

**TITLE 471
SERVICES**

NEBRASKA MEDICAL ASSISTANCE PROGRAM

CHAPTER 32

**CHILDREN'S MENTAL HEALTH AND SUBSTANCE
USE DISORDER TREATMENT SERVICES**

2.

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 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.

002.02 APPLIED BEHAVIOR ANALYSIS (ABA). Applied behavior analysis (ABA) is a type of therapy that uses behavior modification principles to treat functional impairments due to maladaptive behaviors in individuals with autism spectrum disorder (ASD) or developmental or intellectual disabilities.

002.03 CHILD PARENT PSYCHOTHERAPY. Child parent psychotherapy is an evidence-based service provided to children from birth to age five, who have experienced at least one traumatic event and, as a result, are experiencing behavior, attachment, or mental health problems, including post-traumatic stress disorder.

002.04 COMMUNITY TREATMENT AIDE SERVICES (CTA). Community treatment aide (CTA) services are supportive and psychoeducational interventions designed to assist the beneficiary and parents or primary caregivers to learn and rehearse the specific strategies and techniques that can decrease the severity of, or eliminate, symptoms and behaviors associated with the beneficiary's mental illness that create significant impairments in functioning.

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

002.06 FAMILY PSYCHOTHERAPY. Family psychotherapy is a treatment session in which an identified beneficiary and the beneficiary's nuclear or extended family interact with a practitioner for the purpose of improving the functioning of the family system and decrease or eliminate the mental health symptoms experienced by the family.

002.07 FAMILY SUBSTANCE USE DISORDER COUNSELING. Family substance use disorder counseling is a treatment session between an identified beneficiary and the beneficiary's nuclear or extended family and a licensed

practitioner.

002.08 FUNCTIONAL FAMILY THERAPY (FFT). 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 GROUP PSYCHOTHERAPY. Group psychotherapy is a treatment session between a beneficiary and a licensed practitioner in the context of a group setting of three to 12 beneficiaries.

002.10 GROUP SUBSTANCE USE DISORDER COUNSELING. Group substance use disorder counseling is a counseling session during which a practitioner directs interactions between three to 12 beneficiaries who have a substance use disorder diagnosis for the purpose of all beneficiaries achieving abstinence from alcohol and drug use.

002.11 INDIVIDUAL PSYCHOTHERAPY. Individual psychotherapy is an active treatment session between a beneficiary and an appropriately licensed practitioner for the purpose of improving the mental health symptoms that are significantly impairing the beneficiary's functioning in at least one life domain.

002.12 INDIVIDUAL SUBSTANCE USE DISORDER COUNSELING. Individual substance use disorder counseling is a counseling session between a beneficiary and a licensed practitioner for a primary substance use disorder.

002.13 INPATIENT HOSPITAL SERVICES FOR BENEFICIARIES AGE 20 OR YOUNGER IN INSTITUTIONS FOR MENTAL DISEASE (IMD). Services provided under the direction of a psychiatrist for the care and treatment of beneficiaries age 20 and younger in an institution for mental disease (IMD) that meets the requirements of federal regulations.

002.14 INSPECTION OF CARE TEAM. Nebraska Medicaid or designee's inspection of care team for institutions of mental disease (IMD), consisting of a psychiatrist knowledgeable about institutions for mental disease (IMD), a qualified registered nurse (RN), and other appropriate personnel as necessary who conduct inspection of care reviews under federal regulations and this regulations.

002.15 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.

002.16 INTERDISCIPLINARY TEAM. The team responsible for developing each beneficiary's individual plan of care.

002.17 MEDICAL NECESSITY. Medical necessity is defined as the need for treatment services which are necessary to diagnose, treat, cure, or prevent regression of significant functional impairments resulting from symptoms of a mental health or substance use disorder diagnosis. Treatment services

must:

- (A) Be provided in the least restrictive level of care that is appropriate to meet the needs of the beneficiary;
- (B) Be supported by evidence that the treatment improves symptoms and functioning for the individual beneficiary's mental health or substance use disorder diagnosis;
- (C) Be reasonably expected to improve the beneficiary's condition or prevent further regression so that the services will no longer be necessary; and
- (D) Be required for reasons other than primarily for the convenience of the beneficiary or the provider.

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

002.19 MEDICATION MANAGEMENT. Medication management is the service provided by a physician, physician assistant (PA), or advanced practice registered nurse (APRN) focused on the monitoring and prescribing of psychopharmacologic agents.

002.20 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. 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 prior-authorization requirements apply.

002.21 PARENT CHILD INTERACTION THERAPY. Parent child interaction therapy is a service provided to children age two to 12 that places emphasis on improving the quality of the parent-child relationship and changing parent-child interaction patterns.

002.22 PSYCHOLOGICAL TESTING. Psychological testing is the administration and interpretation of standardized tests used to assess a beneficiary's psychological or cognitive functioning. It assists in gaining an understanding of a beneficiary's diagnostic presentation and informs the appropriate course of treatment.

002.23 SELF-CARE SERVICES. Self-care services are services supervised by a registered nurse (RN) or occupational therapist (OT) who is oriented toward activities of daily living and personal hygiene.

002.24 SEX OFFENDER RISK ASSESSMENT. A sex offender risk assessment is a structured evaluation for the purpose of recommending whether sex offender specific treatment is necessary, the most appropriate intensity, frequency and type(s) of sex offender treatment and to recommend safety

parameters, including the level of supervision and monitoring needed during treatment.

002.25 TREATMENT PLAN. The treatment plan is a written, comprehensive plan of care to address mental health and substance use disorder symptoms identified in the initial diagnostic interview.

003. GENERAL REQUIREMENTS.

003.01 ELIGIBILITY. A beneficiary is eligible for mental health or substance use treatment services, or both, set forth in this chapter when:

- (A) The beneficiary has a diagnosis of a mental health or substance use disorder;
- (B) The mental health or substance use disorder results in functional impairment that substantially interferes with or limits the beneficiary's role or functioning within their family, school, or community. Coexisting conditions must be carefully evaluated in order to identify the functional impairments resulting from the mental health or substance use disorder diagnosis and those resulting from the coexisting condition. In the evaluation of coexisting conditions, evidence of the conditions will not automatically result in denial of eligibility; and
- (C) The services meet medical necessity criteria.

003.02 FAMILY COMPONENT. Unless otherwise prohibited, providers must involve the family in assessment, treatment planning, updating of the treatment plan, therapy and transition, and discharge planning. Providers must schedule meetings and sessions in a flexible manner to accommodate a family's schedule, including weekends and evenings. Family involvement, or lack thereof, must be documented in the clinical record. Parental or caregiver involvement in treatment is essential and evidence-based practices, which include parents or caregivers in therapy are the expectation for treatment.

003.03 CULTURAL COMPETENCE. Providers must be culturally competent. This includes awareness, acceptance, and respect of differences and continuing self-assessment regarding culture.

003.04 INITIAL DIAGNOSTIC INTERVIEW. The initial diagnostic interview is required prior to initiation of treatment services and must include a history, mental status, and a disposition and may include communication with family or other sources. If circumstances require, family members, guardians, or other supports may be interviewed to supplement the interview of the beneficiary. Except that beneficiaries receiving acute inpatient hospital services, crisis services, or substance use disorder services subject to the requirements of this chapter are not required to receive an initial diagnostic interview before services are initiated.

003.04(A) 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.

003.05 PRACTITIONERS REQUIRING SUPERVISION. A practitioner who is not eligible to practice independently and who provides mental health or substance use treatment services, or both, must be supervised by a supervising practitioner. A supervising practitioner must be a:

- (A)Provisionally licensed mental health practitioner (LMHP);
- (B)Registered nurse (RN);
- (C)Provisionally licensed psychologist; or
- (D)Provisional licensed alcohol and drug counselor (LADC).

003.05(i) SUPERVISING PRACTITIONER. A supervising practitioner must be:

- (1)A licensed physician who has a Doctor of Medicine (M.D.) or a Doctor of Osteopathic Medicine degree (D.O.) and has completed a psychiatric residency or similar training program and preferably is board certified in psychiatry or addiction medicine, for any level of mental health or substance use services;
- (2)A licensed psychologist who has a Doctor of Philosophy (Ph.D) or Doctor of Psychology degree (Psy.D.) for any level of mental health or substance use services except psychiatric residential treatment facility (PRTF);
- (3)A licensed independent mental health practitioner (LIMHP) for outpatient services, intensive outpatient, and community treatment aide (CTA) services only; and
- (4) A licensed advanced practice registered nurse (APRN) who has proof of a current certification from an approved certification program in a psychiatric or mental health specialty for any level of mental health or substance use services except psychiatric residential treatment facility (PRTF).

003.05(ii) RESPONSIBILITIES OF A SUPERVISING PRACTITIONER. A supervising practitioner must :

- (1)Approve and supervise the beneficiary's assessment and treatment plan. This requires facilitation of an assessment in order to develop, approve, and supervise the beneficiary's assessment and treatment

plan;

(2)Direct patient care by reviewing and approving beneficiary specific treatment plans and progress notes within the timelines specified for each level of care, not to exceed 90 days; and

(3)Assure treatment provided meets standards of care.

003.05(iii) REIMBURSEMENT FOR SUPERVISION. Assessments and other services provided by the supervising practitioner, directly to the beneficiary, are reimbursable. Supervision is not reimbursable either by the supervising practitioner or the practitioner who is being supervised.

003.06 PROVIDER ENROLLMENT. All providers of mental health and substance use treatment services must submit a completed medical assistance provider agreement to Nebraska Medicaid for approval. A separate application must be submitted for each particular mental health and substance use treatment service.

003.06(A) NEBRASKA HEALTH CONNECTION ENROLLMENT. In order to be reimbursed for providing services to beneficiaries in Nebraska Health Connection, providers must be credentialed by and under contract with the Nebraska Medicaid managed care behavioral health contractor.

003.07 ACTIVE TREATMENT. Treatment must be provided in an interactive environment with the beneficiary present, and must be focused on reducing or controlling the beneficiary's mental health and substance use disorder symptoms that cause functional impairments and promoting the beneficiary's movement to less restrictive treatment in the most time efficient manner consistent with sound clinical practice.

003.08 TREATMENT PLANS. The treatment plan must include transition and discharge planning and must be amended as needed as treatment progresses. The treatment plan must:

(A)Be individualized to the beneficiary;

(B)Include the specific symptoms or skills to be addressed;

(C)Provide clear and realistic goals;

(D)Include treatment objectives services, strategies, and methods of intervention to be implemented;

(E)Describe the methods for evaluating both the beneficiary's progress and the performance of the practitioner facilitating the intervention; and

(F)Estimate the length of time or number of sessions necessary to complete the treatment goals.

003.09 TRANSITION AND DISCHARGE PLANNING. Providers must begin and document transition and discharge planning at the time of admission or

onset of treatment and continue to update the documentation throughout the treatment episode.

003.10 COORDINATION OF CARE. Providers must coordinate services for beneficiaries who receive services from more than one mental health and substance use provider .

003.11 CLINICAL RECORDS. Each provider must maintain a legible clinical record for each beneficiary that includes a complete record of all the treatment services rendered. The clinical record must contain documentation sufficient to justify reimbursement and must allow an individual not familiar with the beneficiary to evaluate the course of treatment. Failure to have sufficient documentation to justify the level of reimbursement may result in recoupment of payments made for services lacking the documentation.

003.11(A) PROGRESS NOTES. Progress notes must identify the beneficiary name, the name and title of the practitioner, and the date of service. The progress note must also identify the type of therapy, beginning and end date, and time of the service delivered.

003.11(B) RECORD RETENTION. Clinical records must be maintained for a minimum of seven years in a secure location.

003.11(C) CONFIDENTIALITY OF RECORDS. Each provider must ensure the confidentiality of clinical data in accordance with state and federal law.

003.12 LOCATION OF COMMUNITY BASED SERVICES. Community based mental health and substance use treatment services must be provided in the beneficiary's home or a professional environment conducive to beneficiary confidentiality and privacy.

003.13 QUALITY ASSURANCE, UTILIZATION REVIEW AND INSPECTION OF CARE. Providers must fully cooperate with any reviews conducted by Nebraska Medicaid or a Nebraska Medicaid designee to determine the quality of care and services provided. Providers must have access to a copy of any final inspection of care report.

003.13(A) RESPONSE TO INSPECTION OF CARE REPORTS. Within 15 days following the receipt of the inspection of care report, the provider must respond in writing and submit a plan of correction for any identified findings and recommendations. The provider may request an extension of time to respond if needed.

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

003.15 INSTITUTION FOR MENTAL DISEASE (IMD). Services provided to beneficiaries residing in an institution for mental disease (IMD) must not be reimbursable by Nebraska Medicaid except as provided in the regulations on

psychiatric residential treatment facilities (PRTF).

004. OUTPATIENT MENTAL HEALTH AND SUBSTANCE USE DISORDER TREATMENT SERVICES.

004.01 COVERED OUTPATIENT MENTAL HEALTH AND SUBSTANCE USE DISORDER TREATMENT SERVICES. Covered services include:

- (A)Crisis outpatient services;
- (B)The initial diagnostic interview;
- (C)Psychological testing;
- (D)Individual psychotherapy;
- (E)Group psychotherapy;
- (F)Family psychotherapy;
- (G)Parent child interaction therapy ;
- (H)Child-parent psychotherapy ;
- (I)Individual substance use disorder counseling;
- (J)Group substance use disorder counseling;
- (K)Family substance use disorder counseling;
- (L)Conferences;
- (M)Community treatment aide;
- (N)Medication management;
- (O)Sex offender risk assessment;
- (P) Annual supervision of Nebraska Medicaid eligible beneficiaries by a psychologist or a licensed independent mental health professional (LIMHP);
- (Q) Functional family therapy (FFT); and
- (R) Applied behavior analysis (ABA).

004.02 NON-COVERED TREATMENT SERVICES. Services not covered include, but are not limited to:

- (A)Biofeedback services;
- (B)Treatment that is primarily supportive, social or educational in nature;

- C) Treatment for prevention, maintenance, socialization, or skill building;
- (D) Behavior modification and planning;
- (E) Eye movement desensitization and reprocessing ; and
- (F) Art, play, or music therapy.

004.03 OUTPATIENT SERVICES PROVIDERS. Outpatient services must be provided by licensed practitioners whose scope of practice includes mental health or substance use disorder services, or both.

004.04 CRISIS OUTPATIENT SERVICES. The provider of crisis outpatient services must develop a short-term plan and must identify ongoing treatment services if services appear to be medically necessary following stabilization. If services are to continue, the provider must perform or arrange for an assessment and develop a treatment plan if one has not already been completed.

004.04(A) SESSION MAXIMUM. A beneficiary is eligible to receive crisis outpatient services of no more than five sessions per episode of crisis, or three occurrences requiring mobile crisis intervention in a 90-day time period.

004.05 INITIAL DIAGNOSTIC INTERVIEW. An initial diagnostic interview as set forth in this chapter .

004.06 PSYCHOLOGICAL TESTING. Testing services must be administered and scored by a licensed psychologist or, under the supervision of a licensed psychologist, by a provisionally licensed psychologist, a licensed psychological assistant or a licensed psychological associate. All interpretation must be done by the licensed psychologist.

004.06(A) PRIOR AUTHORIZATION. Psychological testing must be prior authorized. Before psychological testing, the beneficiary must be assessed to determine the need for and extent of the psychological testing. Testing may be authorized at the onset of treatment when it is necessary for reaching a diagnosis or helps resolve specific treatment planning questions, or both. It may also occur later in treatment if the beneficiary's condition has not progressed and there is no clear explanation for the lack of improvement. Psychological testing that is available in schools is not covered by Nebraska Medicaid.

004.07 INDIVIDUAL PSYCHOTHERAPY. The treatment plan must identify the diagnosis that is the focus of treatment, the specific target symptoms, the goals, the frequency, and the estimated duration of the service and must be individualized according to the beneficiary's needs and the identified symptoms experienced by the beneficiary. Services must be treatment focused and not rehabilitative or habilitative in nature.

004.08 GROUP PSYCHOTHERAPY. Group psychotherapy must be provided as an active treatment service for a primary psychiatric disorder in which identified treatment goals, frequency and duration of service are a part of the beneficiary's active treatment plan and there is reasonable expectation that group psychotherapy will improve the beneficiary's psychiatric symptoms so that therapy will no longer be needed.

004.09 FAMILY PSYCHOTHERAPY. Depending on the clinical appropriateness, it is expected that all members of the family residing in the same household as the beneficiary participate in family therapy. Others significant to the beneficiary or the family may also be in attendance at family psychotherapy if their attendance will be meaningful in improving family functioning.

004.10 PARENT-CHILD INTERACTION THERAPY (PCIT). Parent-child interaction therapy (PCIT) is used to treat clinically significant disruptive behaviors due to the child's primary mental health disorder.

004.10(A) SERVICE IDENTIFICATION BASED ON NEED. The goals, frequency, and duration of the service must be identified in the child's treatment plan and must vary according to the child's individual needs and the identified symptoms experienced by the child. Services must be treatment focused and not rehabilitative or habilitative in nature. Young children should receive parent-child interaction therapy (PCIT) services only after a recent appropriate medical evaluation to rule out conditions of a general medical nature.

004.10(B) REASONABLE EXPECTATION OF IMPROVEMENT. There must be a reasonable expectation that parent-child interaction therapy (PCIT) will improve the child's psychiatric symptoms so that the services will no longer be necessary.

004.10(C) NON-COVERED TREATMENT SERVICES. Services not following the parent-child interaction therapy (PCIT) evidence-based treatment model or performed by an individual not appropriately trained in parent-child interaction therapy (PCIT) are not covered.

004.11 CHILD-PARENT PSYCHOTHERAPY (CPP). Child-parent psychotherapy (CPP) must be designed to support and strengthen the relationship between a child and their parent or caregiver, and to improve and restore the child's cognitive, behavioral, and social functioning.

004.11(A) SERVICE IDENTIFICATION BASED ON NEED. The goals, frequency and duration of the service must be identified in the child's treatment plan and must vary according to the child's individual needs and the identified symptoms experienced by the child. Services must be treatment-focused and not rehabilitative or habilitative in nature. Young children should receive child-parent psychotherapy (CPP) services only after a recent appropriate medical evaluation to rule out conditions of a general medical nature.

004.11(B) REASONABLE EXPECTATION OF IMPROVEMENT. There must be a reasonable expectation that child-parent psychotherapy (CPP) therapy will improve the child's psychiatric symptoms so that the services will no longer be necessary.

004.11(C) NON-COVERED TREATMENT SERVICES. Services not following the child-parent psychotherapy (CPP) evidence-based treatment model or performed by an individual not appropriately trained in child-parent psychotherapy (CPP).

004.12 INDIVIDUAL SUBSTANCE USE DISORDER COUNSELING. Individual substance use disorder counseling must be designed to assist the beneficiary in achieving and maintaining abstinence from alcohol and drug use. This includes motivational enhancement and interventions .

004.12(A) REASONABLE EXPECTATION OF IMPROVEMENT. Outpatient substance use disorder counseling must reasonably be expected to improve the symptoms of the beneficiary's substance use disorder which are identified in the beneficiary's treatment plan.

004.12(B) SERVICE IDENTIFICATION BASED ON NEED. The treatment plan must identify the diagnosis that is the focus of treatment, the specific target symptoms, goals, the frequency and the estimated duration of the service and must be individualized according to the beneficiary's needs and the identified symptoms experienced by the beneficiary. Services must be treatment focused and not rehabilitative or habilitative in nature.

004.13 FAMILY SUBSTANCE USE DISORDER COUNSELING. The services must focus on the beneficiary's substance use disorder needs and the family as a system and must include a comprehensive family assessment. Depending on the clinical appropriateness, it is expected that all members of the family residing in the same household as the beneficiary participate in family substance use disorder counseling. Services must be designed to increase the functional level of the identified beneficiary and the beneficiary's family related to substance use.

004.13(A) LEVEL OF CARE (LOC). The service must be for a beneficiary with a substance related disorder and meet the criteria of level of care (LOC) standards .

004.14 CONFERENCES. Conferences with family or other persons advising them on how to assist the beneficiary can be covered under limited circumstances.

004.14(A) DEMONSTRATION OF NEED. These circumstances must demonstrate a need for the therapeutic involvement and include:

- (i)Following psychiatric testing ;
- (ii)As required during the provision of multisystemic therapy (MST) services; or
- (iii)As a treatment intervention, identified in the beneficiary's treatment plan and requiring a progress note.

004.14(B) PRIOR AUTHORIZATION. All conferences must be prior approved by Nebraska Medicaid or its designee.

004.14(C) EXCLUSIONS. Scheduling appointments and reporting beneficiary progress are not considered conferences and must not be reimbursable. Supervisory meetings or care coordination meetings are not conferences, and must not be reimbursable.

004.15 COMMUNITY TREATMENT AIDE SERVICES (CTA). The beneficiary's community treatment aide (CTA) plan must be a part of the comprehensive treatment plan developed by the beneficiary's outpatient psychotherapy provider and be developed in close collaboration with the therapy provider. The community treatment aide (CTA) interventions, the beneficiary's progress and modifications to the plan must be reviewed and approved by the outpatient therapist and must be documented by the community treatment aide (CTA) and the therapist.

004.15(A) PLACE OF SERVICE. Community treatment aide (CTA) services must be provided primarily in the beneficiary's natural environment, but

may also include other appropriate community locations where the parent or caregiver are present. Community treatment aide (CTA) services must not be used in place of a school aide or other similar services not involving the parent.

004.15(B) THERAPIST DIRECTION AND SUPERVISION. Community treatment aide (CTA) services must be delivered under the direction and supervision of the therapist providing family or individual therapy, or both, on a regular basis to the beneficiary and the beneficiary's caregiver or family. The community treatment aide (CTA) and the licensed therapist must coordinate care and document their collaboration at least every other week to ensure the community treatment aide (CTA) activities delivered to the beneficiary remain relevant to the beneficiary's treatment plan.

004.15(C) COMMUNITY TREATMENT AIDE (CTA) ACTIVITIES. Activities designed by community treatment aide (CTA) providers may include activities related to:

- (i) Developing a written safety plan with input from the therapist, the beneficiary, and the parents or caregivers;
- (ii) Instructing the parents or caregivers in de-escalation techniques and strategies;
- (iii) Teaching and modeling appropriate behavioral treatment interventions and techniques and coping skills with the beneficiary and the beneficiary's parents or caregivers;
- (iv) Collecting information about medication compliance and developing reminder strategies and other interventions to enhance compliance as needed;
- (v) Assisting parents or caregivers with reporting medication effects, side effects, concerns regarding side effects or compliance problems, and other information regarding progress and barriers to the treating therapist and the prescribing physician or advanced practice registered nurse (APRN);
- (vi) Teaching and modeling proper and effective parenting practices; and
- (vii) Providing training and rehabilitation regarding basic personal care and activities of daily living.

004.15(D) PRIOR AUTHORIZATION. Community treatment aide (CTA) services must be prior authorized by Nebraska Medicaid or its designee in order to be eligible for reimbursement.

004.15(E) PROGRAM DESCRIPTION APPROVAL. Community treatment aide (CTA) agencies must have a program description approved by Nebraska Medicaid or its designee.

004.15(F) COMMUNITY TREATMENT AIDE (CTA) PROGRAM OR CLINICAL DIRECTOR. The community treatment aide (CTA) program or clinical director may be a licensed physician who has completed a psychiatric residency or similar training program and preferably is board certified in psychiatry or addiction medicine, a psychologist, a licensed mental health practitioner (LMHP), a registered nurse (RN), an advanced practice registered nurse (APRN), or a licensed independent mental health practitioner (LIMHP). The director must have two years of professional experience in mental health or substance use disorder treatment, or both, of individuals under the age of 21.

004.15(G) COMMUNITY TREATMENT AIDE (CTA) THERAPIST. The community treatment aide (CTA) therapist must be a licensed physician who has completed a psychiatric residency or similar training program and preferably is board certified in psychiatry or addiction medicine, a psychologist, a licensed independent mental health practitioner (LIMHP), a licensed mental health practitioner (LMHP), or an advanced practice registered nurse (APRN). The community treatment aide (CTA) may be a provisionally licensed mental health practitioner (LMHP) or a provisionally licensed psychologist only if employed by an accredited organization or by exception by Nebraska Medicaid or its designee. The community treatment aide (CTA) therapist must meet all the requirements for outpatient therapy and must coordinate and collaborate with the community treatment aide (CTA) direct care staff.

004.15(H) COMMUNITY TREATMENT AIDE (CTA) DIRECT CARE STAFF. The community treatment aide (CTA) direct care staff must :

- (i) Have a bachelor's degree in psychology, social work, child development or a related field and the equivalent of one year of full-time experience in direct child or adolescent services, or both, or mental health or substance use disorder services, or both. Equivalent time in graduate studies may substitute for work experience; or
- (ii) Have two years post-high school education in the human services or related fields and a minimum of two years' experience in direct child or adolescent services, or both or mental health or substance use disorder services, or both.

004.15(I) BACKGROUND CHECKS AND TRAINING. Prior to allowing staff to treat beneficiaries, community treatment aide (CTA) agencies must gather information from abuse and neglect registries and conduct criminal background checks of all potential community treatment aide (CTA) workers and must assure that all workers have completed the community treatment aide (CTA) agency's basic training program.

004.15(J) UNIT OF SERVICE. The unit of service for community treatment aide (CTA) staff persons must be 15 minutes.

004.16 MEDICATION MANAGEMENT. Medication management must include relevant history, a mental status examination, and medical decision-making regarding initiating or adjusting pharmacological agents.

004.17 SEX OFFENDER RISK ASSESSMENT. The resulting recommendations from a sex offender risk assessment should address treatment needs for medical, mental health and substance use disorder conditions that are diagnosed during the assessment. The assessment is not a forensic evaluation.

004.17(A) WRITTEN REPORT. Practitioners providing this assessment must provide a written report which includes the components listed below that support the treatment recommendations.

004.17(B) REPORT SIGNAGE. The report must be signed by the psychologist although parts of the assessment may be conducted by others who operate within the scope of their license and who are under the supervision of the signing psychologist.

004.17(C) RISK ASSESSMENT COMPONENTS. The components for a sexual offender risk assessment include demographic, biopsychosocial, psychological assessment results and treatment recommendations as follows:

- (i)Demographic Information: Reasons for the assessment, police reports and other relevant court documents, clinical interview of beneficiary, family members and other collateral contacts, initial diagnostic interview and review of previous mental health and substance use disorder treatment, and psychological testing records;
- (ii)Biopsychosocial Information: Background information, family relations and dynamics, family response to the current symptoms and problems, social functioning, school and academic history, substance use disorder history, legal history, mental health treatment history, sexual offense history, trauma and victimization history, and personal strengths;
- (iii)Psychological Evaluations: Level of cognitive and adaptive functioning, personal and behavior factors, sex offender risk assessment using both static and dynamic factors, sexual misconduct patterns, perception, understanding, motivation, and empathy for victim, current supervision and access to victim as well as protective factors and strengths; and
- (iv)Case Formulation and Treatment Recommendations: An integrated discussion of the relevant factors in determining the treatment recommendations and an assessment of the beneficiary's current risk to reoffend.

004.18 ANNUAL SUPERVISION OF NEBRASKA MEDICAID ELIGIBLE INDIVIDUALS. 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.

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

004.19(A) 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.

004.19(B) STAFF NEEDS AND RESPONSIBILITIES. 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.

004.19(C) ASSESSMENT AND TREATMENT 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:

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

004.19(D) PROVIDER AND TEAM REQUIREMENTS. 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.

004.19(D)(i) TREATMENT PROVIDERS. Treatment providers may be any of the following: physicians, physician assistants (PA), advanced practice registered nurses (APRN), nurse practitioners (NP), licensed psychologists, provisionally licensed psychologists, licensed independent mental health practitioners (LIMHP), licensed mental health professionals (LMPH), or provisionally licensed mental health practitioners (LMHP) acting within their scope of practice.

004.19(D)(ii) TREATMENT CLINICAL SUPERVISORS. Treatment clinical supervisors must be physicians, physician assistants (PA), advanced practice registered nurses (APRN), 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.

004.19(D)(iii) TREATMENT ASSESSMENT PROVIDERS. Treatment assessment providers may be any of the following: physicians, psychiatric advanced practice registered nurses (APRN), nurse practitioners (NP), licensed psychologists, provisionally licensed psychologists, or licensed independent mental health practitioners (LIMHP) all acting within their scope of practice.

004.20 APPLIED BEHAVIOR ANALYSIS (ABA) SERVICES. Applied behavior analysis (ABA) must involve systematically applying interventions based upon the principles of learning theory to improve socially significant behaviors and must demonstrate that the interventions employed are responsible for the improvement in behavior for individuals with autism spectrum disorder (ASD) or developmental or intellectual disabilities. Necessity for applied behavior analysis (ABA) services must be determined based on an initial diagnostic interview (IDI) and a behavior identification assessment. Applied behavior analysis (ABA) services must meet the requirements as noted in the appropriate Medicaid service definitions.

005. TREATMENT CRISIS INTERVENTION SERVICES. Crisis intervention services are available to beneficiaries age 20 or younger when the treatment of a condition needing care leads to a health check or Early and Periodic Screening, Diagnostic and Treatment (EPSDT) screen and the treatment is clinically necessary. Crisis intervention services are appropriate for a family in the midst of a child or adolescent mental health or substance use disorder crisis. The interventions focus on reducing stress and helping resolve the crisis in a positive manner, and facilitating the beneficiary's involvement to treatment. Crisis intervention services must meet all requirements in this chapter. All crisis intervention service providers must facilitate a referral for a complete health check or Early and Periodic Screening, Diagnostic and

Treatment (EPSDT) screen within eight weeks of the crisis intervention. This referral must be documented in the beneficiary's clinical record.

005.01 SERVICE REQUIREMENTS. Crisis intervention services must be family-centered, community-based, developmentally appropriate, culturally competent, and must take into account the individual needs of beneficiaries age 20 and younger.

005.02 FAMILY COMPONENT. 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. Providers must be available to schedule meetings and sessions in a flexible manner to accommodate and work with a family's schedule. This includes the ability to schedule sessions at a variety of times including weekends or evenings. The provider must document their attempts to involve the family in treatment plan development and treatment plan reviews. A variety of means of communication should be considered.

005.03 TYPES OF CRISIS INTERVENTION SERVICES. One of the following services must be included in a crisis intervention program to be approved for participation in Nebraska Medicaid .

005.03(A) NON-RESIDENTIAL CRISIS INTERVENTION. Non-residential crisis intervention services are provided to the family and beneficiary outside of a residential or institutional setting. This service includes supportive services therapy, brief assessment, and coordination services to help a family alleviate a crisis. These services must be directed by a supervising practitioner and psychiatric consultation must be readily available. Some assessment and intervention activities may be carried out by a clinical professional who is acting within their scope of practice under the direction of a supervising practitioner. The provider must have the capacity to respond to the family to unscheduled crisis intervention contacts 24 hours a day, seven days a week.

005.03(B) DAY RESIDENTIAL CRISIS INTERVENTION. Day residential crisis intervention services are provided to families when a safe and secure setting is needed to provide a therapeutic milieu for a child or adolescent for up to 23 hours and 59 minutes. This level is used when a brief stay in a secure setting will facilitate a de-escalation of the crisis. These services must be directed by a supervising practitioner with access to psychiatric consultation. The milieu and direct care interventions may be staffed by clinical professionals or technicians, under the direction of a supervising practitioner.

005.03(C) RESIDENTIAL ACUTE CRISIS INTERVENTION. Residential acute crisis intervention services are available to children and adolescents experiencing acute psychiatric crisis. The program provides crisis

treatment and close supervision to stabilize a beneficiary and facilitate admission to the most appropriate treatment setting. The milieu and direct care interventions may be staffed by clinical professionals or technicians, under the direction of a supervising practitioner.

005.03(D) PROVIDERS OF CRISIS INTERVENTION SERVICES. Providers of crisis intervention services must facilitate the referral to or provide the initial diagnostic interview if it has not already occurred.

005.04 STANDARDS FOR PARTICIPATION AS A PROVIDER OF CRISIS INTERVENTION SERVICES. Programs must meet the following standards to participate in Nebraska Medicaid as a provider of crisis intervention service in addition to the standards listed in this chapter.

005.04(A) PROVIDER AGREEMENT. The provider must submit the following with the appropriate Nebraska Medicaid approved provider agreement form F:

- (i) A written overview of the program's philosophy and objectives of treating youth including:
 - (1) A description of each available service;
 - (2) A list of treatment modalities available and the capacity for individualized treatment planning;
 - (3) A statement of qualification, education, and experience of each staff member providing treatment and the supervising practitioner and the therapeutic services each provides;
 - (4) A schedule covering the total number of hours that the program operates;
 - (5) A program overview; and
 - (6) Any other information requested by Nebraska Medicaid; and
- (ii) Copies of licensure and certification, through the Nebraska Department of Health and Human Services, Division of Public Health, the Joint Commission, Council on Accreditation (COA), American Osteopathic Association (AOA) or Commission on the Accreditation of Rehabilitation Facilities (CARF) as appropriate.

005.04(B) STAFFING STANDARDS FOR PARTICIPATION. An agency providing crisis intervention services for children and adolescents must meet the following staffing standards to participate in Nebraska Medicaid :

- (i) All services must be provided under the supervision of the supervising practitioner. This practitioner must be available at all times for consultation or face-to-face beneficiary assessment; and

- (ii) Direct intervention services must be provided by a clinical staff person who is acting within their scope of practice .

005.04(C) PLACE OF SERVICE. Crisis intervention services may be provided in any of the following locations:

- (i) The beneficiary's home;
- (ii) A physician's private office;
- (iii) A community mental health program which meets the criteria for approval by the Joint Commission or is accredited by Commission on the Accreditation of Rehabilitation Facilities (CARF), Council on Accreditation (COA), or American Osteopathic Association (AOA), and is appropriately licensed by the Nebraska Department of Health and Human Services, Division of Public Health;
- (iv) A hospital licensed and certified by the State of Nebraska which is accredited by the Joint Commission or American Osteopathic Association (AOA) and has in effect a utilization review plan applicable to all Nebraska Medicaid beneficiaries;
- (v) The private office of a licensed practitioner of the healing arts who is licensed by the Nebraska Department of Health and Human Services, Division of Public Health;
- (vi) The beneficiary's school;
- (vii) Other appropriate locations to meet the beneficiary needs for intervention; or
- (viii) A facility enrolled as a residential treatment center or therapeutic group home (ThGH) under this chapter .

005.04(D) ANNUAL UPDATE. The provider must submit the following information on an annual basis:

- (i) An overview of any changes in the program including any new services;
- (ii) A current list of staff; and
- (iii) Current copies of all licenses, letters of accreditation, and certifications.

005.05 COVERED SERVICES. Payment for crisis intervention services under Nebraska Medicaid is limited to services for clinically necessary primary psychiatric diagnoses. Nebraska Medicaid covers the following crisis intervention services:

- (A) Active treatment, which must be:

- (i) Provided under the supervision of the supervising practitioner by clinical staff members acting within their scope of practice ; and
- (ii) Reasonably expected to improve the beneficiary's condition or resolve the crisis. The treatment interventions must, at a minimum, be designed to reduce or control the beneficiary's symptoms to facilitate the resolution of a crisis or prevent the need for care in a more restrictive level of care.

005.05(A) SPECIAL TREATMENT PROCEDURES IN CRISIS INTERVENTION SERVICES.

If a child or adolescent needs behavior management and containment beyond unlocked time outs or redirection, special treatment procedures may be utilized. For crisis intervention services provided in therapeutic group homes (ThGH), please refer to the sections covering those services. For crisis intervention services provided in the child or adolescent's home, school, or other appropriate location, special treatment procedures is limited to physical restraint. Mechanical restraints and pressure point tactics are not allowed. Parents, the legal guardian, or Nebraska Medicaid case manager must approve use of these procedures and must be informed within 24 hours each time they are used. 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 child or adolescent's behavior presents a danger to self or others, or to prevent serious disruption to the therapeutic environment;
- (iii) The child or adolescent's treatment plan must address the use of special treatment procedures and have a clear plan to decrease the behavior requiring intervention; and
- (iv) Attempts to de-escalate, the special treatment procedure, and subsequent processing must be documented in the clinical record and reviewed by the supervising practitioner.

005.06 ADMISSION CRITERIA. The provider of crisis intervention services must develop admission criteria for the types of services they provide. The admission criteria must be approved by Nebraska Medicaid as part of the provider enrollment.

005.07 DOCUMENTATION IN BENEFICIARY'S MEDICAL RECORD. Providers of crisis intervention services must follow the standards for clinical records specified in this chapter. Clinical records for crisis intervention services must also include, at a minimum, the following:

(A)The referral source and description of the crisis;

(B)The provider's plan to facilitate referrals to the appropriate ongoing care for the family; and

(C)The follow-up contacts with the beneficiary or family, or both.

005.08 LIMITATIONS. Nebraska Medicaid limits payment for crisis intervention to medically necessary services, subject to Nebraska Medicaid's utilization review. This period includes an average crisis resolution period of three to five days with an occasional need for up to seven days when the beneficiary's condition dictates. Payment for crisis intervention services is not available for services past seven days.

005.09 PAYMENT FOR CRISIS INTERVENTION SERVICES. If crisis intervention services are provided in the home between the hours of 10:00 p.m. and 8:00 a.m., the fee will be paid at one- and one-half times the regular rate. This shift differential is only available for unscheduled emergency services that are part of a crisis intervention service.

006. MENTAL HEALTH AND SUBSTANCE USE DISORDER DAY TREATMENT SERVICES. Day treatment services are available to beneficiaries age 20 or younger when the beneficiary has participated in a health check or Early and Periodic Screening, Diagnostic and Treatment (EPSDT) screen, the treatment is clinically necessary, and the need for this level of care is identified as part of an initial diagnostic interview, a substance use disorder assessment, or a substance use disorder addendum. These services are part of a continuum of care designed to prevent hospitalization or to facilitate the movement of the beneficiary in an acute psychiatric setting to a status in which the beneficiary is capable of functioning within the community with less frequent contact with the mental health or substance use disorder provider. Day treatment services must be community based, family centered, culturally competent, and developmentally appropriate. Day treatment services must meet all requirements in this chapter.

006.01 FAMILY COMPONENT. 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. Providers must be available to schedule meetings and sessions in a flexible manner to accommodate and work with a family's schedule. This includes the ability to schedule sessions at a variety of times including weekends or evenings. The provider must document their attempts to involve the family in treatment plan development and treatment plan reviews. A variety of communication means should be considered.

006.02 COVERED DAY TREATMENT SERVICES. 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. Individual services to the beneficiary by a supervising practitioner that are not administrative in nature and are clinically necessary will be considered for payment when billed by the supervising practitioner. Providers must not make any additional charges to Nebraska Medicaid or to the beneficiary.

006.02(A) MANDATORY SERVICES. The following services must be included in a program for day treatment to be approved for participation in Nebraska Medicaid

(i) MEDICALLY NECESSARY PSYCHOTHERAPY AND SUBSTANCE USE DISORDER. These services must demonstrate active treatment of a patient with a serious emotional disturbance. These services are subject to program limitations.

(1) Individual psychotherapy or substance use disorder counseling;

(2) Group psychotherapy or substance use disorder counseling;

(3) Family psychotherapy or substance use disorder counseling; and

(4) Family assessment.

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

(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, specially licensed psychologist or a psychology resident acting within their scope of practice. Clinical necessity must be documented by the program supervising practitioner. Reimbursement for psychological diagnostic services is included in the per diem.

(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 or provider. All medications must be stored in a special locked storage space and administered only by a physician, advanced practice registered nurse (APRN), registered nurse (RN), or licensed practical nurse (LPN).

(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 diet

needs. Day treatment programs may contract for these services through an outside facility or provider.

- (vi) TRANSITION AND DISCHARGE. Transition and discharge planning that meets the requirements of this chapter.

006.02(B) OPTIONAL SERVICES. The program must provide two of the following optional services. The beneficiary must have a need for the services, the 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 day treatment 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 licensed or certified professional as listed below:
 - (1) Recreational therapy;
 - (2) Speech therapy;
 - (3) Occupational therapy (OT);
 - (4) Vocational skills therapy; and
 - (5) Self-care services ;
- (ii) Therapeutic psychoeducational services may be provided as part of a total program. Therapeutic psychoeducational services must be provided by teachers specially trained to work with child and adolescents experiencing mental health or substance use disorder problems. These services may meet some strictly educational requirements, but must also include the therapeutic component. Professionals providing these services must be appropriately licensed and certified for the scope of practice;
- (iii) Social work services 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;
- (iv) Crisis intervention ;
- (v) Social skills building;
- (vi) Life survival skills; and
- (vii) Substance use disorder prevention, intervention, or treatment by a licensed alcohol and drug counselor (LADC) or provisionally

licensed alcohol and drug counselor (LADC).

006.02(C) EDUCATIONAL PROGRAM SERVICES. Educational services, when required by law, must be available, though not necessarily provided by the day treatment program. Educational services must be only one aspect of the treatment plan, not the primary reason for admission or treatment. Educational services are not eligible for payment by Nebraska Medicaid, and do not apply towards the three hours or six hours of therapeutic services.

006.02(D) SPECIAL TREATMENT PROCEDURES IN DAY TREATMENT. If a child or adolescent 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. Parents or legal guardian or a Nebraska Medicaid case manager must approve use of these procedures through informed consent and must be informed within 24 hours each time they are used. 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 child or adolescent's behavior presents a danger to self or others, or to prevent serious disruption to the therapeutic environment;
- (iii) The child or adolescent'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; and
- (iv) Attempts to de-escalate, the special treatment procedure and subsequent processing must be documented in the clinical record and reviewed by the supervising practitioner.

006.03 STANDARDS FOR PARTICIPATION.

006.03(A) PROVIDER STANDARDS. Providers of day treatment services must meet the following standards:

- (i) A community mental health or substance use disorder program providing day treatment must meet the following standards:
 - (1) A community-based treatment facility appropriately licensed as determined by the Department of Health and Human Services,

Division of Public Health; and

- (2) Accreditation by the Joint Commission , the Commission on the Accreditation of Rehabilitation Facilities (CARF), the Council on Accreditation (COA) or the American Osteopathic Association (AOA). Agencies that have applied for accreditation may be enrolled on a provisional status;

(ii) A psychiatric or substance use disorder hospital providing day treatment must:

- (1) Be maintained for the care and treatment of patients with primary psychiatric or substance use disorder disorders;
- (2) Be licensed or formally approved as a hospital by the Nebraska Department of Health and Human Services, Division of Public Health;
- (3) Be accredited by the Joint Commission or the American Osteopathic Association (AOA);
- (4) Have licensed and certified psychiatric or substance use disorder beds;
- (5) Meet the requirements for participation in Medicare; and
- (6) Have in effect a utilization review plan applicable to all Nebraska Medicaid beneficiaries;

(iii) A licensed and certified hospital which provides acute care services and which:

- (1) Is maintained for the care and treatment of patients with acute medical disorders;
- (2) Is licensed or formally approved as a hospital by the Nebraska Department of Health and Human Services, Division of Public Health;
- (3) Is accredited by the Joint Commission or the American Osteopathic Association (AOA);
- (4) Meets the requirements for participation in Medicare for acute medical hospitals;
- (5) Has in effect a utilization review plan applicable to all Nebraska Medicaid beneficiaries; and
- (6) Has adequate staff to meet the requirements of the mental health or substance use disorder day treatment standards; and

(iv) If day treatment services will be provided in a school, the school must have a written contract with a mental health or substance use

disorder program that meets these standards community mental health program or licensed hospital. This contract must demonstrate the working relationship between the school and the community mental health or substance use disorder program to provide the day treatment service.

006.03(B) SERVICE STANDARDS.

- (i) The program must provide a minimum of three hours of services five days a week, which is considered a half day for billing purposes. Six hours a day of services is considered a full day of services. Services may not be prorated for under three hours of service for a half day or six hours of services for a full day, but may be for up to 12 hours of service;
- (ii) A designated supervising practitioner must be responsible for the care provided in a day treatment program. The supervising practitioner must be present on a regularly-scheduled basis and must assume responsibility for all beneficiaries. If the supervising practitioner is present on a part-time basis, one of the clinical staff professionals acting within the scope of practice standards of the Nebraska Department of Health and Human Services, Division of Public Health must assume delegated professional responsibility for the program and must be present at all times when the program is providing services. Psychotherapy and substance use disorder counseling services must be provided by clinical staff who are operating within their scope of practice and under the direction of the supervising practitioner. The supervising practitioner's personal involvement must be documented in the beneficiary's clinical record;
- (iii) A licensed psychologist, physician, doctor of osteopathy, physician assistant (PA), or advanced practice registered nurse (APRN) may refer a beneficiary to a day treatment program, but all treatment must be prescribed and directed by the program supervising practitioner;
- (iv) All treatment must be conducted under the direction of the supervising practitioner in charge of the program;
- (v) The following criteria must be met for a beneficiary's admission to a day treatment program:
 - (1) The beneficiary must have sufficient need for active 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 treatment available to the beneficiary, treatment in this program must be the best choice for expecting a reasonable improvement in the beneficiary's condition;

- (vi) Before the beneficiary is admitted to the program, a supervising practitioner must complete an initial diagnostic interview to validate the appropriateness of care;
- (vii) The program supervising practitioner must determine the diagnosis and prescribe the treatment, including the modalities and the professional staff to be used. They must be responsible and accountable for all evaluations and treatment provided to the beneficiary. 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:
 - (1) The multi-disciplinary team must complete the treatment plan within the first 14 days after the beneficiary's admission to the program. The plan must be reviewed and revised by the multi-disciplinary team, including the supervising practitioner, at least every 30 days or more often if necessary; and
 - (2) Changes in the treatment plan must be noted on the treatment planning document. An updated treatment plan must be completed every 30 days, or more frequently if necessary, to reflect changes in treatment needs. The treatment plan must be signed by the supervising practitioner for day treatment services. The treatment plan review must be documented on the treatment plan, if required, and in the medical records;
- (viii) The supervising practitioner must meet personally with the beneficiary for evaluation every 30 days, or more often, as clinically necessary. Reimbursement for the 30-day update visit is not included in the day treatment per diem and can be reimbursed separately;
- (ix) Every 30 days a utilization review must be conducted in accordance with this chapter. This review must be documented on the treatment plan, and the facility's treatment plan review form. Utilization review is not required for the calendar month in which the beneficiary was admitted;
- (x) The program must have a description of each of the services and treatment modalities available. This includes psychotherapy services, substance use disorder counseling, nursing services, psychological diagnostic services, pharmaceutical services, dietary services, and other 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 services;
- (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;
- (xi) When appropriate for brief crisis stabilization, outpatient observation up to 23 hours 59 minutes in an emergency room or acute hospital may be used in accordance with the definition of outpatient in this chapter; and
- (xii)The program must have a written plan for immediate admission or readmission for appropriate inpatient services, if necessary. The written plan must include a cooperative agreement with a psychiatric or substance use disorder hospital or distinct part of a hospital, as outlined in this chapter. A copy of this agreement must accompany the provider application and agreement.

006.04 PROVIDER AGREEMENT. A provider of day treatment services must complete a provider agreement and submit the form to Nebraska Medicaid for approval. The provider must attach to the provider agreement a written overview of the program including philosophy, objectives, policies and procedures, and documentation of the requirements in this chapter are met. Staff must meet the standards outlined in this chapter, and

- (A)Community mental health or substance use disorder programs and licensed health clinics must complete the appropriate Nebraska Medicaid approved provider agreement form, and submit the completed form to Nebraska Medicaid for approval. A Nebraska Medicaid approved cost reporting document must also be submitted. Satellites of community programs must bill Nebraska Medicaid through their main community program, unless the satellite has a separate provider number under Medicare. A satellite of a community 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 clients; and

- (B) Hospitals must complete the appropriate Nebraska Medicaid approved provider agreement form and submit the completed form to Nebraska Medicaid for approval. A Nebraska Medicaid approved cost reporting document must also be submitted.

006.04(i) ANNUAL RENEWAL. The program must renew the provider agreement, program overview, and cost report annually and whenever requested by Nebraska Medicaid .

006.05 COVERAGE CRITERIA FOR MENTAL HEALTH OR SUBSTANCE USE DISORDER DAY TREATMENT. Nebraska Medicaid covers day treatment services for beneficiaries age 20 and younger when the services meet the requirements in in this chapter and the beneficiary has participated in a health check or Early and Periodic Screening, Diagnostic and Treatment (EPSDT) screen. Day treatment services must be prior authorized by Nebraska Medicaid or its designee. The beneficiary must be observed and interviewed by the supervising practitioner at least once every 30 days, or more frequently if medically necessary, and the interaction must be documented in the beneficiary's clinical record.

006.05(A) SERVICES NOT COVERED UNDER NEBRASKA MEDICAID. Payment is not available for day treatment services for beneficiaries:

- (i)Receiving services in an out-of-state facility, except as outlined in this title ;
- (ii)In long term care facilities;
- (iii)Whose needs are social or educational and may be met through a less structured program;
- (iv)Whose primary diagnosis and functional impairment is acutely psychiatric in nature and whose condition is not stable enough to allow them to participate in and benefit from the program; or
- (v)Whose behavior may be very disruptive or harmful to other program participants or staff members.

006.06 DOCUMENTATION IN THE BENEFICIARY'S CLINICAL RECORD. All documents submitted to Nebraska Medicaid must contain sufficient information for identification . In addition to the requirements of this chapter, each beneficiary's medical record must contain the following documentation:

- (A)The supervising practitioner's orders;

(B)The treatment plan;

(C)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 daily. 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;

(D)Documentation indicating compliance with all requirements in this chapter;

(E)Records of the treatment plan review by the multi-disciplinary team including attendees and decisions;

(F)The program's utilization review committee's abstract or summary; and

(G)The discharge summary.

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

006.08 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.

006.08(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.

006.08(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 every 30 days ;
- (iii)The type of records to be kept; and

- (iv)The arrangement for committee reports and their dissemination, including how the program and supervising practitioner is informed of the findings.

006.08(C) UTILIZATION REVIEW COMMITTEE. The utilization review committee must contain a licensed provider who is able to diagnose and treat major mental illness within their scope of practice and at least two clinical staff professionals, as defined in this chapter. 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 beneficiary 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.

006.08(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's plan of treatment; and
- (vi)Other supporting materials the group may deem appropriate.

006.08(E) CONTENTS OF REPORT. 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 and dated. The supervising practitioner must sign and date all of their 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, or both; and
- (3) Disapproval of continued treatment;
- (iv) The date of the review;
- (v) The names of the program utilization review committee members;
- (vi) The date of the next review if continued treatment is recommended; and
- (vii) A copy of the admission review and the extended stay review must be attached to all claims for mental health services submitted to Nebraska Medicaid for payment.

006.09 LIMITATIONS ON REIMBURSEMENT OF ALLOWABLE COSTS. The following limitations apply to reimbursement of allowable costs:

- (A) Payment for a full day of day treatment is allowable when services are provided to a beneficiary for at least six hours per day;
- (B) Payment for a half day of day treatment is allowable when services are provided to a beneficiary for at least three hours per day but less than six hours per day. The rate for a half day of day treatment is limited to one half of the full day rate; and
- (C) For programs that provide services for more than six hours, and up to twelve hours, payment can be prorated by the hour. For each additional hour of service beyond six, Nebraska Medicaid will pay an additional amount based on the cost-report.

006.09(i) DOCUMENTATION FOR CLAIMS. The following documentation is required for all claims for day treatment and claims and must be kept in the beneficiary's record:

- (1) A psychiatric assessment with mental status exam and diagnosis;
- (2) The treatment plan for admission and every 30 days thereafter;
- (3) Orders by the supervising practitioner;
- (4) A complete family assessment;
- (5) Nurses' notes;
- (6) Progress notes for all disciplines; and
- (7) All claims are subject to utilization review by Nebraska Medicaid prior to payment.

006.09(ii) EXCEPTION. Additional documentation from the beneficiary's medical record may be requested by Nebraska Medicaid prior to considering authorization of payment.

006.09(iii) 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 policy:

- (1) Direct beneficiary services performed by the supervising practitioner;
- (2) Prescription medications, including injectable medications;
- (3) Direct beneficiary services performed by a physician, physician assistant (PA), or advanced practice registered nurse (APRN) other than the supervising practitioner;
- (4) Treatment services for a physical injury or illness provided by other professionals; and
- (5) If the beneficiary is enrolled with another Nebraska Health Connection vendor for medical-surgical services, it may be necessary to pursue prior authorization or referral with that entity.

006.10 PROCEDURE CODES AND DESCRIPTIONS FOR MENTAL HEALTH OR SUBSTANCE USE DISORDER DAY TREATMENT. Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT); procedure codes used by Nebraska Medicaid are listed in the Nebraska Medicaid Practitioner Fee Schedule .

007. THERAPEUTIC GROUP HOME (ThGH) SERVICES. Therapeutic group home (ThGH) services are available to beneficiaries age 20 or younger when the

beneficiary has participated in a health check or Early and Periodic Screening, Diagnostic and Treatment (EPSDT) screen, the treatment is clinically necessary, and the need for this level of care is identified as part of an initial diagnostic interview, initial diagnostic interview addendum, a substance use disorder assessment, or a substance use disorder addendum. These services are part of a continuum of care designed to prevent hospitalization or to facilitate the movement of the beneficiary in an acute psychiatric setting to a status in which the beneficiary is capable of functioning within the community with less frequent need for clinical contact with the mental health or substance use disorder provider. Therapeutic group home (ThGH) services must be community based, family centered, culturally competent, and developmentally appropriate. Therapeutic group home (ThGH) must meet all requirements in this chapter.

007.01 FAMILY COMPONENT. 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. Providers must be available to schedule meetings and sessions in a flexible manner to accommodate and work with a family's schedule. This includes the ability to schedule sessions at a variety of times including weekends or evenings. The provider must document their attempts to involve the family in treatment plan development and treatment plan reviews. A variety of communication means should be considered.

007.02 MANDATORY SERVICES. The following services must be included in a program for the therapeutic group home (ThGH) to be approved for participation in Nebraska Medicaid.

007.02(A) ACTIVE AND REHABILITATIVE TREATMENT SERVICES. Each beneficiary must be involved in at least 21 hours of active and rehabilitation treatment per week. In addition, the program must provide access to daily recreational activities for all beneficiaries, but these recreational activities are not considered a part of the 21 required treatment hours.

007.02(B) MEDICALLY NECESSARY PSYCHOTHERAPY AND SUBSTANCE USE DISORDER SERVICES. Medically necessary psychotherapy services and substance use disorder services must demonstrate active treatment of a beneficiary with a serious emotional disturbance. Beneficiaries must receive individual psychotherapy, group psychotherapy, or substance use disorder counseling for at least three hours per week, and family psychotherapy or family substance use disorder counseling at least twice monthly. Medically necessary psychotherapy and substance use disorder services include:

- (i) Individual psychotherapy or substance use disorder counseling;
- (ii) Group psychotherapy or substance use disorder counseling;
- (iii) Family psychotherapy or substance use disorder counseling; and
- (iv) Family assessment.

007.02(C) PSYCHOEDUCATIONAL GROUPS AND INDIVIDUAL PSYCHOEDUCATIONAL THERAPY SERVICES. Psychoeducational services must be available from the therapeutic group home (ThGH) and must be modified to meet the unique treatment needs of the beneficiary as described in the beneficiary's treatment plan.

007.02(D) MEDICALLY NECESSARY NURSING SERVICES. Medical services provided by an advanced practice registered nurse (APRN), registered nurse (RN), or licensed practical nurse (LPN) under registered nurse (RN) supervision, who evaluates the particular medical nursing needs of each beneficiary and provides for the medical care and treatment that is indicated on a Nebraska Medicaid approved treatment planning document and approved by the supervising practitioner. Therapeutic group home (ThGH) programs may contract for these services through an outside facility or provider.

007.02(E) 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 beneficiary. Testing and evaluation services may be performed by a licensed psychologist, specially licensed psychologist or a psychology resident acting within their scope of practice. Clinical necessity must be documented by the program supervising practitioner. Therapeutic group home (ThGH) programs may contract for these services through an outside facility or provider.

007.02(F) 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 or provider. All medications must be stored in a special locked storage space and administered only by a physician, advanced practice registered nurse (APRN), registered nurse (RN), licensed practical nurse (LPN), or a direct care staff person approved by the Nebraska Department of Health and Human Services, Division of Public Health as a medication aide. Therapeutic group home (ThGH) programs may contract for these services through an outside facility or provider.

007.02(G) MEDICALLY NECESSARY DIETARY SERVICES. If meals are provided by a therapeutic group home (ThGH) program, services must be supervised by a registered dietitian, based on the beneficiary's individualized diet needs. Therapeutic group home (ThGH) programs may contract for these services through an outside facility or provider.

007.02(H) EDUCATIONAL AND VOCATIONAL ASSISTANCE. The beneficiary must attend a school in the community. In this setting, the beneficiary remains involved in community-based activities and may attend a community educational, vocational program or other treatment setting. The therapeutic group home (ThGH) is required to coordinate with the beneficiary's community resources, including schools or vocational services, with the goal of transitioning the beneficiary out of the program

to a less restrictive care setting for continued, sometimes intensive, services as soon as possible and as appropriate.

007.02(I) TRANSITION AND DISCHARGE. Transition and discharge planning that meets the requirements of this chapter.

007.02(J) SPECIAL TREATMENT PROCEDURES IN THERAPEUTIC GROUP HOMES (ThGH). If a child or adolescent needs behavior management and containment beyond unlocked time outs or redirection, special treatment procedures may be utilized. Special treatment procedures in therapeutic group homes (ThGH) are limited to physical restraint, and locked time out (LTO). Mechanical restraints and pressure point tactics are not allowed. Parents or legal guardian must approve use of these procedures through informed consent and must be informed within 24 hours each time they are used. 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 child or adolescent's behavior presents a danger to self or others, or to prevent serious disruption to the therapeutic environment;
- (iii) The child or adolescent'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; and
- (iv) Attempts to de-escalate, the special treatment procedure and subsequent processing must be documented in the clinical record and reviewed by the supervising practitioner.

007.03 STANDARDS FOR PARTICIPATION.

007.03(A) PROVIDER STANDARDS. Providers of therapeutic group home (ThGH) services must meet the following standards:

- (i) Be a community-based treatment facility appropriately licensed as determined by the Department of Health and Human Services, Division of Public Health;
- (ii) Be accredited by the Joint Commission, the Commission on the Accreditation of Rehabilitation Facilities (CARF), or the Council on Accreditation (COA). Agencies that have applied for accreditation may be enrolled on a provisional status;
- (iii) To ensure a more home-like setting, each location where beneficiaries live must be in a residential community to facilitate community integration through public education, recreation, and maintenance of family connections;

- (iv) Therapeutic group home (ThGH) facilities must not have more than eight beds. Existing facilities providing therapeutic group home (ThGH) services may not add beds if the bed total would exceed eight. Facilities exceeding 15 beds may not enroll as a therapeutic group home (ThGH). Facilities enrolled as a therapeutic group home (ThGH) with 9-15 bed capacity on the operative date of these regulations may continue to be operative at that capacity until alterations are made. Any facility alterations must comply with the eight bed limit; and
- (v) If a provider operates multiple therapeutic group homes (ThGH), they must ensure that they do not meet the definition of an institution of mental disease (IMD).

007.03(B) SERVICE STANDARDS.

- (i) The program must provide services 24 hours a day, seven days a week, 365 days per year with 24-hour awake staffing;
- (ii) Staffing:
 - (1) A designated supervising practitioner must be responsible for the care provided in a therapeutic group home (ThGH) program and the clinical supervision of direct care staff. The supervising practitioner must be present on a regularly scheduled basis and must assume responsibility for all beneficiaries. Psychotherapy and substance use disorder counseling services must be provided by clinical staff who are operating within their scope of practice and under the direction of the supervising practitioner. The supervising practitioner's personal involvement must be documented in the beneficiary's clinical record;
 - (2) All treatment must be prescribed and conducted under the direction of the supervising practitioner in charge of the program;
 - (3) A therapeutic group home (ThGH) clinical director may be a physician with a specialty in psychiatry, physician, psychologist, advance practice registered nurse (APRN), physician assistant (PA), licensed independent mental health practitioner (LIMHP), or licensed mental health practitioner (LMHP), who is practicing within their scope of practice. Dual licensure is preferred for therapeutic group home (ThGH) services when co-occurring mental health and substance use diagnoses occur. The clinical director may not also serve in the role of the program's therapist;
 - (4) A therapeutic group home (ThGH) therapist may be a psychiatrist, physician, psychologist, provisionally licensed psychologist, advanced practice registered nurse (APRN), physician assistant (PA), licensed independent mental health practitioner (LIMHP), licensed mental health practitioner (LMHP),

or a provisionally licensed mental health practitioner (LMHP) who is working within their scope of practice;

- (5) Therapeutic group home (ThGH) direct care staff must be 20 years of age or older and at least two years older than the oldest resident under the age of 20. Direct care staff must have a high school diploma or equivalent, and must have demonstrated skills and competencies in treatment with beneficiaries with a behavioral health diagnosis, demonstrated by at least one of the following:
 - (a) Bachelor's degree or higher in psychology, sociology, or a related field (preferred);
 - (b) One year of coursework in the human services field; or
 - (c) Two years of recovery experience with demonstrated competencies and skills in the treatment of individuals with a behavioral health diagnosis;
- (6) Staffing ratios must be adequate to meet the individualized treatment needs of the beneficiary and each staff must meet the responsibilities outlined in the staffing requirements. Acceptable hours and ratios include:
 - (a) Direct care staffing ratios must be 1:6 during awake hours and 1:8 during sleep hours. At least one staff member per shift is required to have a current cardiopulmonary (CPR) and first aid certification;
 - (b) A registered nurse (RN) or advanced practice registered nurse (APRN) must be available in person or on-call 24 hours a day, seven days a week, 365 days per year; and
 - (c) The ratio of therapeutic group home (ThGH) therapists to beneficiaries served must be no greater than 1:12;
- (iii) The following criteria must be met for a beneficiary's admission to a therapeutic group home (ThGH) program:
 - (1) The beneficiary must have sufficient need for active 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 treatment available to the beneficiary, treatment in this program must be the best choice for expecting a reasonable improvement in the beneficiary's condition;
- (iv) Before the beneficiary is admitted to the program, a licensed provider must complete an initial diagnostic interview to validate the appropriateness of care;

- (v) 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:
 - (1) The multi-disciplinary team must complete the treatment plan within the first seven days after the beneficiary's admission to the program. The plan must be reviewed and revised by the multi-disciplinary team, including the supervising practitioner, at least every 14 days or more often if necessary; and
 - (2) Changes in the treatment plan must be noted on the treatment planning document. An updated treatment plan must be completed every 14 days, or more frequently, if necessary, to reflect changes in treatment needs. The treatment plan must be signed by the beneficiary and their parent or guardian, and the supervising practitioner for therapeutic group home (ThGH) services. The treatment plan review must be documented on the treatment plan, if required, and in the clinical records;
- (vi) The supervising practitioner must meet personally with the beneficiary for evaluation every 30 days, or more often, as clinically necessary. Reimbursement for the 30-day update visit is not included in the therapeutic group home (ThGH) per diem and can be reimbursed separately as an individual psychotherapy service;
- (vii) Every 30 days a utilization review must be conducted per this chapter. This review must be documented on the treatment plan, and the facility's treatment plan review form. Utilization review is not required for the calendar month in which the beneficiary was admitted;
- (viii) The program must have written documentation of each of the services and treatment modalities available. This includes psychotherapy services, substance use disorder counseling, nursing services, psychological diagnostic services, pharmaceutical services, dietary services, and other therapeutic group home (ThGH) services:
 - (1) The program must have written documentation of how the family-centered requirement in this chapter will be met, including a complete description of any family assessment and family services;
 - (2) The program must have written documentation of how the community-based requirement in this chapter will be met; and

- (3) The program must state the qualifications, education, and experience of each staff member and the therapy services each provides;
- (ix) When brief crisis stabilization is clinically necessary, outpatient observation up to 23 hours 59 minutes in an emergency department or acute hospital may be used as follows:
 - (1) In accordance with the definition of outpatient in this chapter; and
- (x) The program must have a written policy for immediate admission or readmission for appropriate inpatient services when it is clinically necessary. The policy must include a cooperative agreement with a psychiatric or substance use disorder hospital or distinct part of a hospital, as outlined in this chapter. A copy of the cooperative agreement must accompany the provider application and provider agreement.

007.04 COVERAGE CRITERIA FOR THERAPEUTIC GROUP HOMES (ThGH). Nebraska Medicaid covers therapeutic group home (ThGH) services for beneficiaries age 20 and younger when the services meet the requirements in this chapter and the beneficiary has participated in a health check or Early and Periodic Screening, Diagnostic and Treatment (EPSDT) screen. Therapeutic group home (ThGH) services must be prior authorized by Nebraska Medicaid or its designee. The beneficiary must be observed and interviewed by the supervising practitioner at least once every 30 days, or more frequently if clinically necessary, and the interaction must be documented in the beneficiary 's clinical record.

007.04(A) COSTS NOT INCLUDED IN THE THERAPEUTIC GROUP HOME (ThGH) FEE. Therapeutic group home (ThGH) services are reimbursed for the treatment of unlicensed direct care staff who are supervised by a licensed practitioner and work in the therapeutic group home (ThGH) milieu. The following charges may be reimbursed separately from the therapeutic group home (ThGH) fee when the services are medically necessary, part of the beneficiary's overall treatment plan, and are in compliance with other state and federal regulations:

- (i) Direct psychotherapy services provided by the supervising practitioner;
- (ii) Prescription drugs including injectable medications;
- (iii) Direct services performed by a physician, advanced practice registered nurse (APRN), or physician assistant (PA), other than the physician directing the program;
- (iv) All laboratory or physical health diagnostic procedures prescribed by a physician, advanced practice registered nurse (APRN), or physician assistant (PA);

(v) Treatment services for physical injury or illness provided by non-mental health practitioners operating within their scope of practice; and

(vi) Individual psychotherapy services provided by licensed clinicians.

007.04(B) SERVICES NOT COVERED. Payment is not available for therapeutic group home (ThGH) services for beneficiaries:

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

(ii) In long-term care facilities (LTC);

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

(iv) Whose primary diagnosis and functional impairment is acutely psychiatric in nature and whose condition is not stable enough to allow them to participate in and benefit from the program; and

(v) Whose primary diagnosis and functional impairment is due to a developmental disability.

007.05 DOCUMENTATION IN THE BENEFICIARY'S CLINICAL RECORD. All documents submitted to Nebraska Medicaid must contain sufficient information for identification of the beneficiary. In addition to the requirements of this chapter, each beneficiary's medical record must contain the following documentation:

(A) The supervising practitioner's orders;

(B) The treatment plan;

(C) 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 daily. 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;

(D) Documentation indicating compliance with all requirements in this chapter;

(E) Records of the treatment plan review by the multi-disciplinary team including attendees and decisions;

(F) The program's utilization review committee's abstract or summary; and

(G) The discharge summary.

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

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

007.07(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.

007.07(B) UTILIZATION REVIEW OVERVIEW. An overview of the program's utilization review process must be submitted with the provider application and provider 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 be not less than once a month;
- (iii) The type of documentation to be kept; and
- (iv) The arrangement for committee reports and their dissemination, including how the program and supervising practitioner is informed of the findings.

007.07(C) UTILIZATION REVIEW COMMITTEE. The utilization review committee must contain a licensed provider who is able to diagnose and treat major mental illness within their scope of practice and at least two clinical staff professionals, as defined in this chapter. 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 beneficiary 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.

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

- (i) The identification of the 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's plan of treatment; and
- (vi) Other supporting materials the group may deem appropriate.

007.07(E) CONTENTS OF REPORT. 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 and dated. The supervising practitioner must sign and date all of their 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, or both; and
 - (3) Disapproval of continued treatment;
- (iv) The date of the review;
- (v) The names of the program utilization review committee members;
- (vi) The date of the next review if continued treatment is recommended; and
- (vii) A copy of the admission review and the extended stay review must be attached to all claims for mental health services submitted to Nebraska Medicaid for payment.

007.08 DOCUMENTATION FOR CLAIMS. The following documentation is required for all claims for therapeutic group homes (ThGH) and claims must be kept in the beneficiary's record. Additional documentation from the beneficiary's medical record may be requested by Nebraska Medicaid prior to considering authorization of payment.

- (A) A psychiatric assessment with mental status exam and diagnosis;
- (B) The treatment plan for admission and every 30 days thereafter;
- (C) Orders by the supervising practitioner;
- (D) A complete family assessment;
- (E) Nurse's notes;
- (F) Progress notes for all disciplines; and
- (G) All claims are subject to utilization review by Nebraska Medicaid prior to payment.

007.09 PROCEDURE CODES AND DESCRIPTIONS FOR MENTAL HEALTH OR SUBSTANCE USE DISORDER THERAPEUTIC GROUP HOMES (ThGH). Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT); procedure codes used by Nebraska Medicaid are listed in the Nebraska Medicaid Practitioner Fee Schedule.

008. INPATIENT PSYCHIATRIC SERVICES FOR BENEFICIARIES UNDER AGE 19 IN PSYCHIATRIC RESIDENTIAL TREATMENT FACILITIES (PRTF).

008.01 PSYCHIATRIC RESIDENTIAL TREATMENT FACILITIES (PRTF) FOR CHILDREN AND ADOLESCENTS. A Psychiatric Residential Treatment Facility (PRTF) is a facility that provides inpatient psychiatric services to beneficiaries under the age of 19. A Psychiatric Residential Treatment Facility (PRTF) must provide the inpatient psychiatric services under the direction of a physician or advanced practice registered nurse (APRN), must be accredited, and must comply with all the requirements of applicable state and federal regulations.

008.02 PRIOR AUTHORIZATION. In order for an admission to a Psychiatric Residential Treatment Facility (PRTF) to be reimbursed by Nebraska Medicaid, the beneficiary must have a certification of need for services as set forth in this chapter and be prior authorized by Nebraska Medicaid or its designee. Prior authorization applies to all admissions described in this chapter.

008.03 CERTIFICATION OF NEED FOR SERVICES. A team certifying need for services must certify, prior to admission, that:

- (A) Ambulatory care resources available in the community do not meet the treatment needs of the beneficiary;
- (B) Proper treatment of the beneficiary's psychiatric condition requires services on an inpatient basis under the direction of a physician or advanced practice

registered nurse (APRN); and

- (C)The services can reasonably be expected to improve the beneficiary's condition or prevent further regression so that the services will no longer be needed.

008.04 TEAM CERTIFYING NEED FOR SERVICES. Certification of need for services must be made by an independent team which includes a physician or advanced practice registered nurse (APRN); has competence in diagnosis and treatment of mental illness, preferably in child psychiatry; and has knowledge of the beneficiary's situation.

008.04(A) INDIVIDUALS WHO BECOME ELIGIBLE FOR NEBRASKA MEDICAID WHILE IN PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY (PRTF). For an individual who applies for Nebraska Medicaid while in the Psychiatric Residential Treatment Facility (PRTF), the certification must be made by the team responsible for the plan of care as specified in this chapter and cover any period before application for which claims are made.

008.04(B) EMERGENCY ADMISSIONS. For emergency admissions, the certification must be made by the team responsible for the plan of care within 14 days after admission.

008.05 ACTIVE TREATMENT. Inpatient psychiatric service must involve active treatment which means implementation of a professionally developed and supervised individual plan of care, as described in this section, which is developed and implemented no later than 14 days after admission and is designed to achieve the beneficiary's discharge from inpatient status at the earliest possible time.

008.06 INDIVIDUAL PLAN OF CARE. The plan of care means a written plan developed for each beneficiary to improve their condition to the extent that inpatient care is no longer necessary. The plan of care must:

- (A)Be based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral and developmental aspects of the beneficiary's situation and reflects the need for inpatient psychiatric care;
- (B)Be developed by a team of professionals specified in this section, in consultation with the beneficiary and their parents, legal guardian, or others in whose care the beneficiary will be released after discharge;
- (C)State treatment objectives;
- (D)Prescribe an integrated program of therapies, activities, and experiences designed to meet the objectives; and
- (E)Include post-discharge plans and coordination of inpatient services with partial discharge plans and related community services to ensure continuity of care with the beneficiary's family, school, and community upon discharge. The discharge plan must:

- (i) Identify the custodial parent or custodial caregiver anticipated at discharge;
- (ii) Identify the school the beneficiary will attend;
- (iii) Include individualized educational program (IEP) recommendations as necessary;
- (iv) Outline the aftercare treatment plan; and
- (v) List barriers to community reintegration, including barriers for the custodial parent or custodial caregiver, and progress toward resolving these barriers since the last review.

008.07 TEAM DEVELOPING INDIVIDUAL PLAN OF CARE.

- (A) The individual plan of care must be developed by an interdisciplinary team of physicians or advanced practice registered nurses (APRN) and other personnel who are employed by, or provide services to beneficiaries in the facility;
- (B) Based on education and experience, the team must be capable of:
 - (i) Assessing the beneficiary's immediate and long-range therapeutic needs, developmental priorities, and personal strengths and liabilities;
 - (ii) Assessing the potential resources of the beneficiary's family;
 - (iii) Setting treatment objectives; and
 - (iv) Prescribing therapeutic modalities to achieve the plan's objectives;
- (C) The team must include, as a minimum, either:
 - (i) A board-eligible or board-certified psychiatrist;
 - (ii) A licensed psychologist and a physician or advanced practice registered nurse (APRN) ; or
 - (iii) A physician or advanced practice registered nurse (APRN) with specialized training and experience in the diagnosis and treatment of mental diseases and a licensed psychologist; and
- (D) The team must also include one of the following:
 - (i) A psychiatric social worker;
 - (ii) A licensed registered nurse (RN) with specialized training or one year's experience in treating mentally ill individuals;
 - (iii) A licensed occupational therapist (OT) who has specialized training or one year of experience in treating mentally ill individuals; or

(iv)A licensed psychologist.

008.08 REPORTS OF EVALUATION AND PLANS OF CARE. A written report of each evaluation and plan of care must be entered in the beneficiary's record:

(A)At the time of admission; or

(B)If the beneficiary is already in the Psychiatric Residential Treatment Facility (PRTF), immediately upon completion of the evaluation or plan.

008.09 REVIEW OF PLAN OF CARE. The plan of care must be reviewed every 30 days by the team as specified in this section, to:

(A)Determine that services being provided continue to be required on an inpatient basis; and

(B)Recommend changes in the plan as indicated by the beneficiary's overall progress from the treatment provided at this level of care.

008.10 TREATMENT SERVICES PROVIDED BY THE PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY (PRTF). Providers of Psychiatric Residential Treatment Facility (PRTF) services must provide 40 hours of psychotherapy and other treatment interventions per week. The following services and frequency of services are included in the Psychiatric Residential Treatment Facility (PRTF) rate and must be available to the beneficiary unless clinically contraindicated:

(A)Twice weekly individual psychotherapy or substance use disorder counseling, or both;

(B)Minimum three times a week group psychotherapy or substance use disorder counseling, or both;

(C)Weekly family mental health or substance abuse disorder counseling, or both. A family therapy session is provided on the day of admission and the day prior to discharge;

(D)Occupational therapy (OT) as clinically indicated;

(E)Physical therapy (PT) as clinically indicated;

(F)Speech therapy as clinically indicated;

(G)Laboratory services;

(H)Transportation;

(I)Medical services, as necessary; and

(J)Nursing service availability seven days a week, 365 days a year by an onsite nurse during awake hours and by an on-call availability during sleep hours.

008.11 PSYCHOEDUCATION SERVICES PROVIDED IN PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY (PRTF). Psychoeducational services must be available from the Psychiatric Residential Treatment Facility (PRTF) and

must be modified to meet the unique treatment needs of the beneficiary as described in the individual's plan of care:

- (A)Crisis intervention and aftercare planning;
- (B)Life survival skills as clinically indicated;
- (C)Social skills building;
- (D)Substance use prevention interventions;
- (E)Self-care services as clinically indicated;
- (F)Medication education, compliance, and information regarding the effectiveness of medication;
- (G)Health care issues which may include nutrition, hygiene, and personal wellness;
- (H)Vocational and career planning as clinically indicated; and
- (I)Recreational activity, which is not considered in 40 hours per week of therapy but healthful outcomes of recreation and exercise may be a part of a psycho-educational group service.

008.12 INDIVIDUAL PARTICIPATION IN PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY (PRTF) SERVICES. Every beneficiary need not partake in all treatment services that are available in the Psychiatric Residential Treatment Facility (PRTF) if such services are clinically contraindicated. If individual, group, or family psychotherapy services are not appropriately beneficial to the beneficiary's need and plan of care, the plan of care must identify the rationale for this omission. However, in no case should a child or adolescent receive less than 40 hours of Psychiatric Residential Treatment Facility (PRTF) services each week.

008.13 STAFFING STANDARDS FOR PSYCHIATRIC RESIDENTIAL TREATMENT FACILITIES (PRTF). A Psychiatric Residential Treatment Facility (PRTF) must operate 24 hours a day, seven days a week, and 365 days per year with 24-hour awake staffing. Staffing ratios should be 1:4 during awake hours and 1:6 during sleep hours. The following positions are required to be staffed, with a minimum of the stated qualifications.

008.13(A) SUPERVISING PRACTITIONER. The Psychiatric Residential Treatment Facility (PRTF) Supervising Practitioner must be a licensed physician.

008.13(B) PROGRAM OR CLINICAL DIRECTOR. A program or clinical director must be a licensed mental health practitioner (LMHP), licensed registered nurse (RN), licensed advanced practice registered nurse (APRN), licensed independent mental health practitioner (LIMHP), licensed physician with a specialty in psychiatry, or licensed psychologist. Dual-credentialing is required for Psychiatric Residential Treatment Facility (PRTF) services when co-occurring conditions occur. The program or clinical director must have two years professional

experience in a treatment setting similar to a Psychiatric Residential Treatment Facility (PRTF). The program or clinical director may not also serve in the role of the program's therapist.

008.13(C) THERAPIST. A Psychiatric Residential Treatment Facility (PRTF) therapist must be a licensed practitioner whose scope of practice includes mental health or substance use disorder services or both, including a licensed mental health practitioner (LMHP), licensed independent mental health practitioner (LIMHP), provisionally licensed mental health practitioner (LMHP), licensed alcohol and drug counselor (LADC), licensed psychologist, provisionally licensed psychologist, licensed advanced practice registered nurse (APRN), or licensed physician with a specialty in psychiatry.

008.13(D) REGISTERED NURSE (RN) OR ADVANCED PRACTICING REGISTERED NURSE (APRN). Nursing services must be provided by a registered nurse (RN), or Advanced Practice Registered Nurse (APRN) licensed by the state in which they practice.

008.13(E) DIRECT CARE STAFF. Direct care staff must meet the following requirements: Be 20 years of age or older and at least two years older than the oldest resident and have a high school diploma or its equivalent. Direct care staff must be appropriately trained and responsible for basic interaction care as well as assisting in the implementation of the plan of care that is within their scope of practice.

008.14 RESTRAINT AND SECLUSION. Restraint and seclusion activities utilized by the Psychiatric Residential Treatment Facility (PRTF) must be in compliance with federal standards for restraint and seclusion.

008.15 MEDICALLY NECESSARY SERVICES AND SUPPLIES. The following services must be available to the beneficiary and may be billed separately to Nebraska Medicaid:

(A) Medically necessary services and supplies not otherwise included in the Psychiatric Residential Treatment Facility (PRTF) rate when that care is reflected in the plan of care; and

(B) The Psychiatric Residential Treatment Facility (PRTF) must :

(i) Arrange for and oversee the provision of such services and supplies;

(ii) Maintain all medical records of care furnished to the beneficiary; and

(iii) Ensure that all services and supplies are furnished under the direction of a physician or advanced practice registered nurse (APRN).

009. INPATIENT MENTAL HEALTH SERVICES FOR BENEFICIARIES 20 AND YOUNGER IN INSTITUTIONS FOR MENTAL DISEASE (IMD).

Inpatient mental health services in an institution for mental disease (IMD) are available to beneficiaries age 20 and younger when the beneficiary participates in a health check or Early and Periodic Screening, Diagnostic and Treatment (EPSDT) screen, and the treatment is medically necessary. Inpatient mental health services in an institution for mental disease (IMD) must be family centered, and

community based, culturally competent, and developmentally appropriate. Services for children who are wards of the State of Nebraska must be prior-authorized by and consent for treatment must be obtained from the beneficiary's case manager or the case manager's supervisor.

009.01 LEGAL BASIS. Nebraska Medicaid covers institution for mental disease (IMD) services according to federal regulations . Nebraska Medicaid provides institution for mental disease (IMD) services under Nebraska Statute

009.02 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.

009.02(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 disease (IMD) of its provider number.

009.02(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.

009.02(iii) MONTHLY REPORTS. The institution for mental disease (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.

009.02(iv) RECORD REQUIREMENTS. Transfers to another institution for mental disease (IMD) or readmission constitutes a new admission for the receiving facility. The psychiatrist must complete, sign, and date the appropriate form within 48 hours after admission. If beneficiary applies for assistance while in the facility, copies of the admission notes, and plan of care must be attached to the appropriate signed form to certify that inpatient services are or were needed.

009.02(iv)(1) AN INDIVIDUAL WHO APPLIES FOR NEBRASKA MEDICAID WHILE IN THE INSTITUTION FOR MENTAL DISEASE (IMD). For an individual who applies for Nebraska Medicaid while in the institution for mental disease (IMD), the certification must be:

- (a)Made by the team that develops the individual plan of care, in compliance with this chapter ; and
- (b)Cover any period before application for which claims are made.

009.02(iv)(2) PRIOR AND CONTINUED AUTHORIZATION. When Nebraska Medicaid eligibility is determined, authorization for previous and continued care must be obtained from the Nebraska Medicaid contracted peer review organization or management designee.

009.03 INTERDISCIPLINARY TEAM.

009.03(A) COMPOSITION. The team must include a board-certified psychiatrist. The team must also include at least two of the following:

- (i)Licensed mental health practitioner (LMHP);
- (ii)A registered nurse (RN) with specialized training or one year's experience in treating individuals with mental illness;
- (iii)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
- (iv)A clinical psychologist.

-009.04 INSPECTIONS OF CARE. Inspections of care will be conducted as outlined in federal regulations.

009.05 INPATIENT MENTAL HEALTH SERVICES FOR BENEFICIARIES 20 AND YOUNGER IN AN INSTITUTION FOR MENTAL DISEASE (IMD). Nebraska Medicaid covers inpatient mental health services in an institution for mental disease (IMD) for beneficiaries age 20 and younger under federal regulations . The following requirements must be met to receive Nebraska Medicaid payment for these services.

009.05(A) ADMISSION CRITERIA. See requirements in this chapter .

009.05(B) ADMISSION EVALUATION. A psychiatrist must make an admission evaluation when the beneficiary is admitted to the hospital. The admission evaluation must include:

- (i)An initial assessment, within 24 working hours of the admission of the health status and related psychological, medical, social, and educational needs of each individual beneficiary;
- (ii)A determination of the range and kind of services required; and
- (iii)If all admission criteria have been met, this evaluation must include an initial treatment plan.

009.05(C) TREATMENT PLAN REQUIREMENTS.

- (i)The treatment plan must meet the requirements in this chapter and in federal regulations ; and
- (ii)The treatment plan must be developed by the psychiatrist and the interdisciplinary team defined in this chapter .

009.05(C)(1) RECERTIFICATION OF NEED. This review also serves as the recertification of need for services. The individual plan of care must be developed by the facility interdisciplinary team.

009.05(D) PRIOR AUTHORIZATION. Institution for mental disease (IMD) services for beneficiaries age 20 and younger must be prior-authorized.

009.05(D)(1) TRANSFERS. Transfers to another institution for mental disease (IMD) or readmissions constitute a new admission for the receiving facility. This procedure must be followed for each transfer or readmission.

009.05(E) CERTIFICATION OF NEED FOR SERVICES. For persons becoming eligible for Nebraska Medicaid after admission, in accordance with federal regulations , the facility interdisciplinary team must certify that:

- (i) Ambulatory care resources available in the community do not meet the treatment needs of the beneficiary;
- (ii) Proper treatment of the beneficiary's psychiatric conditions requires services on an inpatient basis under the direction of a psychiatrist; and
- (iii) The services can reasonably be expected to improve the beneficiary's condition or prevent further regression so that the services will no longer be needed.

009.05(E)(1) CERTIFICATION PROCEDURE. The certification must be made at the time of admission, or if the individual applies for Nebraska Medicaid while in the institution for mental disease (IMD), before Nebraska Medicaid authorizes payment. This is accomplished by completion of the appropriate Nebraska Medicaid approved confidential report form. The form must be signed by the team physician, psychiatrist, or advanced practice registered nurse (APRN) making the determination. A copy of the physician referral must accompany the completed appropriate Nebraska Medicaid approved confidential report form .

009.05(F) INITIAL CERTIFICATION. A psychiatrist must pre-certify, at the time of admission, that the individual requires inpatient services in a psychiatric hospital. The psychiatrist must complete the appropriate Nebraska Medicaid approved confidential report form at the time of admission or within 48 hours of admission. If the individual applies for Nebraska Medicaid while in a psychiatric hospital, the psychiatrist must certify the individual's needs before Nebraska Medicaid authorizes payment.

009.05(G) SIXTY-DAY RECERTIFICATION. A psychiatrist must recertify, in the beneficiary's record, the beneficiary's need for continued care in an institution for mental disease (IMD) or need for alternative arrangements at least every 60 days after the initial certification.

009.05(H) 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. Care plans must address family involvement. This requirement may be met by completion of the appropriate form, which is retained in the beneficiary's record. The written plan of care must include:

- (i) Diagnoses, symptoms, complaints, and complications indicating the need for admission;
- (ii) A description of the beneficiary's functional level;
- (iii) Objectives;
- (iv) Any orders for:
 - (1) Medications;
 - (2) Treatments;
 - (3) Restorative and rehabilitative services;
 - (4) Activities;
 - (5) Therapies;
 - (6) Social services;
 - (7) Diet; and
 - (8) Special procedures recommended for the beneficiary's health and safety;
- (v) Plans for continuing care, including review and modification of the plan of care;
- (vi) Appropriate medical treatment in the institution for mental disease (IMD) every 60 days;
- (vii) Appropriate social services every 60 days; and
- (viii) Plans for discharge, including referrals for outpatient follow-up care.

009.05(J) REQUIRED PSYCHIATRIST SERVICES. The beneficiary must be treated by a psychiatrist at least six out of seven days, or as medically necessary and the interaction must be documented in the beneficiary's medical record.

009.05(K) 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 30 days. The beneficiary's record must contain documentation of the 30-day

interdisciplinary team review.

009.05(L) ADMISSION EVALUATION. Institution for mental disease (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 :

- (i)The appropriate Nebraska Medicaid approved confidential report form pursuant to this chapter ;
- (ii)A medical evaluation, including:
 - (1)Diagnosis;
 - (2)Summary of current medical findings;
 - (3)Medical history;
 - (4)Mental and physical functional capacity;
 - (5)Prognosis; and
 - (6)The psychiatrist's recommendation concerning the beneficiary's admission to the institution for mental disease (IMD) or the beneficiary's need for continued care in the institution for mental disease (IMD) if the beneficiary applies for Nebraska Medicaid while in the institution for mental disease (IMD) ;
- (iii)A psychiatric evaluation;
- (iv)A social evaluation; and
- (v)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.

009.05(M) DISCHARGE PLANNING. The institution for mental disease (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. The institution for mental disease (IMD) is responsible for discharge planning. In cooperation with community regional mental health programs, the institution for mental disease (IMD) must :

- (i)Initiate alternate care arrangements;
- (ii)Assist in beneficiary transfer; and
- (iii)Follow-up on the beneficiary's alternate care arrangements.

009.05(M)(1) LONG-TERM CARE (LTC) FACILITY STAFF INVOLVEMENT AND TRAINING. 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 disease (IMD) must also contact Nebraska Medicaid .

010. THERAPEUTIC FAMILY CARE SERVICES. Therapeutic family care occurs in a foster home when specially trained foster parents are available at all times to provide consistent behavior management programs. Therapeutic family care services must be community-based, family focused, culturally competent, and developmentally appropriate. Treatment is provided within a family environment with services that focus on improving the beneficiary and family's adjustment emotionally, behaviorally, socially, and educationally. Nebraska Medicaid does not make payment for care that is custodial in nature.

