand the interplay between policy and practice, and are committed to policies that enhance services to diverse beneficiaries.

009. Dually Diagnosed Beneficiaries. The treatment provider must incorporate the needs of the dually diagnosed beneficiary and provide active treatment for beneficiaries with concurrent or secondary complicating problems. Dual diagnosis treatment is the simultaneous and integrated treatment of coexisting disorders.

010. Coordinated Services. If a beneficiary is receiving services from more than one psychiatric provider, the providers must assure coordination of all services. That coordination must be documented in the beneficiary'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.

011. PROVIDER ENROLLMENT.

011.01 PROVIDER AGREEMENT. A provider of psychiatric services for beneficiaries age 21 and over must complete the appropriate Nebraska Medicaid approved provider agreement form , and submit the completed form to Nebraska Medicaid 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 Nebraska Medicaid. Nebraska Medicaid 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. The provider must meet the standards for participation as outlined in each subpart of the provider agreement.

011.02 PROVIDER ENROLLMENT STATUS. The provider enrollment process allows for three types of provider enrollment status based on information from the provider and other sources. Nebraska Medicaid must notify the provider of the status assigned.

011.02(A) PROVISIONAL STATUS. A provider who has recently established services within this chapter or who is new to Nebraska Medicaid will be enrolled with a provisional status. After a minimum of one year of services, Nebraska Medicaid may choose to grant ongoing status to the provider.

011.02(A)(i) APPEAL OF TERMINATION OF PROVIDER ENROLLMENT.

Providers can appeal the decision to terminate a provider enrollment.

011.02(B) ONGOING STATUS. A provider must establish ongoing status after a minimum of one year of service within the Nebraska Medicaid requirements.

011.02(C) PROBATIONARY STATUS. A provider can be placed on probationary status when there are deficiencies in meeting Nebraska Medicaid requirements or there are other concerns about the provider's program or practices. While on probationary status, a provider can be required to work with Nebraska Medicaid to develop a corrective action plan. This plan must be submitted to Nebraska Medicaid for approval.

011.02(C)(i) APPEAL OF PROBATIONARY STATUS. Providers can appeal the decision to place a provider on probationary status.

011.02(C)(ii) PROBATIONARY STATUS EVALUATION. The probationary status will be evaluated by Nebraska Medicaid 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 can appeal these decisions.

011.02(C)(iii) CONTINUED PARTICIPATION. If the deficiencies are not causing immediate jeopardy or compromising the safety of the beneficiaries, then the facility can continue to participate in Nebraska Medicaid. A prohibition of new admissions may occur if there are allegation of abuse or neglect under investigation in relation to the program or staff, the quality of treatment is significantly compromised by the deficiencies, or the provider is violating any laws, regulations, or code of ethics governing their program.

011.02(D) UPDATES. The provider will send to Nebraska Medicaid 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 beneficiaries 21 and over. This information will also be sent to Nebraska Medicaid if a provider makes changes in how they provide a service. These changes and updates must be indicated on the appropriate Nebraska Medicaid approved provider agreement form.

012. OUT-OF-STATE SERVICES. Potential out-of-state providers of services in this chapter must have a specific plan of how they will meet the family and community requirements. This plan will be approved by Nebraska Medicaid to become a provider of Nebraska Medicaid services.

013. Quality Assurance and Utilization Review. All Nebraska Medicaid providers have agreed to provide services under the requirements of this title regarding , provider agreements. If there is any question or concern about the quality of service being provided by an enrolled provider, Nebraska Medicaid may perform quality assurance and utilization review activities 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 or denial of provider agreement for good cause . Nebraska Medicaid may request a refund for all services not meeting the requirements. If beneficiaries are in immediate jeopardy, the sanctions will be imposed without a hearing.

014. OBSERVATION ROOM SERVICES (23:59). When appropriate for brief crisis stabilization, Nebraska Medicaid covers outpatient hospital observation room services up to 23 hours 59 minutes in an emergency room or acute hospital with the following qualifiers:

- (A) If a beneficiary receives 24 or more hours of continuous outpatient care, that beneficiary is defined as an inpatient regardless of the hour of admission, whether they used a bed, and whether they remained in the hospital past midnight or the census-taking hour;
- (B) When the beneficiary reaches 24 hours of continuous outpatient care, all inpatient medical review prior-authorization requirements noted in this chapter apply; and
- (C) The services must be billed as an outpatient hospital psychiatric service on the appropriate Nebraska Medicaid approved health care claim form .

015. PSYCHIATRIC THERAPEUTIC STAFF STANDARDS. Psychiatric therapeutic staff for adult services will meet the following requirements:

015.01 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) 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 they practice and must be enrolled with Nebraska Medicaid with a primary specialty of psychiatry;
- (B) 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 they practice and

must be enrolled with Nebraska Medicaid with a primary specialty of clinical psychology;

- (C) Must be a licensed advanced practice registered nurse (APRN) by the Nebraska Department of Health and Human Services, Division of Public Health or the appropriate licensing agency of the state in which they practice, must be enrolled with Nebraska Medicaid, and have proof of a current certification from an approved certification program in a psychiatric or mental health specialty; or

(D) Licensed independent mental health practitioners (LIMP).

015.02 PRACTICE OF SUPERVISION. The critical involvement of the supervising practitioner must be reflected in the initial diagnostic interview, the treatment plan, and the interventions provided.

015.02(A) SUPERVISING PRACTITIONER. 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.

015.02(B) SUPERVISORY CONTACT. Supervisory contact may occur in a group setting.

015.02(C) SUPERVISION NOT BILLABLE. Supervision is not billable by either the therapist or the supervising practitioner as it is considered a mandatory component of the care.

015.02(D) SUPERVISOR LIMITATIONS. Psychiatric resident physicians may not supervise allied health therapists for Nebraska Medicaid services.

015.02(E) PERIODIC EVALUATION. 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.

015.03 LICENSED INDEPENDENT MENTAL HEALTH PRACTITIONERS (LIMHP). Licensed independent mental health practitioners (LIMHP) may provide direct care as allowed by the scope of practice requirements set by Nebraska Department of Health and Human Services, Division of Public Health.

015.04 ALLIED HEALTH THERAPISTS. All psychotherapy services provided by allied health therapists must be prescribed by the supervising practitioner and provided under their supervision. All allied health therapists must have knowledge of the interactional systems within families. Allied health therapists include:

- (A) SPECIALY 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 they practice;
- (B) LICENSED MENTAL HEALTH PRACTITIONERS (LMHP). Persons who are licensed as mental health practitioners (LMHP) by the Nebraska Department of Health and Human Services, Division of Public Health or the appropriate licensing agency of the state in which they practice;
- (C) PROVISIONALLY LICENSED MENTAL HEALTH PRACTITIONERS (LMHP). 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 they practice;
- (D) QUALIFIED REGISTERED NURSES (RN). A registered nurse (RN) with a bachelor's, master's, or Doctor of Philosophy (Ph.D.), or certification as a psychiatric clinical specialist or nurse practitioner (NP) 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 they practice; and
- (E) QUALIFIED MENTAL HEALTH PROFESSIONAL OR MASTER'S EQUIVALENT. A holder of a master's degree in a closely related field that is applicable to the bio, psycho, or 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 Doctor of Philosophy (Ph.D.) candidate who has bypassed the master's degree but has sufficient hours to satisfy a master's degree requirement.

015.05 SUBSTANTIATED DISCIPLINARY ACTION. Any Nebraska 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 Nebraska Medicaid 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 a Nebraska Medicaid provider.

016. PAYMENT LIMITATIONS. Payment for psychiatric services for beneficiaries age 21 and older under Nebraska Medicaid is limited to payment for medically necessary psychiatric services for medically necessary primary psychiatric diagnoses.

016.01 CHRONIC OR CUSTODIAL. Nebraska 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 beneficiary . Documentation is kept in the beneficiary's medical record. Nebraska Medicaid does not reimburse for services for diagnoses of developmental disabilities, or V codes as part of this chapter.

017. MEDICAL NECESSITY.

017.01 NECESSARY TREATMENT INTERVENTIONS AND SUPPLIES. Biopsychosocially necessary treatment interventions and supplies are those which are:

- (A) Consistent with the behavioral health condition and conducted with the treatment of the beneficiary as the primary concern;
- (B) Supported by sufficient evidence to draw conclusions about the treatment intervention's effects of behavioral health outcomes;
- (C) Supported by evidence demonstrating the treatment intervention can be expected to produce its intended effects on behavioral health outcomes;
- (D) Supported by evidence demonstrating the intervention's intended beneficial effects on behavioral health outcomes outweigh its expected harmful effects;
- (E) Cost effective in addressing the behavioral health outcome;
- (F) Determined by the presentation of behavioral health conditions, not necessarily by the credentials of the service provider;
- (G) Not primarily for the convenience of the beneficiary or the provider; and
- (H) Delivered in the least restrictive setting that will produce the desired results in accordance with the needs of the beneficiary.

017.02 BEHAVIORAL HEALTH CONDITIONS. Behavioral health conditions are the diagnoses identified in diagnostic manuals commonly recognized in this field.

018. 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 comprehensive evaluation of the beneficiary's restorative needs and potentialities for a primary psychiatric diagnosis. An isolated service not furnished under a planned program of therapy or diagnosis is not active treatment even when the service is therapeutic or diagnostic in nature.

018.01 SERVICES REQUIRED TO IMPROVE CONDITION OR DIAGNOSE. The services must be reasonably expected to improve the beneficiary's condition or to determine a psychiatric diagnosis. The treatment must, at a minimum, be designed to reduce or control the beneficiary's psychiatric symptoms to facilitate the beneficiary's movement to a less restrictive environment within a reasonable period of time.

018.02 ACTIVE TREATMENT. The administration of a drug or drugs does not by itself necessarily constitute active treatment .

018.03 ACTIVE TREATMENT REQUIREMENT. The active treatment services must be supervised, directed, and evaluated by a supervising practitioner. The services of other qualified professionals must be prescribed by a supervising practitioner to meet the specific needs of the beneficiary. 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, 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 beneficiary's clinical record, and regularly scheduled beneficiary interviews as required for the level of care being provided.

019. TREATMENT PLANS. A treatment plan must be established for each beneficiary. 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 beneficiary. 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.

019.01 TREATMENT PLAN. The treatment plan must be based upon an assessment of the beneficiary's problems and needs in the areas of emotional, behavioral, and skills development. The treatment plan must be individualized to the beneficiary 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 beneficiary's progress; and the responsible professional.

019.02 GOALS AND OBJECTIVES. 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 beneficiary's response to the treatment interventions based on the recommendations, goals and objectives.

019.02(A) SUFFICIENT NEED. The beneficiary must have sufficient need for active psychiatric treatment at the time the psychiatric service provider accepts the beneficiary.

019.02(B) BEST CHOICE. The treatment must be the best choice for expecting reasonable improvement in the beneficiary's psychiatric condition.

019.03 TREATMENT PLAN TIME FRAMES. A treatment plan must be developed for every beneficiary within the time frames specified for each type of service and must be placed in the beneficiary's clinical record. If a treatment plan is not developed within the specified time frames, services rendered may not be reimbursable by Nebraska Medicaid.

019.04 TREATMENT PLAN REVIEW. The treatment plan must be reviewed and updated by the treatment team according to the beneficiary'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 beneficiary's current needs, and to assess the beneficiary'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.

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

019.06 BENEFICIARY AND FAMILY INVOLVEMENT. The provider must work with the beneficiary and family, at the beneficiary's discretion, to develop the treatment plan.

019.07 DOCUMENTATION. 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. 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 beneficiary, the development of the treatment plan, and all aspects of the beneficiary's treatment unless prohibited by the beneficiary, through legal action, or because of federal confidentiality laws.

019.08 TREATMENT PLANNING DOCUMENT UPDATE. The treatment plan must be reviewed and updated every 90 days, or more frequently if indicated. The beneficiary's clinical record must include the supervising practitioner's comments on the beneficiary'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 beneficiary's medical record.

019.08(A) SIGNATURE. For services provided under the supervision of a supervising practitioner, the signature of the supervising practitioner on the treatment planning document indicates their agreement that the scheduled treatment interventions are appropriate.

020. TRANSITION AND DISCHARGE PLANNING. When a beneficiary 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.

020.01 STANDARDS FOR TRANSITION AND DISCHARGE PLANNING. Providers must meet the following standards regarding transition and discharge planning:

- (A) Transition and discharge planning must begin on admission;
- (B) Discharge planning must be based on the treatment plan to achieve the beneficiary's discharge from the current treatment status and transition into a different level of care;
- (C) Transition and discharge planning must address the beneficiary's need for ongoing treatment to maintain treatment gains and to continue normal physical and mental development following discharge;
- (D) Discharge planning must include identification of and clear transition into developmentally appropriate services needed following discharge;
- (E) Treatment providers must make or facilitate referrals and applications to the next level of care or treatment provider;
- (F) 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
- (G) A written transition and discharge summary must be provided as part of the medical record.

021. 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.

021.01 RECORDS REQUIREMENTS. Treatment provided to the beneficiary 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 beneficiary's reaction to it. If three separate individuals cannot understand the information written in a record because of handwriting which is difficult to read, the program must provide a readable format. Reimbursement for services may be denied if claims 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 beneficiary .

021.02 INSPECTION. Providers of psychiatric services to beneficiaries age 21 and older must comply with Nebraska Medicaid requests to review clinical records. This review may be of photocopies or on-site at the discretion of Nebraska Medicaid .

022. INSPECTIONS OF CARE. Inspections of care will be conducted as outlined in federal regulations .

023. PROCEDURE CODES. Providers must use Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) procedure codes when submitting claims to Nebraska Medicaid for services.

024. INITIAL DIAGNOSTIC INTERVIEW. For services in this chapter to be covered by Nebraska Medicaid, the necessity of the service for the beneficiary must be established through an initial diagnostic interview. The beneficiary must have a diagnosable mental health disorder of sufficient duration to meet diagnostic criteria that results in functional impairment which substantially interferes with or limits the beneficiary's role or functioning within the family, job, school, or community. The initial diagnostic interview is used to determine the presence or absence of a mental health disorder, identify the problems and needs, develop goals and objectives, and determine appropriate strategies and methods of intervention for the beneficiary. This comprehensive plan of care will be outlined in the individualized treatment plan and should reflect an understanding of how the beneficiary'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 beneficiary's current functioning and treatment needs. Except for beneficiaries receiving acute inpatient hospital services, crisis services, or substance use disorder services are not required to receive an initial diagnostic interview before services are initiated. Initial diagnostic interviews that are incomplete will not be reimbursable.

024.01 COVERED SERVICES. Initial diagnostic interviews must contain:

- (A) A mental health evaluation with relevant beneficiary information, mental status exam, and diagnosis; and
- (B) Recommendations:
 - (i) Treatment needs and recommended interventions for beneficiary and family;
 - (ii) Identification of who needs to be involved in the beneficiary's treatment;
 - (iii) Overall plan to meet the treatment needs of the beneficiary including transitioning to lower levels of care and discharge planning;
 - (iv) A means to evaluate the beneficiary's progress throughout their treatment and outcome measures at discharge;
 - (v) Recommended linkages with other community resources; and
 - (vi) Other areas that may need further evaluation.

024.02 PROVIDER AGREEMENT. Providers of the acute services must facilitate or perform the initial diagnostic interview. Providers of crisis

intervention services must facilitate the referral to or provide the initial diagnostic interview if it has not already occurred. For providers of substance use disorder services, if a co-occurring mental health condition is known or suspected, the clinician will refer the beneficiary for an initial diagnostic interview, if the clinician is unable to also do an initial diagnostic interview by scope of practice.

024.03 INVOLVEMENT OF THE SUPERVISING PRACTITIONER. The supervising practitioner must 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.

024.04 PAYMENT FOR INITIAL DIAGNOSTIC INTERVIEW. 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.

024.04(A) PROVIDERS OF THE INITIAL DIAGNOSTIC INTERVIEW. Providers of the initial diagnostic interview must bill on the appropriate Nebraska Medicaid approved health care claim form or electronic claim. The completed initial diagnostic interview must be included in the beneficiary file and available for review upon request. Failure to produce documentation of an initial diagnostic interview upon request, or lack of inclusion in the beneficiary file determined during review, must be cause for claim denial or refund.

024.04(B) REIMBURSEMENT. Nebraska Medicaid will provide reimbursement for one initial diagnostic interview per treatment episode. Addendums may be included if additional information becomes available. If the beneficiary remains involved continuously in treatment for more than one year, reimbursement for an initial diagnostic interview may be available annually. If the beneficiary 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.

024.05 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.

025. OUTPATIENT PSYCHIATRIC SERVICES. All requirements in this chapter apply to outpatient psychiatric services.

025.01 COVERED OUTPATIENT PSYCHIATRIC THERAPEUTIC SERVICES. Nebraska Medicaid covers the following outpatient psychiatric therapeutic services for beneficiaries age 21 and older as defined in this chapter:

- (A)Psychiatric evaluation;
- (B)Psychological evaluation;
- (C)Psychological testing;
- (D)Individual psychotherapy;
- (E)Group psychotherapy overview must be approved by Nebraska Medicaid prior to billing for this service;
- (F)Family psychotherapy services;
- (G)Family assessment;
- (H)Medication checks by a physician, physician assistant (PA), or advanced practice registered nurse (APRN) ;
- (I)Electroconvulsive therapy;
- (J) Annual supervision of eligible beneficiaries by a psychologist or a licensed independent mental health practitioner (LIMHP);
- (K) Functional family therapy (FFT); and
- (L) Opioid treatment program (OTP).

025.02 RESTRICTIONS. Nebraska Medicaid does not reimburse for services for diagnoses of developmental disabilities, or V codes as part of this chapter.

025.03 SKILLED NURSING. Skilled nursing services for the monitoring of medications is available through home health agencies .

025.04. PSYCHIATRIC THERAPEUTIC STAFF STANDARDS. The following psychiatric therapeutic staff may provide services and must meet the requirements as defined in this chapter:

- (A)Physician;
- (B)Licensed psychologist;
- (C) Physician assistant (PA);
- (D) Advanced practice registered nurse (APRN);
- (E)Licensed independent mental health practitioner (LIMHP); and
- (F)Allied health therapists.

025.04(i) 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, the Commission on Accreditation of Rehabilitation Facilities (CARF), the Council on Accreditation (COA), or the American Osteopathic Association (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 or the American Osteopathic Association (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 Nebraska 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 or the American Osteopathic Association (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 Nebraska Medicaid beneficiaries;
- (4) A physician's private office;
- (5) A licensed psychologist's private office;

- (6)An allied health therapist's private office;
- (7)The beneficiary's home;
- (8)Nursing homes; or
- (9)Rural mental health clinics or federally qualified health centers.

025.05 PROVIDER AGREEMENT. A provider of psychiatric outpatient services must complete a provider agreement, and submit the form to Nebraska Medicaid for approval.

025.05(A) INDEPENDENT PSYCHIATRIC SERVICE PROVIDERS. Independent psychiatric service providers must complete the appropriate form . The provider agreement issued to the supervising practitioner or clinic is used to claim services provided by allied health therapists who are in the practitioner's or clinic's employ or supervision. For outpatient psychiatric services provided through a group practice, the provider agreement must be kept current by providing Nebraska Medicaid with:

- (i)The termination date of any therapist leaving the group practice;
- (ii)The initial employment date of any therapist joining the group practice;
and
- (iii)A current resume detailing education and clinical experience for each application for allied health therapists.

025.05(B) HOSPITALS. Hospitals as defined in this chapter providing outpatient psychiatric services must complete the appropriate Nebraska Medicaid approved provider agreement form .

025.05(C) VERIFICATION. Providers are responsible for verifying that allied health therapists, physicians, physician assistants (PA), advanced practice registered nurses (APRN), and licensed psychologists are appropriately licensed for the correct scope of practice.

025.05(D) GEOGRAPHICALLY DEPRIVED AREAS. 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 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.

025.06 COVERAGE CRITERIA FOR OUTPATIENT PSYCHIATRIC SERVICES. Nebraska Medicaid covers outpatient psychiatric therapeutic services listed in this chapter when the services are medically necessary and provide active treatment as defined in this chapter.

025.06(A) DOCUMENTATION OF MEDICAL NECESSITY AND ACTIVE TREATMENT. Medical necessity and active treatment for outpatient services is documented through the use of Nebraska Medicaid's approved treatment planning document, in accordance with this chapter which must be developed by a licensed practitioner and supervising practitioner based on a thorough evaluation of the beneficiary's restorative needs and potentialities for a primary psychiatric diagnosis.

025.06(B) SERVICES PROVIDED BY ALLIED HEALTH THERAPISTS. Services provided by allied health therapists, as defined in this chapter must be prescribed and provided under the direction of a supervising practitioner. Supervision must meet the active treatment criteria in this chapter .

025.06(B)(i) RE-EVALUATION. The supervising practitioner must personally re-evaluate the beneficiary through a face-to-face contact annually or more often, if necessary.

psychiatric service provider accepts the client; and

025.07 DOCUMENTATION IN BENEFICIARY'S CLINICAL RECORDS. : All documents submitted to Nebraska Medicaid must contain sufficient information for identification . . The beneficiary's medical record must also include:

- (A)The initial diagnostic interview;
- (B)The treatment plan, including the initial document, updates, and current treatment plan;
- (C)The beneficiary's diagnosis. A provisional or interim psychiatric diagnosis must be established by the supervising practitioner at the time the beneficiary is accepted for treatment. This diagnosis must be reviewed and revised as a part of the treatment plan;
- (D)A chronological record of all psychiatric services provided to the beneficiary, the date performed, the duration of the session, and the staff member who conducted the session;
- (E)A chronological account of all medications prescribed, the name, dosage, and frequency to be administered and beneficiary's response;
- (F)6A comprehensive family assessment;

(G)A clear record of family and community involvement;

(H)Documentation verifying coordination with other therapists when more than one provider is involved with the beneficiary and family; and

(I)Transition and discharge planning.

025.08 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.

025.08(A) ADDITIONAL DOCUMENTATION. Additional documentation from the beneficiary'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.

025.09 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 beneficiary.

025.09(A) PROVIDER. 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.

025.09(A)(i) SUPERVISING PRACTITIONER. If testing and evaluation services are provided by a licensed, non-certified psychologist, the services must be ordered by a supervising practitioner.

025.09(A)(ii) COPY OF TESTING NARRATIVE SUMMARY. A copy of the testing narrative summary must be kept in the beneficiary'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.

025.09(B) GRAND-PARENTED MASTERS PSYCHOLOGISTS. Services provided by master's level clinical psychologists whose certification has been grand-parented by the Department of Health and Human Services, Division of Public Health may be covered under this chapter. Documentation of the grand-parented status may be required.

025.09(C) MEDICATION CHECKS. Medication checks may only be done when medically necessary. When a physician, physician assistant (PA) or advanced practice registered nurse (APRN) provides psychotherapy services, medication checks are considered a part of the psychotherapy service.

025.09(C)(i) MEDICATION CHECK. 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 assistants (PA) or advanced practice registered nurses (APRN) may provide medication checks.

025.09(D) TRAVEL TO THE HOME OF BENEFICIARIES WHO HAVE HANDICAPS. If a beneficiary 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 beneficiary's home. The information requested must be provided, in writing, to Nebraska Medicaid or their designee for consideration. The following requirements must be met:

- (i)The provider requests prior authorization before the initiation of services;
- (ii)The treatment must meet the criteria for active treatment and medical necessity;
- (iii)The beneficiary's handicapping physical condition prevents their travel to the mental health clinic or office; and
- (iv)The beneficiary's home is more than 30 miles from the clinic or office.

025.09(E) FAMILY ASSESSMENT. Nebraska Medicaid 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 beneficiary and collateral parties.

025.09(F) ANNUAL SUPERVISION OF NEBRASKA MEDICAID ELIGIBLE BENEFICIARIES BY A PSYCHOLOGIST OR A LICENSED INDEPENDENT MENTAL HEALTH PRACTITIONER (LIMHP). The supervising practitioner must be available in person or by telephone to provide assistance as needed during the time services are being provided. The critical involvement of the supervising practitioner is to be reflected in the initial diagnostic interview, the treatment plan, and the interventions provided.

025.09(G) FUNCTIONAL FAMILY THERAPY (FFT). Functional family therapy (FFT) is family therapy targeted at youth.

025.09(G)(i) INITIAL DIAGNOSTIC INTERVIEW. An initial diagnostic interview must be completed prior to the beginning of treatment and will serve as the initial treatment plan until a comprehensive treatment plan is completed.

025.09(G)(ii) STAFFING. All staffing must be adequate to meet the individualized treatment needs of the beneficiary and meet the responsibilities of each staff position as outlined in the functional family therapy (FFT) model.

025.09(G)(iii) TREATMENT PLAN REQUIREMENTS. Assessments and treatment must address mental health and substance use disorder needs,

and mental health and emotional issues related to medical conditions. The treatment plan must be individualized and 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 beneficiary's progress; and the responsible professional. The treatment plan must be developed with the beneficiary and the identified, appropriate family members as part of the outpatient family therapy treatment planning process. The treatment plan must meet the following requirements:

- (1) The treating provider must consult with or refer to other providers for general medical, psychiatric, and psychological needs as indicated;
- (2) It is the treating provider's responsibility to coordinate with other treating professionals as needed;
- (3) The treatment plan will be reviewed every 90 days or more often if clinically indicated;
- (4) After hours crisis assistance must be available; and
- (5) Services must be trauma informed, culturally sensitive, age and developmentally appropriate, and incorporate evidence-based practices when appropriate._

025.09(G)(iv) FUNCTIONAL FAMILY THERAPY (FFT). A functional family therapy (FFT) treatment provider must have a master's degree or greater and be a member of an active team. An active functional family therapy (FFT) team requires a functional family therapy (FFT) certified clinical supervisor and at least three functional family therapy (FFT) certified treatment providers working collaboratively with one another using the functional family therapy (FFT) model.

025.09(G)(v) TREATMENT PROVIDERS. Treatment providers may be any of the following: physician, physician assistant (PA), advanced practice registered nurse (APRN), nurse practitioner (NP), licensed psychologist, provisionally licensed psychologist, licensed independent mental health practitioner (LIMHP), licensed mental health professional, and a provisionally licensed mental health practitioner (LMHP) acting within their scope of practice.

025.09(G)(v)(1) TREATMENT CLINICAL SUPERVISORS. Treatment clinical supervisors must be physicians, physician assistants (PA), licensed psychologists, or licensed independent mental health practitioners (LIMHP) certified in functional family therapy (FFT) model and with experience in the practice of psychotherapy. All psychiatric and psychotherapy services will be prescribed and provided under the supervision and direction of a supervising practitioner. Supervision is not a billable service._

025.09(G)(v)(2) TREATMENT ASSESSMENT PROVIDERS. Treatment assessment providers may be any of the following: physicians, physician assistants (PA), psychiatric advanced practice registered nurse practitioners (APRN), psychologists, provisionally licensed psychologists,

or licensed independent mental health practitioners (LIMHP), all acting within their scope of practice._

025.09(H) OPIOID TREATMENT PROGRAM (OTP). An opioid treatment program (OTP) treatment must be compliant with federal regulations.

025.09(H)(i) CERTIFICATION. Treatment must be provided by Substance Abuse and Mental Health Services Administration (SAMHSA) certified treatment centers that meet federal regulatory requirements.

025.09(H)(ii) COORDINATION. Opioid treatment must be coordinated through a collaborative process that implements, monitors, and evaluates the options and services required to meet the beneficiary's needs and includes referrals to outside resources when the needed services are not offered by the opioid treatment program (OTP). Providers must establish a plan of care with a clinically appropriate maintenance period that is based on assessments of withdrawal symptoms using standardized scales and evidence-based practice.

025.09(H)(iii) ASSESSMENTS. Ongoing assessments must meet the following requirements:

- (1) A substance use assessment must be completed prior to initiation of services and must be updated annually;
- (2) A substance use addendum should be completed if determined to be medically necessary; and
- (3) Assessments and addendums must be completed by one of the following licensed medical professionals:
 - (a) Licensed or provisionally licensed psychologist;
 - (b) Licensed independent mental health practitioner (LIMHP);
 - (c) Licensed or provisionally licensed mental health practitioner (LMHP); and
 - (d) Licensed or provisionally licensed alcohol and drug counselor (LADC).

025.09(H)(iv) OPIOID AGONIST. Opioid agonist medications must be administered and dispensed by licensed professionals authorized by law. A physician, physician assistant (PA) or advance practice registered nurse (APRN) must determine and document, in writing, the initial dose of opioid agonist medications and schedule to be followed for each beneficiary. This information is to be communicated to the licensed medical staff supervising the dispensing of any opioid replacement treatment medication. Opioid agonist medications are provided in conjunction with rehabilitative and medical services.

025.10 PAYMENT FOR OUTPATIENT BEHAVIORAL HEALTH SERVICES IN A HOSPITAL. Nebraska Medicaid pays for covered outpatient mental health services, except for laboratory services, at the lower of:

- (i) The provider's submitted charge; or
- (ii) 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:
 - (1) The unit value multiplied by the conversion factor;
 - (2) The maximum allowable dollar amount; or
 - (3) The reasonable charge for the procedure as determined by Nebraska Medicaid, indicated as BR - by report or RNE - rate not established in the fee schedule.

025.10(B) REVISIONS OF THE FEE SCHEDULE. Nebraska Medicaid reserves the right to adjust the fee schedule to:

- (i) Comply with changes in state or federal requirements;
- (ii) Comply with changes in national standard code sets ;
- (iii) 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
- (iv) Adjust the allowable amount when Nebraska Medicaid determines that the current allowable amount is:
 - (1) Not appropriate for the service provided; or
 - (2) Based on errors in data or calculation.

025.10(C) UPDATES TO FEE SCHEDULE. Nebraska Medicaid 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.

025.11 BILLING REQUIREMENTS. For outpatient psychiatric service providers, the following requirements must be met:

- (A) Community mental health programs providing outpatient psychiatric services must submit all claims for outpatient services on the appropriate Nebraska Medicaid approved health care claim form or electronic claim;
- (i) Payment for approved outpatient psychiatric services provided by employees of a community mental health program is made to the facility;

(B) Hospitals providing outpatient psychiatric services must submit all claims for non-physician services on the appropriate Nebraska Medicaid approved health care claim form or electronic claim;

(i) All physician services must be submitted on the appropriate Nebraska Medicaid approved health care claim form ; and

(ii) Payment for approved outpatient psychiatric services provided by employees of a hospital is made to the facility;

(C) Independent providers of outpatient psychiatric services must submit all claims for outpatient psychiatric services provided in their private office on the appropriate Nebraska Medicaid approved health care claim form or electronic claim; and

(i) 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.

025.12 DOCUMENTATION FOR CLAIMS. For outpatient psychiatric services, unless otherwise instructed by Nebraska Medicaid or their designee, the following documentation must be kept in the beneficiary's file for each claim:

(A) The initial treatment plan; or

(B) An updated version of the treatment plan completed every 90 days.

025.13 PSYCHOLOGICAL TESTING AND EVALUATION. For psychological testing and evaluation services, unless otherwise instructed by Nebraska Medicaid, the following information must be kept in the beneficiary's file:

(A) The treatment plan;

(B) Medical necessity for the service documented on the treatment plan;

(C) The documentation that the evaluation services will reasonably be expected to contribute to the diagnosis and plan of care established for the individual beneficiary; and

(D) A narrative of the testing results.

025.14 PROCEDURE CODES AND DESCRIPTIONS. Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) procedure codes used by Nebraska Medicaid are listed in the Nebraska Medicaid Practitioner Fee Schedule .

026. ADULT DAY TREATMENT PSYCHIATRIC SERVICES.

026.01 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 Nebraska Medicaid or to the beneficiary.

026.01(A) 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.

026.01(A)(i) MEDICALLY NECESSARY PSYCHOTHERAPY SERVICES. These services must demonstrate active treatment of a beneficiary with a psychiatric condition. These services are subject to program limitations and must be provided by professionals operating within the appropriate scope of practice, including individual psychotherapy, group psychotherapy, family psychotherapy, and family assessment if appropriate.

026.01(A)(ii) MEDICALLY NECESSARY NURSING SERVICES. Services directed by a registered nurse (RN) who evaluates the particular medical nursing needs of each beneficiary and provides for the care and treatment that is indicated by Nebraska Medicaid approved treatment planning document approved by the supervising practitioner.

026.01(A)(iii) 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 beneficiary. 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.

026.01(A)(iv) 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 facility that meets applicable provider participation requirements. All medications must be stored in a special locked storage space and administered only by a physician, physician assistant (PA), advanced practice registered nurse (APRN), registered nurse (RN), or licensed practical nurse (LPN).

026.01(A)(v) MEDICALLY NECESSARY DIETARY SERVICES. If meals are provided by a day treatment program, services must be supervised by a registered dietitian, based on the beneficiary's individualized medical diet needs. The program may contract for these services through an outside licensed certified facility.

026.01(A)(vi) TRANSITION AND DISCHARGE. Transition and discharge planning must meet the requirements of this chapter .

026.01(B) OPTIONAL SERVICES. The program must provide two of the following optional services. The beneficiary must have a need for the services, a supervising practitioner must order the services, and the services must be a part of the beneficiary'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 (OT) may be covered if prescribed as an activities therapy in a psychiatric program:

(i) 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 professional that meets applicable provider participation requirements, as listed below:

(1) Recreational therapy;

(2) Speech therapy;

(3) Occupational therapy (OT);

(4) Vocational skills therapy; and

(5) Self-care services: services supervised by a registered nurse (RN) or occupational therapist (OT) who is oriented toward activities of daily living and personal hygiene;

(ii) 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 ;

(iii) Social skills building; and

(iv) Life survival skills.

026.01(C) SPECIAL TREATMENT PROCEDURES IN DAY TREATMENT. If a beneficiary 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:

(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 a beneficiary's behavior presents a danger to self or others, or to prevent serious disruption to the therapeutic environment; and

- (iii)The beneficiary's treatment plan must address the use of special treatment procedures and have a clear plan to decrease the behavior requiring locked time out (LTO) or physical restraints.

026.01(D) STANDARDS DOCUMENTED. 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.

026.02 PROVIDER STANDARDS. Providers of day treatment services must meet the following standards:

026.02(A) NON-HOSPITAL BASED DAY TREATMENT. A center providing day treatment must be:

- (1)Appropriately licensed by the Nebraska Department of Health and Human Services, Division of Public Health; and
- (2)Accredited by the Joint Commission , the Commission on Accreditation of Rehabilitation Facilities (CARF), the Council on Accreditation (COA), or the American Osteopathic Association (AOA).

026.02(A)(i) HOSPITAL BASED DAY TREATMENT. A hospital providing on-site day treatment must:

- (1)Be licensed or formally approved as a hospital by the Nebraska Department of Health and Human Services, Division of Public Health;
- (2)Be accredited by the Joint Commission or the American Osteopathic Association (AOA);
- (3)Meet the requirements for participation in Medicare; and
- (4)Have in effect a utilization review plan applicable to all Nebraska Medicaid beneficiaries.

026.02(A)(ii) FREESTANDING FACILITIES. 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.

026.02(B) HOURS. 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 hours of services for half day of service or six hours of services for full day of service.

026.02(B)(i) SUPERVISING PRACTITIONER. 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:

- (1) A licensed physician;
- (2) A licensed psychologist;
- (3) Licensed independent mental health practitioner (LIMHP); or
- (4) An allied health therapist.

026.02(B)(ii) REFERRAL. Any supervising practitioner may refer a beneficiary to a day treatment program, but all treatment must be prescribed and directed by the program supervising practitioner.

026.02(B)(iii) SUPERVISION. All treatment must be conducted under the supervision of the supervising practitioner in charge of the program.

026.02(B)(iv) PSYCHOTHERAPY STAFF. Psychotherapy staff as outlined in this chapter include the following:

- (1) Physician;
- (2) Licensed psychologist;
- (3) Licensed independent mental health practitioner (LIMHP); and
- (4) Allied health therapists. All psychotherapy services provided by allied health therapists must be prescribed by the supervising practitioner and provided under their supervision. The supervising practitioner's personal involvement in all aspects of the beneficiary's psychiatric care must be documented in the beneficiary's medical record through physician's orders, progress notes, and nurse's notes.

026.02(B)(v) ADMISSION CRITERIA. The following criteria must be met for a beneficiary's admission to a psychiatric day treatment program:

- (1) The beneficiary must have sufficient medical need for active psychiatric treatment at the time of admission to justify the expenditure of the beneficiary's and program's time, energy, and resources; and
- (2) Of all reasonable options for active psychiatric treatment available to the beneficiary, treatment in this program must be the best choice for expecting a reasonable improvement in the beneficiary's psychiatric condition.

026.02(B)(vi) PRE-ADMISSION EVALUATION. Before the beneficiary is admitted to the program, the supervising practitioner must complete an initial diagnostic interview to validate the appropriateness of care. When a beneficiary 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 beneficiary's medical record. The pre-admission evaluation must include:

- (1) A clinical assessment of the health status and related psychological, medical, social, and educational needs of the beneficiary; and
- (2) A determination of the range and kind of services required.

026.02(B)(vii) 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. The program supervising practitioner must be responsible and accountable for all evaluations and treatment provided to the beneficiary. The treatment plan must be completed upon the beneficiary's admission to the program.

026.02(B)(xiii) TREATMENT PLAN REVIEW. At least every 30 days thereafter, a treatment plan review must be conducted by the multidisciplinary 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.

026.02(B)(ix) PERSONAL EVALUATION BY SUPERVISING PRACTITIONER. The supervising practitioner must personally evaluate the beneficiary 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.

026.02(B)(x) UTILIZATION REVIEW. Every 30 days a utilization review must be conducted in accordance with this chapter. This review must be documented on the treatment plan. Utilization review is not required for the calendar month in which the beneficiary was admitted.

026.02(B)(xi) DESCRIPTIONS OF TREATMENTS AND SERVICES. 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:

- (1) The program must have a description of how the family-centered requirement in this chapter will be met, including a complete description of any family assessment and family psychotherapy

services:

- (a) Providers must encourage family members to be involved in the assessment of the beneficiary, the development of the treatment plan, and all aspects of the beneficiary's treatment unless prohibited by the beneficiary, through legal action, or because of federal confidentiality laws;
 - (b) 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; and
 - (c) 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;
- (2)The program must have a description of how the community-based requirement in this chapter will be met;
- (3)The program must state the qualifications, education, and experience of each staff member and the therapy services each provides; and
- (4)The program must have a daily schedule covering the total number of hours the program operates per day. The schedule must be submitted to Nebraska Medicaid 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.

026.02(B)(xii) 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. If a beneficiary receives 24 or more hours of continuous outpatient care, that beneficiary is defined as an inpatient regardless of the hour of admission, whether they used a bed and whether they remained in the hospital past midnight or the census-taking hour, and all inpatient medical review prior-authorization requirements apply.

026.02(B)(xiii) INPATIENT SERVICES PLAN. 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 this chapter. A copy of this agreement must accompany the provider application and agreement.

026.03 PROVIDER AGREEMENT. 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 this chapter are met, and any other information requested by Nebraska Medicaid . Staff must meet the standards outlined in this chapter; and:

(A)Community mental health programs and licensed mental health clinics must complete the appropriate Nebraska Medicaid approved provider agreement form , and submit the completed form to Nebraska Medicaid for approval. 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 Nebraska Medicaid 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 Nebraska Medicaid by these satellites must be filed under the satellite's Nebraska Medicaid provider number. The facility must have in effect a utilization review plan applicable to all Nebraska Medicaid beneficiaries; and

(B)Hospitals must complete the appropriate Nebraska Medicaid approved provider agreement form and submit the completed form to Nebraska Medicaid for approval.

026.03(i) ANNUAL UPDATE. The program must update the provider agreement, program overview, and cost report annually and whenever requested by Nebraska Medicaid .

026.04 COVERAGE CRITERIA FOR DAY TREATMENT PSYCHIATRIC SERVICES. Nebraska Medicaid covers psychiatric day treatment services for beneficiaries age 21 and over when the services meet the requirements in this chapter.

026.04(A) OBSERVATION AND INTERVIEW. The beneficiary 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 beneficiary's medical record.

026.04(B) SERVICES NOT COVERED UNDER NEBRASKA MEDICAID. Payment is not available for psychiatric day treatment services for beneficiaries :-

(i)Receiving services in an out-of-state facility, except as outlined in this title ;

(ii)Living in long-term care facilities or institutes for mental disease (IMD);

(iii)Whose needs are social or educational and may be met through a less structured program;

(iv)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

- (v) Whose behavior may be very disruptive or harmful to other program participants or staff members.

026.05 DOCUMENTATION IN THE BENEFICIARY'S RECORD. All documents submitted to Nebraska Medicaid must contain sufficient information for identification . Each beneficiary's clinical record must contain the following documentation:

- (A) The supervising practitioner's orders;
- (B) The initial diagnostic interview and referral documented by the supervising practitioner;
- (C) The treatment plan;
- (D) The team progress notes, recorded chronologically. The frequency is determined by the beneficiary's condition, but the team's progress notes must be recorded at least weekly. The progress notes must contain a concise assessment of the beneficiary's progress and recommendations for revising the treatment plan, as indicated by the beneficiary's condition, and discharge planning;
- (E) Documentation indicating compliance with all requirements in this chapter;
- (F) The program's utilization review committee's abstract or summary; and
- (G) The discharge summary.

026.06 TRANSITION AND DISCHARGE PLANNING. Each provider must meet the requirements in this chapter for transition and discharge planning.

026.07 UTILIZATION REVIEW. Each program is responsible for establishing a utilization review plan and procedure which meets the following requirements. A site visit by Nebraska Medicaid for purposes of utilization review may be required for further clarification.

026.07(A) COMPONENTS OF UTILIZATION REVIEW. Utilization review must provide:

- (i) Timely review, at least every 30 days, of the medical necessity of admissions and continued treatment;
- (ii) Utilization of professional services provided;
- (iii) High quality patient care; and
- (iv) Effective and efficient utilization of available health facilities and services.

026.07(B) UTILIZATION REVIEW 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 Nebraska Medicaid provider. The overview must include:

- (i)The organization and composition of the utilization review committee which is responsible for the utilization review function;
- (ii)The frequency of meetings, which must occur at least once every 30 days ;
- (iii)The type of records to be kept; and
- (iv)The arrangement for committee reports and their dissemination, including how the supervising practitioner is informed of the findings.

026.07(C) UTILIZATION REVIEW COMMITTEE. The utilization review committee must consist of a supervising practitioner and at least two mental health practitioners as defined in this chapter. 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 Nebraska Medicaid's discretion, an alternative plan for facilities that do not have these resources readily available may be approved.

026.07(D) BASIS OF REVIEW. The review must be based on:

- (i)The identification of the individual beneficiary by appropriate means to ensure confidentiality;
- (ii)The identification of the supervising practitioner;
- (iii)The date of admission;
- (iv)The diagnosis and symptoms;
- (v)The supervising practitioner plan of treatment; and
- (vi)Other supporting materials the group may deem appropriate.

026.07(E) CONTENTS OF REPORT. A copy of the admission review and the extended stay review must be attached to all claims for psychiatric services submitted to Nebraska Medicaid for payment. In addition, the written report must contain:

- (i)An evaluation of treatment, progress, and prognosis based on:
 - (1)Appropriateness of the current level of care and treatment;
 - (2)Alternate levels of care and treatment available; and
 - (3)The effective and efficient utilization of services provided;
- (ii)Verification that:
 - (1)Treatment provided is documented in the beneficiary's record;

- (2) All entries in the beneficiary's record are signed by the person responsible for entry. The supervising practitioner must sign all orders; and
- (3) All entries in the beneficiary's record are dated;
- (iii) Recommendations for:
 - (1) Continued treatment;
 - (2) Alternate treatment or level of care; and
 - (3) Disapproval of continued treatment;
- (iv) The date of the review;
- (v) The names of the program utilization review committee members; and
- (vi) The date of the next review if continued treatment is recommended.

026.08 PAYMENT FOR PSYCHIATRIC DAY TREATMENT SERVICES. Payment for psychiatric day treatment services will be based upon rate setting by Nebraska Medicaid .

026.08(A) PAYMENT RATES. Payment rates for psychiatric day treatment services for beneficiaries 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.

026.08(B) COST REPORTS. 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.

026.08(C) COST AND STATISTICAL DATA REQUIREMENTS. Providers must submit cost and statistical data on the appropriate Nebraska Medicaid approved cost reporting document . The provider must submit one original Nebraska Medicaid approved cost reporting document to Nebraska Medicaid 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 Nebraska Medicaid for verification. If the provider fails to file a cost report as due, Nebraska Medicaid will suspend payment. At the time the

suspension is imposed, Nebraska Medicaid will send a letter informing the provider that no further payment will be made until a proper cost report is filed.

026.08(D) COSTS CONSIDERED. In setting payment rates, Nebraska Medicaid will consider those costs which are reasonable and necessary for the active treatment of the beneficiaries 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.

026.08(E) NOT ALL COSTS REIMBURSED. Nebraska Medicaid does not guarantee that all costs will be reimbursed. The cost reporting document is used by Nebraska Medicaid only as a guide in the rate setting process. Actual costs incurred by the providers may not be entirely reimbursed.

026.08(F) PAYMENT RATES FOR PSYCHIATRIC DAY TREATMENT SERVICES PROVIDED BY THE STATE. 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.

026.08(G) UNALLOWABLE COSTS. The following costs are not allowable:

- (i)Provisions for income tax;
- (ii)Fees paid board of directors;
- (iii)Non-working officers' salaries;
- (iv)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;
- (v)Travel and entertainment, other than for professional meetings and direct operations of the day treatment program ;
- (vi)Donations;
- (vii)Expenses of non-related facilities and operations included in expense;
- (viii)Insurance and annuity premiums on the life of officer or owner;
- (ix)Bad debts, charity, and courtesy allowances;
- (x)Cost and portions of costs which are determined by Nebraska Medicaid not to be reasonably related to the efficient production of service because of either the nature or amount of the particular expenditure;
- (xi)Education costs;

- (xii) Services provided by the beneficiaries' 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;
- (xiii) Return on equity;
- (xiv) Costs for services which occurred in a prior or subsequent fiscal year ;
- (xv) Expenses for equipment, facilities, and programs provided to beneficiaries which are determined by Nebraska Medicaid not to be reasonably related to the efficient production of service because of either the nature or amount of the particular service;
- (xvi) Costs of amusements, social activities, and related expenses for employees and governing body members , except when part of an authorized beneficiary treatment program;
- (xvii) Costs of alcoholic beverages ;
- (xviii) Costs resulting from violations of, or failure to comply with federal, state, and local laws and regulations ;
- (xix) Costs relating to lobbying or attempts to influence or promote legislative action by local, state, or federal government ; and
- (xx) Costs of lawsuits or other legal or court proceedings against Nebraska Medicaid , or its employees, or State of Nebraska .

026.08(H) SUSPENSION OR TERMINATION OF LICENSE. Nebraska Medicaid 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. Nebraska Medicaid does not make payment for care provided to beneficiaries who were admitted after the date of expiration or termination of the provider's license or certificate to operate under Title XIX.

026.08(I) 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.

026.08(J) ADMINISTRATIVE FINALITY. An administrative decision or inaction in the allowable cost determination process, which is otherwise final, may be reopened by Nebraska Medicaid within three years of the date of notice of the decision or inaction.

026.08(K) REOPENING. Reopening is an action taken by the Medicaid and Long-Term Care Director to re-examine or question the correctness of a determination or decision which is otherwise final. The Director of Medicaid and Long-Term Care is the sole authority for deciding whether to reopen an administrative decision or inaction. The action may be taken:

(i) On the initiative of Nebraska Medicaid within the three-year period;

(ii) In response to a written request of a provider or other entity within the three-year period. Whether the Director of Medicaid and Long-Term Care 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, or general instructions; or

(iii) Any time fraud or abuse is suspected.

025.08(K)(1) NO APPEAL RIGHT. A provider has no right to appeal a finding by the Director of Medicaid and Long-Term Care that a reopening or correction of a determination or decision is not warranted.

026.09 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.

026.10 BILLING REQUIREMENTS. For day treatment services, the following requirements must be met:

- (A) Providers of non-hospital based day treatment services must submit claims for day treatment services on the appropriate Nebraska Medicaid approved health care claim form or electronic claim. Payment for approved day treatment services is made to the facility; and
- (B) Providers of hospital-based day treatment services must submit claims for services on the appropriate Nebraska Medicaid approved health care claim form or electronic claim. Payment for approved hospital based day treatment services is made to the hospital.

026.10(i) DOCUMENTATION FOR CLAIMS. The following documentation, kept in the beneficiary'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.

026.10(i)(a) UTILIZATION REVIEW. All claims are subject to utilization review by Nebraska Medicaid prior to payment.

026.10(ii) EXCEPTION. Additional documentation from the beneficiary's medical record may be requested by Nebraska Medicaid prior to considering authorization of payment. Progress notes for other Nebraska Medicaid beneficiaries may be requested when the treatment report does

not adequately explain family psychotherapy or medical necessity cannot be determined.

026.11 PROCEDURE CODES AND DESCRIPTIONS FOR PSYCHIATRIC DAY TREATMENT. Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) procedure codes used by Nebraska Medicaid are listed in the Nebraska Medicaid Practitioner Fee Schedule .

026.12 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 beneficiary's overall treatment plan, and in compliance with Nebraska Medicaid requirements:

- (A) Direct beneficiary services performed by the supervising practitioner;
- (B) Prescription medications including injectable medications;
- (C) Direct beneficiary services performed by a physician or advanced practice registered nurse (APRN) other than the supervising practitioner; and
- (D) Treatment services for a physical injury or illness provided by other professionals.

026.12(i) SECOND MANAGED CARE VENDOR. If the beneficiary is enrolled with another managed care vendor for medical-surgical services, it may be necessary to pursue prior authorization or referral with that entity.

027. ADULT SUBACUTE INPATIENT HOSPITAL PSYCHIATRIC SERVICES.

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 Nebraska Medicaid provider . Subacute inpatient hospital psychiatric services must be prior-authorized by Nebraska Medicaid contracted peer review organization or management designee. In addition, out-of-state subacute hospitalizations must be approved by Nebraska Medicaid .

027.01 PROVIDER AGREEMENT. A hospital that provides subacute inpatient psychiatric services must complete the appropriate Nebraska Medicaid approved provider agreement form and submit the completed form to Nebraska Medicaid for approval and enrollment as a Nebraska Medicaid provider of subacute inpatient hospital psychiatric services. The hospital must submit with the provider agreement:

- (A) A complete description of the psychiatric program and the elements of the program ;
- (B) 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;

- (C) Documentation that the subacute inpatient program meets the family-centered, community-based requirements in this chapter;
- (D) A description of how beneficiary, group, and family psychotherapy services as well as other psycho-educational and rehabilitation services will be provided;
- (E) A description of how the subacute inpatient hospital psychiatric services will interface with community services for discharge planning and service provision after discharge;
- (F) A copy of the most recent Joint Commission) or the American Osteopathic Association (AOA) accreditation survey; and
- (G) Any other information requested.

027.01(i) ON-SITE REVIEW. Any facility requesting a provider agreement must make the facility available for an on-site review before issuance of a provider agreement.

027.02 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:

- (A) Is maintained for the care and treatment of beneficiaries 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 or by the American Osteopathic Association (AOA);
- (D) Meets the requirements for participation in Medicare for psychiatric hospitals;
- (E) Has in effect a utilization review plan applicable to all Nebraska Medicaid beneficiaries ;
- (F) Must have medical records that are sufficient to permit Nebraska Medicaid to determine the degree and intensity of treatment furnished to the beneficiary;
- (G) Must meet staffing requirements Nebraska Medicaid finds necessary to carry out an active treatment program as described in this chapter;
- (H) Must encourage the beneficiary and family members to be involved in the assessment of the beneficiary, the development of the treatment plan, and all aspects of the beneficiary's treatment unless prohibited by the beneficiary, through legal action, or because of federal confidentiality laws;

- (I) Must be available to schedule meetings and sessions in a flexible manner to accommodate and work with a family, guardian, or caretaker schedule. This includes the ability to schedule sessions at a variety of times including weekends or evenings; and
- (J) Must document their attempts to involve the beneficiary and the family in treatment plan development and treatment plan reviews. A variety of communication means should be considered to involve family. .

027.03 STANDARDS FOR PARTICIPATION FOR SUBACUTE INPATIENT HOSPITAL PSYCHIATRIC SERVICE PROVIDERS. Subacute inpatient psychiatric hospital must have staff adequate in number and qualified to carry out a subacute psychiatric program for treatment for beneficiaries who are in need of further psychiatric stabilization, treatment, rehabilitation, and recovery activities. The hospital must meet the following standards.

027.03(A) 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 beneficiary and family needs; establishment of beneficiary 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:

- (i) Qualified professional psychiatric staff must be available to evaluate each beneficiary 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 (RN);
 - (3) Substance use disorder assessment and development of a substance use disorder addendum 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, physician assistant (PA), or advanced practice registered nurse (APRN);
- (ii) 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 , appropriate nursing interventions and structured milieu therapy. Available services must include beneficiary, group, and family therapy, group living experiences, occupational and recreational therapy and other prescribed activities to maintain or increase the beneficiary's capacity to manage their psychiatric condition and activities of daily living. A minimum of 42 structured, scheduled, and documented treatment hours are required per week; and
- (2) The program must provide environmental and physical limitations required to protect the beneficiary's health and safety with a plan to develop the beneficiary's potential for return to their home, supervised adult living, or skilled nursing facility (NF). 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 beneficiary.

027.03(B) MEDICAL DIRECTOR OF SUBACUTE INPATIENT SERVICES. Subacute inpatient psychiatric services must be under the supervision of a psychiatrist who is identified as the 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 beneficiary depending on the size of the program. The following standards must be met:

- (i)The medical director and any attending psychiatrists must meet the training and experience requirements for a psychiatrist licensed to practice in the state where services are provided;
- (ii)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 beneficiary and the treatment program;
- (iii)The psychiatrist's personal involvement in all aspects of the beneficiary's psychiatric care must be documented in the beneficiary's medical record, consisting of the physician's orders, the progress notes, and the nurse's notes; and
- (iv)The medical director or attending psychiatrist must be available, in person or by telephone, to provide assistance and direction to the treatment team as needed.

027.03(C) AVAILABILITY OF PHYSICIANS AND OTHER MEDICAL CONSULTATION. Physicians and other appropriate professional consultants 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.

027.04 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 beneficiaries being served. The following positions and services are required.

027.04(A) PROGRAM AND CLINICAL DIRECTOR. Must be a fully licensed clinician who is skilled and knowledgeable to provide leadership and clinical direction to the treatment team. The duties and responsibilities of a program or clinical director are:

- (i)Oversee, implement, and coordinate all treatment services and activities provided within the program 24 hours a day;
- (ii)Incorporate new clinical information and best practices into the program to assure effectiveness, viability and safety;
- (iii)Oversee the process to identify, respond to and report crisis situations on a 24-hour per day, seven day per week basis;
- (iv)Be responsible, in conjunction with the medical director or 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;
- (v)Communicate with the attending psychiatrist regarding individual treatment needs of the beneficiary;
- (vi)Assure quality organization and management of clinical record documentation and confidentiality; and
- (vii)Oversee and be responsible for the safety of beneficiaries and staff.

027.04(B) 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 beneficiary. The following standards must be met:

- (i)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 beneficiary 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 beneficiary's treatment plan;
- (ii)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;
- (iii)The number of registered professional nurses must be adequate to formulate a nursing care plan in writing for each beneficiary and to ensure that the plan is carried out; and
- (iv)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 beneficiaries. 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.

027.04(C) 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:

- (i)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 ; and
 - (4) Interdisciplinary conferences and meetings held to establish diagnoses, goals, and treatment programs; and
- (ii)Psychological testing must be ordered and directed by a psychiatrist.

027.04(D) 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 beneficiary. Licensed clinicians may include psychologists (Psy.D.), licensed independent mental health practitioners (LIMHP), licensed mental health practitioners (LMHP), licensed alcohol and drug counselors (LADC), and advanced practice registered nurses (APRN). Individual, group, and family psychotherapy must be available to each beneficiary and provided according to the beneficiary's individual treatment

plan. Services must be able to meet the unique needs of each beneficiary. Minimum requirements for psychotherapy offered and available to the beneficiary are:

- (i) Individual therapy minimum two times weekly;
- (ii) Group therapy minimum three times weekly; and
- (iii) Family therapy and intervention as appropriate and consented to by the beneficiary. With consent of the beneficiary, family therapy must be provided at the frequency and intensity to meet the unique needs of beneficiary and the family.

027.04(E) LICENSED ADDICTION AND DRUG ABUSE SERVICES.

Substance use disorder assessment, development of a substance use disorder addendum as needed, and treatment must be available to beneficiaries 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, develop a substance use disorder addendum, and provide treatment of substance use disorder problems must provide services according to and within their scope of practice. Usually, services are provided by a licensed alcohol and drug counselor (LADC).

027.04(F) PSYCHOEDUCATIONAL SERVICES. Psychoeducational services must be offered in the program, and providers must have psychoeducational services available to beneficiaries 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 (RN). Other psychoeducational services may be provided by a paraprofessional whose education and training provides competency to provide the service.

027.04(G) CASE MANAGEMENT SERVICES AND SOCIAL SERVICES STAFF. Case Management and social services staff must be under the supervision of the program or clinical director. The case management and social service staff must be adequate in numbers and be qualified to fulfill responsibilities related to the specific needs of individual beneficiaries and their families.

The role and responsibility of case management and social services staff is to:

- (i) Assist the beneficiary with accessing community resources and services;
- (ii) Consult with other staff and community agencies to coordinate beneficiary care;
- (iii) Assist the beneficiary with accessing alternative services and maintaining a safe living environment according to the treatment plan; and

- (iv) Perform daily case management services and maintain a summary of services in the beneficiary's clinical record.

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027.04(H) ANCILLARY SERVICES. Recreational or activity therapy services must be available and offered to the beneficiary daily and directly supervised by the program or clinical director who has supervisory responsibility to the entire treatment team and the services they provide.

027.04(I) 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:

- (i) Intervene in the treatment milieu;
- (ii) Provide treatment interventions to the beneficiary which meet the specific psychiatric needs of the beneficiary as identified in the treatment plan;
- (iii) Demonstrate competency in applying the learned treatment interventions; and
- (iv) Have direct knowledge of policies and procedures of the agency.

027.04(I)(1) PSYCHIATRIC TECHNICIANS. Psychiatric technicians must have completed the program's initial training program and continued ongoing training requirements. 75 percent of the psychiatric technician staff must have completed a Bachelor of Science (BS) or Bachelor of Arts (BA) degree in the human services field or have five years' experience providing health care services.

027.05 COVERAGE CRITERIA FOR SUBACUTE INPATIENT PSYCHIATRIC HOSPITAL SERVICES. Nebraska Medicaid covers subacute inpatient hospital psychiatric services for beneficiaries age 21 and over when the services meet the criteria in this chapter and when the following requirements are met:

- (A) The attending psychiatrist must personally and face-to-face evaluate the beneficiary and document the psychiatric evaluation and diagnosis formulation within 24 hours of admission;
- (B) The attending psychiatrist assumes accountability to direct the care of the beneficiary at the time of admission;
- (C) The beneficiary 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 beneficiary's clinical record;
- (D) The attending psychiatrist describes the medical necessity and active treatment requirements for the beneficiary;

(E)The attending psychiatrist provides certification and recertification of the beneficiary's need for subacute inpatient psychiatric services; and

(F)Clinical supervision of the multi-disciplinary treatment team and treatment team planning meetings as necessary to meet the individualized treatment needs of the beneficiary.

027.06 TREATMENT PLANNING. An initial treatment plan must be implemented upon admission. The master or comprehensive treatment plan must be developed within 72 hours and reviewed by the treatment team a minimum of three times weekly. The master or comprehensive treatment plan must be developed from the recommendations made by the attending psychiatrist who has provided evaluation of the beneficiary and the input from all other assessments completed following admission to subacute inpatient treatment services. Comprehensive treatment plans must meet medical necessity requirements.

027.06(A) DISCHARGE PLANNING. Discharge planning must be a part of the comprehensive treatment plan. Discharge planning must be specific, realistic and individualized for the beneficiary from the time of admission and revised as medically necessary with treatment planning reviews.

027.07 CRITERIA FOR SUBACUTE INPATIENT PSYCHIATRIC HOSPITAL SERVICES. One or more of the following criteria must be present:

(A)The beneficiary can benefit from longer-term evaluation, stabilization, and treatment services;

(B)The beneficiary is at moderate to high risk to harm self or others;

(C)The beneficiary has active symptomatology ;

(D)The beneficiary has the ability to respond to intensive structured intervention services;

(E)The beneficiary is at moderate to high risk of relapse or symptom reoccurrence;

(F)The beneficiary has high need of professional structure and intervention services; or

(G)The beneficiary can be treated with short term intensive intervention services.

027.08 PRIOR AUTHORIZATION. All subacute inpatient psychiatric admissions must be prior-authorized by Nebraska Medicaid's contracted peer review organization or management designee. If the admission is approved, the Nebraska Medicaid's contracted peer review organization or management designee must assign a specific prior-authorization number. Providers must follow the Nebraska Medicaid's contracted peer review

organization or management designee requirements 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 Nebraska Medicaid's contracted peer review organization or management designee.

027.09 DOCUMENTATION IN THE BENEFICIARY'S CLINICAL RECORD. The medical records maintained by a hospital permit determination of the degree and intensity of the treatment provided to beneficiaries 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 beneficiary is hospitalized. The clinical record must include:

- (A)The identification data, including the beneficiary's name, date of service, provider's name, and beneficiary's legal status, whether the admission is voluntary , by the Board of Mental Health , or court mandated;
- (B)A provisional or admitting diagnosis which is made on every beneficiary at the time of admission and includes the diagnoses of intercurrent diseases as well as the psychiatric diagnoses;
- (C)The complaint of others regarding the beneficiary, as well as the beneficiary's comments;
- (D)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 beneficiary's strengths in a descriptive, not interpretative, fashion;
- (E)A complete neurological examination, when indicated, recorded at the time of the admitting physical examination;
- (F)Reports of consultations, psychological evaluations, electroencephalograms, dental records, and special studies;
- (G)The beneficiary's treatment plan and treatment plan reviews;
- (H)The treatment received by the beneficiary, which is documented in a manner and with a frequency to ensure that all active therapeutic efforts are included;
- (I)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 beneficiary, 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 beneficiary's progress and recommendations for revising the treatment plan as indicated by the beneficiary's condition;
- (J)The psychiatric diagnosis contained in the final diagnosis

(K)Transition and discharge planning documentation including relapse and crisis prevention planning;

(L)Proof of family and community involvement; and

(M)The discharge summary, including a recapitulation of the beneficiary's hospitalization, recommendations for appropriate services concerning follow-up, and a brief summary of the beneficiary's condition on discharge.

027.10 CERTIFICATION AND RECERTIFICATION BY PSYCHIATRISTS FOR SUBACUTE INPATIENT HOSPITAL PSYCHIATRIC SERVICES. Nebraska Medicaid 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 beneficiary's condition.

027.10(A) CERTIFICATION OR WRITTEN ORDER REQUIRED. For beneficiaries admitted to a subacute program, a psychiatrist's certification by written order for admission is required at the time of admission.

027.10(B) FAILURE TO CERTIFY. If a hospital fails to obtain the required certification and recertification statements for the beneficiary's stay, Nebraska Medicaid will not make payment for the services that are not certified.

027.11 HOSPITAL UTILIZATION REVIEW. A site visit by Nebraska Medicaid staff for purposes of utilization review may be required for further clarification.

027.12 BILLING. Providers must submit claims for subacute inpatient hospital psychiatric services on the appropriate Nebraska Medicaid approved health care claim form. Providers must enter the prior authorization number as required for subacute inpatient services.

027.13 LIMITATIONS. For subacute inpatient hospital psychiatric services, the following limitations apply:

(A)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;

(B)All subacute inpatient hospital psychiatric services must be prior-authorized; and

(C)Payment for subacute inpatient hospital services is made according to this title .

027.14 DOCUMENTATION. Additional documentation from the beneficiary's medical record may be requested by Nebraska Medicaid prior to considering authorization of payment of subacute inpatient psychiatric care.

027.15 EMERGENCY PROTECTIVE CUSTODY (EPC). A hospital may be reimbursed for beneficiaries under an emergency protective custody (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:

- (A)The hospital is licensed by the Nebraska Department of Health and Human Services Division of Public Health;
- (B)The hospital is accredited by the Joint Commission
or the American Osteopathic Association (AOA);
- (C)The admitting and attending physician is a psychiatrist;
- (D)The hospital provides a setting that is separate from the rest of the hospital activities and is a safe, therapeutic environment;
- (E)The hospital provides an active treatment program in the form of assessment and diagnostic interventions;
- (F)The hospital emergency protective custody (EPC) program is approved by Nebraska Medicaid ; and
- (G)The hospital emergency protective custody (EPC) program meets all other standards for inpatient hospital psychiatric care.

028. ADULT INPATIENT HOSPITAL PSYCHIATRIC SERVICES. The care and treatment of an inpatient with a primary psychiatric diagnosis who is receiving inpatient care must be under the direction of a psychiatrist or physician who meets the State's licensing criteria and is enrolled as a provider with Nebraska Medicaid 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 Nebraska Medicaid.

028.01 PROVIDER AGREEMENT. A hospital which provides inpatient psychiatric services must complete the appropriate Nebraska Medicaid approved provider agreement form and submit the completed form to Nebraska Medicaid for approval and enrollment as a provider. The hospital must submit with the provider agreement:

- (A)A complete description of the psychiatric program and the elements of the program ;
- (B)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;

- (C) Documentation that the inpatient program meets the family-centered, community-based requirements in this chapter;
- (D) A description of how family psychotherapy services will be provided;
- (E) A description of how the hospital services will interface with community services for discharge planning and service provision after discharge;
- (F) A copy of the most recent Joint Commission or American Osteopathic Association (AOA) accreditation survey; and
- (G) Any other information requested.

028.01(i) ON-SITE REVIEW. Any facility requesting a provider agreement must make the facility available for an on-site review before issuance of a provider agreement.

028.01(ii) 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 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 Nebraska Medicaid beneficiaries;
- (6) Must have medical records that are sufficient to permit Nebraska Medicaid to determine the degree and intensity of treatment furnished to the client; and
- (7) Must meet staffing requirements Nebraska Medicaid finds necessary to carry out an active treatment program in compliance with this chapter.

028.01(iii) DISTINCT PART OF A HOSPITAL AS A PSYCHIATRIC UNIT. 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.

028.01(iv) STAFFING STANDARDS FOR PARTICIPATION. The hospital must have staff adequate in number and qualified to carry out an active program of treatment for beneficiaries who are provided services in the hospital. The hospital must meet the following standards.

028.01(iv)(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 beneficiary and their family. The following standards must be met:

- (a) Qualified professional and technical personnel must be available to evaluate each beneficiary at the time of admission, including diagnosis of any intercurrent disease. Services necessary for the evaluation include:
 - (i) Laboratory, radiological, and other diagnostic tests;
 - (ii) Obtaining psychosocial data;
 - (iii) A complete family assessment in compliance with the requirements in this chapter;
 - (iv) Carrying out psychiatric and psychological evaluations; and
 - (v) 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 beneficiary based on scientific interpretation of:
 - (i) The degree of physical disability and indicated remedial or restorative measures, including nutrition, nursing, physical medicine, and pharmacological therapeutic interventions;
 - (ii) The degree of psychological impairment and appropriate measures to be taken to relieve treatable distress and to compensate for nonreversible impairments where found;
 - (iii) 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 beneficiary's capacity to manage activities of daily living; and

- (iv)The environmental and physical limitations required to protect the beneficiary's health and safety with a plan to compensate for these deficiencies and to develop the beneficiary's potential for return to their own home, a foster home, a skilled nursing facility (NF), a community mental health center, or other alternatives to full-time hospitalization.

028.01(iv)(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 Nebraska Medicaid ;
- (b)The medical staff must be qualified legally, professionally, and ethically for the positions to which they are appointed;
- (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 beneficiary's psychiatric care must be documented in the beneficiary's medical record ; and
- (e)The physician must be available, in person or by telephone, to provide assistance and direction as needed.

028.01(iv)(3) AVAILABILITY OF PHYSICIANS AND OTHER PERSONNEL. Physicians, advanced practice registered nurses (APRN), 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 beneficiaries to a general hospital certified for Medicare.

028.01(iv)(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 (LPN), and other nursing personnel must be adequate to formulate and carry out the nursing components of a treatment plan for each beneficiary. 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:

- (i) Participate in interdisciplinary formulation of treatment plans;
 - (ii) Give skilled nursing care and therapy; and
 - (iii) Direct, supervise, and train others who assist in implementing and carrying out the nursing components of each beneficiary's treatment plan;
- (b) The staffing pattern must ensure the availability of a registered professional nurse 24 hours each day for:
- (i) Direct care;
 - (ii) Supervising care performed by other nursing personnel; and
 - (iii) Assigning nursing care activities not requiring the services of a professional nurse to other nursing service personnel according to the beneficiary'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 beneficiary 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 beneficiaries. The meetings include diagnostic conferences, treatment planning sessions, and meetings held to consider alternative facilities and community resources.

028.01(iv)(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:
 - (i) Program development and evaluation of program effectiveness;
 - (ii) Training and research activities;
 - (iii) Therapeutic interventions ; and

(iv) Interdisciplinary conferences and meetings held to establish diagnoses, goals, and treatment programs; or

(c) Psychotherapy must be ordered and directed by a physician or advanced practice registered nurse (APRN) .

028.01(iv)(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 beneficiaries 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 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:

(i) Provide psychosocial data for diagnosis and treatment planning, and for direct therapeutic services to beneficiaries, 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;

(c) Qualified therapists, consultants, volunteers, assistants, or aides must be sufficient in number to provide comprehensive therapeutic activities, including occupational, recreational, and physical therapy (PT), as needed, to ensure that appropriate treatment is provided to each beneficiary, and to establish and maintain a therapeutic milieu. The following standards must be met:

(i) Occupational therapy (OT) services must be provided preferably under the supervision of a graduate of an occupational therapy (OT) 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 (OT), an occupational therapy assistant (OTA) may function as the director of the activities program with consultation from a fully-qualified occupational therapist (OT);

- (ii) When physical therapy (PT) services are offered, the services must be given by or under the supervision of a qualified physical therapist (PT) who is a graduate of a physical therapy (PT) 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 (PT), physical therapy (PT) 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 (PT);
- (iii) Educational program services, when required by law, must be available. Educational program services must only be one aspect of the treatment plan, not the primary reason for admission or treatment. Educational program services are not covered for payment by Nebraska Medicaid ;
- (iv) 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;
- (v) Other occupational therapy (OT), recreational therapy, activity therapy, physical therapy assistants (PTA), or aides must be directly responsible to qualified supervisors and must be provided special on-the-job training to fulfill assigned functions;
- (vi) 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 beneficiaries; and
- (vii) 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 beneficiaries and their families in support of therapeutic activities.

028.02 COVERAGE CRITERIA FOR INPATIENT HOSPITAL SERVICES. Nebraska Medicaid covers inpatient hospital psychiatric services for beneficiaries age 21 and over when the services meet the criteria in this chapter and when the following requirements are met:

- (A) The attending physician must personally and face-to-face evaluate the beneficiary and write the psychiatric evaluation and diagnosis formulation;
- (B) The beneficiary must be treated by a physician or advanced practice registered nurse (APRN) personally and face-to-face at least six out of seven days and the interaction must be documented in the beneficiary's clinical record;
- (C) A psychiatrist or physician for Nebraska Medicaid serves as the attending physician and defines the medical necessity and active treatment requirements noted in this chapter's General Requirements; and
- (D) 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 this chapter.

028.03 ADMISSION CRITERIA FOR INPATIENT HOSPITAL PSYCHIATRIC SERVICES. One or more of the following problems must be present:

- (A) The beneficiary 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 beneficiary's treatment;
- (B) Specific observations are needed for evaluation and disposition;
- (C) Specific observations are needed for following treatment, or control of behavior is necessary for effective somatic therapy or psychotherapy;
- (D) The beneficiary's disorder is a serious threat to their adaptation to life and continuing developmental process, and hospitalization at this time is necessary to control this factor;
- (E) The beneficiary is experiencing psychiatric symptoms, the magnitude of which is not tolerable to self or society and that cannot be alleviated through treatment;
- (F) The beneficiary is unable to be cared for by self or others, due to psychiatric disorder;
- (G) All beneficiaries must require and receive active treatment as defined in federal regulations, which is available only in an inpatient setting, except that beneficiaries that are age 65 and older in an institution for mental

disease (IMD) pursuant to this chapter); or

- (H) Ambulatory care services in the community do not meet the treatment needs of the beneficiary. In those communities where outpatient resources are not available, the community pattern of referral must be used when appropriate.

028.03(i) GUIDELINES FOR INTERPRETATION. Admission of a beneficiary 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 Nebraska 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 learning disabilities.

028.03(ii) BENEFICIARY ASSESSMENT. Admission to an acute care facility must meet the first two elements listed below plus at least one other element from this beneficiary assessment section. The additional element must be as a result of the major psychiatric disorder referred to in the first element below. In addition, one element from the acute services section must be met. Elements 1 and 2 must be met on all admissions, plus one of the elements from 3 to 7:

- (1) Documented evidence of a major psychiatric disorder that necessitates 24-hour medical supervision and daily physician or advanced practice registered nurse (APRN) contact; and
- (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 beneficiary's safety; and

- (d) Discharge plan initiated at the time of admission.
- (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 or 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 beneficiary at significant risk ;
 - (d) Severe impairment in concentration or hyperactivity; or
 - (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; or
 - (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; or
 - (d) Lack of beneficiary participation in or response to outpatient treatment modalities; or
- (7) Admissions ordered by the court will be covered when accompanied by substantiation of medical necessity.

028.03(iii) DOCUMENTATION SUPPORT. Documentation supports the need for controlled, clinical observation and psychiatric evaluation, where acute care is the least restrictive treatment alternative.

028.03(iv) JUSTIFICATION FOR CONTINUED STAY. The beneficiary must meet the first two elements listed below plus two additional elements for the approval of continued stay. Elements 1 and 2 must be met on all admissions, plus one of the elements from 3 to 7.

- (1) Evidence of a major psychiatric disorder that necessitates 24-hour medical supervision and physician or advanced practice registered nurse (APRN) contact; and
- (2) A comprehensive treatment plan and clinical pathway of inpatient care must be completed within 72 hours of admission and implemented to facilitate the beneficiary's progression toward living in a less supervised setting. Documentation must support the beneficiary's and family's active involvement with the treatment goals and with revisions in the treatment plan as appropriate based on the beneficiary's progress or lack of progress.
- (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 behaviors reflecting significant risk, imminent danger, or actual demonstrated danger to self or others; requiring one-to-one suicide or homicide precautions, close observation, step down precautions including checks every 15-60-minute;
- (5) Monitoring or 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;
- (6) Persistence of psychotic symptoms and continued temporary inability of the beneficiary 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 beneficiary; or
- (7) Continued need for 24-hour medical supervision, reevaluation or diagnosis of a beneficiary exhibiting behaviors consistent with acute psychiatric disorder. Referral for physician or advanced practice registered nurse (APRN) review is necessary if symptoms are unimproved or worse within any seven-day interval.

028.03(v) 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 beneficiary is not able to communicate or perform life-sustaining activities of daily living;
- (3) Delusions or hallucinations that significantly impair the beneficiary'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 beneficiary 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.

028.04 PRIOR AUTHORIZATION PROCEDURES. All inpatient admissions must be prior-authorized by the Nebraska Medicaid's contracted peer review organization or management designee. Each beneficiary will have a specific prior-authorization number assigned by the Nebraska Medicaid's contracted peer review organization or management designee if the admission is approved. Providers should follow the Nebraska Medicaid's contracted peer review organization or management designee requirements on facilitating prior authorization.

028.05 DOCUMENTATION IN THE BENEFICIARY'S CLINICAL RECORD. The medical records maintained by a hospital permit determination of the degree and intensity of the treatment provided to beneficiaries 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 beneficiary is hospitalized. All documents from the beneficiary's medical record submitted to Nebraska Medicaid must contain sufficient information for identification. The medical record must include:

- (A) The identification data, including the beneficiary's legal status and whether the admission is voluntary a Mental Health Board commitment, or court mandated;
- (B) A provisional or admitting diagnosis which is made on every beneficiary at the time of admission and includes the diagnoses of intercurrent diseases as well as the psychiatric diagnoses;
- (C) The complaint of others regarding the beneficiary, as well as the beneficiary's comments;
- (D) 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 beneficiary's strengths in a descriptive, not interpretative, fashion;

- (E) A complete neurological examination, when indicated, recorded at the time of the admitting physical examination;
- (F) A social history sufficient to provide data on the beneficiary's relevant past history, present situation, social support system, community resource contacts, and other information relevant to good treatment and discharge planning;
- (G) A family assessment as described in this chapter;
- (H) Reports of consultations, psychological evaluations, electroencephalograms, dental records, and special studies;
- (I) The beneficiary's treatment plan and treatment plan reviews;
- (J) The treatment received by the beneficiary, which is documented in a manner and with a frequency to ensure that all active therapeutic efforts are included;
- (K) 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 beneficiary, but progress notes must be recorded daily by nursing staff, and at each contact by psychiatrist or physician and by all other therapeutic staff. Progress notes must contain a concise assessment of the beneficiary's progress and recommendations for revising the treatment plan as indicated by the beneficiary's condition;
- (L) The psychiatric diagnosis contained in the final diagnosis ;
- (M) Transition and discharge planning documentation;
- (N) Proof of family and community involvement;
- (O) A copy of the appropriate Nebraska Medicaid approved confidential report certification; and
- (P) The discharge summary, including a recapitulation of the beneficiary's hospitalization, recommendations for appropriate services concerning follow-up, and a brief summary of the beneficiary's condition on discharge.

028.06 CERTIFICATION AND RECERTIFICATION BY PSYCHIATRISTS. Nebraska Medicaid 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 beneficiary's condition. For beneficiaries 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.

028.06(A) FAILURE TO CERTIFY OR RECERTIFY. If a hospital fails to obtain the required certification and recertification statements in an individual case, Nebraska Medicaid must not make payment for the case.

028.07 HOSPITAL UTILIZATION REVIEW (UR). . A site visit by Nebraska Medicaid for purposes of utilization review (UR) may be required for further clarification.

028.08 BILLING. Providers must submit claims for inpatient hospital psychiatric services on the appropriate Nebraska Medicaid approved health care claim form or electronic claim.

028.09 OTHER REGULATIONS. For inpatient services provided by an institution for mental disease (IMD), public or private, see the requirements in this chapter, inpatient hospital services for beneficiaries age 65 and over in institutions for mental disease (IMD's).

028.10 LIMITATIONS. For inpatient hospital psychiatric services, the following limitations apply:

(A) Care must be supervised by a psychiatrist or physician. All inpatient hospital services must be prior-authorized; and

(B) Payment for inpatient hospital services is made according to this title .

028.11 FORM COMPLETION. Inpatient hospital psychiatric service providers must enter the review number from Nebraska Medicaid contracted peer review organization or management designee as required. Payment for approved services is made to the hospital.

028.12 EXCEPTIONS. Additional documentation from the beneficiary's medical record may be requested by Nebraska Medicaid's psychiatric consultants prior to considering authorization of payment.

028.13 EMERGENCY PROTECTIVE CUSTODY (EPC) SERVICES 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:

- (A)The hospital is licensed by the Nebraska Department of Health and Human Services, Division of Public Health;
- (B)The hospital is accredited by the Joint Commission or the American Osteopathic Association (AOA);
- (C)The admitting and attending physician is a psychiatrist;
- (D)The hospital provides a setting that is separate from the rest of the hospital activities and is a safe, therapeutic environment;
- (E)The hospital provides an active treatment program in the form of assessment and diagnostic interventions;
- (F)The hospital emergency protective custody (EPC) services is approved by Nebraska Medicaid ; and
- (G)The hospital emergency protective custody (EPC) services meets all other standards for inpatient hospital psychiatric care.

028.13(i) EMERGENCY PROTECTIVE CUSTODY (EPC) SERVICES LIMITATION.
The exception for emergency protective custody (EPC) services is available only to hospitals that do not have licensed psychiatric beds.

029. INPATIENT HOSPITAL SERVICES FOR BENEFICIARIES AGE 65 AND OVER IN INSTITUTIONS FOR MENTAL DISEASE (IMD).

029.01 LEGAL BASIS. Nebraska Medicaid covers institution for mental disease (IMD) services, for beneficiaries age 65 and over according to federal regulations Nebraska Medicaid provides institution for mental disease (IMD) services according to Nebraska statutes.

029.02 STANDARDS FOR PARTICIPATION. To participate in Nebraska Medicaid , the institution for mental disease (IMD) must:

- (A)Be in conformity with all applicable federal, state, and local laws;
- (B)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 institution for mental disease (IMD) is located;
- (C)Be certified as meeting the conditions of participation for hospitals in federal regulations ;
- (D)Be accredited by the Joint Commission or the American Osteopathic Association (AOA), and submit a copy of the most recent accreditation survey with the appropriate Nebraska Medicaid approved provider agreement form ;
- (E)Meet the definition of an institution for mental disease (IMD) as stated in this chapter;

(F)Meet the current Joint Commission or American Osteopathic Association (AOA) standards of care; and

(G)Meet all requirements in this chapter except active treatment.

029.02(i) PROVIDER AGREEMENT. The provider must complete the appropriate Nebraska Medicaid approved provider agreement form , and submit the form, along with a copy of its current Joint Commission or American Osteopathic Association (AOA) accreditation survey, program, policies, and procedures to Nebraska Medicaid to enroll in Nebraska Medicaid as a provider. If approved, Nebraska Medicaid notifies the institution for mental diseases (IMD) of its provider number.

029.02(ii) 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 Nebraska Medicaid. Claims will not be paid if this has not been received and approved. This information must be submitted with a new copy of the appropriate Nebraska Medicaid approved provider agreement f.

029.02(iii) MONTHLY REPORTS. The institution for mental diseases (IMD) must submit a monthly report to Nebraska Medicaid . The report must be submitted by the 15th of the following month. The report must contain:

(1)The names of all Nebraska Medicaid beneficiaries admitted or discharged during the month; and

(2)The date of each Nebraska Medicaid beneficiary's admission or discharge.

029.02(iv) RECORD REQUIREMENTS. The institution for mental diseases (IMD) must enter the appropriate Nebraska Medicaid approved inpatient mental health services form or electronic claim that is submitted to Nebraska Medicaid.

029.02(iv)(1) TRANSFER. Transfer to another institution for mental diseases (IMD) or readmission constitutes a new admission for the receiving facility.

029.02(iv)(2) AN INDIVIDUAL WHO APPLIES FOR NEBRASKA MEDICAID. For an individual who applies for Nebraska Medicaid while in the institution for mental diseases (IMD), the certification must be:

(a)Made by the team that develops the individual plan of care as outlined in this chapter; and

(b)Cover any period before application for which claims are made.

029.02(iv)(3) NEBRASKA MEDICAID. When Nebraska Medicaid eligibility is determined, authorization for previous and continued care must be obtained from the Department contracted peer review organization or management

designee.

029.03 ADMISSION CRITERIA. As outlined in this chapter.

029.04 SIGNS AND SYMPTOMS. As outlined in this chapter.

029.05 PRIOR AUTHORIZATION AND INITIAL CERTIFICATION PROCEDURES. Institution for mental diseases (IMD) services for beneficiaries age 65 or older must be prior-authorized as follows:

- (A) Admissions must be prior-authorized by the Nebraska Medicaid's contracted peer review organization or management designee. Providers should follow the Nebraska Medicaid's contracted peer review organization or management designee requirements on facilitating prior authorization. The appropriate Nebraska Medicaid approved confidential report form received from the peer review organization or management designee must be maintained in the beneficiary's medical record;
- (B) A psychiatrist must pre-certify, at the time of admission, that the beneficiary requires inpatient services in a psychiatric hospital. The psychiatrist must complete, sign, and date the appropriate Nebraska Medicaid approved confidential report form 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 appropriate Nebraska Medicaid approved confidential report form to certify that inpatient services are or were needed;
- (C) The facility must contact Nebraska Medicaid for determination of medical eligibility;
- (D) The facility must complete the appropriate Nebraska Medicaid approved inpatient mental health services form, attach a copy of the completed appropriate Nebraska Medicaid approved confidential report form, and forward to Nebraska Medicaid. The facility must retain the original copy of the appropriate Nebraska Medicaid approved confidential report form in the beneficiary's medical record;
- (E) The document number on the appropriate Nebraska Medicaid approved inpatient mental health services form must be entered on each Nebraska Medicaid approved health care claim form or standard electronic health care claim transaction and submitted to Nebraska Medicaid; and

(F)When the individual is discharged or expires, the facility must complete the appropriate form and forward to Nebraska to close the authorization.

029.06 TRANSFERS. Initial certification procedures must be followed for each transfer or readmission.

029.07 SIXTY-DAY RECERTIFICATION. A psychiatrist must recertify, in the beneficiary's record, the beneficiary's need for continued care in a mental hospital or need for alternative arrangements at least every 60 days after the initial certification.

029.08 INTERDISCIPLINARY PLAN OF CARE. The psychiatrist and the facility interdisciplinary team must develop and implement an individual written plan of care for each beneficiary within 48 hours after the beneficiary's admission. This plan of care must be placed in the beneficiary's chart when completed. This requirement is met by completion of the appropriate form, which is retained in the beneficiary's record. The written plan of care must include:

- (A)Diagnoses, symptoms, complaints, and complications indicating the need for admission;
- (B)A description of the beneficiary's functional level;
- (C)Objectives;
- (D)Any orders for:
 - (i)Medications;
 - (ii)Treatments;
 - (iii)Restorative and rehabilitative services;
 - (iv)Activities;
 - (v)Therapies;
 - (vi)Social services;
 - (vii)Diet; and
 - (viii)Special procedures recommended for the beneficiary's health and safety;
- (E)Plans for continuing care, including review and modification of the plan of care;
- (F)Appropriate medical treatment in the institution for mental diseases (IMD) every 60 days;
- (G)Appropriate social services every 60 days;
- (H)Family involvement; and

(I)Plans for discharge, including referrals for outpatient follow-up care.

029.09 FACILITY INTERDISCIPLINARY PLAN OF CARE TEAM REVIEW. The attending or staff psychiatrist and other personnel involved in the beneficiary's care must review each plan of care at least every 90 days. The beneficiary's record must contain documentation of the 90-day interdisciplinary team review.

029.10 ADMISSION EVALUATION. Institution for mental diseases (IMD) staff must develop an admission evaluation for each beneficiary within 30 days after the beneficiary's admission. This evaluation must be placed in the beneficiary's record when completed. The admission evaluation must include:

(A)The appropriate form ;

(B)A medical evaluation, including:

(i)Diagnosis;

(ii)Summary of current medical findings;

(iii)Medical history;

(iv)Mental and physical functional capacity;

(v)Prognosis;

(vi)The psychiatrist's recommendation concerning the beneficiary's admission to the mental hospital or the beneficiary's need for continued care in the mental hospital, if the beneficiary applies for Nebraska Medicaid while in the mental hospital;

(C)A psychiatric evaluation;

(D)A social evaluation; and

(E)An initial plan of care sufficient to meet the beneficiary's needs until the facility interdisciplinary team has developed the individual written plan of care.

029.11 ADMISSION EVALUATION. The institution for mental diseases (IMD) must make available to the psychiatrist current information on resources available for continued out-of-hospital care of beneficiaries and must arrange for prompt transfer of appropriate medical and nursing information to ensure continuity of care upon the beneficiary's discharge. Federal regulations require that, when the beneficiary is approved for an alternate plan of care, the institution for mental diseases (IMD) is responsible for discharge planning. In cooperation with community regional mental health programs, the institution for mental diseases (IMD) must:

(A)Initiate alternate care arrangements;

(B) Assist in beneficiary transfer; and

(C) Follow-up on the beneficiary's alternate care arrangements.

029.11(i) TRANSFER. When the beneficiary is being transferred to a long-term care (LTC) facility , 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 institution for mental diseases (IMD) must also contact Nebraska Medicaid .

030. MEDICALLY MONITORED INPATIENT WITHDRAWAL MANAGEMENT

(MMIW). Medically monitored inpatient withdrawal management (MMIW) is a non-hospital intervention that provides 24-hour medically monitored evaluation under physician-approved policies and procedures or clinical protocols. This service is suitable for beneficiaries that require 24-hour care, but do not require the full resources of an acute care general hospital or a medically managed intensive inpatient program.

030.01 ACCREDITATION. Medically monitored inpatient withdrawal management (MMIW) services must be accredited by a national accrediting agency for the appropriate inpatient setting.

030.02 REQUIREMENTS. The following requirements must be met for the medically monitored inpatient withdrawal program (MMIW):

- (A) A physician, physician assistant (PA), or advanced practice registered nurse (APRN) must complete a physical assessment within 24 hours of admission or immediately, if medical necessity arises;
- (B) A licensed medical professional including a physician, physician assistant (PA), and advanced practice registered nurse (APRN) or a licensed therapist operating within their scope of practice, must complete a mental status examination as part of the intake and assessment process;
- (C) A physician, physician assistant (PA), or advanced practice registered nurse (APRN) must be available to provide on-site care and further evaluation on a daily basis and be available 24 hours a day by telephone to provide access to the patient;
- (D) A licensed physician, physician assistant (PA), advanced practice registered nurse (APRN), or therapist operating within their scope of practice must conduct a substance use assessment, including the risk to self or others, and determination of appropriate level of care;
- (E) The substance use assessment must be used to develop the individual treatment plan; and

- (F) The withdrawal management program must provide random urine drug testing, health education, and addiction education services and laboratory and toxicology tests, as ordered by the physician, physician assistant (PA) or advanced practice registered nurse (APRN).

